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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
April 25, 2019

DoubleTree by Hilton Hotel
Anaheim - Convention Center
2085 S Harbor Blvd
Anaheim, CA 92802

Call-in Number: 1-866-817-6550
Participant Passcode: 3190377

Mental Health Services
Oversight & Accountability Commission

Khatera Tamplen
Chair
Lynne Ashbeck
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

April 25, 2019
9:00 AM – 4:30 PM

DoubleTree by Hilton Hotel
Anaheim - Convention Center
2085 S Harbor Blvd
Anaheim, CA 92802

Call-in Number: 866-817-6550; Code: 3190377

Public Notice

The public is requested to fill out a "Public Comment Card" to address the Commission on any agenda item before the Commission takes an action on an item. Comments from the public will be heard during discussion of specific agenda items and during the General Public Comment period. Generally an individual speaker will be allowed three minutes, unless the Chair of the Commission decides a different time allotment is needed. Only public comments made in person at the meeting will be reflected in the meeting minutes; however, the MHSOAC will also accept public comments via email, and US Mail. The agenda is posted for public review on the MHSOAC website http://www.mhsoac.ca.gov 10 days prior to the meeting. Materials related to an agenda item will be available for review at http://www.mhsoac.ca.gov.

All meeting times are approximate and subject to change. Agenda items are subject to action by the MHSOAC and may be taken out of order to accommodate speakers and to maintain a quorum.

As a covered entity under Title II of the Americans with Disabilities Act, the Commission does not discriminate on the basis of disability and upon request will provide reasonable accommodation to ensure equal access to its meetings. Sign language interpreters, assisted listening devices, or other auxiliary aids and/or services may be provided upