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Mental Health Services  
Oversight & Accountability Commission

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## Commission Packet

**Commission Teleconference Meeting**  
**January 28, 2021**  
**9:00 AM – 1:00 PM**



Mental Health Services  
Oversight & Accountability Commission

1325 J Street, Suite 1700, Sacramento, California 95814

Phone: (916) 445-8696 \* Email: [mhsoac@mhsoac.ca.gov](mailto:mhsoac@mhsoac.ca.gov) \* Website: [www.mhsoac.ca.gov](http://www.mhsoac.ca.gov)

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## Commission/Teleconference Meeting Notice

**NOTICE IS HEREBY GIVEN** that the Mental Health Services Oversight Accountability and Commission (the Commission) will conduct a **teleconference meeting on January 28, 2021**.

This meeting will be conducted pursuant to Governor Newsom's Executive Order N-29-20, issued March 17, 2020, which suspended certain provisions of the Bagley-Keene Open Meeting Act during the declared State of Emergency response to the COVID-19 pandemic. Consistent with the Executive Order, in order to promote and maximize social distancing and public health and safety, this meeting will be conducted by teleconference only. The locations from which Commissioners will participate are not listed on the agenda and are not open to the public. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

**DATE: January 28, 2021**

**TIME: 9:00 a.m. – 1:00 p.m.**

**ZOOM ACCESS:**

**Link:** <https://zoom.us/j/95178117972>

**Dial-in Number:** 408-638-0968

**Meeting ID:** 951 7811 7972

**Passcode:** 661614

**Public Participation:** The telephone lines of members of the public who dial into the meeting will initially be muted to prevent background noise from inadvertently disrupting the meeting. Phone lines will be unmuted during all portions of the meeting that are appropriate for public comment to allow members of the public to comment. Please see additional instructions below regarding Public Participation Procedures.

**\*The Commission is not responsible for unforeseen technical difficulties that may occur in the audio feed.**

**PUBLIC PARTICIPATION PROCEDURES:** All members of the public shall have the right to offer comment at this public meeting. The Commission Chair will indicate when a portion of the meeting is to be open for public comment. **Any member of the public wishing to comment during public comment periods must do the following:**

- **If joining by call-in, press \*9 on the phone.** Pressing \*9 will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. **When it is your turn to comment, the meeting host will unmute your line and announce the last three digits of your telephone number.** The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.
- **If joining by computer, press the raise hand icon on the control bar.** Pressing the *raise hand* will notify the meeting host that you wish to comment. You will be placed in line to

comment in the order in which requests are received by the host. **When it is your turn to comment, the meeting host will unmute your line and announce your name and ask if you'd like your video on.** The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

### **Our Commitment to Excellence**

The Commission's 2020-2023 Strategic Plan articulates three strategic goals:

- 1) Advance a shared vision for reducing the consequences of mental health needs and improving wellbeing – and promote the strategies, capacities and commitment required to realize that vision.
- 2) Advance data and analysis that will better describe desired outcomes; how resources and programs are attempting to improve those outcomes; and, elevate opportunities to transform and connect programs to improve results.
- 3) Catalyze improvement in state policy and community practice by (1) providing information and expertise; (2) facilitating networks and collaboratives; and, (3) identifying additional opportunities for continuous improvement and transformational change.

### **Our Commitment to Transparency**

Per the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at [www.mhsoac.ca.gov](http://www.mhsoac.ca.gov) at least 10 days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 445-8696 or by emailing [mhsoac@mhsoac.ca.gov](mailto:mhsoac@mhsoac.ca.gov)

### **Our Commitment to Those with Disabilities**

- Pursuant to the American with Disabilities Act, individuals who, because of a disability, need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 445-8696 or by emailing [mhsoac@mhsoac.ca.gov](mailto:mhsoac@mhsoac.ca.gov). Requests should be made one (1) week in advance whenever possible.

## **AGENDA**

**Lynne Ashbeck**  
Chair

**Mara Madrigal-Weiss**  
Vice Chair

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### **Commission Meeting Agenda**

All matters listed as "Action" on this agenda, may be considered for action as listed. Any item not listed may not be considered at this meeting. Items on this agenda may be considered in any order at the discretion of the Chair.

**9:00 AM**      **Call to Order and Welcome**

Chair Lynne Ashbeck will convene the Mental Health Services Oversight and Accountability Commission meeting and make announcements.

**9:05 AM**      **Roll Call**

Roll call will be taken.

**9:10 AM**      **General Public Comment**

General Public Comment is reserved for items not listed on the agenda. No debate nor action by the Commission is permitted on general public comments, as the law requires formal public notice prior to any deliberation or action on agenda items.

- 9:40 AM Action**  
**1: Approve November 19, 2020 MHSOAC Meeting Minutes**  
The Commission will consider approval of the minutes from the November 19, 2020 teleconference meeting.
- Public Comment
  - Vote
- 9:50 AM Action**  
**2: CRDP-California Reducing Disparities Project**  
**Presenters:**
- **Cullen Fowler-Riggs, Health Program Specialist II CDPH, CRDP Lead**
  - **Sosha Marasigan-Quintero, Health Program Specialist I CDPH, CRDP**
  - **Josefina Alvarado Mena, Esq., Chief Executive Officer, Safe Passages**
- The Commission will hear a presentation from representatives of the California Department of Public Health, Office of Health Equity and the Chair of the California Reducing Disparities Project Sustainability Steering Committee on the implementation, evaluation, and sustainability efforts of the CRDP project.
- Public comment
  - Vote
- 10:50 AM 10 Minute Break**
- 11:00 AM Action**  
**3: Schools & Mental Health Report Implementation Plan**  
**Presenter:**
- **Kai Dawn Stauffer LeMasson, Ph.D., Senior Researcher**
- The Commission will consider adopting a plan for implementing recommendations from the report, *Every Young Heart and Mind: Schools as Centers of Wellness*.
- Public comment
  - Vote
- 11:45 AM Action**  
**4: COVID-19 Related Funding Allocation**  
**Presenter:**
- **Toby Ewing, Executive Director**
- The Commission will consider the allocation of \$2.02 million authorized to fortify the public mental health system's response to COVID-19.
- Public comment
  - Vote



**12:40 PM**

**Information**

**5: Governor's Proposed Budget for 2021-2022**

**Presenter:**

- **Norma Pate, Deputy Director**

The Commission will be presented with an update of the proposed budget for Health and Human Services.

- Public comment

**1:00 PM**

**Adjournment**

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# AGENDA ITEM 1

**Action**

**January 28, 2021 Commission Meeting**

**Approve November 19, 2020 MHSOAC Teleconference Meeting Minutes**

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**Summary:** The Mental Health Services Oversight and Accountability Commission will review the minutes from the November 19, 2020 Commission teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

**Presenter:** None.

**Enclosures (2):** (1) November 19, 2020 Meeting Minutes, (2) November 19, 2020 Motions Summary

**Handouts:** None.

**Proposed Motion:** The Commission approves the November 19, 2020 meeting minutes.

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**State of California**

**MENTAL HEALTH SERVICES  
OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Minutes of Teleconference Meeting  
November 19, 2020

MHSOAC  
1325 J Street, Suite 1700  
Sacramento, CA 95814

408-638-0968; Code 085310

Lynne Ashbeck  
Chair  
Mara Madrigal-Weiss  
Vice Chair  
Toby Ewing, Ph.D.  
Executive Director

**Members Participating:**

Lynne Ashbeck, Chair  
Mara Madrigal-Weiss, Vice Chair  
Mayra Alvarez  
Reneeta Anthony  
Ken Berrick  
Sheriff Bill Brown

Keyondria Bunch, Ph.D.  
Itai Danovitch, M.D.  
David Gordon  
Khatera Tamplen  
Tina Wooton

**Members Absent:**

Senator Jim Beall  
John Boyd, Psy.D.  
Assembly Member Wendy Carrillo  
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

## **CALL TO ORDER AND WELCOME**

Chair Lynne Ashbeck called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 10:04 a.m. and welcomed everyone.

Chair Ashbeck reviewed the meeting protocols.

## **ROLL CALL**

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

## **GENERAL PUBLIC COMMENT**

Steve Leoni, consumer and advocate, stated the jail population has been reduced during the COVID-19 pandemic and, as a result, counties have saved millions of dollars. Santa Clara Superior Court Judge Stephen Manley made a plea at the Council on Criminal Justice and Behavioral Health, as county budgets come up, not to let the money go back to the jails, but to use some of that money in the communities to help released individuals and to keep them from reentering the system.

Herman DeBose, Ph.D., former member of the Cultural and Linguistic Competence Committee (CLCC), asked if the CLCC is discussing or making recommendations on the impacts of the COVID-19 pandemic on individuals of color, especially in Los Angeles County.

Chair Ashbeck asked staff to follow up with Dr. DeBose offline.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated in the Assembly Bill (AB) 1315 Early Psychosis Intervention Plus (EPI Plus) Advisory Committee meeting of November 9, 2020, stakeholders raised the possibility of using the leftover \$5.5 million for underserved racial, ethnic, and LGBTQ communities due to the unprecedented impacts of the COVID-19 pandemic and ethnic violence. This was not possible due to the constraints of the legislative language. The speaker noted that public members of the EPI Plus Committee listened to stakeholder concerns and did what they could to accommodate the request. They were supportive of the efforts to alleviate the suffering and disproportionate hardship being experienced by communities. The speaker stated appreciation for the collaborative efforts and hoped for continued joint efforts and successes.

Jim Gilmer thanked the Commission for sending out the recent Student Mental Health Report. It was well-written and had a nice section on reducing disparities for racial and ethnic communities; however, the speaker was concerned about the recommendation for developing school wellness centers, which mentioned universal programs focused on evidence-based practices. The speaker's concern was relative to the wonderful work that has been done through the California Reducing Disparities Project (CRDP) and community-based practices. The speaker suggested providing opportunities for more feedback on the final plan to keep from developing wellness centers without culturally-

congruent practices so the wellness centers will meet needs of local schools and communities of color.

## **ACTION**

### **1: Approve October 22, 2020, MHSOAC Meeting Minutes**

Chair Ashbeck stated the Commission will consider approval of the minutes from the October 22, 2020, teleconference meeting.

#### **Public Comment**

Herman DeBose, Ph.D., referred to the third and fourth bullets on page 17 and asked why the CLCC was not involved in the discussion on the Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). The speaker asked if Los Angeles County was one of the 30 counties that expressed interest in the National CLAS Standards.

Executive Director Ewing stated the Innovation Subcommittee recently had a broader discussion around identifying shared opportunities for Innovation and Innovation funding opportunities for counties to co-invest in Innovations that were of interest across county lines. There is a presentation on that project later in the agenda. He stated he will connect with Dr. DeBose offline for further discussion.

Commissioner Bunch asked to be included in the conversation with Dr. DeBose.

Chair Ashbeck asked for a motion to approve the minutes from the October 22, 2020, teleconference meeting.

Commissioner Alvarez made a motion to approve the October 22, 2020, teleconference meeting minutes.

Commissioner Berrick seconded.

Action: Commissioner Alvarez made a motion, seconded by Commissioner Berrick, that:

- *The Commission approves the October 22, 2020, Teleconference Meeting Minutes as presented.*

Motion carried 6 yes, 0 no, and 3 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Berrick, Brown, Danovitch, and Gordon, and Chair Ashbeck.

The following Commissioners abstained: Commissioners Anthony, Bunch, and Wooton.

## **ACTION**

### **3: EPI Plus Funds Allocation**

#### **Presenters:**

- Toby Ewing, Executive Director
- Tom Orrock, Chief of Commission Grants

Chair Ashbeck stated the Commission will consider recommendations from the AB 1315 Advisory Committee on the allocation of \$5,565,000 of remaining funds from the Early Psychosis Intervention Plus Fund. She asked staff to present this agenda item.

Tom Orrock, Chief of Commission Grants, provided an overview, with a slide presentation, of the background, Advisory Committee recommendations, goals for reducing disparities, and Request for Application (RFA) requirements for the EPI Plus funds allocation.

Executive Director Ewing clarified that the clinical research is not about areas of clinical practice but is more on the issue of the alignment between services, the population being served, and the capacity to expand access.

### **Commissioner Questions**

Commissioner Berrick asked about the concern for evaluation and how it will be substituted.

Mr. Orrock stated the original RFA asked the applicants to include a self-evaluation of 22 areas within their existing programs so that information could be provided to the technical assistance provider to help get the programs to full fidelity. That requirement is not included in the current RFA to make it less burdensome to apply.

Executive Director Ewing added that the first-round funding was only available to counties that have a program in place already. There was a heavy emphasis on fidelity to the model and expanding the impact of those services. In this round, counties with no existing programs can apply.

Commissioner Alvarez asked if there will be an opportunity as part of the application process to include in the eligibility or minimum qualifications for counties to demonstrate relationships with community organizations or previous commitment to working with racial, ethnic, or LGBTQ diverse communities depending on their proposal.

Executive Director Ewing stated there is. He stated there is also opportunity around the outreach, education, and research components to better understand some of the tension between the existing care model and the extent that it does or does not apply to communities of color that have shared that they do not feel that the model is culturally appropriate. The RFA will try to do both.

Commissioner Alvarez stated her understanding that fidelity to the statewide coordinated care model is part of the goal of this RFA, but there will also be some flexibility around community-defined interventions.

Executive Director Ewing stated this question of whether the funding that is designed to access care could be used to support alternative models was raised in the Advisory Committee meeting. The Advisory Committee determined that the intent of the legislation was to grow a statewide model and expand the model that is part of a national strategy.

Executive Director Ewing stated, at the same time, the Advisory Committee recognized that that model may not be appropriate to all parts of the community. There are not enough individuals of color working in this field, which creates a barrier to care for

individuals who do not see staff who look and talk like them or have the same cultural perspective in these programs. Part of the outreach, education, and engagement is to learn how to strengthen the alignment between this model and communities of color. He noted that the other side of this question is whether this model works in communities of color. Part of the funding will be used to research this issue.

Commissioner Wooton stated the workforce and development piece of the RFA mentions hiring peers and staff of color. She encouraged including peer staff members moving forward.

### **Public Comment**

Stacie Hiramoto stated the Advisory Committee voted that each of the priorities in the RFA should be pursued with an explicit focus on reducing racial, ethnic, and LGBTQ disparities. The speaker stated REMHDCO is concerned that, although that is included in the RFA, no language about that specific focus is currently included in the RFA outline.

Mandy Taylor, Outreach and Advocacy Coordinator, California LGBTQ Health and Human Services Network, asked that Commissioners specifically ask staff to include changes like those recommended by Commissioner Alvarez into the RFA. Historically, Commissioners agree that equity issues brought up by the public are important and, although they ask staff if the Request for Proposals (RFP) or RFA allows for these changes and staff assures Commissioners that the changes can or will be made, ultimately, the changes to support marginalized communities are not made. The speaker asked the Commission to make concrete changes to support equity beginning with the RFP and RFA process.

Mandy Taylor pointed out that it is possible to specifically prioritize communities of color and LGBTQ communities within the coordinated specialty care system without creating or appropriating funds for alternative models. The speaker asked that the remaining funds be used to ensure that counties are incorporating and affirming communities within the current coordinated specialty care system.

Mandy Taylor stated the RFA makes no mention of prioritizing communities of color, LGBTQ communities, or other marginalized communities that are least likely to have access. The speaker suggested that the Commission implement the equity initiative with concrete steps like including equity requirements and measurements in every RFP and RFA that it releases beginning with this one. Equity to support diverse communities should not be an option or a possibility of something that can be done but should be a foundational and integral component of every program and policy that is overseen by the Commission.

Laurel Benhamida, Ph.D., Muslim American Society – Social Services Foundation and REMHDCO, echoed the comments of the previous speakers. Dr. Benhamida suggested that the scoring rubric explicitly mention and award points for the kinds of content in the project design mentioned by the previous speakers. Waiting to include this in evaluation is too late. It needs to be in the RFP or RFA and in the scoring rubric.

Dr. DeBose echoed the comments of the previous speakers. The speaker asked how the public can be assured that Commissioner recommendations are made before the RFP or RFA goes out.

Dr. DeBose asked if examples of barriers will be included in the RFA so individuals will better understand what is being referred to. It is important to go beyond the barriers to the public policy that creates those barriers.

Steve Leoni spoke in support of the comments made by the previous speakers. The speaker stated there is an overlap between the population served in many of the full-service partnerships (FSPs) to do street outreach and coordinated specialty care programs. These programs are different from each other. Coordinated specialty care is a national model that is supported strongly while the FSPs are an organic outgrowth of the research of Mark Ragins, M.D., at the Village and adopted via legislation and regulation around the state.

Steve Leoni stated the Commission is the maintainer, defender, and developer of the legacy and heritage of the Mental Health Services Act (MHSA). The speaker suggested taking some of the funding to do research where appropriate and where there is an overlap between populations from FSPs and coordinated specialty care to see if there are things each is doing that would help one or the other.

Poshi Walker, LGBTQ Program Director, Cal Voices, and Co-Director, #Out4MentalHealth, echoed the comments of the previous speakers. The speaker stated the term "minorities" was used while people of color represent at least 60 percent of the California population.

Poshi Walker stated the need to ensure that reducing disparities language be included in the RFA, that counties that respond to the RFA should have to say which marginalized populations they will be serving, and that it should be part of the scoring criteria and be made very clear. It is important when talking about workforce, education, and training (WET) that it is not just workforce expansion but that competency and training be included.

Poshi Walker stated any writing or addressing of racial and ethnic populations have to include LGBTQ communities because LGBTQ individuals exist in all racial and ethnic populations and have disproportionate disparities within those racial and ethnic populations.

Poshi Walker echoed Mandy Taylor's caution to the Commissioners that just seeing an outline or having verbal assurance that recommendations will be included in the RFA or RFP is not enough. The speaker suggested that all Commissioners or a select subcommittee of Commissioners be shown the RFA or RFP before it is released to assure that the wishes of the Commissioners and the public that were promised to be adhered to are adhered to in the document.

Michaela, Social Work Intern, California LGBTQ Health and Human Services Network, supported recommendations made by Stacie Hiramoto, Mandy Taylor, Poshi Walker, and others. The speaker suggested changing the option in the RFA to require partnerships with community-based organizations, universities, or other partners that



serve communities of color and LGBTQ communities. This would prioritize underserved communities that have faced longstanding inequities that have been exacerbated by the COVID-19 pandemic.

Mark Karmatz, consumer and advocate, suggested that peer positions lean toward the professional end rather than coming from a peer purview. Some of the language heard today was offensive because it puts individuals in a step-down position.

Tiffany Carter, Statewide Advocacy Liaison, ACCESS California, a program of Cal Voices, supported statements of the previous speakers. The speaker echoed Dr. DeBose's request about ensuring that the finalized document accurately reflects the language being advocated for. Supporting diverse communities is not optional, especially in California that is made up of multitudes of communities. Every meeting represents the opportunity and responsibility to make changes to the system that will improve care and reduce racial, ethnic, and LGBTQ disparities. The speaker stated, when the individuals, advocates, family members, consumers, and stakeholders who provide public comment see that their recommendations are reflected in documents such as RFPs or RFAs, it strengthens the collaborative bonds and stakeholder engagement, which is at the heart of the MHSA. Additionally, the public can be assured that their voices matter when they come to the table.

### **Commissioner Discussion**

Commissioner Berrick thanked members of the public for the collaborative way in which they gave feedback and the spirit of working together. He stated he likes the idea of a review process for the RFP or RFA in a way that does not compromise or slow the process down.

Chair Ashbeck asked for a motion to adopt the Advisory Committee's recommendations and to direct staff to add language that reflects the feedback received – to include specific attention to the equity issues in the RFA language more explicitly and to engage with community-based organizations with a track record of serving the various groups discussed in the RFA.

Commissioner Alvarez moved the Advisory Committee's recommendations with direction to staff to include specific attention to the equity issues in the RFA language more explicitly and to engage with community-based organizations with a track record of serving the various groups discussed in the RFA.

Commissioner Bunch seconded.

Chair Ashbeck stated the language in the RFA asks for a description of prior work done. She asked to add the words "evidence of" so the RFA will ask for a description and evidence of prior work done. She suggested that the Chair and Vice Chair review the RFA prior to its release.

Commissioners Alvarez and Bunch agreed to Chair Ashbeck's friendly amendments.

Action: Commissioner Alvarez made a motion, seconded by Commissioner Bunch, that:

- *The Commission adopts the Advisory Committee’s recommendations on the allocation of \$5,565,966 from the Early Psychosis Intervention Plus Fund and asks staff to add language to the RFA that reflects the feedback received. That language is to include: (a) specific attention to the equity issues; (b) engaging with community-based organizations with a track record of serving the various groups discussed in the RFA; and (c) the words “evidence of” so the RFA will ask for a description and evidence of prior work done. The Chair or Vice Chair and Commissioner Alvarez are to review the RFA prior to its release.*

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

The following Commissioners voted “Yes”: Commissioners Alvarez, Anthony, Berrick, Brown, Bunch, Gordon, Tamplen, and Wooton, Vice Chair Madrigal-Weiss, and Chair Ashbeck.

## **10-MINUTE BREAK**

## **INFORMATION**

### **3: Staff Report**

#### **Presenter:**

- Toby Ewing, Executive Director

Chair Ashbeck stated Executive Director Ewing will report out on projects underway, county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

Executive Director Ewing presented his report as follows:

#### Personnel

New staff member Anissa Padilla joined the Commission staff since the last Commission meeting.

Two additional staff members will begin in the next few weeks and will be introduced at the January Commission meeting.

#### Meeting Participation

The Research and Evaluation Subcommittee met on November 18<sup>th</sup>.

Staff partnered in Breaking Barriers and participated in the launch of Breaking Barriers this morning.

The third of three Youth Innovation Labs met on November 13<sup>th</sup>.

Words to Deeds met on November 12<sup>th</sup>. Commissioner Brown participated along with staff.

The EPI Plus Committee met twice.

Staff participated in a check-in with Wellbeings, which is the WETA PBS documentary that the Commission is partnering on on children's crisis work. In that meeting, one of the comments made was that the producers had shifted their focus away from the documentary focusing on the voices of experts and instead focusing on individuals who have the expertise of lived experience.

Staff is represented on a national conversation on early psychosis strategies. The state of Massachusetts put together an advisory committee, which Executive Director Ewing serves on, that is having similar conversations as part of that process around better align early psychosis services with communities of color.

### Upcoming Meetings

The Rules of Procedure Subcommittee meeting is scheduled for December 2<sup>nd</sup>.

The Client and Family Leadership Committee (CFLC) will meet on December 9<sup>th</sup> and among other things will discuss how to deploy the \$2 million in COVID-19 response funding.

Executive Director Ewing will be presenting before the Council on Criminal Justice and Behavioral Health on December 11<sup>th</sup> on the Commission's work on criminal justice diversion and COVID-19 response.

Staff will participate in a criminal justice diversion conference in the second week of December.

The state's Behavioral Health Task Force is meeting on January 7<sup>th</sup>.

Staff is part of the National Action Agenda conversation that is happening on January 25<sup>th</sup> about interoperability.

### Innovation Plan Approval

The Commission delegated authority to the Chair to approve Innovation plans if they are less than a certain dollar threshold. Since the last meeting, the Chair approved a San Mateo County Innovation plan to co-locate the prevention and early intervention services around housing. As with all Innovation plans, staff does an analysis. The county's proposal along with the staff analysis, is widely distributed to all stakeholder contract holders and others who are interested to receive comments. The San Mateo County Innovation plan was approved for \$925,000 over four years and is designed to better connect housing and prevention and early intervention services.

The Chair approved a \$91,000 augmentation to an existing Modoc County Innovation, which is a project to strengthen the county's electronic health record.

### COVID-19 Response Funding

Staff will present at the December 9<sup>th</sup> CFLC meeting for feedback and possibly at the January Commission meeting on the Commission's efforts to assess the impacts of the COVID-19 pandemic on mental health.

Staff has received nearly 300 responses to a survey asking for information on how the COVID-19 pandemic has impacted communities and the mental health system and the kinds of opportunities that stakeholders see to use the \$2 million COVID-19 response

funding to better align the work with new priorities, given the context of COVID-19 and the economic impacts it has had for communities. Staff will provide a report at the January Commission meeting.

#### Governor's Office of Planning and Research

The Commission has been asked to partner with the Governor's Office of Planning and Research (OPR) along with other state and statewide agencies and organizations, in an effort to strengthen opportunities to engage diverse communities around health care goals as part of a national strategy linked to the OPR's work on precision medicine. Staff is talking with the OPR about how the Commission can support their efforts to connect with diverse communities, particularly working with the stakeholder contractors who are doing some of this work around mental health.

#### Fiscal Transparency Tool

Progress is being made on the fiscal transparency work. The data has not been updated in the fiscal transparency tool for approximately 18 months. Staff has been in negotiations with the Department of Health Care Services (DHCS) and the counties to understand the new way in which they are presenting the data. There are discrepancies in the fiscal data that is publicly reported by the DHCS. The goal is to develop a single set of numbers that are trusted, valid, and reliable over time for all counties with a level of detail that the Commission and stakeholders look for in terms of available funding, funding received, and funding spent, which is essential to support the community planning process. Staff will provide a report at the January or February Commission meeting.

#### Project Portfolio

Staff needs to get better at efficiently streamlining and sharing its portfolio of projects so Commissioners can see the decisions that come in front of them on a given day in the context of the broader workload to help staff see opportunities to connect the work such as between the early psychosis work and the school mental health work.

### **Commissioner Questions and Discussion**

Chair Ashbeck stated sharing the portfolio of projects will add to the engagement of stakeholders.

Commissioner Alvarez asked for an update on the COVID-19 response funding.

Executive Director Ewing stated staff has sent out a survey to partners on challenges, opportunities, and priorities and how to make the best use of the \$2 million COVID-19 response funding. The Commission asked the Legislature to give the Commission authority to renegotiate ways in which counties are prioritizing funding, if needed, and to skip prepayment of certain obligations and instead to be used to strengthen the COVID-19 response. Staff will provide a report on the survey response at the December 9<sup>th</sup> CFLC meeting for feedback and possibly at the January Commission meeting.

Commissioner Bunch asked if there is a database to learn the status of different Innovation projects that were approved.

Executive Director Ewing stated learning from past Innovation plans has been a perennial challenge in part due to time limitations. It is part of what will be addressed in the portfolio of projects. The next agenda item is one of the first opportunities the Commission has had to hear an update on a past Innovation plan and to encourage other counties to take that plan and move it to scale. The Innovation Subcommittee has been discussing ways to improve understanding of those shared opportunities.

Commissioner Anthony asked about the amount of funding from the MHSA that has been moved over to the State of California Business, Consumer Services, and Housing Agency.

Executive Director Ewing stated he will provide that information to Commissioners offline. He noted that it is annually updated on January 15<sup>th</sup>.

Commissioner Anthony asked that the new January 15<sup>th</sup> figure be posted on the website along with where that information can be found.

### **Public Comment**

Mandy Taylor highlighted staff who have done a great job reaching out to the stakeholder advocates and ensuring that communities are able to get involved in these projects.

Poshi Walker stated the Rules of Procedure Subcommittee meeting is not listed on the website. The speaker asked that the dates and times of these types of meetings be published as soon as possible.

Poshi Walker stated appreciation for renegotiating contracts because of the COVID-19 pandemic, including the stakeholder contracts. The speaker suggested an agenda item to look at the stakeholder contracts and to provide the opportunity for the public and Commissioners to make recommendations to help them meet the needs of communities during the COVID-19 pandemic.

Stacie Hiramoto requested that the COVID-19 response funding update be presented to the CLCC along with the CFLC to shorten the number of public commenters at the next Commission meeting. The speaker stated appreciation for sending out the survey on the COVID-19 funding.

Hector Ramirez, consumer and advocate, discussed data inaccuracy as it pertains to the community planning process, particularly in Los Angeles County. The speaker stated the data their county utilizes is outdated and inaccurate particularly in highlighting the disparities that are happening in Latinx, black and African heritage, Native American, Asian/Pacific Islander, and LGBTQ communities. The speaker stated stakeholders cannot make accurate recommendations on county three-year plans due to the faulty data, particularly as it relates to the COVID-19 pandemic and the significant disparities happening in communities. The speaker advocated for a needs assessment to look at the current needs of communities. Inaccurate information harms the community. The speaker suggested that the Commission recommend that the data it is being given to make decisions is current and accurate.

## **INFORMATION**

### **4: Solano County's Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) Innovation Project**

#### **Presenters:**

- Tracy Lacey, LMFT, Senior Mental Health Services Manager-MHSA Coordinator, Solano County Department of Health and Social Services Behavioral Health Division
- Sergio Aguilar-Gaxiola, M.D., Ph.D., Director, Center for Reducing Health Disparities, Professor of Clinical Internal Medicine, UC Davis Health

Chair Ashbeck stated the Commission will hear an update on the progress made on the ICCTM Innovation project approved by the Commission on May 28, 2015. She asked the project representatives to present this agenda item.

Sergio Aguilar-Gaxiola, M.D., Ph.D., Director, Center for Reducing Health Disparities, Professor of Clinical Internal Medicine, UC Davis Health, provided an overview, with a slide presentation, of the ICCTM Project background, goals, and evaluation of the five-year three-phase MHSA Innovation Project. He stated the project is anchored in the nationally recognized Culturally and Linguistically Appropriate Services (CLAS) Standards and is the first project of its kind combining the CLAS Standards with community engagement.

Tracy Lacey, LMFT, Senior Mental Health Services Manager-MHSA Coordinator, Solano County Department of Health and Social Services Behavioral Health Division, continued the slide presentation and discussed the 14 culturally and linguistically relevant quality improvement (QI) action plans, highlighted current QI action plan activities such as LGBT ethnic posters, school-based wellness centers, a county resource guide, and workforce development, and reviewed the ICCTM outcomes. She stated it is important to note that the ICCTM Project has been significantly impacted by the COVID-19 pandemic since many QI action plans involve engagement with the community.

#### **Commissioner Questions and Discussion**

Commissioner Alvarez commended the county for putting the CLAS Standards into practice. She asked for further details on the evaluation of these efforts, especially around the wellness centers, the data, and the call centers and how to measure the impacts of the public education campaign and other resources.

Ms. Lacey stated five school-based wellness centers were opened prior to the COVID-19 pandemic and school closures, and 30 additional wellness centers have since been funded, set up, and are ready for students to go back to school. In the meantime, virtual wellness rooms have been developed. She stated data has yet to be collected due to school closures but good outcomes are anticipated once the schools reopen.

Dr. Aguilar-Gaxiola added that the county and UC Davis have good evaluation teams that take into consideration what matters to the community. The evaluation plans are

tailored to each QI action plan and are community-, outcome-, and sustainability-driven. Detailed reports are provided listing the specific indicators for each QI action plan.

Ms. Lacey stated the total number of calls to the access line for new services in 2020 was 2,502. In fiscal year 2014-15, the total number of calls was 1,713. She stated there are quick response (QR) codes and web shorteners on the posters that will take individuals to a subpage of the website specific to their community of interest with access line, crisis, and other resource information. She stated the number of hits to those subpages are tracked. Also, the access line includes questions about how individuals learned about these services. This information will be tracked closely as the posters are live and in the community.

Commissioner Alvarez asked if committing to equity as a county happened prior to this project or if it was on a parallel timeline. It is important that they are simultaneous conversations. The work to advance mental health and wellbeing in communities has to be aligned with the work to advance racial equity.

Ms. Lacey stated, simultaneously to the launching of this project, the individuals in public health and behavioral health providers were trained in the Government Alliance on Race and Equity (GARE). While the GARE team is doing work at the Department level, staff at the wellness centers are being trained in advancing health equity, which is being implemented into the county's 40-hour crisis intervention team training. She stated other county departments will soon be joining the team, and an equity committee to the board of supervisors is being considered.

Chair Ashbeck asked about the amount of funding required for the school-based wellness centers.

Ms. Lacey stated approximately \$950,000 was invested in the furnishings, wall hangings, and supplies for all 35 school-based wellness centers. She noted that this also includes funding the Office of Education to provide the support for the wellness centers.

### **Public Comment**

Mark Karmatz announced that the Project Return Peer Support Network currently has job openings for regional coordinator and warmline workers.

Karen Vicari, Director of Policy, Cal Voices, asked why the penetration rates were so high in 2013-14. The speaker suggested that other counties that implement this plan incorporate an advocacy or training component or tie the outreach into the county community planning process to build on this outreach to get communities more active in the process. The speaker stated there is more learning to be done on the evaluation piece for advocates and other counties. The speaker suggested learning about beliefs, values, and barriers to seeking care that were found in the focus groups and making that information public.

Karen Vicari stated this project was presented in the meeting materials as an opportunity for counties to model this or to work together on this. The speaker cautioned that the value of this project is that it is localized. If the Commission uses this project to

help other counties, the speaker suggested that it remain very localized and that each county will go into their diverse populations to find its unique needs.

Mandy Taylor stated they would love to see this project implemented in every county across the state. The speaker stated they will contact the project representatives offline to discuss collaboration and relationship-building with other counties. The speaker asked how the county is compensating their community members for their expertise, input, and involvement.

Poshi Walker stated the CLAS Standards do not include sexual orientation and gender identity and was glad to hear that the project representatives were aware of that. The speaker stated the hope that the project representatives join them in ongoing advocacy efforts to include the LGBTQ inclusive standards in the National CLAS Standards. The speaker asked to be a part of the sexual orientation and gender identity trainings for county staff and contracted providers.

Dr. DeBose asked about the contributing factor for the county to decide to focus on Latinx and Asian/Pacific Islander populations and if only Latinos and Asians were included in the LGBTQ population. The speaker noted that black transgender individuals have one of the highest incidents of mental health and being killed in this society. The speaker stated they did not understand how the black community was left out as an underserved population. Along with the Innovation Subcommittee, the CLCC should be involved in the process of looking at this project to determine how to utilize resources to ensure that, when looking across the state of California, this project can be reproduced.

Jim Gilmer applauded the county for their strong statements on the website for racial and social equity as it relates to mental health. The speaker spoke in support of this plan and its focus on the populations but stated it is another fragmented attempt to focus on certain populations to the exclusion of others. The speaker stated the CRDP went through this where stakeholders were fighting over funds amongst communities of color when the amount of funding allocated to communities of color was less than 1 percent of MHSOAC funds. This is the real issue.

Jim Gilmer stated the blueprint has been available through the CRDP for years, which is congruent to this study. The speaker stated it is troublesome that everyone is still here doing similar reports when the CRDP has been pitching the same message for years that the problem is about the lack of resources. In this report there is no mention of the CRDP and that foundation. There is much to build upon and all communities of color can be reached if the decision is made to look at the resources and target them appropriately so everyone is not fighting amongst themselves.

Stephanie Franco, California Pan-Ethnic Health Network (CPEHN), spoke in support of the project as a backbone for the diverse racial and ethnic community stakeholder contracts. The speaker urged the Commission to use the tools at their disposal to ensure that counties are using their Innovation dollars to take a population-specific approach. A one-size-fits-all approach does not work. Culture is essential to addressing communities as Solano County has proved.



Kit Wall, Project Director, Words to Deeds, asked how the county is engaging law enforcement and how law enforcement and the forensics population is interfacing.

Mark Karmatz encouraged the Commission to listen to a webinar on culturally and linguistically appropriate services recently put out by Doors to Wellbeing.

Chair Ashbeck asked the project representatives to answer a few of the questions asked during public comment. She asked staff to make the list of questions and the answers available online or put together another network call with the county and others who want to learn more.

Ms. Lacey answered Karen Vicari's question about the values the public identified. She stated three narrative reports by UC Davis based on the health assessment for the three priority populations are listed on the Innovation page of the county website in multiple languages. The county learned from the community where improvements were needed, what their values were, and what needed to be implemented, which helped develop the training that UC Davis provided for the county.

Ms. Lacey answered the questions about why the African American and Native American communities were not chosen for this project. She stated her predecessor and the team at the time was focused on looking at the penetration rates and the communities that were considered underserved in the county. At that time, it was the Latino and Filipino communities and, because there was no data on the LGBTQ community, the team knew that if that data was not being collected, they were not doing a good job of providing culturally-responsive services.

Ms. Lacey stated work groups were done prior to initiating the project. One of them was with the African American community. The county continued to fund the African American Faith-Based Initiative in tandem with this project. The county learned that everything it is doing to improve services and having a cultural lens will improve services for all. The county is transferring lessons learned from this project to other communities that may not have been included in the original project. She acknowledged that the county has a lot of work yet to do.

Ms. Lacey answered the question about the differences in other counties implementing this project. She acknowledged that this project cannot be done in the same way in each community because each community has different populations that are marginalized and need attention. She stated the hope to find a way for counties to at least be more familiar with the CLAS Standards and community engagement practices and with working with communities that are marginalized to find the solutions for that community on how to do things differently and better.

Ms. Lacey stated the county knows this project is not the end-all, be-all. There are many years of institutional racism that one Innovation project cannot undo, but the county is trying to make an effort to learn how to do better.

Dr. Aguilar-Gaxiola assured Dr. DeBose that they are being heard. The first question UC Davis asked when the county approached them was about including African Americans and Native Americans. The county assured that they were including those populations in other efforts.

MHSOAC Teleconference Meeting Minutes

November 19, 2020

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Chair Ashbeck asked staff to continue to engage with Solano County and stakeholders to do a follow-up session or to make the list of questions and the answers available online.

**ADJOURNMENT**

There being no further business, the meeting was adjourned at 1:28 p.m.



**Motions Summary**

**Commission Meeting  
 November 19, 2020**

**Motion #: 1**

**Date:** November 19, 2020

**Time:** 10:29 AM

**Motion:**

The Commission approves the October 22, 2020 meeting minutes as presented.

**Commissioner making motion:** Commissioner Alvarez

**Commissioner seconding motion:** Commissioner Berrick

Motion carried 6 yes, 0 no, and 3 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Berrick	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Boyd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Brown	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Danovitch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Gordon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Tamplen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14. Vice Chair Madrigal-Weiss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**Motions Summary**

**Commission Meeting  
November 19, 2020**

**Motion #: 2**

**Date:** November 19, 2020

**Time:** 11:25 AM

**Motion:**

- The Commission adopts the Advisory Committee’s recommendations on the allocation of \$5,565,966 from the Early Psychosis Intervention Plus Fund and asks staff to add language to the RFA that reflects the feedback received. That language is to include: (a) specific attention to the equity issues; (b) engaging with community-based organizations with a track record of serving the various groups discussed in the RFA; and (c) the words “evidence of” so the RFA will ask for a description and evidence of prior work done. The Chair or Vice Chair and Commissioner Alvarez are to review the RFA prior to its release.

**Commissioner making motion:** Commissioner Alvarez

**Commissioner seconding motion:** Commissioner Bunch

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Berrick	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Boyd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Brown	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Bunch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Gordon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice Chair Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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# AGENDA ITEM 2

Action

January 28, 2021 Commission Meeting

California Reducing Disparities Project (CRDP)

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**Summary:** The Commission will hear a presentation from the California Department of Public Health, Office of Health Equity and the Chair of the California Reducing Disparities Project Cross Population Sustainability Steering Committee on the implementation, evaluation, and sustainability efforts of the CRDP project.

**Background:** Through its Cultural and Linguistic Competence Committee meeting, Early Psychosis Intervention Advisory Committee meeting, and the Client and Family Leadership Committee meeting, and other outreach activities, the Commission has heard broad interest in the activities, accomplishments, and future of the CRDP, whose current funding expires in the Spring of 2022. Recognizing the urgency expressed by the advocates, Commission Chair Lynne Ashbeck extended an invitation to the California Department of Public Health and the CRDP Cross Population Sustainability Steering Committee to present on the project and the request for Commission support and partnership.

The CRDP--one of the original statewide PEI projects funded through the Mental Health Services Act--was developed to address mental health disparities that exist for diverse racial and ethnic populations and LGBTQ+ communities. Disparities exist in the availability and appropriateness of care as well as in access to services that are linguistically and culturally relevant.

Thirty-five community-based organizations serving African American, Asian and Pacific Islander, Latino, Native American and LGBTQ+ communities make up the CRDP Implementation Pilot Projects (IPP). The goal of these projects is to develop and test the effectiveness of interventions specifically designed for the target population so that effective mental health services can be made available to all Californians regardless of race, ethnicity, sexual orientation or gender identity. These interventions are called Community Derived Evidence Based Practices (CDEPs). The current phase of the project, Phase II, was designed to implement the strategies that were developed during the Phase I.

The Office of Health Equity oversees the activities of the thirty-five projects as well as the CRDP statewide and local evaluations. Five technical assistance providers work with each of the population-specific organizations to assist with program development, administration, and evaluation efforts.

**Related Activities of the Commission:** The Commission is engaged in several projects which may provide context for the goal of reducing mental health disparities

for marginalized communities. The Commission may consider how these projects relate to and potentially support the CRDP request.

- Stakeholder Contracts: The Commission has awarded 12 stakeholder contracts to local and statewide organizations for mental health advocacy efforts on behalf of Clients and Consumers, Diverse Racial and Ethnic Communities, Families of Clients and Consumers, Immigrants and Refugees, LGBTQ Communities, Parents and Caregivers, Transition Age Youth, and Veterans. These contracts include a scope of work which delivers local level advocacy efforts. Over the three-year term, more than 90 local-level advocacy events will take place in 37 counties. This approach was adopted in response to feedback from local organizations who expressed the need for assistance in advocating for relevant mental health services in their counties.
- Innovation Incubator: In 2018 the Legislature authorized the Commission to establish an innovation incubator and allocated \$5 million over two years in one-time funds to work with counties to develop innovative approaches to reduce criminal justice involvement of persons with mental health needs. Historically, persons of color and LGBTQ+ persons are arrested at disproportionate rates and often are disproportionately underserved by the behavioral health system.
- Solano County's ICCTM Innovation Project: In November 2020, the Commission heard a report on Solano County's \$6 million Innovation project, approved in May 2015, for their Interdisciplinary and Collaboration Cultural Transformation Model (ICCTM) Innovation Project. The purpose of the project was to enhance community collaboration and engagement with local agencies around mental health services, supports, or outcomes for diverse populations. The project utilized the Culturally and Linguistically Appropriate Services (CLAS) Standards as a guide for achieving culturally proficient services.
- Prevention and Early Intervention (Senate Bill 1004): Senate Bill 1004 (Chapter 843, Statutes of 2018) directs the Commission to establish Prevention and Early Intervention priorities and to develop a statewide strategy for monitoring implementation and effectiveness of Prevention and Early Intervention services. In recent months the Commission has engaged stakeholders from diverse communities to hear of the unique challenges facing unserved and underserved populations, and to discuss ways of overcoming those challenges through expansion of prevention and early intervention services.

**Request for Support:** The presenters will provide information on the specific program goals, evaluation, and efforts of the Cross Population Sustainability Steering Committee to support the programs in future years. The Commission will be asked to support and partner with the CRDP organizations as they seek to; 1) extend the Phase II pilot projects for an additional three years, and 2) identify funds to engage state and county decision makers to create opportunities to scale the CRDP projects as part of the county innovation, prevention and early intervention strategies, and other strategies to reduce racial, ethnic, and LGBTQ+ disparities.

**Presenters:**

- Cullen Fowler- Riggs, Health Programs Specialist II CDPH, CRDP Lead
- Sosha Marasigan-Quintero, Health Programs Specialist I CDPH, CRDP
- Josefina Alvarado Mena, Chair, CRDP Cross Population Sustainability Steering Committee and CEO, Safe Passages CRDP IPP

**Enclosures:** (1) Letters from CRDP and REMHDCO, (2) Invitation Letters, (3) Presenter Bios, (4) CRDP Brochure, (5) Community Mental Health Equity Project CMHEP Factsheet, (6) CMHEP Logic Model, (7) CMHEP Project Domains, and (8) Document with Links to Project Evaluation Guidelines and Outcomes

**Handout:** PowerPoint presented by Office of Health Equity



December 7, 2020

Lynne Ashbeck, Chair  
Mental Health Services Oversight and Accountability Commission  
1325 J Street, Suite 1700  
Sacramento, CA 95814

Dear Chair Ashbeck,

We write to you today on behalf of the 35 members of the of Phase 2 of the California Reducing Disparities Project (CRDP) Coalition, representing five marginalized communities, including African American, Latinx, API, LGBTQ+, and Native American. ***We respectfully request time on the agenda of the January 28, 2021 meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC).*** We have important information to share with the Commission that is a matter of urgency.

All the members and organizations of the CRDP Phase 2 are working diligently to address the urgent mental health needs in our communities. Additionally, we have stretched our organizations to help anchor our communities as the COVID-19 pandemic and the police killings of Black people seared into our memories washed over us.

We are requesting to present at the January MHSOAC meeting because we must secure the support of the Commission in seeking sustainability for the CRDP. The funding for the CRDP runs out in mid-year 2022 and we must find a way to extend the projects under Phase 2, and hopefully begin planning for a Phase 3.

We believe that if the MHSOAC could just see a presentation of the CRDP Phase 2, the Commissioners would consider supporting this ground-breaking project that is even more crucial to reducing disparities and providing desperately needed services to our communities that have been ravaged by the events of 2020. Please allow us an hour to present at the January 28, 2021 Commission meeting.

Please do not hesitate to contact me in the meantime if you have any questions.

Sincerely,

Josefina Alvarado Mena  
Chair  
CRDP Cross Population Sustainability Steering Committee

cc: Members of the MHSOAC  
Toby Ewing, Executive Director, MHSOAC





# REMHDCO

Racial and Ethnic Mental Health Disparities Coalition

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December 14, 2020

Lynne Ashbeck

Chair

Mental Health Services Oversight and Accountability Commission

1325 J Street, Suite 1700

Sacramento, CA 95814

Dear Chair Ashbeck,

The Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), writes today in strong support of the letter sent to you and the other Commissioners by the Cross Population Sustainability Steering Commission of the California Reducing Disparities Project (CRDP), dated December 7, 2020. Echoing the letter, REMHDCO requests that the members of the CRDP Phase II be allowed to present to the full Commission at the upcoming January 28, 2021 meeting.

We believe the CRDP deserves this opportunity because throughout 2019, REMHDCO and other supporters of the CRDP, made a concerted and continual effort to secure backing from the MHSOAC for the CRDP. We went through what we believed was the logical route: through the Commission's Cultural and Linguistic Competence Committee (CLCC). Although an initial presentation by the CRDP was well-received by that committee in September of 2019, there was not another meeting of the full CLCC until July of 2020. The CRDP was not on the agenda of that meeting, and no meeting has been scheduled since then.

The MHSOAC has an amazing opportunity to be on the forefront of ensuring that historically underserved, unserved, and inappropriately served communities have the opportunity to get care in a manner that is most congruent to their needs and preferences. The CRDP Phase 2 participants have shown initial success in reaching

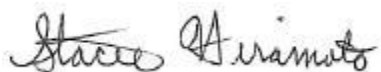
**717 K Street, Suite 232, Sacramento, CA 95814-3477  
(916) 705-5018 [shiramoto@remhdco.org](mailto:shiramoto@remhdco.org)**

and providing services these communities that are usually not adequately or appropriately served by mainstream mental health programs.

Unfortunately, the funding for the CRDP is set to run out in mid-2022, and based on the work that the CRDP has been doing throughout Phase II there is an opportunity to extend this project. By presenting at the January 2021 MHSOAC meeting, the hope is to receive the backing and support of the project, and empower the Executive Director to support the extension legislatively and administratively. Particularly in these difficult times, where historically underserved communities have been detrimentally impacted by COVID-19, the CRDP can be another beacon of hope for equitable mental health services for these communities.

REMHDCO believes that if the MHSOAC could just see a presentation of the CRDP Phase 2, the Commissioners would consider supporting this ground-breaking, world class project. Mental health providers and advocates around the county are watching to see how California proceeds. Racial, ethnic, and LGBTQ communities have been ravaged by the events of 2020. Considering that, we hope you will grant this request. Please allow the CRDP at least an hour to give a presentation at the January 28<sup>th</sup>, 2021 Commission meeting. Thank you!

Sincerely,

A handwritten signature in cursive script that reads "Stacie Hiramoto".

Stacie Hiramoto  
Director

cc: Members of the MHSOAC  
Toby Ewing, Executive Director, MHSOAC



STATE OF CALIFORNIA  
GAVIN NEWSOM, Governor



WELLNESS • RECOVERY • RESILIENCE

LYNNE ASHBECK  
Chair

January 14, 2021

MARA MADRIGAL-WEISS  
Vice-Chair

Ms. Marina Castillo-Augusto, MS  
Chief, Community Development and Engagement  
California Department of Public Health, Office of Health Equity  
1616 Capitol Avenue  
Sacramento CA 95814

MAYRA ALVAREZ  
Commissioner

RENEETA ANTHONY  
Commissioner

Letter sent via email

JIM BEALL  
Senator  
Commissioner

Dear Ms. Castillo-Augusto:

KEN BERRICK  
Commissioner

Thank you for meeting with Commission staff and agreeing to have a representative from the Office of Health Equity present on the California Reducing Disparities Project (CRDP) at the Commission's January 28th meeting. Your presentation will help to set up a discussion among the CRDP stakeholders, Commissioners, and the public about the efforts underway to sustain the programs into the future. This meeting will take place via Zoom and you will be provided pertinent information including the time and meeting link by the end of this week.

JOHN BOYD, Psy.D.  
Commissioner

BILL BROWN  
Sheriff  
Commissioner

As discussed, please plan to present for approximately 15 minutes. Your presentation will be followed by testimony from CRDP stakeholder representative, Josefina Alvarado Mena. We would recommend that you speak specifically on the following topics:

KEYONDRIA D. BUNCH, Ph.D.  
Commissioner

- A background of the CRDP project including populations served, specific accomplishments, and the project timeframe.
- Statewide and local level program evaluation efforts including what you have learned and what you hope to learn.
- Background of the Community Mental Health Equity Project and how the program seeks long-term sustainability by bridging the gap between CBOs and County Behavioral Health Departments.

WENDY CARRILLO  
Assembly Member  
Commissioner

ITAI DANOVITCH, M.D.  
Commissioner

We ask that you send a brief biography on the presenter as well as related materials such as Fact Sheets and information on the Community Mental Health Equity Project to Tom Orrock [tom.orrock@mhsaac.ca.gov](mailto:tom.orrock@mhsaac.ca.gov) by Thursday, January 14th so that we can prepare our meeting agenda and Commissioner packet.

DAVID GORDON  
Commissioner

GLADYS MITCHELL  
Commissioner

Should you have any questions, I can be reached at [toby.ewing@mhsaac.ca.gov](mailto:toby.ewing@mhsaac.ca.gov) or you may contact Mr. Orrock directly. Thank you again for your willingness to present on this important work.

KHATERA TAMPLIN  
Commissioner

TINA WOOTON  
Commissioner

Respectfully,

TOBY EWING  
Executive Director

Toby Ewing, Ph.D.  
Executive Director



STATE OF CALIFORNIA  
GAVIN NEWSOM, Governor



WELLNESS • RECOVERY • RESILIENCE

January 11, 2021

LYNNE ASHBECK  
Chair

MARA MADRIGAL-WEISS  
Vice-Chair

MAYRA ALVAREZ  
Commissioner

RENEETA ANTHONY  
Commissioner

JIM BEALL  
Senator  
Commissioner

KEN BERRICK  
Commissioner

JOHN BOYD, Psy.D.  
Commissioner

BILL BROWN  
Sheriff  
Commissioner

KEYONDRIA D. BUNCH, Ph.D.  
Commissioner

WENDY CARRILLO  
Assembly Member  
Commissioner

ITAI DANOVITCH, M.D.  
Commissioner

DAVID GORDON  
Commissioner

GLADYS MITCHELL  
Commissioner

KHATERA TAMPLIN  
Commissioner

TINA WOOTON  
Commissioner

TOBY EWING  
Executive Director

Ms. Josefina Alvarado Mena J.D., Chair  
CRDP Cross Population Sustainability Steering Committee

Letter sent via email

Dear Ms. Alvarado Mena:

In response to your communication, the Chair of the Mental Health Services Oversight and Accountability Commission requests that you present on the California Reducing Disparities Project (CRDP) at the Commission's January 28, 2021 meeting.

Your presentation will provide the Commission and the public with information regarding the implementation of CRDP programs, specific accomplishments, and testimony regarding the need for continued funding to sustain the programs into the future. In your presentation, we ask that you provide a short overview of your involvement in the project and the approach used by the 35 community organizations to reduce mental health disparities for the five specific populations: African Americans; Asians and Pacific Islanders; Latinos; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning communities; and Native Americans.

We would recommend that you speak specifically on the following topics:

- The approach used by the CRDP programs to reduce mental health disparities in the five target populations.
- How the programs can fulfil the goals of the MHSA related to culturally competent mental health care.
- The Sustainability Steering Committee's challenges in securing additional funding to continue the projects including specific barriers to funding at the local level.
- The specific request to the Commission for its support regarding any legislative proposals to extend or expand the work of the CRDP.

As discussed, please plan to limit your prepared remarks to no more than 15 minutes to allow sufficient time for dialogue with Commissioners. Your presentation will follow a project overview from the Office of Health Equity on the background of the CRDP, the evaluation efforts underway, and the Community Mental Health Equity Project. Following both presentations, we will have Commissioner questions and a public comment period.

This meeting will take place via Zoom. All pertinent information, including the time and meeting link, will be provided by the end of this week.

We ask that you send your brief biography as well as related materials such as the CRDP Sustainability Executive Summary program descriptions that we can distribute publicly. Please provide those materials by Thursday, January 14<sup>th</sup> to Tom Orrock at [tom.orrrock@mhsoac.ca.gov](mailto:tom.orrrock@mhsoac.ca.gov) so that they can be included in the posted meeting agenda and information packets.

We also request that you share by Tuesday, January 19<sup>th</sup> any prepared materials, such as PowerPoint slides, you intend to present so that we may provide them to Commissioners and the public in advance of the meeting, as well as a link to the video – if any – that you will use in presentation. If possible, we would also like to have a transcript of the video content to support accessibility to the material for persons who may be hearing impaired.

Should you have any questions, I can be reached at [tooby.ewing@mhsaoc.ca.gov](mailto:tooby.ewing@mhsaoc.ca.gov) or you may contact Mr. Orrock directly. Thank you again for your willingness to present on this important work.

Respectfully,

A handwritten signature in blue ink that reads "Toby Ewing". The signature is written in a cursive, flowing style.

Toby Ewing, Ph.D.  
Executive Director

**Cullen Fowler-Riggs  
Lead, CRDP**



Cullen Fowler-Riggs is a Health Program Specialist II in the Office of Health Equity (OHE) at the California Department of Public Health (CDPH). Cullen serves as the Lead of the California Reducing Disparities Project (CRDP). He is also the interim LGBTQ Population Lead and Contract Manager, a role he has held since December 2016. Cullen has been employed with the State of California for eleven years, formerly serving as a HIV Surveillance Coordinator for the CDPH, Office of AIDS, and as an Unemployment and Disability Insurance Program Analyst for the Employment Development Department. Cullen's public service career began in 2005 at the City of Stockton as an Assistant to the Grants Manager, where he helped secure funding for citywide projects focused on improving the social determinates of health. It was in this role that Cullen developed a passion for helping unserved/under-served communities through authentic community engagement and a shared vision of success to secure grant funding for programs and projects aimed at improving the lives of the diverse residents of Stockton, California. Cullen holds a Bachelor of Arts in Communications from California State University, Sacramento and a Master of Public Health in Epidemiology from the University of South Florida, Tampa. In his free time, he enjoys gardening, cooking, reading, and traveling with his partner.

## Sosha Marasigan-Quintero, MPA | Brief Bio



Sosha Marasigan-Quintero, MPA is the lead for the Community Mental Health Equity Project (CMHEP) a new mental health effort from The Office of Health Equity. Sosha possesses over 15 years of on the ground experience working directly with California's most vulnerable. This has included farmworkers, disadvantaged communities of color, the LGBT & Queer community, and young & expecting mothers. Sosha is a former workforce development director at a federally qualified health center, has worked in local Sacramento county mental health programs (MHSA) and for the last seven years has implemented public health initiatives at the California Department of Public Health (CDPH) as a high level program specialist working in Cancer Prevention, Tobacco Control, and Home Visiting. Increasing health equity is her passion. Sosha is motivated by her professional proximity working and learning about health outcomes and disparities but more importantly her humble upbringing in California's central valley and strong cultural understanding of impoverished and/or vulnerable communities. Based on her lived and professional experiences, Sosha specializes in the Latino health disparities, women's health, and LGBT health disparities and issues. Sosha holds an MPA from the University of San Francisco and is a combat veteran of the United States Air Force serving tours in both Saudi Arabia and Iraq. Sosha speaks Spanish and most importantly is a boy mommy.

Josefina Alvarado Mena was awarded an Echoing Green Fellowship in 1996 after finishing her J.D. at the University of California, Berkeley School of Law. Josefina used her Echoing Green Fellowship to create the Educational Empowerment Program to provide free legal education and representation to low income students caught in the school to prison pipeline in Oakland, California. During her fellowship, Josefina further developed her legal expertise in education law and civil rights. In 1999, Josefina was recruited by an incoming Superintendent of Oakland Unified School District to head the Department of Student, Family, and Community Services. During her tenure she helped expand after-school programs, violence prevention programs, health services, family engagement, and mental health programs throughout the school district. As director of the department, she also led the effort to develop the Safe Passage Middle School Strategy that resulted in a 72% decrease in suspensions for violence at target high need middle schools in Oakland.

In 2003, Josefina was recruited to lead Safe Passages, a citywide initiative designed to reduce violence among the children and youth of Oakland. Josefina was one of only 5 employees when she arrived at Safe Passages. Currently the organization has a staff of 125 and serves over 4000 children, youth, and families in Oakland and other high need areas of Alameda County. As the Chief Executive Officer for Safe Passages, Josefina has grown the organization from a foundation funded initiative to a leading independent 501(c)(3) Multi-service Nonprofit Organization that implements a continuum of programs that serve children and youth, from birth through college and career. Because of its strong track record of successful innovative intervention programs, Safe Passages was named an Implementation Pilot Program of the California Reducing Disparities Project (CRDP) and currently serves as the Chairperson of the CRDP Cross Population Sustainability Steering Committee.

A native of Oakland, Josefina grew up in one of the neighborhoods served by Safe Passages. She received her B.A. in Ethnic Studies from UC Berkeley in 1993, and a Juris Doctorate from the University of California, Berkeley School of Law in May 1996. She is also a recipient of the following honors and awards: Echoing Green Global Fellowship 1996-1998, Education Advocacy Award 2003, Hispanic Chamber of Commerce of Alameda County; Outstanding Education Advocate 1999, People United for a Better Oakland (PUEBLO); Advocacy Award, California Latino Civil Rights Network 1998, James Irvine Foundation California Leadership Award 2009; and was named a 2016 SEERS (Social Entrepreneurs in Residence at Stanford University) Fellow.





# California Reducing Disparities Project

a culturally responsive mental health initiative





## A Culturally Responsive Mental Health Initiative

California voters have a unique history of anticipating and addressing critical policy issues well ahead of the national curve. With the passage of the Mental Health Services Act in 2004, Californians demonstrated their distinct character and courage in putting our government to work for all its people. We did this by recognizing that the crisis in national health care compels us to define mental health as an essential right, alongside access to medical care and prevention. Painfully, it is a right that has been unevenly recognized and protected among marginalized communities. To make progress, things had to change. We needed to fundamentally reconsider how mental health services were being designed and delivered to our many diverse communities.

*The California Reducing Disparities Project is an unprecedented, historic, cross population solution that has never happened before at a state, national, or international level.*



Photos (clockwise from top left): La Familia Counseling Center, On the Move LGBTQ+ Connection, Two Feathers Native American Family Services, and the Hmong Cultural Center of Butte County

African Americans; Asians and Pacific Islanders (API); Latinx; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ+) communities; and Native Americans are now a plurality in California. Reflecting honestly, it was clear our public health system repeatedly failed these communities. In many cases, the system was contributing to ongoing and historic trauma by reinforcing and enforcing racist and discriminatory policies, procedures and practices. The Mental Health Services Act opened the door for a new generation of practices and policies to begin transforming our assumptions and approach. After many years of funding traditional clinical approaches, this movement produced the California Reducing Disparities Project (CRDP) within the Office of Health Equity, at the California Department of Public Health. The CRDP establishes a platform for community defined evidence-based practices (CDEP) to orient and ground the next generation of care.



*A goal of this project was to build a new body of knowledge coming from these communities. The intended goal was that these communities get the services they need and can most benefit from, and designed by communities that look like them and understand their needs... There had already been lots of research and documentation of why these problems existed. The project was designed to move beyond the defined problems and fund a vision toward new solutions and new approaches.*

*This project was seeking to grow new evidence to address the historical disparities in care and in research. It was designed as a community investment in growing new community-based evidence, from a Community Participatory Research approach. We sought to begin to add to evidence through the evaluation of projects these communities said were effective... But I had no evidence back then!*

*At that time, the Mental Health sector was headed toward funding only “Evidence Based Practices”. Unsurprisingly, our communities also had large disparities in this. ‘Whose Evidence?’ was a popular response. We pushed back on the idea of implementing evidence-based programs not based in our communities. This was another successful advocacy approach for creating the CRDP. We coined the term ‘Community Defined Evidence’ for this project.*

**Rachel Guerrero, LCSW**

Retired Chief, Office Multicultural Service (served 12 years )  
CA Department of Mental Health

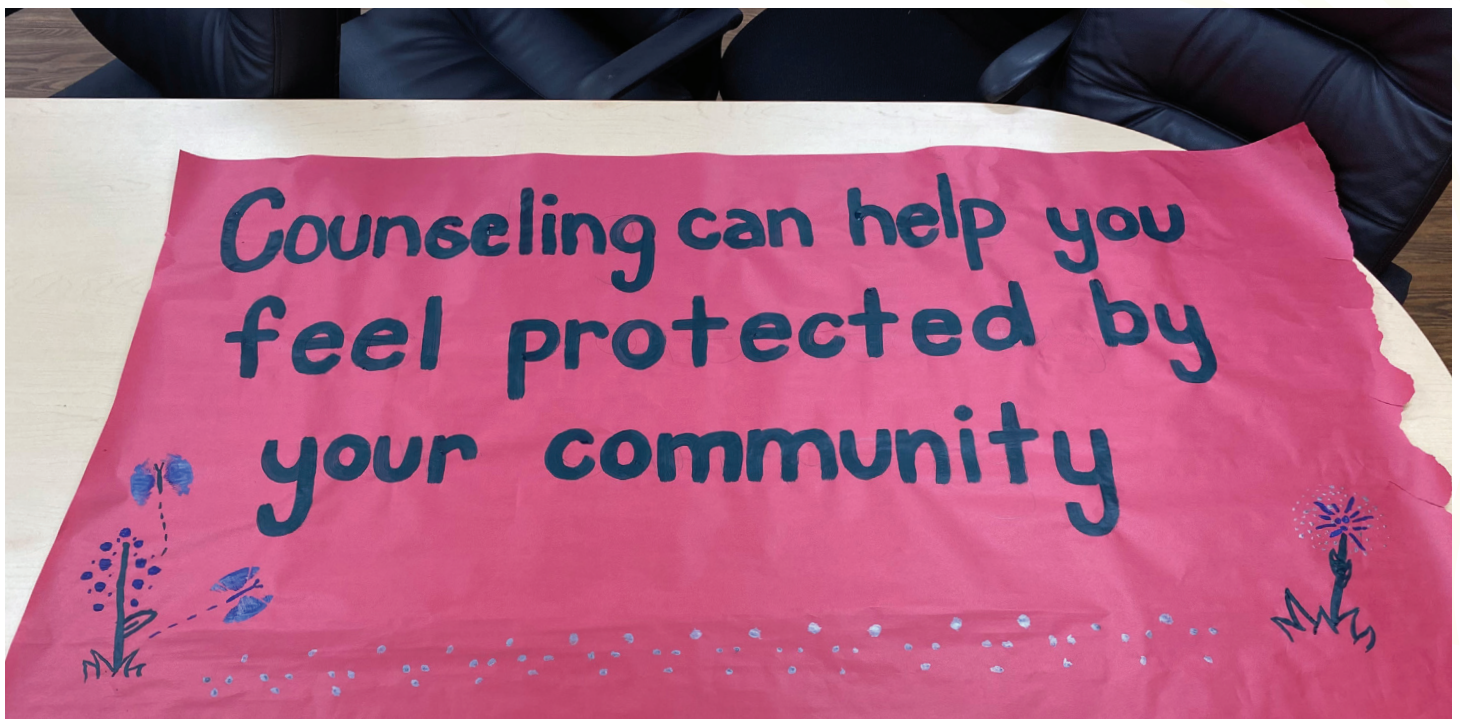


Photo: Indian Health Council, Inc

*Culture is prevention. The Western clinical model is not enough. The CRDP is an opportunity to prove that our traditional practices are effective, including deculturalization and decolonization.*

Drawing stakeholders from all corners of California, the CRDP was an act of hope for the hundreds of contributors who participated. Together they helped to craft, test and communicate the complex questions that the Office of Health Equity considered in its deliberations on reverse engineering the systemic issues confronting the growing needs of our communities. This work, this story, became the expression of our collective democratic voices across five significantly underserved California populations. It became the intersection of public health, public policy, and the public interest. The CRDP before us today is the imprint of this intersectionality, the contours of which define our narrative and distinguish our impact.

## *Initiative Highlights*

1. Mental health disparities across our five population groups are unconscionable, intergenerational, and given the lack of investment, seemingly intractable.
2. California Reducing Disparities Project (CRDP) funds 35 culturally responsive, innovative Implementation Pilot Projects (IPPs) across the state of California working in the five population groups: African American; Latino/x; Asian and Pacific Islander; Native American; and LGBTQ+.
3. IPPs are implementing proven community derived mental health strategies and programs, including but not limited to, Traditional Healers; Life Coaching; Sister Circles; Mindfulness, Radical Inclusivity, and Bilingual/Bicultural Outreach Workers. Collectively, these approaches leverage the historical knowledge and assets of our communities, and improve mental health along the life trajectory.
4. The goal of the CRDP is to simultaneously demonstrate that community derived mental health practices reduce mental health disparities across the five unserved, underserved, and inappropriately served population groups as opposed to traditionally funded mental health services based on Western clinical models.
5. The state must make a commitment to support, research, implement, and evaluate community defined approaches such as those identified in the five CRDP Population Reports in order to reduce disparities. Intergenerational mental health disparities will remain intractable without a sustained and aggressive level of State investment.
6. COVID-19 exponentially amplifies health disparities across CRDP focus communities. Mental health implications of the pandemic will be acute and broad based but as decades of data demonstrate, clinical mental health strategies will not address the urgent need in African American, Latino/x, API, Native American, and LGBTQ+ communities. Now more than ever, California needs to invest in the community base infrastructure and promising practices represented by the CRDP to buffer the state's most vulnerable populations.
7. The state of California's support should go beyond Phase II funding of the CRDP, it must address the new mental health crisis resulting from COVID-19, and leverage all MHA Prevention and Early Intervention investments, state and local, to develop and institutionalize local and statewide infrastructure to support the reduction of mental health disparities in the face of unprecedented need.

## *Mental Health is a Human Right*

Mental health in communities of color and LGBTQ+ is no less essential than our physical and economic well-being. Underrepresented communities have negotiated oppressive systems for generations through culture, agility and resiliency. The strategies cultivated may have masked the underlying negative impacts on their personal and collective mental well-being. Our task is to understand this trauma and create the space for finding a new paradigm to move us forward. The question is how do we demonstrate its importance?

We have to investigate how resources are directed to ensure that everyone has equal access. Our commitment has to be proactive and it has to work for those who need it most. Reducing disparities in this field is not a matter of choice. It is essential for protecting the essential rights and liberties of all Californians. It is also a platform for addressing the structural and systemic inequities which lock people into generational poverty and injustice. Understanding the legacy of racism and discrimination that segregated and regulated opportunities in California and the United States is a first step. Applying these learnings as we move forward allows us to work together with impacted communities to heal.

The hope we place in this work is not offered in a vacuum. We invest it through our relationships embedded in the organizations that serve communities today and have for generations. The program design of the CRDP expresses this by working through community-based organizations on the Implementation Pilot Projects (IPPs). Collectively, the IPPs represent decades of experience and credibility. By building evidence for the models and programs these organizations are running, we have learned lessons on the front lines that can inform policy makers committed to the mental health of their constituents.

CRDP is the culmination of the work in communities, not the excuse for it.

***Culture is healing. Culture is life. Our shared goal is systems change through community defined evidence-based interventions.***

## *Culture is Health*

Cultural awareness is not a slogan. It is a strategy which unlocks community intelligence. The wisdom of listening to those we serve provides an advantage for any system operating with a public mandate, supported by public funding. The problems for mental health service providers are real, the need for resources is extreme. Frontline organizations serving diverse communities do not have the luxury of disengaging. These organizations are compelled to address legacy gaps in funding and focus by recognizing the capacity within our communities to design and activate solutions to the most acute mental health disparities in our state.

The CRPD initiative understands this and builds with a sense of possibility that by incorporating community intelligence into program design and delivery, greater numbers of people will find and engage the resources of the IPPs. These IPPs are more than delivery outlets for funding initiatives. Together they represent decades of experience and community capital, leveraged to advantage California in investing in more effective approaches to addressing the needs of its constituents.

Data driven and highly localized, the IPPs operate in 18 counties in California. Rigorous evaluation and reporting are central to validating the results of these pilots. What we learn must be applied going forward if we have any hope of reducing the mental health disparities in our communities.

***The CRDP is a culturally competent, evaluation and data driven movement that deserves continued funding and support.***



# Implementation Pilot Projects

Organization	County	Assembly District	Senate District	Population
Catholic Charities of the East Bay	Alameda	Asm District 18	Sen District 9	African American
Gender Spectrum	Alameda	Asm District 21	Sen District 9	LGBTQ+
La Clinica de la Raza	Alameda	Asm District 20	Sen District 9	Latino/x
Native American Health Center	Alameda	Asm District 22	Sen District 9	Native American
Safe Passages	Alameda	Asm District 19	Sen District 9	African American
Hmong Cultural Center of Butte County	Butte	Asm District 3	Sen District 4	Asian and Pacific Islander
Integral Community Solutions Institute	Fresno	Asm District 33	Sen District 14	Latino/x
The Fresno Center	Fresno	Asm District 32	Sen District 14	Asian and Pacific Islander
West Fresno Health Care Center	Fresno	Asm District 31	Sen District 14	African American
Two Feathers Native American Family Services	Humboldt	Asm District 2	Sen District 2	Native American
The Center for Sexuality & Gender Diversity	Kern	Asm District 34	Sen District 16	LGBTQ+
California Black Women's Health Project	Los Angeles	Asm District 62	Sen District 35	African American
Cambodian Association of America	Los Angeles	Asm District 70	Sen District 33	Asian and Pacific Islander
United American Indian Involvement, Inc.	Los Angeles	Asm District 53	Sen District 24	Native American
Whole Systems Learning	Los Angeles	Asm District 58	Sen District 32	African American
The Village Project	Monterey	Asm District 29	Sen District 17	African American
LGBTQ Connection, a program of On The Move	Napa	Asm District 4	Sen District 4	LGBTQ+
Korean Community Services	Orange	Asm District 65	Sen District 32	Asian and Pacific Islander
Healthy Heritage Movement	Riverside	Asm District 61	Sen District 31	African American
East Bay Asian Youth Center	Sacramento	Asm District 9	Sen District 6	Asian and Pacific Islander
La Familia Counseling Center	Sacramento	Asm District 7	Sen District 6	Latino/x
Muslim American Society - Social Services Foundation	Sacramento	Asm District 8	Sen District 6	Asian and Pacific Islander
Gender Health Center	Sacramento	Asm District 7	Sen District 6	LGBTQ+
Indian Health Council, Inc.	San Diego	Asm District 75	Sen District 38	Native American
Friendship House Association of American Indians, Inc.	San Francisco	Asm District 17	Sen District 11	Native American
Openhouse	San Francisco	Asm District 17	Sen District 11	LGBTQ+
San Francisco Community Health Center	San Francisco	Asm District 17	Sen District 11	LGBTQ+
San Joaquin County Pride Center	San Joaquin	Asm District 13	Sen District 5	LGBTQ+
Asian American Recovery Services, a program of HealthRIGHT360	San Mateo	Asm District 19	Sen District 13	Asian and Pacific Islander
Indian Health Center of Santa Clara Valley	Santa Clara	Asm District 28	Sen District 15	Native American
Humanidad Therapy & Education Services	Sonoma	Asm District 10	Sen District 2	Latino/x
Latino Service Providers	Sonoma	Asm District 2	Sen District 2	Latino/x
Sonoma County Indian Health Project	Sonoma	Asm District 10	Sen District 2	Native American
Mixteco-Indigena Community Organizing Project	Ventura	Asm District 44	Sen District 19	Latino/x
Health Education Council	Yolo	Asm District 7	Sen District 6	Latino/x

# Location of Pilot Projects in California on California Indian Cultural & Lands Map

The CRDP acknowledges that all of California includes tribal lands, both those recognized and not officially recognized by U.S. governmental entities. This map represents the cultural groups and lands.



\*Map design inspired by the work of Timara Lotak Link, a Chumash artist

# Federally Recognized Native American Tribes in California

Alpine	<b>Washoe Tribe of CA and NV</b>	Mendocino	<b>Cahto Tribe</b>	San Diego	<b>Inaja-Cosmit Band of Mission Indians</b>
Amador	<b>Buena Vista Rancheria of Mi-Wuk Indians</b>	Mendocino	<b>Coyote Valley Band of Pomo Indians</b>	San Diego	<b>Jamul Indian Village</b>
Amador	<b>Ione Band of Miwok Indians of California</b>	Mendocino	<b>Guidiville Indian Rancheria</b>	San Diego	<b>La Jolla Indian Reservation</b>
Amador	<b>Jackson band of of Mi-Wuk Indians</b>	Mendocino	<b>Hopland Band of Pomo Indians</b>	San Diego	<b>La Posta Band of Mission Indians</b>
Butte	<b>Tyme Maidu Tribe- Berry Creek Reservation</b>	Mendocino	<b>Manchester Band of Pomo Indians</b>	San Diego	<b>Los Coyotes Band of Mission Indians</b>
Butte	<b>Enterprise Rancheria</b>	Mendocino	<b>Pinoleville Pomo Nation</b>	San Diego	<b>Manzanita Band of Kumeyaay Nation</b>
Butte	<b>Mechoopda Indian Tribe</b>	Mendocino	<b>Potter Valley Tribe</b>	San Diego	<b>Mesa Grande Band of Mission Indians</b>
Butte	<b>Mooretown Rancheria</b>	Mendocino	<b>Redwood Valley Little River Band of Rancheria of Pomo</b>	San Diego	<b>Pala Band of Mission Indians</b>
Colusa	<b>Cachil DeHe Band of Wintun Indians of the Colusa Indian Community</b>	Mendocino	<b>Round Valley Reservation</b>	San Diego	<b>Pauma Band of Mission Indians</b>
Colusa	<b>Cortina Rancheria</b>	Mendocino	<b>Sherwood Valley Rancheria</b>	San Diego	<b>Rincon Band of Luiseno Indians</b>
Del Norte	<b>Elk Valley Rancheria</b>	Modoc	<b>Alturas Rancheria</b>	San Diego	<b>Rincon Band of Luiseno Indians</b>
Del Norte	<b>Resighini Rancheria</b>	Modoc	<b>Cedarville Rancheria</b>	San Diego	<b>San Pasqual Band of Diegueño Mission Indians</b>
Del Norte	<b>Tolowa Dee-ni Nation</b>	Mono	<b>Fort Bidwell Reservation</b>	San Diego	<b>Sycuan Band of the Kumeyaay Nation</b>
Del Norte	<b>Yurok Tribe of California</b>	Mono	<b>Bridgeport Indian Colony</b>	San Diego	<b>Viejas Band of Kumeyaay Indians</b>
El Dorado	<b>Shingle Springs Band of Miwok Indians</b>	Placer	<b>Benton Paiute Reservation</b>	San Diego	<b>California Valley Miwok Tribe</b>
Fresno	<b>Big Sandy Rancheria</b>	Plumas	<b>United Auburn Indian Community</b>	San Joaquin	<b>Santa Ynez Band of Chumash Mission Indians</b>
Fresno	<b>Cold Springs Rancheria</b>	Riverside	<b>Greenville Rancheria</b>	Shasta	<b>Pit River Tribe</b>
Fresno	<b>Table Mountain Rancheria</b>	Riverside	<b>Agua Caliente Band of Cahuilla Indians</b>	Shasta	<b>Redding Rancheria</b>
Glen	<b>Grindstone Indian Rancheria</b>	Riverside	<b>Augustine Band of Mission Indians</b>	Siskiyou	<b>Karuk Tribe of California</b>
Humboldt	<b>Bear River Band of the Rohnerville Rancheria</b>	Riverside	<b>Cabazon Band of Mission Indians</b>	Siskiyou	<b>Quartz Valley Reservation</b>
Humboldt	<b>Big Lagoon Rancheria</b>	Riverside	<b>Cahuilla Band of Indians</b>	Sonoma	<b>Cloverdale Rancheria of Pomo Indians of California</b>
Humboldt	<b>Blue Lake Rancheria</b>	Riverside	<b>Morongo Band of Mission Indians</b>	Sonoma	<b>Dry Creek Rancheria of Pomo Indians</b>
Humboldt	<b>Trinidad Rancheria</b>	Riverside	<b>Pechanga Band of Luiseño Indians</b>	Sonoma	<b>Federated Indians of Graton Rancheria</b>
Humboldt	<b>Hoopa Valley Tribe</b>	Riverside	<b>Ramona Band of Cahuilla Mission Indians</b>	Sonoma	<b>Kashia Band of Pomo Indians of the Stewart's Point Rancheria</b>
Humboldt	<b>Wiyot Tribe</b>	Riverside	<b>Santa Rosa Band of Cahuilla Indians</b>	Sonoma	<b>Lower Lake Rancheria</b>
Imperial	<b>Quechan Indian Tribe</b>	Riverside	<b>Soboba Band of Luiseno Indians</b>	Sonoma	<b>Lytton Band of Pomo Indians</b>
Inyo	<b>Big Pine Paiute Tribe of the Owens Valley</b>	Riverside	<b>Torres-Martinez Desert Cahuilla Indians</b>	Tehama	<b>Paskenta Band of Nomlaki Indians</b>
Inyo	<b>Bishop Tribe</b>	Riverside	<b>Twenty-Nine Palms Band of Mission Indians</b>	Tulare	<b>Tule River Indian Reservation</b>
Inyo	<b>Timbi-Sha Shoshone Tribe</b>	Riverside	<b>Wilton Rancheria</b>	Tuolumne	<b>Chicken Ranch Rancheria o</b>
Inyo	<b>Fort Independence Community of Paiute</b>	Riverside	<b>Chemehuevi Indian Tribe</b>	Tuolumne	<b>Tuolumne Band of Me-Wuk I</b>
Inyo	<b>Lone Pine</b>	Riverside	<b>Colorado River Indian Tribe</b>	Yolo	<b>Yocha Dehe Wintun Nation</b>
Kern	<b>Tejon Indian Tribe</b>	Sacramento	<b>Fort Mojave</b>		
Kings	<b>Tachi-Yokut Tribe</b>	San Bernardino	<b>San Manuel Band of Mission Indians</b>		
Lake	<b>Big Valley Band Rancheria</b>	San Bernardino	<b>Barona Band of Mission Indians</b>		
Lake	<b>Elem Indian Colony</b>	San Bernardino	<b>Campo Band of Kumeyaay Indians</b>		
Lake	<b>Habematolel Pomo of Upper Lake</b>	San Bernardino	<b>Ewiaapaayp Band of Kumeyaay Indians</b>		
Lake	<b>Middletown Rancheria of Pomo Indians</b>	San Diego	<b>Santa Ysabel Band of Diegueno Indians</b>		
Lake	<b>Robinson Rancheria</b>	San Diego			
Lake	<b>Scotts Valley Reservation</b>	San Diego			
Lassen	<b>Susanville Indian Rancheria</b>	San Diego			
Madera	<b>North Fork Rancheria</b>	San Diego			
Madera	<b>Picayune Rancheria of Chukchansi Indians</b>	San Diego			

*\*This is a list of currently federally recognized tribes in California. There are a number of tribes in California who remain unrecognized or are petitioning for recognition. To learn more about recognition and CA Indian tribes, see here: <https://www.aisc.ucla.edu/ca/Tribes14.htm>*

*\*\* This list is continuing to be updated. Here is a list of CA recognized tribes: <https://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx#ca>*





Photos (right to left): Openhouse, Sisters Mentally Mobilized

## *A Place for New Thinking, New Solutions, and New Commitments*

Community innovation is a persistent strategy learned and deployed to sustain ourselves in the face of systems designed to regulate and restrain instead of restore and reimagine. We have a narrative of change in the market that privileges profit driven markets such as technology and financialization. This ignores the other channels for change that impact our society. The dynamics of social impact are more complex than any operating system.

The ecology of human intelligence is expanding faster than any technology. Communications networks, formal and informal, are defying computational and broadband capacity. California is the home of an extraordinary share of the global innovation market. Its next great tide can come in public health. From responding to pandemics to unpacking generational poverty, no other state is better positioned for radical progress.

Scale requires smart implementation and prudent investment. California has to manage its resources while responding to unanticipated challenges. We are confronted by this today. Yet, how we cope and how we manage defines our best chances for success. We must leverage our community assets including community-defined evidence-based practices.

***The CRDP is a culturally competent, evaluation and data driven movement that deserves continued funding and support.***

### *The Ask*

The moment to step up is now. The time for allies is here. The early results from the IPPs demonstrate the potential to make a generational impact on the very nature of mental health care services in California. By expanding the resources for CRDP, policy makers can accelerate the solutions being driven by the community-based organizations at the center of the project. The networks activated by the IPPs combine to provide a platform that the state would be unable to build on its own. Investments of this kind are rare.

We have the California voters to thank for their vision and commitment. Now it is our turn. Community health is an economic imperative to expand opportunity and ensure equal access. It also inoculates us from the adverse effects of poverty, racism and discrimination in ways that return greater value and impact than any other form of funding can. People of color and LGBTQ+ communities have survived centuries of pressure from systems designed without their consent, much less their sensibilities and intelligence. We are past the time when this is acceptable.

Now, a government of the people and by the people must open the possibility that together we can overcome the failings of our institutional past and commit to a future built together. This future requires the best evidence, the most robust practice, and the critical lever of culture to find its way to equitable mental health.

***Looking for more information? Feel free to reach out to California Department of Public Health, Office of Health Equity: [OHE@cdph.ca.gov](mailto:OHE@cdph.ca.gov)***

# Community Mental Health Equity Project



Office of Health Equity

Community Development and Engagement Unit

## CMHEP Domains

The CMHEP is a collaborative effort of CDPH - OHE and DHCS - MCBHD.

Project Domains include:

- **Communication & Outreach Efforts**— To increase culturally and linguistically responsive mental health messaging and interventions to underserved populations.
- **Workforce Development** - Ensuring staff are representative of the communities they serve.
- **Case Management & Increased Access** - Linking individuals with culturally and linguistically appropriate community resources.
- **Mental Health Direct Services** - Ensuring direct services on grief and loss, post-traumatic stress, and other mental health concerns are culturally informed.
- **Technology Access & Enhancement**- Enhancing technology to operate virtually and/or supporting organizational capacity.



## BACKGROUND

In 2019 California Assembly Bill (AB) 74 authorized \$8M in General Funds to the California Department of Public Health (CDPH) to address and reduce mental health disparities across the state.

In 2020 the Community Mental Health Equity Project (CMHEP) became a collaborative effort of the CDPH Office of Health Equity (OHE) and Department of Health Care Services (DHCS) Medical Behavioral Health Division (MCBHD). Given CDPH’s previous experience with community mental health programs, OHE will administer \$4,500,000 in grants to community based organizations (CBOs) to implement and enhance community defined mental health equity programs. Similarly, since MCBHD has oversight and monitoring responsibilities over county mental health cultural competence plans, \$3,000,000 will be used by DHCS to contract with consultants with cultural competence expertise to provide cultural competence training and technical assistance to county behavioral health departments and ensure linkages with community based organizations in order to reduce mental health disparities and better serve vulnerable populations.

These funds are available for expenditure or encumbrance until June 30, 2022.



## Culture Heals

At OHE we believe culture catalyzes change and gives hope to every community. A reimagined culturally inclusive mental health system acknowledges and respects the beliefs and behaviors of underserved consumers and subsequently heals from the roots.

## CMHEP COLLABORATIVE

### CDPH-OHE

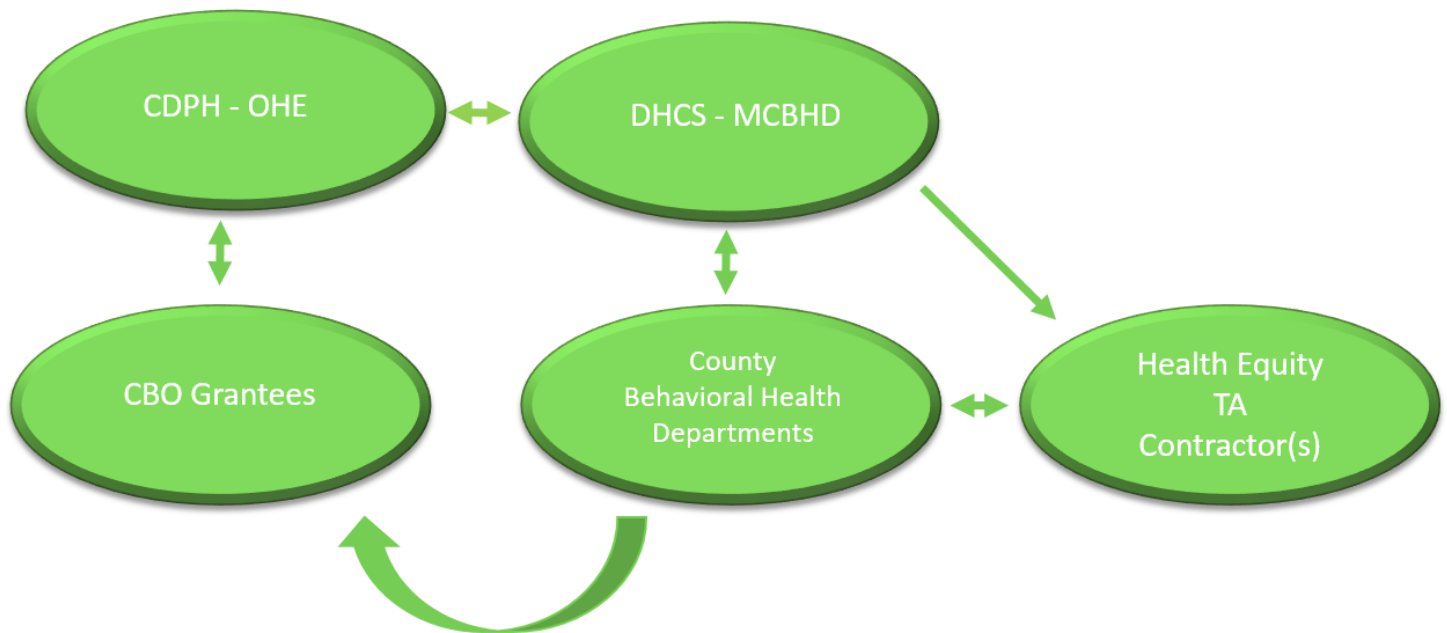
- Serve as principal project manager for CMHEP efforts;
- Update and solicit input from the CDPH OHE Advisory Committee, which will serve as the stakeholder workgroup for the CMHEP;
- Work in consultation with DHCS and interested stakeholders;
- Collaborate with DHCS on performance measures and program evaluation;
- Convene regular team meetings between DHCS and CDPH/OHE staff; and
- Procure contracts with community-based organizations to implement community-defined approaches to mental health for underserved communities.

### DHCS-MCBHD

- Conduct state and national level research on efforts;
- Convene cross-county learning collaboratives;
- Design virtual TA and training for community-based organizations to enhance data collection, data analysis, and quality improvement efforts;
- Provide virtual TA and training to community-based organizations to enhance data collection, data analysis, and quality improvement efforts;
- Participate in OHE’s quarterly OHE Advisory Committee and report on DHCS’ progress on the provision of TA and training; and
- Hire health equity expert consultants to inform the development and implementation of population-specific and community-driven approaches.

# Community Mental Health Project

## PROJECT FLOW



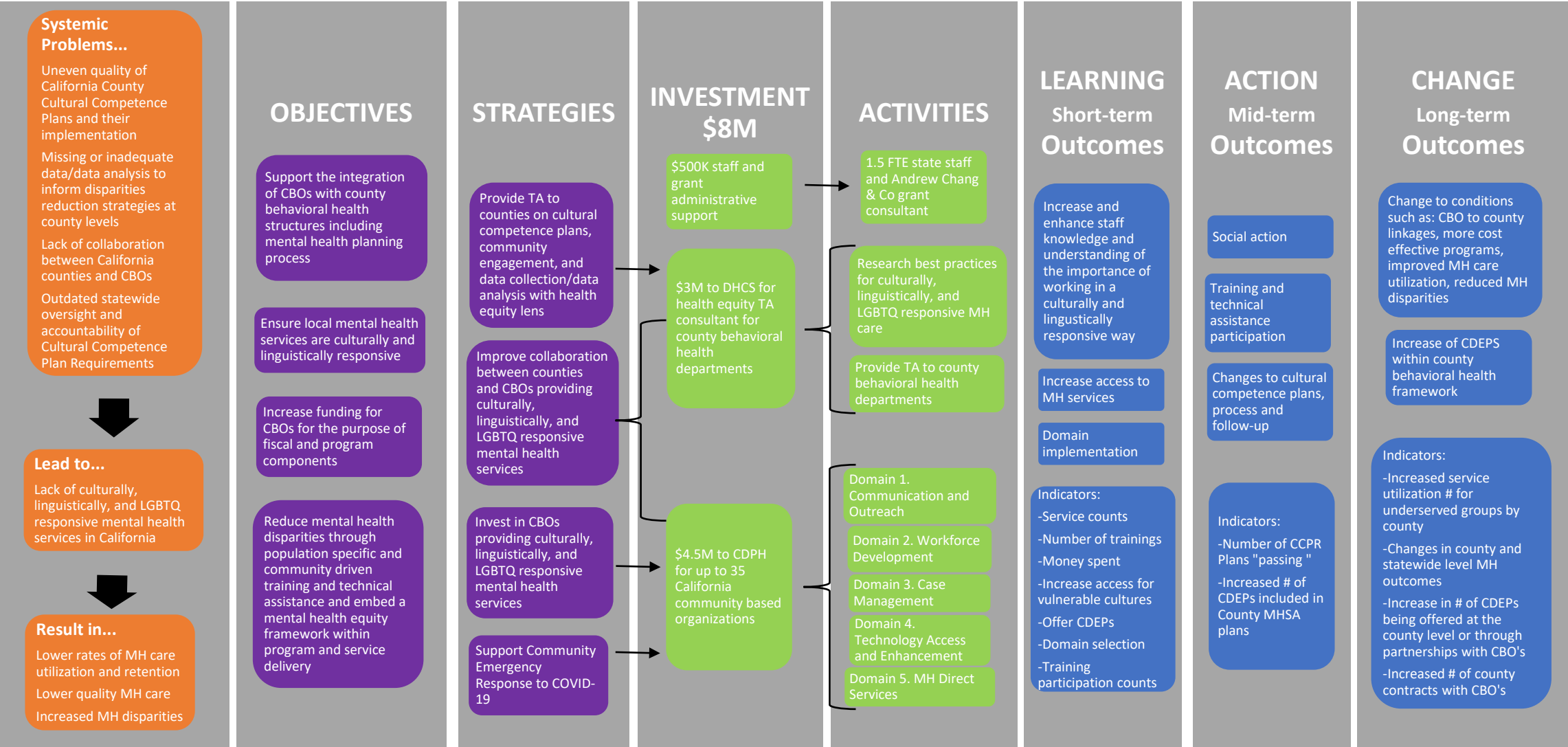
## GRAPHIC TIMELINE

March 2020– June 2022



## CMHEP GUIDING PRINCIPLES

- Honor beliefs, traditional healing, values, religions, and spirituality of California's cultures
- Promote and create effective engagement between diverse consumers and mental health community based organizations
- Create intersectional partnerships and movement building around mental health
- Advocate for cultural inclusion and promote tailored mental health service delivery
- Capture and capitalize on the strength of people power to advance mental health equity



External Factors: COVID-19, Stakeholder support, culture, language etc.

## Project Domains

### Community Mental Health Equity Project (CMHEP)

- 1. Improving Communication and Outreach Efforts:** In line with emerging data on racial and ethnic disparities around the COVID-19 pandemic, community based organizations (CBOs) are encouraged to increase outreach for their culturally tailored interventions by a self-selected percentage. Concerning communication and outreach efforts, CBOs will be expected to provide critical cultural responsive COVID-19 information to vulnerable and multi-cultural communities. As part of this work, CBOs may also develop increased communication strategies centered on building trust and partnerships. Including but not limited to in-language materials and culturally curated social media coverage around mental health resources, accessing mental health services, and self-care techniques. All communication strategies should support and be tailored for California's most underserved and vulnerable populations.
- 2. Support Workforce Development:** To best support the second COVID-19 surge CBOs will increase culturally congruent on the ground staff support for mental health initiatives by ensuring staff are able to effectively communicate and representative of the communities they serve. Staff may serve in the form of promotoras, behavioral health student interns, allied behavioral health professionals and other mental health professional development opportunities. Further, CBOs will ensure staff are culturally informed and prepared to offer culturally responsive mental health services upon intake.
- 3. Increased Access and Case Management:** Enhance, strengthen, or partially support a case management system/centralized patient intake system for the purpose of increasing mental health access to underserved families and more efficiently linking them with culturally appropriate community resources such as patient navigators, language access services, therapy, and peer support groups.
- 4. Technology Access and Enhancement:** To provide for additional technology needs as a result of extended COVID-19 surge. These are costs all CBOs may have on an ongoing basis. For the short-term, including but not limited to expanding technology hardware and software resources to operate virtually. For the long-term, supporting organizational capacity building to offer culturally tailored mental health services in alternate formats utilizing technology platforms and participating in advance technology trainings.
- 5. Mental Health Direct Services:** To best support second surge of COVID-19 and exacerbated health disparities amongst underserved populations, training will be critical for community-defined mental health programs and staff to offer culturally informed direct services on grief and loss, post-traumatic stress, and other mental health concerns. These culturally informed mental health services are vital in creating a bridge to serving vulnerable communities with respect to their cultural values and beliefs during a time of crisis.



## California Reducing Disparities Project Additional Documents

### Evaluation Guidelines

- [African American](https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Guidelines%20-%20African%20American.pdf) <https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Guidelines%20-%20African%20American.pdf>
- [Asian & Pacific Islander](https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Guidelines%20-%20Asian%20%26%20Pacific%20Islander.pdf) <https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Guidelines%20-%20Asian%20%26%20Pacific%20Islander.pdf>
- [Latinx](https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Guidelines%20-%20Latinx.pdf) <https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Guidelines%20-%20Latinx.pdf>
- [LGBTQ](https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Guidelines%20-%20LGBTQ.pdf) <https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Guidelines%20-%20LGBTQ.pdf>
- [Native American](https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Guidelines%20-%20Native%20American.pdf) <https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Guidelines%20-%20Native%20American.pdf>

### Outcomes

- [African American](https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Outcomes%20-%20African%20American.pdf) <https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Outcomes%20-%20African%20American.pdf>
- [Asian & Pacific Islander](https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Outcomes%20-%20Asian%20and%20Pacific%20Islander.pdf) <https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Outcomes%20-%20Asian%20and%20Pacific%20Islander.pdf>
- [Latinx](https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Outcomes%20-%20Latinx.pdf) <https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Outcomes%20-%20Latinx.pdf>
- [LGBTQ+](https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Outcomes%20-%20LGBTQ.pdf) <https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Outcomes%20-%20LGBTQ.pdf>
- [Native American](https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Outcomes%20-%20Native%20American.pdf) <https://www.mhsoac.ca.gov/sites/default/files/CRDP%20Outcomes%20-%20Native%20American.pdf>

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# AGENDA ITEM 3

Action

January 28, 2021 Commission Meeting

School Mental Health Implementation Plan

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**Summary:** The Mental Health Services Oversight and Accountability Commission will consider priority areas for the school mental health implementation plan consistent with [Every Young Heart and Mind: Schools as Centers of Wellness](#). The enclosed implementation plan outlines several priority opportunities and potential actions the Commission could take to drive the transformational change in school mental health envisioned in the report.

**Background:** The Commission's Schools and Mental Health Subcommittee is led by Commissioners Dave Gordon (Chair), Gladys Mitchell, Mara Madrigal-Weiss, and Ken Berrick. The Commission adopted *Every Young Heart and Mind: Schools as Centers of Wellness* in October 2020.

In that report, the Commission highlighted three broad recommendations for promoting the mental wellbeing and success of children throughout California, under the headings of State Leadership, State Investment, and State-supported Capacity Building.

## I. STATE LEADERSHIP

The Commission's report calls for the Governor's office and the Legislature to establish a statewide leadership body that brings together different state agencies and departments to develop a statewide agenda and strategy for establishing schools as centers for wellness and healing.

## II. STATE INVESTMENT

The Commission's report also calls for the State to make a multi-year foundational investment that increases services while also building the necessary infrastructure of programming, data management, workforce and sustainable funding models so all schools are centers of wellness and healing regardless of the economic cycle.

## III. STATE SUPPORTED CAPACITY BUILDING

Lastly, the Commission's report recommends that the State provide technical assistance to schools, health agencies, and other community partners to strengthen capacity to integrate local resources and service systems, adapt proven practices and drive continuous improvement.

**Presenter:** Commissioner and Subcommittee Chair Dave Gordon  
Kai LeMasson, Senior Researcher

**Enclosures :** None

**Handouts (2):** (1)Draft Implementation Plan, *Every Young Heart and Mind: Schools as Centers of Wellness*; (2) PowerPoint presentation

**Proposed Motion:** Based on the Commission's direction, the staff will work with the Chair, the School Mental Health Subcommittee and other Commissioners to pursue the prioritized actions. Full implementation of this proposal may require additional staff and funding.



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# AGENDA ITEM 4

Action

January 28, 2021 Commission Meeting

COVID-19 Related Funding Allocation

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**Summary:** The Commission will consider authorizing staff to release \$2.02 million to fortify the public mental health system's response to COVID-19.

**Background:** The Budget Act of 2020 authorized the Commission to direct \$4,020,00 of its budget to support suicide prevention and COVID-19.

During its September 2020 meeting the Commission authorized the release of \$2 million to begin implementing California's suicide prevention plan.

The Commission also directed staff to explore potential uses of the remaining \$2.02 million to support COVID response.

To inform the Commission's discussion on opportunities to allocate the COVID funding, the enclosed memo reviews the following:

1. The legislative intent of the funding.
2. The needs and emerging priorities identified through community outreach and engagement.
3. The Commission's strategic priorities and opportunities for aligning those priorities with COVID-related needs.

As outlined in the memo, over the last six months Commission staff have conducted surveys and convened meetings with stakeholders and counties to better understand the impact of the pandemic on Californians' mental wellbeing and to identify urgent needs.

Among other priorities, two areas have been elevated as the most pressing for the Commission's consideration:

## Investing in Reducing Racial/Ethnic and LGBTQ Disparities

Community stakeholders, and county leaders have highlighted the urgent need to address disparities in access to culturally appropriate and effective behavioral health services. The Commission should consider allocation a portion of the available funding to improve county and community efforts to reduce disparities, including those directly related to the COVID pandemic.

Consistent with the Commission's efforts through the Innovation Incubator, the Commission should consider authorizing staff to engage counties and community partners to strengthen response to disparities. That work should include two strategic and timely opportunities:

1. Supporting the replication of the Solano County Innovation project, Interdisciplinary Collaboration and Cultural Transformation Model Innovation Project, a successful innovation presented to the Commission at its November 19, 2020 meeting. The project, supported by the University of California, Davis Center for Reducing Health Disparities, implemented the nationally-recognized Cultural and Linguistically Appropriate Services (CLAS) standards in the county.
2. Engage county behavioral health leaders on opportunities to adapt, extend and replicate the work of the California Reducing Disparities Project (CRPD). As outlined in the meeting packet, the state has invested in a state-level project to address disparities in the African American, Latinx, Asian/Pacific Islander, Native American and LGBTQ communities. That project has supported more than 30 community-based organizations to develop and adapt mental health approaches that are tailored to community needs and culturally competent. As those projects mature and approach the end of their current funding, the Commission should encourage counties to explore opportunities to leverage the work of the CRDP partners to address disparities in their community mental health systems. Fresno County is already moving in this direction.

### Investing in Youth

The pandemic has put tremendous stress on young people, through the loss of their traditional school supports, the isolation associated with quarantining, and the economic distress that has impacted families, particularly low-income and racial and ethnic communities.

Consistent with the Commission's work on youth innovation, school mental health and suicide prevention, the Commission should consider authorizing staff to further strengthen our school mental health work with an emphasis on suicide risk and prevention.

During the Commission's September 24, 2020 meeting, it authorized spending up to \$150,000 in suicide prevention funds to deliver standardized suicide risk screening training materials for use in schools.

Recognizing community and county support for responding to ongoing student mental health needs driven by the pandemic, the Commission could support opportunities to improve the capacity of schools and county behavioral health programs to meet those needs, with an emphasis on suicide risks and suicide prevention. That support could be in the form of a learning collaborative that builds upon the Commission's ongoing work in school mental health.

**Presenter:** Toby Ewing, Executive Director

**Enclosures (2):** (1) A Framework for Responding to COVID-19 Impacts; (2) January 11, 2021 letter from CBHDA.

**Handout:** None

# A Framework for Responding to COVID-19 Impacts

Revised Draft / December 18, 2020

## SUMMARY

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The Legislature, informed by the Commission's success in building capacity for system-level improvements, directed the Commission in the 2020-21 Budget Act to help local governments and community partners improve their response to COVID-19. This framework distills information about the impact of the pandemic on mental health needs and the service system and identifies strategic opportunities for the Commission to consider in determining how to allocate those funds to catalyze improvement in services.

## OVERVIEW

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The pandemic has simultaneously aggravated conditions for mental health consumers and family members, has expanded risk factors such as anxiety and isolation for all Californians, and has disrupted the ability to provide services to those needing and seeking care. Advocates and service providers are particularly concerned that pre-existing disparities in terms of access to quality care have worsened for some racial, ethnic and cultural communities.

After months of scrambling to adapt services to changing needs, public agencies and service providers are recognizing that what had been viewed as temporary shifts now need to further adapt to meet the longer lasting impacts on the economy and jobs, on home life and social activities, and on the prevalence and characteristics of health and mental health needs.

The Legislature, recognizing the value of the Commission's efforts to drive improvements, authorized the Commission in the 2020-21 Budget to spend \$2.02 million to fortify the public mental health system's response to COVID-19.

That spending authority is in addition to the \$2 million to support implementation of *Striving for Zero*, the state suicide prevention strategic plan.

To inform the Commission's decision on how to allocate the COVID-related funds, this framework describes:

1. The intended scope of activities expected by the Governor and Legislature.
2. Related Commission projects, including *Striving for Zero* implementation.
3. The needs as expressed in multiple ways from community members and county partners, including interviews, a survey and a Client and Family Leadership Committee meeting.
4. The Commission's strategic priorities, and options for aligning COVID-focused projects.
5. Emerging public priorities, and options for aligning COVID-focused projects.

## 1. LEGISLATURE’S SCOPE OF INTENDED ACTIVITIES

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Discussions with legislators and their staff produced two possible objectives for the project:

- ✓ Support county behavioral health agencies and their community-based service providers to adapt to the three-fold challenge of 1) meeting the changing and increasing mental health needs associated with the pandemic, 2) providing services in ways consistent with public health requirements, and 3) sustaining essential services with declining revenues.
- ✓ Engage other community government partners such as schools, as well as private sector health providers and employers and other potential allies, to develop and scale mental health models that would respond to the broader public mental health needs resulting from the pandemic.

## 2. RELATED COMMISSION PROJECTS

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**Suicide Prevention.** The Commission adopted *Striving for Zero: California’s Strategic Plan for Suicide Prevention, 2020-2025* in November 2019. The 2020-21 Budget Act, the Commission was authorized to allocate \$2 million of its budget over the next two fiscal years to begin implementing the strategic plan. During its August and September meetings, the Commission approved several initiatives to address critical statewide gaps in strategic planning, data, safety, training, and support. Staff are developing scopes of work for the following initiatives:

- Advance local strategic planning and Implementation
- Increase lethal means safety
- Accelerate standardized suicide risk assessment and management training and technology support
- Deliver standardized suicide risk screening training
- Create a suicidal behavior research agenda and action plan and begin implementation

**Rapid Response Network.** The Commission in April launched a Rapid Response Network with Social Finance, which developed detailed expert responses to challenges facing counties, community service providers and county First Five Commissions. The requests, which also indicate pandemic-related stresses on the service system, included information regarding telehealth and other adaptations of care, managing the needs of homeless individuals, evaluating adaptations and business operations. The project also documented the value of rapidly providing specific information to service providers adapting to a changing environment.

**Attachment A** summarizes those activities.

## 3. NEEDS AND OPPORTUNITIES FOR IMPACT

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The Centers for Disease Control and Prevention and others have documented increased anxiety and depression, suicidal ideation and substance use as a result of the pandemic, the social disruptions and economic fallout. The impacts have exacerbated pre-existing economic, health

and mental health disparities in low-income communities with high concentrations of people of color. **Attachment B** summarizes those impacts. The Commission augmented that baseline information with the following:

- ✓ To gather community perspectives, the staff interviewed Triage grantees early in the epidemic and documented disruptions to the service system and the adaptations made to keep staff safe while maintaining crisis services and adjusting to virtual service delivery. Attachment A summarizes those interviews. **Attachment C** summarizes those interviews.
- ✓ To gather additional community perspectives, the Commission surveyed county agencies, community service providers and stakeholders and received more than 200 responses, including scores of responses from most counties and immigrant, racial, ethnic and cultural organizations and advocates. Respondents validated an increase demand for services, while also struggling to connect with individuals in need of care. The rapid shift to tele-mental health services raised concerns that clients without digital access will be left further behind. Providers anticipate long-term challenges associated with declining staff and revenues. Attachment B summarizes key findings of the survey. **Attachment D** summarizes responses.
- ✓ To invite feedback on emerging options, the Client and Family Leadership Committee meet on December 9, 2020, in part to provide feedback on a previous version of this framework and to solicit additional public input. **Attachment E** summarizes that discussion.
- ✓ The Commission has received two direct requests for funding. On June 16, Teachers for Healthy Kids requested \$50,000 to provide training to mental health practitioners in schools. On September 8, the Cross Population Sustainability Steering Committee of the California Reducing Disparities Project urged the Commission to allocate \$2 million to Community-Defined Evidence-Based Practices to address the impacts of systemic racism compounded by COVID-19.

#### 4. COMMISSION'S STRATEGIC PRIORITIES

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The Commission has prioritized innovations and improvements that can significantly improve outcomes for individuals and communities. The Commission has advanced these priorities with a portfolio of activities that are building capacity and having an impact. Following each initiative is an opportunity to expand existing activities to respond to pandemic-related needs.

**Prevention and Early Intervention.** The Commission's project to advance prevention and early intervention is exploring the imperative to increase awareness and connect people and families to mental health supports and services as early as possible. This need is elevated by the increased depression, anxiety and other mental health needs associated with the pandemic, especially in underserved communities.

- Train cultural brokers to reach highly impacted communities. The Commission could work with the California Pan-Ethnic Health Network to develop a learning community involving counties and the community organizations associated with the CRDP. The project could

distill and deploy what has been learned through CRDP and coordinate and connect those activities to county behavioral health agencies and their services. The project also would incorporate and test emerging knowledge about the role of respectful and linguistically competent cultural brokers in prevention and early intervention strategies, including the development of networked partnerships with cultural brokers, traditional healers and other culturally diverse service providers.

**School mental health.** The Commission is promoting the recommendations in *Every Young Heart and Mind*, implementing the Mental Health Student Services Act and Triage grants, and exploring ways to increase federal funding.

- Support a learning collaborative on school mental health partnerships. Sacramento County has demonstrated the interest in and an ability to develop a county-school partnership without MHSSA funds. The school mental health report calls for helping to counties develop effective and financially sustainable partnerships. The Commission could fund the technical assistance to help willing counties develop partnerships initially focused on connecting with and serving students most impacted by the pandemic.

**Early Psychosis Learning Healthcare Network/EPI+.** The Commission is supporting a healthcare learning network with 11 community partners to improve early response to psychosis using the nationally recognized Coordinated Specialty Care model. The Commission has authorized \$5 million to expand access to care, improve awareness, increase workforce diversity, and study barriers to services for diverse groups and public and private reimbursement mechanisms.

- Early Psychosis and COVID. Stress can trigger psychotic symptoms for those who are at high risk. Expansion of services for first episodes of psychosis could be a critical step to meeting emerging needs; focus could be placed on reducing racial, ethnic and cultural disparities exacerbated by the pandemic.

**Youth Empowerment.** The Commission is partnering with Stanford to launch allcove, funding five youth drop-in centers, supporting youth innovation labs and implementing the state Suicide Prevention Plan, an issue of heightened concern during the pandemic.

- Youth and COVID. The Commission could support additional collaborations among partners working on school mental health, youth drop-in, suicide prevention and early psychosis programs to improve the integration of these services.

**Workplace Mental Health.** Low-wage “essential workers” and their families, who are disproportionately people of color, have been particularly hard hit by COVID-19. The stigma associated with acknowledging a mental health issue in the workplace is compounded by the different characteristics of stigma within distinct racial, ethnic and cultural communities.

- Support employer-advocate partnerships. The Commission could explore partnerships between employers, employer associations, labor unions, community organizations and stakeholder groups to build awareness, counter stigma and connect workers to services.

## 5. EMERGING PUBLIC PRIORITIES

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**Disparities / Diverse communities.** The disproportionate impacts of the pandemic and renewed calls for social justice have amplified the need to address racial, ethnic and cultural disparities. Solano County presented at the Commission’s November meeting on a successful Innovation project that engaged diverse communities to better understand their needs and to tailor strategies and services to those communities.

- Support adaption of the Solano project. The Commission could work with the UC Davis Center for Reducing Health Disparities to replicate Solano’s disparity assessments and adaption of the standards for Culturally and Linguistically Appropriate Services. This could include technical support to develop one more INN projects. The Commission could explore with UCD the potential to focus the project in ways that would meet the more urgent needs of the isolated communities. Some 40 counties have expressed interest in adapting the project and this option was prioritized in a discussion of county MHSA coordinators.

**Behavioral Health Disaster Planning.** As the pandemic worsens, officials are equally concerned about the impact of multiple and diverse disasters. The Department of Health Care Services drafted an emergency preparedness plan that would benefit from increased public engagement and review. Butte County responded to the Paradise fire with an Innovation project to pilot a recovery center to support mental health needs.

- Encourage Mental Health Disaster Preparedness. The Commission could explore a learning collaborative (including the potential use of INN funds) to support counties interested in developing and testing emergency service responses. The project could be coordinated with the Department of Healthcare Services and the Office of Emergency Services. It could be designed to help support responses underway now that are then assessed and formalized for future use.

**Rapid Response Network 2.0.** The Rapid Response project tapped into a national network of experts and practitioners to distill the best available information to specific and urgent challenges facing service providers. The project also revealed the potential for a knowledge network to drive cooperative improvement across systems.

- Relaunch the Rapid Response Support Center. The Commission could design the next iteration of the RRN to encourage coordination among agencies and associations. The Center could help community-level governments assess the changes they have had to make because of the pandemic and determine how to structure services going forward. For example, the project could address issues related to tele-mental health and help assess the lasting impacts on underserved and disproportionately impacted communities.

## 6. OPPORTUNITIES TO LEVERAGE CHANGE

The Commission’s strategy for driving transformational change includes research and evaluation, policy development, financial incentives, and technical assistance and capacity building. The table summarizes the above opportunities to leverage additional change.

Strategic Project Opportunities			
Priorities	Strategic Approach	Impact on Individuals	System-level impacts
Prevention & Early Intervention	Promote awareness and connection to support	Reduce suffering from unmet needs	Fortify effective outreach to reduce disparities
School Mental Health	T/A for new county-school partnerships	Strengthen connection and services to children	Partnerships can link funding, other resources
Early Psychosis	Expand learning network to reach culturally and geographically isolated	Connect and serve high-risk and underserved individuals	Fill high priority service gaps for high-risk underserved individuals
Youth	Support youth leaders to identify and fill gaps	Strengthen services for high-risk individuals	Increase peer voice and leadership
Workplace Mental Health	Engagement with employer community	Improve access for low-wage essential workers	Reduce stigma, build workplace awareness
Reducing Disparities	Learning collaborative to adapt Solano INN project	Increase peer voice and services to underserved	Strengthen community engagement throughout
Behavioral Health Disaster Planning	Link state-county efforts to improve response	Serve most vulnerable during emergencies	Develop models for replication elsewhere
Rapid Response Network	Link knowledge with critical service needs	Adapt services to those most impacted	Develop a model to accelerate learning

For more information, contact Sharmil Shah, chief of program operations: [Sharmil.shah@mhsoc.ca.gov](mailto:Sharmil.shah@mhsoc.ca.gov).



## Attachment A: Rapid Response Support Center

### *Meeting the information demands of emergent pandemic-related mental health challenges*

#### **Executive Summary**

***Learning from the Rapid Response Network pilot.*** Beginning in early April, the Mental Health Services Oversight and Accountability Commission partnered with nonprofit Social Finance to pilot a new county support mechanism. The Rapid Response Network enabled county officials to easily elevate issues and connect with organizations or experts with relevant information. Over six months, the RRN completed nearly 30 requests. Early requests were largely focused on telehealth and care adaptation; later requests focused more on business and staff planning, evaluation, and care coordination.

The project experienced significant and sustained demand from public leaders for rapid, low-barrier technical assistance. County capacity has been strained to the breaking point by the pandemic. Easy and fast access to expert perspectives and literature reviews helped counties adapt to changing conditions.

***Looking toward the future.*** The pandemic's long-term fallout will be considerable and ongoing: waves of deferred mental health needs; reduced access due to county budget reductions; demand surges and shifts from the evolving economic paralysis; stresses on children in constantly changing care arrangements; novel criminal justice diversions and release programs—all buffeted by an unpredictable disease and a challenging funding environment.

Feedback from the Rapid Response Network has been overwhelmingly positive. As detailed below, nearly every respondent rated the service as a 10/10; many have submitted multiple requests.

There is a promising opportunity to expand, strengthen, and improve these efforts. A steady flow of counties has requested support, despite almost no outreach. More substantial marketing efforts—including a monthly “pulse check” to understand key issues; an opt-in list to alert partners about new responses; and publishing select findings—would expand the pool of partners.

Looking ahead, a Rapid Response Support Center could proactively research emerging priorities—such as children zero through five; school-based mental health; aging; and criminal justice re-entry. As described below, this would enable a range of activities to support agile evolution of programs to better serve those most impacted.

#### **Background**

The global pandemic has tested California counties and their community allies in new ways. The behavioral health system, already strained, has been forced to stretch and adapt at breakneck speed; each day has required complex decisions, often with few precedents. Agencies are overwhelmed. Even where additional resources are available, defining the needs, identifying useful resources, and procuring support can be onerous. And while local leaders receive waves of general information, they lack the time and resources to triage that information and adapt the most relevant aspects to their specific challenges.

The Rapid Response Network was designed to meet these specific circumstances. The RRN has replied to dozens of requests, largely from county behavioral health agencies and First 5s. [Examples of those responses](#) are posted on the Commission’s website.

The Network has four operating criteria: (1) provide demand-driven responses to the needs of behavioral health leaders; (2) make it radically easy for partners to initiate a request; (3) provide specific information responsive to the circumstance; (4) provide fast responses to maximize usefulness (vs. “perfect” answers).

The Network also committed to respond to every request and if the Network could not meet the need, to find an appropriate resource that could. No request was declined.

### **Evolving Information Needs Require a Responsive Platform**

During the first six months, 28 requests were fielded. The median time between request initiation and draft response was just over two weeks. (In response to an urgent request, the response was completed within 48 hours.)

Requesters most commonly asked the Network to contact, interview, and summarize perspectives from experts; review, synthesize, and present emerging literature; and benchmark COVID-19 responses from analogous jurisdictions, accelerating information flow across jurisdictions.

#### **OVERVIEW OF RESPONSES**

As of October, the Rapid Response Network completed 28 requests. The most common topics included telehealth (7 requests), staff and business planning (6), evaluation planning (5), care adaptation (5), field interactions / street medicine (2), homelessness (2), and eviction prevention (1).

Most commonly, requests asked for the network to summarize expert perspectives, conduct literature reviews, and to learn from comparable jurisdictions through case studies and data benchmarks.

Feedback has been positive. The Net Promoter Score is a commonly used metric for customer satisfaction. Requesters were asked: How likely is it that you would recommend the Rapid Response Network to a relevant colleague, with 1 being “not at all likely” and 10 being “extremely likely”? The Network received an average score of 10. Additional feedback suggests that responses were successful at informing department’s priorities, policies, or decisions; that they were a good use of time; and that requesters would use this service again. Many requesters did reuse the service: one submitted six requests; two others submitted four; and four others were repeat clients.

Qualitative feedback has been positive as well. As one county behavioral health director wrote:

*“Well, I did not know what to expect as [this was the] first time to work with you all. This is great. Very good*

*and useful information. We will implement some of these strategies. Today. Some we have already implement[ed] so this gives us acknowledgement that we are on the right track. I am meeting today with our management team and this will be used to kick off our meeting. Thanks so much.”*

## Piloting a longer-term Rapid Response Support Center

Based on our experience thus far, this short-term, low-barrier and timely technical assistance fills an important gap for busy county leaders. The implications of the pandemic continue to evolve; and while the urgency of adaptation has decreased, new challenges continue to arise.

More recent requests focused less on immediate practice changes and focused more on evaluating changes; navigating long-term remote working policies; and adapting emerging telehealth networks for greater cultural competency. For counties that were stretched before the crisis, we believe that “surge capacity”—trusted technical assistants able to take on time-bound, discrete research and analytics—can play a valuable role in informing hard decisions.

## Potential Adaptations

MHSOAC and Social Finance have identified ways to mature the Network into a virtual Rapid Response Support Center to help counties and communities struggling with pandemic.

- **Strengthening demand generation.** The initial round of requests arose from a very limited outreach effort, supplemented by word-of-mouth. This allowed for quick responses to

every request. However, the only insight into on-the-ground needs came through time-sensitive requests, limiting the Network’s ability to invest in responses that may be less urgent yet have broad relevance.

A more substantial outreach and engagement effort could include overview documents and a dedicated web presence; a simple, fast, monthly “pulse check” to communicate key issues; and partnerships with networks (such as the First 5 Association, County Offices of Education, California Behavioral Health Directors Association, and others) to ensure partners are aware of the service offerings.

- **Improving distribution.** During the initiation phase, responses were largely intended for individual requesters. In addition, most were posted on the MHSOAC website.

### Potential Focus Areas for Second Phase of RRN

#### Operations

- Perform literature reviews and expert outreach to respond to novel operational conditions.
- Analyze programmatic data to inform operational issues, such as service gaps.
- Facilitate discussions among counties on best practices and lessons learned.
- Benchmark the performance of community initiatives against similar communities.

#### Policy

- Identify innovative responses to unprecedented issues.
- Help counties determine best use cases for federal, state, and local COVID-19 funding.
- Conduct cost-benefit analyses of programs.

#### Capacity building

- Construct evaluation frameworks to help counties determine what works during the response to COVID-19.
- Structure performance management systems to manage fiscal pressures.
- Lead scenario-planning workshops to help agencies respond to changing client needs.

Looking ahead, distribution efforts could include an opt-in list to alert county partners about new responses; host regular webinars; proactively publish select findings as white papers; and, where appropriate, partner with journalists to reach a wider set of stakeholders.

- **Defining focus areas.** Requests could be clustered to enable proactive research and publication of emerging priority issues—such as school-based mental health, aging, provider workforce and/or reentry. This also will support sharing information among like agencies.

The Center also could work closely with other state-level agencies—sharing knowledge and resources with others working on similar issues, such as the Department of Aging, the Department of Corrections and Rehabilitation, and the Department of Public Health.

### **Timeline**

The initial phase of the Network is drawing to an end as external grant resources are exhausted.

The Network could be developed to relaunch early in 2021. The next phase of this work would extend for 12-18 months.

## Attachment B: Mental Health Implications of COVID-19

December 18, 2020

### SUMMARY

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The mental health implications of the Coronavirus Disease (COVID-19) have been profound. Many of those consequences are related to the extensive public health mitigations that have shuttered schools and businesses, and complicated mental health service delivery.

This brief summarizes the impact of COVID-19 on the quality of life as a determinant of mental health and the impact of the disease and public health mitigations across age groups to inform decisions by the Mental Health Services Oversight and Accountability Commission and its stewardship of that mental health service system.

### COVID-19 IMPACT ON QUALITY OF LIFE

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The Novel Coronavirus Disease COVID-19 pandemic has impacted the quality of life, mental health, and mental health service delivery. COVID-19 causes mild to serious illness for those infected and easily spreads by person-to-person contact.<sup>1</sup> To mitigate the spread, states, counties, and local municipalities have issued stay-at-home and shelter-in-place orders. Such mitigation efforts include the closure of non-essential businesses and limitations on operational capacity, closure of schools, social distancing, and use of personal protective equipment.<sup>1,2</sup>

The effects of these mitigation efforts are widespread. The United States has experienced an increase in unemployment due to the closure of many non-essential businesses, whether temporarily or permanently. Workers have shifted to tele-working if they could. Education delivery, both K-12 and post-secondary institutions, is taking place online through telecommunication applications. Hospitals have decreased the number of optional procedures and appointments to respond to the influx of patients diagnosed with COVID-19.

In addition, the COVID-19 pandemic and mitigation efforts have negatively impacted the mental health of many Americans. The mitigation efforts to slow down the spread of COVID-19 has affected individual mental health and the delivery of mental health services.<sup>3-5</sup>

### IMPACT ON MENTAL HEALTH

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During this unprecedented time many Americans have experienced new or worsening mental health or behavioral health symptoms or conditions. Organizations across the U.S., including the Centers for Disease Control and Prevention and Kaiser Family Foundation, have reported an increase of certain mental health symptoms associated with the COVID-19 pandemic.<sup>3</sup>

During the COVID-19 pandemic, Americans have reported an increase in the symptoms of anxiety, depression and traumatic-stress disorder, and increases in suicidal ideation, substance

use, isolation, and loneliness.<sup>3</sup> Some groups are more susceptible than others to experience an increase in mental health symptoms because of the COVID-19 pandemic.<sup>3</sup> The mental health effects of COVID-19 have been experienced differently by children and teens, caregivers and adults, and older adults ages 65+.

### Mental Health Impact on Children and Teens

In late March 2020, school closures forced many students to participate in web-based classrooms from home. The duration and instruction style of web-based classrooms are at the discretion of the school or teacher. Some students can spend as little as 30 minutes or up to six hours a day in a telecommunication application for school. Other curriculum adjustments include an increase in independent study. Services such as free or reduced lunches, student support services, extra-curricular education and activities, and mental health screening and services are limited due to the school closures. Over 300 million K-12 students are participating in distance learning as a result of school closures.<sup>3-5,8-11</sup>

**Prior to COVID-19:** Prior to the pandemic in 2016-2018, children ages 3 to 17 were more likely to experience symptoms of depression or anxiety.<sup>7,9,11</sup> In 2016-2018, 1 in 10 youth ages 10 to 17 experienced symptoms of anxiety or depression. Also prior to the pandemic suicide was the second leading cause of death among youth ages 10-24.<sup>7,9,11</sup>

**During COVID-19:** The estimated number of youths experiencing the adverse mental health effects due to the stress of the COVID-19 pandemic is not fully known. The reduction in mental health services in schools and community programs have made it increasingly difficult to assess the mental health of children and teens. However, an influx of children and teens have been admitted to hospital emergency departments with symptoms of depression or anxiety since the onset of the pandemic.<sup>7</sup> The influx of emergency room visits may correlate to a possible influx in adverse mental health symptoms among youth during the COVID-19 pandemic.<sup>7,9</sup>

### Mental Health Impact on Caregivers/ Adults

Adults have also experienced an increase in adverse mental health symptoms during the COVID-19 pandemic. In a Kaiser Family Foundation poll conducted in March 2020, 47 percent of respondents reported major or mild negative effects associated with sheltering in place compared to 37 percent of respondents not sheltering in place.<sup>3-5</sup>

**Prior to COVID-19:** The groups most vulnerable prior to the pandemic to experience adverse mental health symptoms or have a mental health diagnosis included adults with less education, lower socioeconomic status, Hispanic, African American, between ages 45 to 65, and with a recent prior family history.<sup>22</sup>

**During COVID-19:** The COVID-19 pandemic has significantly increased unemployment. Many have lost jobs due to the closure of “non-essential” businesses.<sup>2,12,13,17</sup> Also, the closure of

schools and daycare centers have forced many adults with young children to leave their jobs to provide care for their children.<sup>12-14</sup> Jobs or income loss have significantly impacted the mental health of many Americans. Those with lost jobs or income had more negative mental health impacts from the pandemic (58 percent) than those who were still employed (50 percent).<sup>3-5</sup> In addition, those making \$40,000 or less were more likely to experience adverse mental health symptoms than those making \$40,000 or more. Also, during the pandemic more women reported losing their jobs to become caregivers than men.<sup>3-5,14</sup> In addition, more women reported higher rates of adverse mental health effects.<sup>3-5</sup>

## Mental Health of Adults with Chronic Health Conditions

Adults with chronic physical health conditions are more likely to experience symptoms of depression and anxiety.<sup>3</sup> Adults with chronic physical health conditions are at higher risk to experience negative mental health impacts compared to individuals in good health. 62 percent of respondents with fair or poor health reported a negative impact on mental health compared to 51 percent of respondents with good health.<sup>3-5</sup>

## Mental Health Impact on Older Adults (65+)

During the COVID-19 pandemic, older Adults reported higher levels of mental health symptoms or an increase in symptoms. In mid-July adults reported an increase in negative mental health symptoms compared to that of mid-May (47 percent; 31 percent respectively).<sup>3-5</sup> Older adults living alone are at higher risk of experiencing adverse mental health symptoms during the COVID-19 pandemic.<sup>1,3</sup>

**Prior to COVID-19:** Adults 65 and older were more susceptible to experiencing symptoms of loneliness and isolation.<sup>3,18,19</sup> In 2018, 14 million out of 51 million adults reported living alone. Adults 65 and over are often misdiagnosed or undertreated for symptoms of depression.<sup>18,19</sup> Adults 65 and over made up one-third of suicides in 2018.<sup>18,19</sup>

**During COVID-19:** Older adults are at higher risk of contracting COVID-19. Older adults are at a higher risk of mortality than other age groups.<sup>1</sup> Due to higher risk many older adults are taking extra precautions to mitigate the risk of exposure.<sup>1</sup> Older adults are more likely to practice quarantine guidelines than other adults. Adults in assisted-living facilities or nursing homes are not permitted to leave or have outside guest.<sup>1</sup> Stricter, mitigation efforts among older adults can correlate with an increase in symptoms of loneliness or isolation, which can further increase the likelihood of developing a mental health condition.

## SERVICE DELIVERY IMPACT DURING COVID-19

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As a result of COVID-19 mitigation efforts, the delivery of mental health services has changed. These changes include in-person services with personal protective equipment, usage of

telemental health platforms, and providing alternatives (i.e., mobile services).<sup>20-21</sup> Many mental health providers were struggling to operate at full capacity prior to the COVID-10 pandemic. In addition, many services such as group, family, or interactive services (i.e., art therapy) have been difficult to deliver.<sup>20,21</sup>

However, the new service delivery methods can potentially increase the capacity of mental health services post-COVID-19. Especially, telemental health service may increase the time availability or reduce scheduling conflicts for clients and providers. In addition, telemental health could allow providers to reach geographically hard-to-reach clients.

Other groups susceptible to increased mental health symptoms as result of the stay-at-Home orders include people with disabilities, college students, racial and ethnic groups, and those experiencing homelessness.<sup>9,15</sup> Changes in service delivery may increase participation among these groups by increasing the availability of treatment modalities.

## CONCLUSION

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Many Americans are negatively impacted by the shelter-in-place and stay-at-home orders. These orders have had a grave effect on the wellbeing and mental health of many residents. The increase of mental health symptoms provides a new challenge on how to provide services to the groups listed above. Elderly, school-aged, people with chronic health conditions, racial and ethnic communities, college students, people with disabilities, and those experiencing homelessness are statistically most vulnerable to experiencing poor mental health and are harder to reach to provide services. These facts and trends can inform the MHSOAC's deliberations regarding program options to mitigate these mental health effects, particularly opportunities to evolve services to better connect and serve those disproportionately impacted by the pandemic and related public health mitigations.

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## Attachment C: COVID-19 Impact on SB 82 Triage Programs

Shortly after the Coronavirus struck California, in late March and early April 2020, the Commission's Triage team contacted all 30 triage programs established under Senate Bill 82 (Adult/TAY, Ages 0-21, and School Collaboration). At that time, the onset of COVID-19 was still recent, and the programs were adjusting to the shelter-in-place recommendation and county public health guidelines while preparing for a surge in COVID-19 cases and mental health crisis calls.

### Highlights:

- The COVID-19 outbreak is causing delays in triage program implementation and expansion, specifically, in Los Angeles and Sacramento Counties.
- Due to the overall COVID-19 impact, many families are struggling and putting services on hold, which negatively impacts the triage programs' revenue and billable services. Flexibility is needed to allow billing for multiple shorter sessions during the week.
- Many of the triage programs would benefit from standardized materials and/or trainings on how to conduct mental health services more effectively using telehealth methods.

### Common Experiences:

- Focus on prevention of mental health crisis and unnecessary hospitalization
- Initial decrease in mental health crisis calls, followed by a steady increase
- Difficulty obtaining PPE
- Preparing for overcrowded ERs and requesting a temporary exclusion to the IMD waiver from DHCS to increase bed capacity for clients experiencing psychiatric emergencies
- Hiring freeze
- Increase in staff absences
- Lack of communication with the homeless population
- Increased responsiveness from TAY clients and families through utilization of telehealth methods

### Program Modifications:

- Ramping up telehealth options for mental health screenings and diversion from ERs
- Moving other staff into triage roles to address mental health crisis needs
- Minimizing face-to-face contact with clients unless necessary to prevent further mental health crisis
- Proactively contacting high utilizers of mental health or special education services to address mental health needs and provide navigation to services
- Launching or expanding warm lines to address COVID-19 specific anxiety and depression
- Rehabilitating existing facilities for use as additional Mental Health Rehabilitation Centers with DHCS certification
- Adjusting staff's work schedules to accommodate uptick in crisis calls occurring later in the day
- Obtaining telehealth consent verbally
- Developing practices for a digital warm handoff to link families to services via conference calls
- Inquiring with families about their technological capacity, food stability, and support needed in applying for benefits

## Attachment D: Survey of COVID-19 Related Impacts

December 2, 2020

### SUMMARY

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The Mental Health Services Oversight and Accountability Commission (MHSOAC) requested information from county behavioral health agencies, community services providers, peers, family members, and stakeholders to better understand the impact of the pandemic on Californians and the system designed to meet their mental health needs. The responses are consistent with the findings in more scientific studies, which underscore and validate the impacts of the novel Coronavirus 2019 (COVID-19), including the necessary public health restrictions and the negative impacts on the economy and employment. The survey is part of the Commission's public engagement effort to inform activities to help the mental health system better serve Californians most impacted by the pandemic.

### METHODOLOGY

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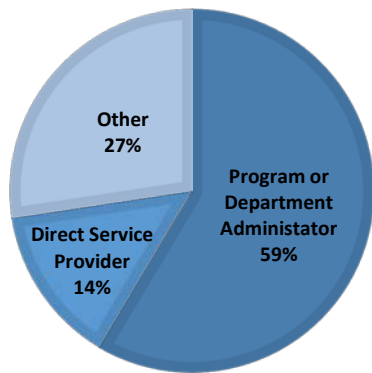
The MHSOAC created two surveys, one for service providers and another for stakeholders, to assess the impact of COVID-19 on mental health services across California. Services providers include county behavioral health departments and mental health service providers. Stakeholders are defined as community-based organizations that provide outreach and advocacy for specifically defined populations, including immigrant groups and other underserved communities. The Commission, for instance, received responses from the Hmong Cultural Center in Butte County, the Friendship House Association of American Indians, the Center for Sexuality and Gender Diversity, and the La Familia Counseling Center. The Commission heard from county First 5 Commissions, school districts and county offices of education. Survey respondents were not randomly selected. Survey respondents included individuals with first-hand knowledge of the pandemic's impact identified through targeted outreach.

All county behavioral health departments and mental health service providers with a prior partnership or association with the MHSOAC received a survey. The MHSOAC received 165 responses. Responses were received from 31 of the 59-county behavioral health agencies and 134 community service providers. The MHSOAC received 107 responses from stakeholders. The breakdown of respondent occupations is displayed in Figure 1 and Figure 2 below.

## Survey Design and Limitations

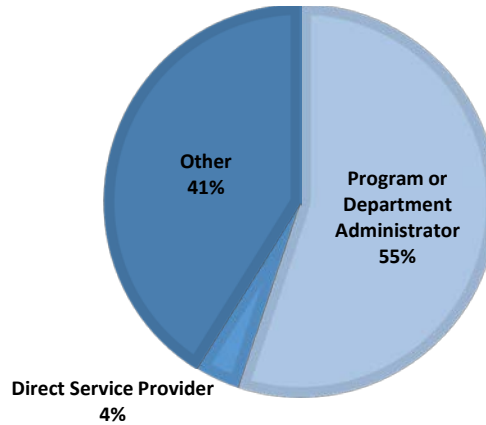
Both surveys included the same 13 opened-ended, closed, Likert-scale, and multiple-choice questions tailored to the appropriate audience. Both surveys shared the same survey limitations, which include non-response to questions, response bias, question interpretation, and other mediating factors.

**Figure 1. Service Provider Survey Breakdown of Respondent Occupations**



*Figure 1. displays the occupation of service provider respondents: program or department administrator (59%), direct service provider (14%), and other (27%), which includes program coordinators and program analysts.*

**Figure 2. Stakeholder Survey Breakdown of Respondents Occupations**



*Figure 2. displays the occupation of stakeholder respondents: program or department administrator (55%), direct service providers (4%), and other (41%) which includes program coordinators and program analysts..*

**Table 1: Geographic Distribution of Respondents**

Geographic Distribution of Respondents		
Region	Service Providers	Stakeholders
Far Northern California	26.7%	28.9%
North Coast	5.6%	5.3%
San Francisco Bay Area	16.1%	13.2%
Northern San Joaquin Valley	8.7%	7.9%
Central Coast	3.7%	8.6%
Southern San Joaquin Valley	19.3%	14.5%
Inland Empire	2.5%	3.3%
Los Angeles County	6.2%	13.2%
Orange County	9.3%	2.0%
San Diego-Imperial	1.9%	3.3%

*Table 1. displays percentages of the geographic distribution of survey respondents. This distribution uses the US Census Bureau 2020 California Regional map to display results. Superior California is labeled as Far Northern California.*

**Far Northern California and Southern San Joaquin Valley had the highest response rates.** Far Northern California had the highest response rates. Sacramento County represents 51.1% of respondents in Far Northern California. Butte County represented 30.2% of stakeholder respondents for this region. Southern San Joaquin Valley had the second highest response rate. 61.3% of service provider respondents were from Kern County. Followed by 86.4% of stakeholder respondents from Fresno County.

**San Diego-Imperial and Inland Empire had the lowest response rates.** San Diego-Imperial region had the lowest response rate with 1.9% of service providers and 3.3% of stakeholders completing the surveys. The Inland Empire had a comparably low response rate with 2.5% of service providers and 3.3% of stakeholders completing surveys.

## KEY FINDINGS

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The following topline highlights the COVID-related concerns and service barriers.

### Impacts on Clients

- Service providers reported a somewhat to significant increase among clients in terms of: family stress (95.4%), isolation (93.4%), school-related stress (88.7%), increased trauma symptoms (86.5%), unemployment (81.5%), clients need for services (82.5%), need for housing support (80.1%), and physical health concerns (75.8%).
- Stakeholders reported similar findings of a somewhat to significant increase among clients in terms of: Isolation (93.9%), increased trauma symptoms (90.7%), need for housing support (83.7%), unemployment (82.47%), need for crisis services (81.6%), and physical health concerns (72.9%). In addition, stakeholders identified a somewhat to significant increase in medication issues (52.58%).
- Additionally, service providers and stakeholders provided further insight of trends prevalent among clients as a result of COVID-19. These trends include increases in domestic abuse, violence in the transgender community, mental health concerns and gaps in services in the LGBTQ+ community, underreporting of child abuse, intergenerational trauma, and substance abuse. Isolation and lack of motivation stemming from limited social connectivity and distance learning challenges are especially prevalent in high school students.

### Impact on Service Delivery

- Service providers identified the following types of services as either challenging or extremely challenging to deliver during the pandemic: group therapy (68.9%), interactive therapy (60.6%) individual therapy (58.5%), family therapy (57.0%), drop-in centers (51.8%), and wraparound services (48.9%).

- Stakeholders reported that the following types of services as either challenging or extremely challenging for clients to obtain: group therapy (69%), drop-in center services (63.5%), interactive therapy (62.8%) family therapy (56.5%), individual therapy (56.3%), and wraparound services (48.2%).

### **Service Delivery Modifications**

- Service providers identified the greatest changes in service delivery: individual therapy via telemental health (TMH) (87.0%), in-person visits with PPE (61.8%), group therapy via TMH (51.2%), alternative care outside the office setting (49.6%), and hybrid treatment model (48.1%).
- Stakeholders indicated the following modifications to be most prevalent: individual therapy via telemental health (89.7%), in-person visits with patients requiring PPE (65.5%), group therapy via telemental health (60.9%), and hybrid model of treatment (60.9%).

### **Target Population Outreach**

- The following target populations have become hardest to reach for service providers: homeless/transitionally housed (61.1%), older adults (48.9%), and younger adults (45.8%). Stakeholders identified homeless/transitionally housed (66.7%), older adults (51.7%), and rural/remote residents (52.6%) as hardest to reach because of the COVID-19 pandemic.
- Respondents to both surveys also indicated difficulty reaching young children, teens, families, LGBTQ+ individuals, the English language learner community, people with disabilities, those with substance use disorders, those without access to technology (Wi-Fi or devices), farmworkers, Native American reservation inhabitants, and those with serious mental illnesses.

### **Gaps in Service**

- Service providers identified the following needs: adequate and accessible technology (64.0%), outreach to specific racial, ethnic, and cultural communities (48.8%), community engagement and planning (46.4%), and group sessions via telemental health (41.6%). Stakeholders reported the following needs to build capacity to provide services: outreach to specific racial, ethnic, and cultural communities (69.0%), community engagement and planning (67.9%), individual sessions via telemental health (65.5%), group sessions via telemental health (61.9%), in-person visits with patients requiring PPE, and crisis services (including warmlines).
- Other gaps in services mentioned in both the service provider and stakeholder survey include housing assistance, medication support services, language support, equal access to technology and adequate training, culturally relevant warmlines and other services,

crisis intervention resources, PPE for crisis intervention professionals and in-person service providers, and safety equipment to allow for compliance with social-distancing and all other COVID-19 public health mandates.

### **Anticipated Impacts on Service Providers**

- Service providers anticipate a decrease in availability of in-person appointments (50.8%) and a higher client-to-staff ratio due to revenue decline (46.2%). Also, stakeholders anticipate need for additional staff (55.4%) and a higher client-to-staff ratio because of COVID-19 (48.2%).
- Other anticipated impacts identified by services providers and stakeholders include: Zoom fatigue, limited assessment capability, staff layoffs, physical location closure, decreased training, increased demand for services, and increased need for providers.

## **CONCLUSIONS AND CONSIDERATIONS**

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All of the data points underscore the concerning mental health impacts on Californians, and particularly on those who were most at-risk of trauma and stress, those most vulnerable to disruptions in the economy and housing, and those historically underserved.

While the pandemic is still surging, the factors associated with the social determinants of mental health, such as housing and unemployment, may have some of the most significant lasting impacts that will not be addressed by vaccines and a reduction in disease prevalence.

The data also elevate concerns exacerbated by the pandemic and amplified by the potential loss and long-term impacts on vulnerable and young Californians, such as the prevalence among high school students of “isolation and lack of motivation stemming from limited social connectivity and distance learning challenges.”

As expressed in the Commission’s Framework for Responding to COVID-19 Impacts, these emerging and concerning needs could be met by partnerships to broadly deploy the latest insights and protocols for dealing with stress and trauma in ways that simultaneously address both historic and aggravated racial, cultural and ethnic disparities.



## Attachment E: Client and Family Leadership Committee Summary

December 10, 2020

### SUMMARY

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The Client and Family Leadership Committee on December 9 reviewed and discussed the “Framework for Responding to COVID-19 Impacts.” The comments from the committee and members of the public provided valuable feedback for how the Commission could use one-time funding to fortify the mental health system to better serve Californians during the pandemic and beyond. Those comments informed selection criteria and a refined list of options below.

### DISCUSSION HIGHLIGHTS

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The Commission received a wide range of comments that reflected the vast mental health needs associated with the pandemic. Participants also elevated several opportunities to help meet those needs, while also building upon existing efforts to improve the mental health system, expand the contribution of peer supports, and reduce racial, ethnic and cultural disparities.

Every comment provided additional detail as to how the pandemic is impacting the mental wellbeing of so many Californians and is further stressing and isolating those with pre-existing mental health needs.

Children and families are being particularly impacted, as school closures and distance learning are compounded by limited access to broadband and technologies. The isolation is adding stress to young clients and the limitations of tele-mental health services in some cases are reducing the effectiveness of needed care and support.

Tele-mental health services were described as a challenge and an opportunity. Concerns were raised about how well the technology works in some critical situations involving children. Access is limited in many rural and low-income communities because of the digital divide – both the lack of technology equipment and access to adequate broadband. Still, some advocates said it was important to lean in to tele-mental health because of its potential to connect people who are unlikely to come to public buildings with law enforcement security or other deterrents.

A number of comments were focused on the need to fund grassroots groups, and specifically to fund the community organizations working through the California Reducing Disparities Project. Many of the groups, CDRP advocates said, had been making progress educating their communities to reduce stigma, increase awareness of health needs and connect individuals to services – actions that are more necessary as the disease spreads, economic pressures grow and physical isolation increases.

Several participants emphasized the potential for peers to be able to close the physical gaps resulting from public health restrictions, as well as the cultural gaps, to connect services with individuals whose mental health needs are growing more serious.

Commissioner Wooten asked that the coordination between the COVID projects and the implementation of Striving for Zero be made explicit in the framework and that the heightened risk of suicide be considered in project selection.

Two speakers encouraged the Commission to make sure that its activities were coordinated with other public efforts, and emphasized the value of activities that will help the mental health system deal with urgent issues and the fundamental changes to services that are likely to continue after the pandemic.

Other stakeholders offered criteria, such as making sure the response was timely given the urgent needs. Based on the framework and comments received, the following criteria are suggested to help the Commission assess its options.

This discussion was considered along with other public comments in developing the staff recommendations.



January 11, 2021

To: MHSOAC Commissioners  
Toby Ewing, Executive Director  
Sharmil Shah, Chief of Program Operations

From: The County Behavioral Health Directors Association (CBHDA)

Subject: MHSOAC Framework for Responding to COVID-19 Impact

The County Behavioral Health Directors Association of California (CBHDA), which represents the public mental health and substance use disorder program authorities in counties throughout California, reviewed the Framework for Responding to COVID-19 Impacts outlining potential areas for the Commission to support and strengthen in response to the public health emergency. While CBHDA and our members believe all the initiatives outlined in this document have merit and would bolster California's behavioral health system during the pandemic and beyond, due to the limited amount of current funding, it is imperative that investments be targeted to a few areas that have been disproportionately exacerbated by the pandemic.

CBHDA, and the counties we represent, identified two priorities that we believe will have the largest return on investment and address key issues that have been intensified by the pandemic. These include reducing racial, ethnic, and cultural disparities and addressing the rapidly climbing suicide rate among California's youth.

**Address Racial/Ethnic Disparities in Accessing Services Amid the Pandemic**

In line with the Commission's identified strategic priorities, CBHDA supports funding efforts to reduce disparities through the MHSOAC establishing a learning collaborative to adapt and extend Solano's Innovation project to other counties. Long-standing systemic health and social inequities have put many people from racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19, according to the Centers for Disease Control and Prevention. The Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that these long-standing inequities create a double jeopardy for communities of color

during a pandemic. According to SAMHSA, given the existing impediments to care for Blacks and Latinos due to social determinants of health, the COVID-19 pandemic will place those with behavioral health problems at even higher vulnerability.<sup>1</sup>

The MHSOAC's Transparency Suite includes information "Highlighting Differences to Understand Disparities", this data set demonstrates that, except for the Asian/Pacific Islander community, the public behavioral health delivery system serves a higher percentage of individuals from communities of color when compared to the percent that these communities represent of California's total population. For example, the Black/African American community represents 6% of California's total population and the Black/African American community represents 12.5% of those receiving publicly funded Specialty Mental Health Services (SMHS) from the county behavioral health delivery system.

Without a question, the public behavioral health delivery system can do better. As mentioned, counties can improve access to behavioral health services for the Asian/Pacific Islander community and increase service delivery to better parallel the percent that these communities represent of California's Medi-Cal population, the primary population served by county behavioral health systems. For example, the Latino community comprises approximately 49.7% of Medi-Cal beneficiaries and 38.6 percent of California's total population. The Latino community represents 39.5 percent of those receiving publicly funded SMHS from the county behavioral health delivery system.

The goals of the Solano's Innovation project include increasing access to the county's most underserved priority populations, improving the quality of mental health services delivered to these communities and apply lessons learned to then address the mental health needs of other underserved marginalized communities. We strongly support using the available funds to build on the lessons learned to support not only Solano county, but other counties as they work to increase access and improve the quality of mental health services for communities underserved before and during the pandemic.

### **Suicide Prevention Efforts Targeting Youth**

The pandemic has placed an unprecedented amount of stress on all populations; however, many youth have experienced significantly worse mental health outcomes, including an increase in suicidal ideation and completed suicides.<sup>2</sup> Prior to the pandemic, suicide was the second leading

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<sup>1</sup> SAMHSA, Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S., available [here](#).

<sup>2</sup> Hill RM, Rufino K, Kurian S, Saxena J, Saxena K, Williams L. Suicide ideation and attempts in a pediatric emergency department before and during COVID-19. *Pediatrics*. 2020; doi: 10.1542/peds.2020-029280

cause of death among youth,<sup>3</sup> and experts predict that we are not seeing the full ramifications of the mental health crisis due to the pandemic. CBHDA agrees with the strategic priority of addressing mental health for school aged children, however, we would suggest that the MHSOAC focuses specifically on suicide prevention for these youth.

Given the limited amount of funding, we do not think that technical assistance to counties to further efforts in line with MHSSA will be the most effective use of these funds. The Governor's proposed January budget includes \$25 million to provide more MHSSA grants. We are strongly supportive of the Governor's proposal and believe the funding amount more adequately represents the need.

For the more limited amount currently available, we would suggest that the Commission build on previous efforts to address suicide risk in youth. One option is to continue investment in a statewide campaign, such as *Know the Signs*, which has been found to be highly effective. Experts identified that that this campaign has been a leader in effective suicide prevention messaging.<sup>4</sup> Furthermore, adults exposed to the *Know the Signs* campaign reported that they were significantly more confident in intervening with individuals displaying warning signs of suicide.<sup>5</sup> A statewide, suicide prevention campaign targeting youth would be a key investment, particularly as students continue to be disconnected from in-person classes.

In addition to raising awareness across the state, we suggest that the Commission use funding to provide grants to increase training opportunities for educators and school staff, as students return to in person learning. Possible trainings include Applied Suicide Intervention Training (ASIST), Youth Mental Health First Aid (YMHFA), and teen Mental Health First Aid (tMHFA). All of these programs have proven to be effective at training individuals to recognize mental health symptoms and warning signs of suicide.

Thank you for the opportunity to review and provide feedback regarding the Commission's Framework for Responding to COVID-19 Impacts. If you have any questions, please feel free to contact Elissa Feld, Senior Policy Analyst at [efeld@cbhda.org](mailto:efeld@cbhda.org), or Elia Gallardo, Director of Government Affairs at [egallardo@cbhda.org](mailto:egallardo@cbhda.org).

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<sup>3</sup> WISQARS (Web-based Injury Statistics Query and Reporting System) |Injury Center| CDC. Centers for Disease Control and Prevention. <http://www.cdc.gov/injury/wisqars/index.html>. Published July 1, 2020. Accessed August 20, 2020.

<sup>4</sup> Acosta, J., Ramchand, R., & Becker, A. (2017). Best practices for suicide prevention messaging and evaluating California's "Know the Signs" media campaign. *Crisis*.

<sup>5</sup> Acosta, Joie D. and Rajeev Ramchand, Adults Exposed to "Know the Signs" Are More Confident Intervening with Those At Risk for Suicide. Santa Monica, CA: RAND Corporation, 2014. [https://www.rand.org/pubs/research\\_reports/RR686.html](https://www.rand.org/pubs/research_reports/RR686.html).

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# AGENDA ITEM 5

## Information

January 28, 2021 Commission Meeting

Governor's Proposed Budget for 2021-22

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**Summary:** The Commission will be presented with an overview of the Governor's Proposed Fiscal Year 2021-22 Budget as it relates to mental health.

**Background:** The Governor's Proposed Budget states that it will advance key priorities to make health care more affordable for all by providing more Californians with coverage and strengthening the health care system during the COVID-19 Pandemic. Priorities to improve parity between behavioral health services and physical health care include:

- Establishing an Office of Health Care Affordability and a system to better use health data to improve health outcomes and address health equity. The Office is charged with promoting investments in primary care and behavioral health (CHHS Page 95).
- Recasting the Office of Statewide Health Planning and Development and the proposed Office of Health Care Affordability under the umbrella of a Department of Health Care Affordability Infrastructure to focus on workforce development (CHHS Page 96).
- Improving outcomes and expanding access to preventative services through county behavioral health departments and schools (CHHS Page 101).
- Implementation of an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools (CHHS Page 101).
- Augmenting the Commission's Budget by \$25 million one-time Mental Health Services Act Funds for the Mental Health Student Services Act Partnership Grant Program to expand partnerships between county mental health plans and school districts. In addition, a proposal to add \$25 million on-going Proposition 98 General Funds for innovative partnerships with county behavioral health departments to support student mental health services (CHHS Pages 101-102).
- Extending for one additional fiscal year the flexibilities in county spending of local Mental Health Services Act funds that were included in the 2020 Budget Act in response to the COVID-19 Pandemic (CHHS Page 102).
- Making behavioral health benefits, more consistent and seamless, by revising behavioral health medical necessity, implementing payment reform, and working toward administrative integration through the California Advancing and Innovating Medi-Cal initiative (CHHS Page 102).

Establishing a grant program for counties to acquire and rehabilitate real-estate assets to expand the community continuum of behavioral health treatment resources (CHHS Page 103)

- Expanding the community treatment programs for the felony incompetent to stand trial population to drive improved outcomes for individuals with serious mental illness and reduce recidivism in this population (CHHS Page 103).

**Presenter:** Norma Pate, Deputy Director

**Enclosures (1):** Health and Human Services Summary from the Governor's Proposed 2021-22 Budget.

**Handouts:** A PowerPoint will be made available at the Commission Meeting.

# HEALTH AND HUMAN SERVICES

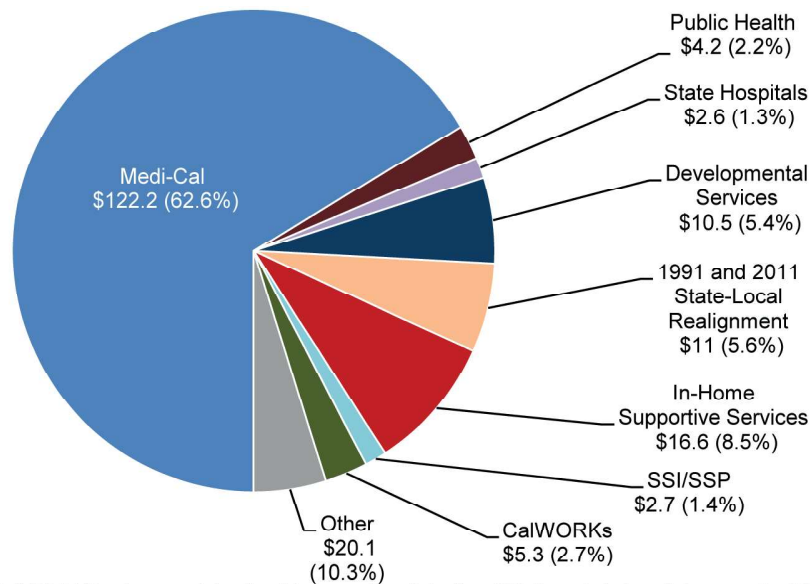
The Health and Human Services Agency oversees departments and state entities that provide health and social services to California's most vulnerable and at-risk residents. Along with the Governor's Office of Emergency Services, the Agency is leading the response to the COVID-19 Pandemic. The Budget includes \$195.1 billion (\$64.3 billion General Fund and \$130.8 billion other funds) for all health and human services programs. This does not include all pandemic response costs. (See COVID-19 Pandemic Response Chapter for more details.)

The COVID-19 Pandemic is having a significant impact on the programs under the Health and Human Services Agency. The Budget assumes that the COVID-19 Pandemic emergency response continues at some level until December 2021. This includes the enhanced Federal Medical Assistance Percentage (FMAP) provided to support the state's Medi-Cal program.

To help address projected structural deficits, the 2020 Budget Act assumed the suspension of various health and human services investments effective July 1, 2021 and December 31, 2021. Given the improved revenue outlook in the short term, the Budget proposes to delay these suspensions by one year. These suspensions include, but are not limited to, Proposition 56 supplemental payment increases, reversing the 7-percent reduction in In-Home Supportive Services hours, and Developmental Services payment increases.



**Health and Human Services Proposed 2021-22 Funding<sup>1/</sup>**  
**All Funds**  
 (Dollars in Billions)



<sup>1/</sup> Totals \$195.1 billion for support, local assistance, and capital outlay. This figure includes reimbursements of \$17.9 billion and excludes \$305,000 in Proposition 98 funding in the Department of Developmental Services budget and county funds that do not flow through the state budget.  
 Note: Numbers may not add due to rounding.

**Major Health and Human Services Program Caseloads**

	2020-21 Revised	2021-22 Estimate	Change
Medi-Cal	13,970,800	15,603,800	1,633,000
California Children's Services (CCS) <sup>1/</sup>	14,571	14,571	0
CalWORKs	405,317	482,436	77,119
CalFresh	2,167,167	2,559,491	392,324
SSI/SSP (support for aged, blind, and disabled)	1,201,565	1,188,055	-13,510
Child Welfare Services <sup>2/</sup>	111,204	110,817	-387
Foster Care	56,923	57,899	976
Adoption Assistance	88,849	89,239	390
In-Home Supportive Services	570,411	592,829	22,418
Regional Centers	357,819	386,431	28,612
State Hospitals <sup>3/</sup>	6,162	6,361	199
Developmental Centers <sup>4/</sup>	322	322	0
Vocational Rehabilitation	108,000	108,000	0

<sup>1/</sup> Represents unduplicated quarterly caseload in the CCS Program. Does not include Medi-Cal CCS beneficiaries.  
<sup>2/</sup> Represents Emergency Response, Family Maintenance, Family Reunification, and Permanent Placement service areas on a monthly basis. Due to transfers between each service area, cases may be reflected in more than one service area.  
<sup>3/</sup> Represents the year-end population at State Hospitals, county Jail-Based Competency Treatment programs, and Kern Admission, Evaluation and Stabilization center.  
<sup>4/</sup> Represents the year-end population.

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## **MAKING HEALTH CARE MORE AFFORDABLE**

More than ever, the COVID-19 Pandemic has underscored the need to expand coverage and increase affordability of health care for all. The state has made significant investments in recent years to expand coverage and increase the affordability of health care, including:

- Augmenting premium assistance for Covered California enrollees, making California the first state in the nation to provide additional state premium assistance for the middle class;
- Instituting a state individual mandate to stabilize the health insurance market;
- Expanding eligibility for no-cost Medi-Cal for persons aged 65 and older and persons with disabilities up to 138 percent of the federal poverty level;
- Extending Medi-Cal to income-eligible young adults regardless of immigration status;
- Addressing the high costs of prescription drugs;
- Restoring optional benefits (most were preventative services) and extending full-scope Medi-Cal coverage to new mothers with a maternal mental health diagnosis; and
- Expanding preventative services with a specific focus on screening for adverse childhood experiences.

These improvements are providing more Californians with coverage and strengthening the health care system during the COVID-19 Pandemic. Keeping people covered and healthy slows the growth of the average Californian's personal health care expenses and encourages the provision of preventative and primary care services.

The Budget takes additional steps to make health care more affordable, including establishing an Office of Health Care Affordability and a system to better use health data to improve health outcomes and address health equity.

### **OFFICE OF HEALTH CARE AFFORDABILITY**

Improving the affordability of health coverage will benefit millions of working Californians, and this endeavor must be accompanied by efforts to address underlying cost drivers. The Budget builds on the Health Care Payment Database, which enables

the Office of Statewide Health Planning and Development to collect and analyze granular utilization and cost data.

Given the size and complexity of California's health care system, the Budget includes \$11.2 million in 2021-22, \$24.5 million in 2022-23, and \$27.3 million in 2023-24 and ongoing from the Health Data and Planning Fund to establish the Office of Health Care Affordability.

This Office will be charged with increasing transparency on cost and quality, developing cost targets for the health care industry, enforcing compliance through financial penalties, and filling gaps in market oversight of transactions that may adversely impact market competition, prices, quality, access, and the total cost of care. In addition to lowering costs, the Office will promote health care workforce stability and training needs, report quality performance and equity metrics on the entire health care system, advance payment models that reward high-quality, cost-efficient care, and promote investments in primary care and behavioral health.

The Office of Statewide Health Planning and Development's programs for data assets and health care workforce development and the Office of Health Care Affordability's focus on health care cost containment present an opportunity for the Administration to better align these priorities. The Administration will submit a proposal in the spring recasting the Office of Statewide Health Planning and Development and the proposed Office of Health Care Affordability under the umbrella of a Department of Health Care Affordability and Infrastructure. The Department will be the dedicated entity within state government with subject matter expertise on health care affordability and infrastructure.

### **UTILIZING HEALTH INFORMATION EXCHANGE**

It is imperative that the state expand the use of clinical and administrative data to better understand the health and social needs of individual patients in order to achieve high-quality, efficient, safe, and timely service delivery while improving outcomes. These goals can be accomplished by building and supporting the infrastructure and information systems to facilitate secure and appropriate exchange of electronic health information among health care providers.

Despite significant federal investment over the past 10 years for adoption of electronic health records and creation of health information exchanges, most patients' medical information, including clinical histories, medications, and test results, is stored on paper or across hundreds of disparate electronic health record systems. The goals of improved

health outcomes and affordability cannot be achieved without unified patient health records and digital infrastructure to support a more integrated provision of health and human services.

To further build on the promise of health information exchange, the Administration is interested in accelerating the utilization and integration of health information exchanges as part of a network that receives and integrates health data for all Californians. The building and operation of the network of exchanges will leverage existing investments in health information exchange and look for additional federal funding in alignment with federal interoperability rules. To do this the state must:

- Enable the right access to health information at the right time resulting in improved health and outcomes for all Californians;
- Identify and overcome the barriers to exchanging health information between public programs, as well as with California providers and consumers; and
- Engage consumers and their providers in managing medical, behavioral and social services through appropriate, streamlined access to electronic health information.

The Administration envisions an environment where health plans, hospitals, medical groups, testing laboratories, and nursing facilities—at a minimum, as a condition of participating in state health programs such as Medi-Cal, Covered California and CalPERS—contribute to, access, exchange, and make available data through the network of health information exchanges for every person.

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## IMPROVING HEALTH EQUITY

The COVID-19 Pandemic has exposed long-standing health inequities seen among people of color. The pandemic has also highlighted systemic racism and discrimination that has created social, economic, and health inequities contributing to disproportionately higher infection and mortality rates for both chronic and infectious diseases; and COVID-19 incidence has been disproportionate in Black, Latinx, and Pacific Islander populations. The higher prevalence of underlying health conditions such as diabetes, obesity, and hypertension among communities of color increases the likelihood of more severe outcomes.

California was the first state in the nation to implement a health equity metric as part of the Blueprint for a Safer Economy framework. The equity metric requires counties to demonstrate an improvement in COVID-19 test positivity rates in neighborhoods facing

the most severe impacts. Addressing differential infection rates in disadvantaged communities is critical to safely reopening California's economy.

Health equity has been a key focus of the Administration and the COVID-19 Pandemic has accelerated the need for additional action. The Budget builds on these efforts to address the need for a more culturally and linguistically competent and responsive health and social services system. The Budget proposes the following initiatives expressly addressing health inequities:

- **Health Plan Equity and Quality Standards**—This spring, the Administration will propose an investment for the Department of Managed Health Care, in collaboration with other entities, to establish a priority set of standard quality measures for full service and behavioral health plans, including quality and health equity benchmark standards, and to take enforcement actions against non-compliant health plans.
- **Improving Equity Through Managed Care Plan Re procurements**—As Medi-Cal and Covered California managed care plan contracts come up for renewal, the Administration will work to include a focus on health disparities and cultural and language competency through health plan contractual language with a framework similar to the Blueprint equity metric.
- **Analysis of COVID-19 Impacts**—The Budget includes \$1.7 million General Fund in 2021-22 and \$154,000 General Fund in 2022-23 and ongoing for the California Health and Human Services Agency to conduct an analysis of the intersection of COVID-19, health disparities, and health equity to help inform any future response.
- **Community Navigators**—The Budget includes \$5.3 million (\$3.2 million General Fund) for the Department of Developmental Services to contract with family resource centers to implement a navigator model statewide. The navigator model would utilize parents of individuals in the regional center system to provide education on resources, advocacy, and mentorship to other parents of individuals being served by the regional center system. The purpose of navigators is to increase service authorization and utilization in diverse communities, furthering health equity within the developmental services system. Funding includes resources for a one-time independent evaluation focused on improving the effectiveness of existing disparity projects.

Addressing health disparities created by systemic racism and discrimination are also central to many of the other budget proposals described later in this Chapter. In addition, the Budget includes \$4.1 million (\$3.7 million General Fund) in 2021-22 and

\$2.1 million (\$1.6 million General Fund) ongoing for the Health and Human Services Agency to further reorient the administration of its programs through the use of data and the development of an equity dashboard.

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## ADDRESSING AGING IN CALIFORNIA

In June 2019, the Governor issued an executive order calling for a 10-year Master Plan for Aging to support aging well across the lifespan. California's 65 and over population is projected to grow to 8.5 million by 2030, nearly doubling from 2010 and increasing from 11.5 percent of the population to 20 percent. The Governor also established a Task Force on Alzheimer's Prevention and Preparedness, chaired by Former First Lady Maria Shriver, to tackle the policy and health challenges faced by the growing number of people living with dementia—more than 690,000 Californians have a diagnosis of Alzheimer's and more than 1.6 million people are responsible for providing care.

Nearly 80 percent of all Californians who have died from COVID-19 in 2020 were age 65 or older. Moreover, nearly 40 percent of all Californians who died from COVID-19 in 2020 were living in nursing homes; early data suggest people with dementia have experienced especially high rates of cases and death. Millions more older and at-risk adults remained home to stay healthy and, as a result, faced isolation and interruption to essential activities, including caregiving. Black, Latinx, and Pacific Islander older Californians have been disproportionately impacted by COVID-19.

The Budget recognizes the extraordinary challenges older Californians and their families face during the COVID-19 Pandemic, and proposes a range of investments to increase opportunities for Californians to age well over the next decade, including developing new strategies with the federal government to leverage Medicare to provide additional long-term services and supports.

The Governor will appoint a Senior Advisor on Aging, Disability and Alzheimer's to advance cross-Cabinet initiatives and partnerships between government, the private sector, and philanthropy, such as closing the digital divide, transportation options beyond driving, and caregiving workforce solutions, for Californians of all ages. The Budget includes a \$5 million General Fund placeholder for spring proposals to further implement the Master Plan for Aging.

To drive innovation in top priorities identified in the Master Plan for Aging, the Budget makes the following targeted investments:



- Medicare Innovation and Integration—The Administration plans to submit a proposal in the spring for state operations to establish a new Office of Medicare Innovation and Integration that will explore strategies and models to strengthen and expand low- and middle-income Californians' access to high-quality services and supports, while developing new partnerships with the federal government.
- Expanded Facilities to Support Housing—The Budget includes \$250 million one-time General Fund for the Department of Social Services to acquire and rehabilitate Adult Residential Facilities (ARF) and Residential Care Facilities for the Elderly (RCFE) with a specific focus on preserving and expanding housing for low-income seniors who are homeless or at risk of becoming homeless. See the Housing and Homelessness Chapter for more information.
- Aging and Disability Resource Connections (ADRC)—The Budget delays suspension of and expands ADRCs, or “No Wrong Door,” networks currently serving approximately one-third of the state to serving the entire state. These centers provide people with “one stop” telephone and online access to information and assistance with aging, disability, and Alzheimer’s, in multiple languages and with cultural competencies. The Budget provides \$7.5 million in 2021-22, half-year funding of \$5 million in 2022-23, and is subject to suspension on December 31, 2022.
- IHSS COVID-19 Back-up Provider System—The Budget includes \$5.3 million one-time General Fund in 2021-22 to extend the back-up provider system and back-up provider wage differential to avoid disruptions to caregiving until December 2021. The Administration will evaluate the need of an IHSS provider backup system for severely impaired individuals as the state recovers from the effects of the COVID-19 Pandemic.
- Increased Geriatric Care Workforce—The Budget includes \$3 million one-time General Fund for the Office of Statewide Health Planning and Development to grow and diversify the pipeline for the geriatric medicine workforce, as the increasing and diversifying numbers of older adults living longer lives require developing a larger and more diverse pool of health care workers with experience in geriatric medicine.

### **EQUITABLE PATH FORWARD ON ALZHEIMER’S**

The Budget proposes a comprehensive and coordinated approach to Alzheimer’s with an emphasis on communities of color and on women, who are disproportionately susceptible to the disease and the primary providers of caregiving. Investments to be administered by the Department of Public Health are five-pronged: \$5 million one-time General Fund for a public education campaign on brain health; \$4 million one-time

General Fund for new training and certification for caregivers; \$2 million one-time General Fund for expanded training in standards of care for health care providers; \$2 million one-time General Fund for grants to communities to become dementia-friendly; and \$4 million one-time General Fund for research to strengthen California's leadership on disparities and equity in Alzheimer's.

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## **ADDRESSING BEHAVIORAL HEALTH**

The COVID-19 Pandemic is having a myriad of impacts on individuals and families. Stay at home orders, which have been necessary to save lives, have also increased isolation for seniors. Families have also struggled with schools closed to in-person instruction and children without many normal physical and social outlets. In addition, the COVID-19 Pandemic induced recession has left many households with increased worry about how they will maintain food and shelter. With this backdrop, the Administration is focused on improving outcomes and expanding access to preventative services through county behavioral health departments and schools. These efforts build on resources provided in the 2020 Budget Act for the Department of Managed Health Care's behavioral health-focused investigations and enforcement of commercial health plan compliance with parity laws.

### **STUDENT MENTAL HEALTH**

COVID-19 stay-at-home orders and school closures have impacted students and caused additional stress and anxiety. Early identification and treatment through school-based, or school-linked, services can reduce emergency room visits, crisis situations, inpatient stays, placement in high-cost special education settings, and out of home placement.

The Budget includes one-time \$400 million (\$200 million General Fund), available over multiple years, for the Department of Health Care Services to implement an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools. This innovative effort seeks to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services from schools, providers in schools, or school-based health centers.

Additionally, the Budget includes \$25 million one-time Mental Health Services Fund, available over five years, for the Mental Health Services Oversight and Accountability Commission to augment the Mental Health Student Services Act Partnership Grant



Program, which funds partnerships between county mental health plans and school districts.

Further, the Budget includes \$25 million ongoing Proposition 98 General Fund to fund innovative partnerships with county behavioral health departments to support student mental health services. This funding would be provided to local educational agencies as a match to funding in county Mental Health Services Act (MHSA) spending plans dedicated to the mental health needs of students. See the K-12 Education Chapter for additional information.

### **STRENGTHENING COUNTY BEHAVIORAL HEALTH**

County behavioral health programs are supported by a combination of 2011 Realignment, MHSA, and other county funding sources, and are responsible for organizing and overseeing local mental health and substance use disorder programs, including specialty mental health for Medi-Cal and uninsured patients. Counties work with Medi-Cal managed care plans to deliver mild and moderate services and provide specialty mental health services not included in managed care plans. The Budget includes several different efforts to improve and add needed infrastructure to county behavioral health programs, including support for individuals acutely impacted by mental illness.

The COVID-19 Pandemic has necessitated changes in the demand for behavioral health services and the delivery of these benefits. Therefore, the Budget proposes statutory changes to extend flexibilities in county spending of local MHSA funds that were included in the 2020 Budget Act in response to the COVID-19 Pandemic for an additional fiscal year. The statutory changes authorize counties to spend down their local MHSA prudent reserves, as opposed to requesting county-by-county authority from the state. Further, the changes authorize counties to spend funds within the Community Services and Supports program component regardless of category restrictions to meet local needs. Lastly, the changes authorize counties to use their existing approved MHSA spending plans, if a new plan is delayed because of COVID-19-related reasons.

As discussed later in this chapter, the Administration is proposing the California Advancing and Innovating Medi-Cal (CalAIM) Initiative to make Medi-Cal, including behavioral health benefits, more consistent and seamless, by among other things, revising behavioral health medical necessity, implementing payment reform, and working toward administrative integration.

The Budget also includes \$750 million one-time General Fund for competitive grants to counties to acquire and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. These community resources are needed to address individuals experiencing a crisis and are a critical component of an overarching framework to solve and not just mitigate homelessness. The Administration is also exploring opportunities to repurpose relinquished adult jail bond financing to add to this effort. See the Criminal Justice Chapter for more information.

The Budget also proposes to greatly expand the community treatment programs for the felony incompetent to stand trial population. This includes a demonstration project that will streamline services to drive improved outcomes for individuals with serious mental illness and reduce recidivism in this population.

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## **DEPARTMENT OF HEALTH CARE SERVICES**

Medi-Cal, California's Medicaid program, is administered by the Department of Health Care Services. Medi-Cal is a public health care program that provides comprehensive health care services at no or low cost for low-income individuals. The federal government mandates that basic services be included in the program, including: physician services; family nurse practitioner services; nursing facility services; hospital inpatient and outpatient services; laboratory and radiology services; family planning; behavioral health; and early and periodic screening, diagnosis, and treatment services for children. In addition to these mandatory services, the state provides optional benefits such as outpatient drugs, adult dental services, home and community-based services, and medical equipment. The Department also operates the California Children's Services and the Primary and Rural Health programs, and oversees county-operated community mental health and substance use disorder programs.

The Medi-Cal budget is \$117.9 billion (\$22.5 billion General Fund) in 2020-21 and \$122.2 billion (\$28.4 billion General Fund) in 2021-22. The Budget assumes that caseload will increase approximately 10.1 percent from 2019-20 to 2020-21 and increase approximately 11.7 percent from 2020-21 to 2021-22. Medi-Cal is projected to cover approximately 15.6 million Californians, nearly 40 percent of the state's population, in 2021-22.

### **CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)**

Medi-Cal has significantly expanded and changed over the last ten years, in large part due to California's implementation of the federal Patient Protection and Affordable Care Act. Since implementing the Act, the Department has undertaken many initiatives

and embarked on innovative demonstration projects to improve the beneficiary experience.

Today, some Medi-Cal enrollees may need to access six or more separate delivery systems, including managed care, fee-for-service, mental health, substance use disorder, dental, developmental, and/or In-Home Supportive Services. Fragmentation of service delivery increases the need for care coordination, increases complexity, and results in greater health inequities. To improve clinical outcomes and assist beneficiaries with navigating this complex system, the Department is seeking to better coordinate and integrate these delivery systems to achieve more equal health outcomes for all across the entire continuum of care.

To this end, the Department is launching CalAIM, which builds upon the critical successes of waiver demonstration programs such as Whole Person Care, the Coordinated Care Initiative, Health Homes, and public hospital system delivery transformation. CalAIM proposes to provide a wider array of services and supports for patients with complex and high needs.

CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing social determinants of health;
- Make Medi-Cal more consistent and seamless by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Transformation of the delivery system is necessary to improve outcomes for Medi-Cal beneficiaries as well as to achieve long-term cost avoidance. The reforms proposed through CalAIM represent a comprehensive approach to achieving these goals. These changes will position the state to better connect individuals—including children and youth in foster care, individuals experiencing homelessness, individuals with mental health challenges and substance use disorders, and individuals involved in the justice system—to the services they need. Attaining these goals will have significant impacts on individuals' health and quality of life and through iterative system transformation, will ultimately reduce healthcare costs over time.

To implement CalAIM effective January 1, 2022, the Budget includes \$1.1 billion (\$531.9 million General Fund) in 2021-22, growing to \$1.5 billion (\$755.5 million General Fund) in 2023-24.

This investment will provide for enhanced care management and in lieu of services, necessary infrastructure to expand whole person care approaches statewide, and build upon existing dental initiatives. Beginning in 2024-25, the Administration proposes to phase out infrastructure funding, resulting in ongoing costs of about \$846.4 million (\$423 million General Fund) per year.

This effort will be complemented by \$750 million one-time General Fund for competitive grants to counties to acquire and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. The Administration is also exploring opportunities to repurpose relinquished adult jail bond financing to add to these efforts. See the Criminal Justice Chapter for additional details.

#### Other Significant Adjustments:

- 2020-21 Budget—The Budget reflects lower expenditures in the Medi-Cal program of approximately \$1.2 billion General Fund in 2020-21 compared with the 2020 Budget Act. The decrease is due primarily to reduced COVID-19 caseload costs, additional enhanced Federal Medical Assistance Percentage (FMAP), reduced costs associated with the state-only claiming adjustment, and additional Hospital Quality Assurance Fee (HQAF) savings. These reduced General Fund costs are partially offset by a one-time retroactive correction to managed care rates associated with dual-eligible beneficiaries and an increase in deferred federal fund claims.
- COVID-19 Medi-Cal Caseload Impacts—The Budget projects an average monthly caseload of 14 million beneficiaries in 2020-21 and 15.6 million beneficiaries in 2021-22, and includes \$5.4 billion (\$1.7 billion General Fund) in 2020-21 and \$13.5 billion (\$4.3 billion General Fund) in 2021-22 for increased caseload attributable to the COVID-19 Pandemic. Caseload is projected to peak at 16.1 million beneficiaries in January 2022, driven by the federal continuous coverage requirement related to the COVID-19 Public Health Emergency and the COVID-19 induced recession.
- Additional COVID-19 Impacts—The Budget includes net costs of \$1.9 billion total funds (\$2 billion General Fund savings) for COVID-19 impacts, including enhanced FMAP savings, vaccine administration costs, and federal waiver flexibilities. The

Budget assumes enhanced FMAP savings and flexibilities will remain in effect through the last quarter of calendar year 2021.

- **State-Only Claiming Adjustment**—The Budget includes \$249.8 million General Fund in 2020-21 and \$279.1 million General Fund in 2021-22 for retroactive and ongoing dental, pharmacy, and managed care, targeted case management, and behavioral health costs associated with state-only populations.
- **Medi-Cal Rx**—The Budget includes costs of \$219.9 million (\$70.2 million General Fund) in 2020-21 and savings of \$612.7 million (\$238.2 million General Fund) in 2021-22 associated with the carve-out of the Medi-Cal pharmacy benefit from managed care to fee-for-service, effective April 1, 2021. Full annual savings are projected to be approximately \$1.2 billion (\$419 million General Fund) by 2023-24.
- **Reinstatement of Adult Acetaminophen and Cough/Cold Products**—The Budget reflects annual savings of \$21 million (\$7.8 million General Fund) to reinstate over-the-counter adult acetaminophen and cough/cold products as covered Medi-Cal benefits effective July 1, 2021. Coverage of these products was temporarily reinstated effective March 1, 2020, as part of the state's federally approved COVID-19 waiver flexibilities.
- **Medi-Cal Coverage of Continuous Glucose Monitors**—The Budget includes \$12 million (\$4.2 million General Fund) in 2021-22 and ongoing to add continuous glucose monitors as a covered Medi-Cal benefit for adult individuals with type 1 diabetes, effective January 1, 2022. This proposal increases health equity.
- **Telehealth Flexibilities in Medi-Cal**—The Budget includes \$94.8 million (\$34 million General Fund) ongoing to expand and make permanent certain telehealth flexibilities authorized during COVID-19 for Medi-Cal providers, and to add remote patient monitoring as a new covered benefit, effective July 1, 2021. This effort will expand access to preventative services and improve health outcomes, thereby increasing health equity.
- **County Administration**—The Budget includes an ongoing increase of \$65.4 million (\$22.9 million General Fund) in 2021-22 for county eligibility determination activities based on growth in the California Consumer Price Index.

### **PROPOSITION 56 SUPPLEMENTAL PAYMENT PROGRAMS**

Given an improved revenue outlook in the short term, the Budget delays the suspension of Proposition 56 programs by 12 months and includes a total of \$3.2 billion (\$275.3 million General Fund, \$717.8 million Proposition 56 Fund, and \$2.2 billion federal

funds) for these programs in 2021-22. (The Budget would have otherwise included \$759.9 million General Fund savings if the suspensions were not delayed.) The General Fund partially supports supplemental payment programs at current levels now that program costs exceed declining tobacco tax revenues, due primarily to the assumed implementation of the ban on flavored tobacco and vaping products pursuant to Chapter 34, Statutes of 2020 (SB 793).

The Budget assumes Proposition 56 suspensions effective July 1, 2022, except for supplemental payments to intermediate care facilities for the developmentally disabled, freestanding pediatric subacute facilities, and Community Based Adult Services, which will be suspended December 31, 2022, due to the managed care calendar rate year. Payments for Women's Health, Family Planning, and the Loan Repayment Program are exempt from suspension. The Budget also proposes to exempt supplemental payments for the Behavioral Health Integration program, the AIDS waiver, Home Health, and Pediatric Day Health from suspension because they would not be deemed eligible by the federal government.

### **OTHER SUSPENDED PROGRAMS**

Given an improved revenue outlook in the short term, the Budget proposes to delay suspensions by one year for the following:

- **Medi-Cal Post-Partum Eligibility Extension**—The Budget delays the suspension of Medi-Cal post-partum extended eligibility by 12 months to December 31, 2022, for a cost of \$27.1 million General Fund in 2021-22.
- **Medi-Cal Adult Optional Benefits Extension**—The Budget includes \$47 million (\$15.6 million General Fund) in 2021-22 to delay by 12 months the suspension of audiology and speech therapy services, incontinence creams and washes, optician and optical lab services, and podiatric services to December 31, 2022.

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## **DEPARTMENT OF SOCIAL SERVICES**

The Department of Social Services (DSS) serves, aids, and protects needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence. The Department's major programs include CalWORKs, CalFresh, In-Home Supportive Services (IHSS), Supplemental Security Income/State Supplementary Payment (SSI/SSP), Child Welfare Services, Community Care Licensing, and Disability Determination. Beginning July 1, 2021, child care and nutrition programs will transition from the California



Department of Education (CDE) to DSS. The Budget includes \$36.2 billion (\$14.4 billion General Fund) for DSS programs in 2021-22.

Significant Adjustments:

- **Food Banks**—The Budget includes \$30 million one-time General Fund above program base funding levels for the Department of Social Services to fund existing Emergency Food Assistance Program providers, food banks, tribes, and tribal organizations to mitigate increases in food needs among low-income and food-insecure populations. The recently enacted federal COVID-19 response and relief bill includes increased benefits for CalFresh and the Emergency Food Assistance Program.
- **Supplemental Nutrition Benefit and Transitional Nutrition Benefit Programs Adjustment**—The Budget includes \$22.3 million ongoing General Fund to reflect adjusted benefit amounts mitigating the effects of the elimination of the SSI Cash-Out policy.
- **California Food Assistance Program (CFAP) Emergency Allotments**—The Budget includes \$11.4 million one-time General Fund for CFAP households to receive the maximum allowable allotment based on household size.

### **CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS**

The CalWORKs program, California's version of the federal Temporary Assistance for Needy Families (TANF) program, provides temporary cash assistance to low-income families with children to meet basic needs. It also provides welfare-to-work services so that families may become self-sufficient. Eligibility requirements and benefit levels are established by the state. Counties have flexibility in program design, services, and funding to meet local needs.

Total TANF expenditures are \$9.3 billion (state, local, and federal funds) in 2021-22. The amount budgeted includes \$7.4 billion for CalWORKs program expenditures and \$1.9 billion in other programs. Other programs include expenditures for Child Care, Child Welfare Services, Foster Care, Department of Developmental Services programs, the Statewide Automated Welfare System, Work Incentive Nutritional Supplement, California Community Colleges Child Care and Education Services, Cal Grants, and the Department of Child Support Services.

The average monthly CalWORKs caseload is estimated to be 482,436 families in 2021-22, a 19 percent increase from the revised 2020-21 projection. Prior to COVID-19, the

CalWORKs caseload had decreased every year since 2010-11. Due to the COVID-19 Pandemic's impact on the economy and initial spikes in caseload in the immediate months following the pandemic, the CalWORKs caseload was projected to grow significantly at the 2020 Budget Act. This caseload did not materialize likely due to expanded and extended unemployment insurance benefits and direct stimulus payments. The Budget includes revised caseload projections, driven by updated assumptions and the uncertainty surrounding further federal relief and duration of the public health emergency.

Significant Adjustments:

- **CalWORKs Time on Aid Exemption**—The Budget includes \$46.1 million one-time General Fund (TANF) block grant funding to temporarily suspend any month in which CalWORKs aid or services are received from counting towards the CalWORKs 48-month time limit based on a good cause exemption due to the COVID-19 Pandemic.
- **CalWORKs Grant Increase**—The Budget reflects a 1.5-percent increase to CalWORKs Maximum Aid Payment levels, effective October 1, 2021, which is estimated to cost \$50.1 million in 2021-22. These increased grant costs are funded entirely by the Child Poverty and Family Supplemental Support Subaccounts of the Local Revenue Fund.

## **IN-HOME SUPPORTIVE SERVICES**

The IHSS program provides domestic and related services such as housework, transportation, and personal care services to eligible low-income aged, blind, and disabled persons. These services are provided to assist individuals to remain safely in their homes and prevent more costly institutionalization. The Budget includes \$16.5 billion (\$5.3 billion General Fund) for the IHSS program in 2021-22, a 10-percent increase in General Fund costs over the revised 2020-21 level. Average monthly caseload in this program is estimated to be 593,000 recipients in 2021-22, a 3.9-percent increase from the revised 2020-21 projection.

Significant Adjustments:

- **IHSS Service Hours Restoration**—The Budget includes \$449.8 million General Fund in 2021-22 and \$242.6 million General Fund in 2022-23 to reflect a delay in suspending the 7-percent across-the-board reduction to IHSS service hours. The increased funding for IHSS service hours is now proposed to be suspended on December 31, 2022. The suspension will be lifted if the Administration determines



through the 2022 Budget Act process that there is sufficient General Fund revenue to support all suspended programs in the subsequent two fiscal years.

- **Minimum Wage**—The Budget reflects \$1.2 billion (\$557.6 million General Fund) to support projected minimum wage increases to \$14 per hour on January 1, 2021 and \$15 per hour on January 1, 2022.
- **IHSS County Administration**—The Budget no longer assumes savings to hold county administration funding at the 2019-20 level, resulting in county administration costs being updated for 2021-22 to include \$17.8 million General Fund to reflect caseload and Consumer Price Index adjustments.

### **SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT (SSI/SSP)**

The federal SSI program provides a monthly cash benefit to eligible aged, blind, and disabled persons who meet the program's income and resource requirements. In California, the SSI payment is augmented with an SSP grant. These cash grants assist recipients with basic needs and living expenses. The federal Social Security Administration administers the SSI/SSP program, making eligibility determinations, computing grants, and issuing combined monthly checks to recipients. The state-only Cash Assistance Program for Immigrants (CAPI) provides monthly cash benefits to aged, blind, and disabled legal noncitizens who are ineligible for SSI/SSP due solely to their immigration status.

The Budget includes \$2.69 billion General Fund in 2021-22 for the SSI/SSP program. This represents a 0.6-percent decrease from the revised 2020-21 level. The average monthly caseload in this program is estimated to be 1.18 million recipients in 2021-22, a 1.1-percent decrease from the 2020-21 projection. The SSI/SSP caseload consists of 69.4 percent persons with disabilities, 29.3 percent persons who are aged, and 1.4 percent blind.

Effective January 2021, the maximum SSI/SSP grant levels are \$955 per month for individuals and \$1,598 per month for couples. The projected growth in the Consumer Price Index is 2.2 percent for 2022. As a result, the maximum SSI/SSP monthly grant levels will increase by approximately \$17 and \$26 for individuals and couples, respectively, effective January 2021. CAPI benefits are equivalent to SSI/SSP benefits.

### **CHILDREN'S PROGRAMS**

Child Welfare Services include family support and maltreatment prevention services, child protective services, foster care services, and adoptions. California's child welfare

system provides a continuum of services to children who are either at risk of or have suffered abuse and neglect. Program success is measured in terms of improving the safety, permanence, and well-being of children and families served. The Budget includes \$700.1 million General Fund in 2021-22 for services to children and families in these programs, a decrease of \$22.6 million General Fund, or 3.1 percent, compared to the 2020 Budget Act. When federal and 1991 and 2011 Realignment funds are included, total funding for children's programs is in excess of \$8.9 billion in 2021-22. The net decrease is primarily attributable to decreased caseload under the Continuum of Care Reform and one-time funding related to child welfare services included in the 2020 Budget Act.

#### Significant Adjustments:

- **COVID-19 Related Supports for Child Welfare Services**—The Budget includes \$61.1 million General Fund in 2021-22 to support services related to quarantine needs for foster youth and caregivers, temporary extension of assistance payments to emergency caregivers, support to Family Resource Centers, state-administered contracts for youth and family helplines, provision of laptops and cellular phones to foster youth, assistance to families with youth who are at-risk of entering foster care, and temporary provision of assistance payments to youth who turn 21 years of age while in extended foster care after April 17, 2020, through December 31, 2021, and for any nonminor dependent who met eligibility requirements for the Extended Foster Care program and lost their employment or has experienced a disruption in their education program resulting from COVID-19, and cannot otherwise meet any of the participation requirements.
- **Federal Family First Prevention Services Act Implementation**—The Budget includes \$61.1 million (\$42.7 million General Fund) to begin implementation of Part IV of the federal Family First Prevention Services Act (FFPSA). FFPSA Part IV sets out new criteria for non-foster home placement settings eligible for federal Title IV-E Foster Care maintenance payments.
- **Child Welfare Workforce Development**—The Budget includes \$10.1 million (\$5.9 million General Fund) ongoing to establish an additional child welfare social workers regional training academy in northern California (bringing the statewide total to five academies), increase ongoing training for social workers and supervisors, assess training effectiveness, and modernize how social worker training is monitored and used to inform workforce development planning.

## HEALTH AND HUMAN SERVICES

- **Delay Suspension of Various Children's Issues**—The Budget proposes to extend the temporary augmentation to the Emergency Child Care Bridge Program, foster family agencies, Child Welfare Public Health Nursing Early Intervention Program, and the Family Urgent Response System from December 31, 2021, to December 31, 2022. Estimated costs to delay the suspension in 2021-22 are \$54.5 million General Fund. The suspension will be lifted if the Administration determines through the 2022 Budget Act process that there is sufficient General Fund revenue to support all suspended programs in the subsequent two fiscal years.
- **Youth Returning from Out of State**—In partnership with the Legislature, \$5.2 million one-time General Fund was allocated in December 2020 for the Department of Social Services to support youth in their transition back to California. These resources are supporting county capacity building and supportive services for the returned youth, COVID-related quarantine costs, and technical assistance to support counties in placing the returning youth.

### **IMMIGRATION SERVICES**

The Department of Social Services funds qualified nonprofit organizations to provide immigration services to immigrants who reside in California via the unaccompanied undocumented minors and Immigration Services Funding programs. The Budget continues to include \$75 million General Fund ongoing for immigration services.

Significant Adjustments:

- **Rapid Response Program**—The Budget includes \$5 million one-time General Fund for the Rapid Response Program to support entities that provide critical assistance/ services to immigrants during emergent situations when federal funding is not available.

### **CHILD CARE**

Since 2019, the state has invested approximately \$400 million ongoing to expand early education and child care. The COVID-19 Pandemic has disrupted the child care system and federal funding has been critical to reducing long-term losses in this system. The Budget focuses on avoiding further loss in this system and builds on the recommendations made in the Master Plan for Early Learning and Care.

The 2020 Budget Act shifted early learning, child care and nutrition programs from the Department of Education to the Department of Social Services. This transition, which

becomes effective July 1, 2021, will align all child care programs within a single department in state government.

Significant Adjustments:

- **State Operations**—The Budget shifts \$31.7 million (\$0.9 million General Fund) and 185.7 positions from the Department of Education to the Department of Social Services to administer early learning, child care, and nutrition programs.
- **Local Assistance**—The Budget includes \$3.1 billion (\$1.3 billion General Fund) and shifts the following programs, including: General Child Care, Alternate Payment Programs, CalWORKs Stage 2 & Stage 3, Resource & Referral Programs, Migrant Child Care Program, Severely Disabled Program, California Child Care Initiative, Quality Improvement Activities, Local Planning Councils, and Child and Adult Care Food Program.
- **COVID-19 Related Support**—The Budget includes \$55 million one-time General Fund to support child care providers' and families' needs as a result of the pandemic.

Updated Proposition 64 cannabis tax revenues will provide an additional \$21.5 million for child care slots in 2020-21 and \$44 million ongoing. These funds will provide for 4,700 new child care slots.

For the first time, the Administration has begun the collective bargaining process with Child Care Providers United representing child care providers to negotiate a memorandum of understanding that governs the payments made to these providers. The California Department of Human Resources is the Governor's designee to meet and confer regarding matters within the scope of representation. DSS will support bargaining and work to meet goals articulated in the Master Plan on Early Learning and Care.

## **RESPONDING TO THE IMMEDIATE NEEDS OF CHILD CARE PROVIDERS**

While conclusive data continue to be collected on the impact of the COVID-19 Pandemic on the state's child care system, preliminary findings and anecdotal evidence suggest that the loss of capacity in the state has been significant. Regardless, many child care providers have gone to great lengths to continue to provide care to children in a safe environment, and have taken on the added responsibility of helping children in distance learning access their public school education. It is a priority for the Administration to support these providers to the greatest extent possible, to preserve the

existing system of care, and provide additional ongoing investments to improve and expand the system.

Despite significant fiscal limitations, the 2020 Budget Act preserved funding for early learning and care programs to the greatest extent possible, with a focus on serving the children of income-eligible essential workers. This included:

- Additional access to subsidized child care for children of essential workers
- Stipends for child care providers
- A funding hold harmless for child care providers that contract directly with the state and have to close for health and safety reasons
- Paid non-operational days when a provider accepting vouchers has to close for health and safety reasons
- Provider reimbursement at a child's maximum certified level of need for all providers accepting vouchers
- Family fee waivers for all families through August 31, 2020, with additional fee waivers for families eligible for, but not receiving, in-person care due to COVID-19, through June 30, 2021

The Administration took further action in October to provide \$110 million to child care providers to reimburse them for the cost of waived family fees and extend the length of care for children of essential workers with temporary vouchers.

### **FEDERAL RELIEF**

In late December, Congress passed a fifth stimulus bill, the Coronavirus Response and Relief Supplemental Appropriations Act that includes approximately \$10.3 billion for child care and Early Start. The state is expected to receive approximately \$1 billion. The 2020 Budget Act included language to guide the prioritization of additional federal funds as follows:

- Up to \$100 million for providers accepting vouchers to extend access to child care for children of essential workers, at-risk children, and other eligible children
- Up to \$90 million in child care provider stipends
- Up to \$35 million to increase the number of paid non-operational days for providers accepting vouchers that must close for health and safety reasons

- Up to \$30 million for reimbursing child care providers for family fees waived for families enrolled, but not receiving in-person care, from September 1, 2020, to June 30, 2021 (these costs were addressed by the Administration through the October action)
- Up to \$30 million to increase capacity for up to two years for subsidized child care and preschool
- Up to \$15 million to assist child care providers with the costs of re-opening

### **MASTER PLAN FOR EARLY LEARNING AND CARE**

The 2019 Budget Act included \$5 million one-time General Fund for a long-term roadmap to universal preschool and a comprehensive, quality, and affordable child care system. The Master Plan for Early Learning and Care was released on December 1, 2020, and provides recommendations and a multi-year plan for transforming the state's child care and early education systems. Specific to child care programs, the Master Plan's recommendations include:

- Streamlining program requirements to unify state child care program.
- Promoting school readiness by increasing access to high-quality preschool.
- Improving quality of care by enhancing educator competencies and providing affordable and accessible pathways for workforce advancement.
- Supporting equity by eliminating bias through practices and training, with specific focus on children with disabilities and dual language learners.
- Adopting a comprehensive reimbursement rate structure that considers care setting, costs associated with quality, characteristics of children served, and workforce competencies.
- Developing data infrastructure that supports the quality of care by aggregating data on the ways that families and educators experience the system.

Implementation of the Master Plan will require years of consistent investment and reform. The 2020 Budget Act began implementation of the Master Plan with funding dedicated to transition child care programs into a single agency. This transition improves the ability of state government to streamline and unify all early childhood services and eases the administration of child care provider collective bargaining, which began in late 2020. The Budget builds on this work by providing an increase of \$44.3 million Cannabis Fund to expand access to child care vouchers for more than

4,500 children, with \$21.5 million available starting in 2020-21. The K-12 Education chapter includes additional information about investments in early learning programs.

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### **DEPARTMENT OF PUBLIC HEALTH**

The Department of Public Health is charged with protecting and promoting the health and well-being of the people of California. The Budget includes \$4.2 billion (\$1.1 billion General Fund) in 2021-22 for the Department.

#### **COVID-19 DISASTER RESPONSE**

The Budget reflects over \$1 billion in 2020-21 which represents state and federal support for emergency response measures including supporting enhanced laboratory capacity and testing, data-driven investigation, response and prevention, coordination with local partners, and the Valencia Branch Laboratory. This total mainly reflects emergency funds and federal grants processed as of late Fall 2020; additional anticipated current year funding as of the Governor's Budget is reflected elsewhere in the budget.

The Budget includes over \$820 million in 2021-22 to continue and build on the emergency response measures described above.

Significant Adjustments:

- **New Cannabis Department**—The Budget proposes to transfer 119 positions and \$29.0 million in 2021-22 from the Department of Public Health to support the consolidation of resources for the new Department of Cannabis Control.
- **Licensing and Certification**—The Budget includes \$19.1 million for year three of the Los Angeles County contract and \$4.5 million to support increased medical breach and caregiver investigation workload.
- **Childhood Reading Augmentation**—The Budget includes \$5 million one-time General Fund for the Department of Public Health to provide books to low-income children to improve child development and literacy.

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### **DEPARTMENT OF DEVELOPMENTAL SERVICES**

The Department of Developmental Services (DDS) provides individuals with developmental disabilities a variety of services that allow them to live and work independently or in supported environments. California is the only state that provides



services to individuals with developmental disabilities as an entitlement. The Budget includes \$10.5 billion (\$6.5 billion General Fund) and estimates that approximately 386,753 individuals will receive developmental services by the end of 2021-22.

### **COVID-19 IMPACTS**

The Budget includes \$211.7 million (\$150.4 million General Fund) to address COVID-19 impacts on the developmental services system. Funding supports utilization increases for purchase of services above base funding levels and direct response expenditures for surge capacity at the Fairview and Porterville Developmental Centers and other operating costs in state-operated facilities.

### **REGIONAL CENTER EMERGENCY RESPONSE**

In the last five years, DDS has been impacted by various emergencies and disasters including wildfires, earthquakes, and public safety power shutoffs. The Budget includes \$2 million (\$1.4 million General Fund) ongoing for regional center emergency coordinators. Each regional center will receive a dedicated position to coordinate emergency preparedness, response, and recovery activities for DDS consumers.

Other Significant Adjustments:

- Youth Returning from Out-of-State Foster Care—The Budget includes ongoing \$5.8 million (\$3.5 million General Fund) for DDS to support approximately ten youth in their transition back to California. In partnership with the Legislature, one-time \$2.9 million (\$1.8 million General Fund) was allocated in December, 2020 for these purposes.
- Supplemental Rate Increase—The Budget includes \$454.6 million (\$261.2 million General Fund) in 2021-22 to continue the supplemental rate increases included in the 2019 and 2020 Budget Acts. The supplemental rate increases will be suspended on December 31, 2022. The suspension will be lifted if the Administration determines through the 2022 Budget Act process that there is sufficient General Fund revenue to support all suspended programs in the subsequent two fiscal years.
- Uniform Holiday Schedule—The Budget includes \$55.9 million (\$35.8 million General Fund) in 2021-22 to suspend implementation of the Uniform Holiday Schedule. The funding will be suspended on December 31, 2022. The suspension will be lifted if the Administration determines through the 2022 Budget Act process that there is sufficient General Fund revenue to support all suspended programs in the subsequent two fiscal years.



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## DEPARTMENT OF STATE HOSPITALS

The Department of State Hospitals (DSH) administers the state mental health hospital system, the Forensic Conditional Release Program, the Sex Offender Commitment Program, and the evaluation and treatment of judicially and civilly committed patients. The Budget includes \$2.5 billion (\$2.3 billion General Fund) in 2021-22 for support of the Department. The patient population is expected to reach 6,361 by the end of 2021-22, including patients receiving competency treatment in jail-based settings.

### COVID-19 IMPACTS

The Budget includes \$51.9 million one-time General Fund in 2021-22 to address the impacts of COVID-19 including, but not limited to, isolation and testing capacity at state hospitals, outside medical invoicing, and other supports for patients and employees. As an additional safeguard, and to provide for increased surge capacity, DSH has contractually secured a portion of the Norwalk facility to use as an alternate care site. Due to the recent increase in COVID-19 cases this facility was activated in mid-December to provide for additional isolation space at DSH-Patton hospital.

### FELONY INCOMPETENT TO STAND TRIAL POPULATION

The Department continues to experience a growing number of incompetent to stand trial (IST) commitments who are referred from trial courts and are awaiting admission to the state hospital system, which has been further exacerbated by the COVID-19 Pandemic. The number of ISTs pending placement into the state hospital system was approximately 1,428 individuals in December 2020.

The Budget includes the followings proposals to address the number of ISTs pending placement by increasing local capacity to provide treatment, housing, and other necessary supports:

- Community Care Demonstration Project for Felony IST (CCDP-IST)—The Budget includes \$233.2 million General Fund in 2021-22 and \$136.4 million General Fund in 2022-23 and ongoing to contract with three counties to provide a continuum of services to felony ISTs in the county as opposed to state hospitals. This proposal seeks to demonstrate the effectiveness of streamlining services to drive improved outcomes for individuals with serious mental illness. This proposal is projected to serve up to 1,252 ISTs in the county continuum of care settings in 2021-22.

- Expansion of Community Based Restoration (CBR)—The Budget includes \$9.8 million General Fund in 2020-21, \$4.5 million General Fund in 2021-22, and \$5 million General Fund in 2022-23 and ongoing to expand the current Los Angeles County CBR program beginning in 2020-21 and establish new CBR programs in additional counties in 2021-22. This proposal is projected to increase capacity by up to 250 beds in 2021-22.
- Reappropriation and Expansion of the IST Diversion Program—The Budget includes \$46.4 million one-time General Fund, available over three years, to expand the current IST Diversion program in both current and new counties. Additionally, the Budget includes five-year limited-term funding of \$1.2 million General Fund annually to support research and administration for the program. Further, the Budget authorizes the reappropriation of existing program funds set to expire in 2020-21.
- Expansion of the Jail-Based Competency Treatment Program—The Budget includes \$785,000 General Fund in 2020-21 and \$6.3 million General Fund in 2021-22 and ongoing to expand the Jail-Based Competency Treatment program to seven additional counties. This expansion is estimated to increase capacity by up to 31 beds in 2021-22.
- Forensic Conditional Release Program (CONREP) Mobile Forensic Assertive Community Treatment (FACT) Team—The Budget includes \$5.6 million General Fund in 2021-22, \$8 million General Fund in 2022-23 and 2023-24, and \$8.2 million General Fund in 2024-25 and ongoing to implement a FACT team model within CONREP, in lieu of the typical centralized outpatient clinic model, to expand community-based treatment options for both ISTs and non-ISTs in counties and backfill State Hospital beds with IST patients. This expansion is estimated to increase capacity by up to 100 beds in 2021-22.
- CONREP Continuum of Care Expansion—The Budget includes \$3.2 million General Fund in 2020-21 and \$7.3 million General Fund in 2021-22 and ongoing to increase the step-down capacity in the community in order to transition more stable non-IST patients out of state hospital beds and backfill state hospital beds with IST patients. This expansion is estimated to increase capacity by up to 40 beds in 2021-22.

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## OTHER HEALTH AND HUMAN SERVICES ADJUSTMENTS

- Supporting Local Child Support Agency Administration—The Budget includes \$24.9 million (\$8.5 million General Fund) ongoing for local child support agencies to improve child support collections and services and \$23.8 million (\$8.1 million General

Fund) ongoing for local child support courts and state operations child support funding.

- Office of Youth and Community Restoration—The Budget includes \$3.4 million General Fund in 2021-22 and \$3.1 million ongoing General Fund to develop reports on youth outcomes in the juvenile justice system, staff a Child Welfare Council committee focused on improving outcomes for justice-involved youth, and create an Office Ombudsperson.
- Center for Data Insights and Innovation—The Budget proposes to consolidate existing resources to establish a Center for Data Insights and Innovation within the Agency. The Center will focus on leveraging data to develop knowledge and insights to improve program delivery and drive system transformation across health and human services.

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### **1991 AND 2011 REALIGNMENT**

The programs for 1991 and 2011 Realignment are funded through two sources: state sales tax and vehicle license fees. These fund sources are projected to increase by 5.6 percent from 2019-20 to 2020-21 and decrease by 1.9 percent from 2020-21 to 2021-22.

## 2011 Realignment Estimate at 2021 Governor's Budget

(\$ millions)

	2019-20	2019-20 Growth	2020-21	2020-21 Growth	2021-22	2021-22 Growth
<b>Law Enforcement Services</b>	<b>\$2,600.4</b>		<b>\$2,633.8</b>		<b>\$2,682.7</b>	
Trial Court Security Subaccount	558.2	0.0	567.0	\$10.1	563.7	0.0
Enhancing Law Enforcement Activities Subaccount	489.9	\$224.4	489.9	247.3	489.9	\$210.7
Community Corrections Subaccount	1,344.7	0.0	1,366.0	75.9	1,408.3	0.0
District Attorney and Public Defender Subaccount	40.9	0.0	41.6	5.1	45.5	0.0
Juvenile Justice Subaccount	166.7	0.0	169.3	10.0	175.3	0.0
<i>Youthful Offender Block Grant Special Account</i>	(157.5)	-	(160.0)	(9.4)	(165.6)	-
<i>Juvenile Reentry Grant Special Account</i>	(9.2)	-	(9.3)	(0.6)	(9.7)	-
<b>Growth, Law Enforcement Services</b>		<b>224.4</b>		<b>348.4</b>	<b>0.0</b>	<b>210.7</b>
<b>Mental Health</b>	<b>\$1,120.6</b>	0.0	<b>\$1,120.6</b>	\$9.4	<b>\$1,120.6</b>	0.0
<b>Support Services</b>	<b>\$3,825.1</b>		<b>\$3,885.6</b>		<b>\$3,969.3</b>	
Protective Services Subaccount	2,359.9	0.0	2,397.2	\$84.6	2,423.9	0.0
Behavioral Health Subaccount	1,465.2	0.0	1,488.4	94.0	1,545.4	0.0
<i>Women and Children's Residential Treatment Services</i>	(5.1)		(5.1)		(5.1)	
<b>Growth, Support Services</b>		<b>0.0</b>		<b>188.0</b>	<b>0.0</b>	
<b>Account Total and Growth</b>	<b>\$7,770.5</b>		<b>\$8,176.4</b>		<b>\$7,983.3</b>	
<b>Revenue</b>						
1.0625% Sales Tax	\$7,050.2		\$7,427.2		\$7,276.7	
General Fund Backfill	6.0		12.0		6.0	
Motor Vehicle License Fee	747.3		749.0		788.1	
<b>Revenue Total</b>	<b>\$7,770.5</b>		<b>\$8,176.4</b>		<b>\$7,983.3</b>	

This chart reflects estimates of the 2011 Realignment subaccount and growth allocations based on current revenue forecasts and in accordance with the formulas outlined in Chapter 40, Statutes of 2012 (SB 1020).

## 1991 Realignment Estimate at 2021 Governor's Budget

Dollars in Thousands

2019-20 State Fiscal Year							
Amount	CaWORKS MOE	Health	Social Services	Mental Health	Family Support	Child Poverty	Totals
<b>Base Funding</b>							
Sales Tax Account	\$742,048	\$-	\$2,296,188	\$-	\$443,649	\$102,919	\$3,584,804
Vehicle License Fee Account	363,383	1,050,566	216,223	-	152,435	290,884	2,073,492
<b>Subtotal Base</b>	<b>\$1,105,432</b>	<b>\$1,050,566</b>	<b>\$2,512,411</b>	<b>\$-</b>	<b>\$596,085</b>	<b>\$393,803</b>	<b>\$5,658,296</b>
<b>Growth Funding</b>							
Sales Tax Growth Account:	-	-	-	-	-	-	-
Caseload Subaccount	-	-	-	-	-	-	-
County Medical Services Growth Subaccount	-	-	-	-	-	-	-
General Growth Subaccount	-	-	-	-	-	-	-
Vehicle License Fee Growth Account	-	-	-	-	-	-	-
<b>Subtotal Growth</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>
<b>Total Realignment 2019-20<sup>1/</sup></b>	<b>\$1,105,432</b>	<b>\$1,050,566</b>	<b>\$2,512,411</b>	<b>\$-</b>	<b>\$596,085</b>	<b>\$393,803</b>	<b>\$5,658,296</b>
2020-21 State Fiscal Year							
<b>Base Funding</b>							
Sales Tax Account	\$742,048	\$23,890	\$2,296,188	\$-	\$419,759	\$102,919	\$3,584,804
Vehicle License Fee Account	363,383	1,016,414	216,223	-	186,586	290,884	2,073,492
<b>Subtotal Base</b>	<b>\$1,105,432</b>	<b>\$1,040,304</b>	<b>\$2,512,411</b>	<b>\$-</b>	<b>\$606,346</b>	<b>\$393,803</b>	<b>\$5,658,296</b>
<b>Growth Funding</b>							
Sales Tax Growth Account:	\$6,372	\$21,182	\$68,917	\$36,594	-	\$50,632	\$183,698
Caseload Subaccount	-	-	(68,917)	-	-	-	(68,917)
County Medical Services Growth Subaccount	-	-	-	-	-	-	-
General Growth Subaccount	(6,372)	(21,182)	-	(36,594)	-	(50,632)	(114,780)
Vehicle License Fee Growth Account	8,747	29,077	-	50,233	-	69,503	157,559
<b>Subtotal Growth</b>	<b>\$15,119</b>	<b>\$50,259</b>	<b>\$68,917</b>	<b>\$86,826</b>	<b>\$-</b>	<b>\$120,135</b>	<b>\$341,257</b>
<b>Total Realignment 2020-21<sup>1/</sup></b>	<b>\$1,120,551</b>	<b>\$1,090,564</b>	<b>\$2,581,328</b>	<b>\$86,826</b>	<b>\$606,346</b>	<b>\$513,938</b>	<b>\$5,999,553</b>
<i>Change From Prior Year</i>	<i>\$15,119</i>	<i>\$39,998</i>	<i>\$68,917</i>	<i>\$86,826</i>	<i>\$10,262</i>	<i>\$120,135</i>	<i>\$341,257</i>
2021-22 State Fiscal Year							
<b>Base Funding</b>							
Sales Tax Account	\$752,888	\$-	\$2,345,276	\$25,545	\$460,934	\$152,263	\$3,736,906
Vehicle License Fee Account	367,663	1,096,570	212,429	47,288	113,889	354,063	2,191,902
<b>Subtotal Base</b>	<b>\$1,120,551</b>	<b>\$1,096,570</b>	<b>\$2,557,704</b>	<b>\$72,833</b>	<b>\$574,823</b>	<b>\$506,327</b>	<b>\$5,928,808</b>
<b>Growth Funding</b>							
Sales Tax Growth Account:	-	-	-	-	-	-	-
Caseload Subaccount	-	-	-	-	-	-	-
County Medical Services Growth Subaccount	-	-	-	-	-	-	-
General Growth Subaccount	-	-	-	-	-	-	-
Vehicle License Fee Growth Account	-	-	-	-	-	-	-
<b>Subtotal Growth</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>
<b>Total Realignment 2021-22<sup>1/</sup></b>	<b>\$1,120,551</b>	<b>\$1,096,570</b>	<b>\$2,557,704</b>	<b>\$72,833</b>	<b>\$574,823</b>	<b>\$506,327</b>	<b>\$5,928,808</b>
<i>Change From Prior Year</i>	<i>\$0</i>	<i>\$6,005</i>	<i>-\$23,624</i>	<i>-\$13,993</i>	<i>-\$31,523</i>	<i>-\$7,611</i>	<i>-\$70,745</i>

<sup>1/</sup> Excludes \$14 million in Vehicle License Collection Account moneys not derived from realignment revenue sources.



## **Calendar of Tentative Commission Meeting Agenda Items**

**Proposed 1/19/2021**

Agenda items and meeting locations are subject to change

### **February 17, 2021: Sacramento, CA (Teleconference)**

#### **Rules of Procedure**

The Commission will consider adopting amendments to the Rules of Procedure.

#### **Budget Overview of Fiscal Year 2020-21**

The Commission will be presented with an update of the status of the current year budget.

#### **Legislative Priorities for 2021**

The Commission will consider legislative and budget priorities for the current legislative session.

#### **Staff Report Out**

Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

### **February 25, 2021: Sacramento, CA (Teleconference)**

#### **Innovation Plan Approval**

Santa Clara County seeks approval of \$1,753,140 in Innovation funding for their Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities innovation project.

#### **Legislative Priorities for 2021**

The Commission will consider legislative and budget priorities for the current legislative session.

#### **COVID-19 Related Funding Opportunities**

The Commission will be asked to approve contracts for the COVID-19 project.

#### **PEI Project Update**

The Commission will hold a hearing to explore key concepts and opportunities for population-based prevention and early intervention, particularly mental health awareness and identifying and removing barriers to access to appropriate services.

#### **EPI Plus Contracts**

The Commission will consider authorizing the Executive Director to enter into contracts not to exceed \$1.56M for Early Psychosis Intervention Public Awareness/ Workforce Development/Retention and contracts to research barriers to care and improved access for diverse populations and improve reimbursement for coordinated care models.

#### **Staff Report Out**

Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

## **Calendar of Tentative Commission Meeting Agenda Items**

**Proposed 1/19/2021**

Agenda items and meeting locations are subject to change

### **March 25, 2021: Sacramento, CA (Teleconference)**

#### **Innovation Plan Approval**

San Francisco County seeks approval of \$5,400,000 in Innovation funding for their Culturally Congruent Practices for Black African Americans innovation project.

#### **Legislative Priorities for 2021**

The Commission will consider legislative and budget priorities for the current legislative session.

#### **Triage Grants – Next Round**

Staff will provide an update on the current Triage grants and evaluation activities and the Commission will consider opportunities for the next round of Triage grants.

#### **Mental Health in the Workplace Project Progress Report**

The Commission will hear an update on the Commission's Mental Health in the Workplace project and a panel presentation on the challenges and opportunities related to workplace mental health.

#### **Staff Report Out**

Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

### **April 22, 2021: Sacramento, CA (Teleconference)**

#### **Potential Innovation Plan Approval**

The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

#### **Legislative Priorities for 2021**

The Commission will consider legislative and budget priorities for the current legislative session.

#### **Award Early Psychosis Intervention Plus (EPI Plus) Phase 2 Grants**

The Commission will consider awarding EPI Plus grants to the highest scoring applications received in response to the Request for Applications for the Early Psychosis Intervention Plus Phase 2 grants.

#### **Outline for Triage Request for Applications**

The Commission will be presented with an outline for the next round of Triage grants.

#### **PEI Project Update**

The Commission will hold a hearing to explore key concepts and opportunities for prevention and early intervention across the lifespan and place-based approaches to prevention and early intervention to meet people where they learn, work, connect with social networks and cultural practices, and receive care and support.

## **Calendar of Tentative Commission Meeting Agenda Items**

**Proposed 1/19/2021**

Agenda items and meeting locations are subject to change

### **Mental Health Student Service Act Update**

The Commission will be presented with an update on the implementation of the Mental Health Student Service Act.

### **Innovation Systems Change Project Recommendations**

#### **Staff Report Out**

Staff will report out on projects underway, on county Innovation plans approved through delegated authority, and other matters relating to the ongoing work of the Commission.

**May 27, 2021: Sacramento, CA (Teleconference)**

#### **Potential Innovation Plan Approval**

The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

**June – No Commission meeting**

**July 22, 2021: Sacramento, CA (Teleconference)**

#### **Potential Innovation Plan Approval**

The Commission reserves time on each month's agenda to consider approval of Innovation projects for counties. At this time, it is unknown if an innovative project will be calendared.

#### **Prevention and Early Intervention Report Presentation**

The Commission will consider the final report of the PEI project subcommittee for adoption.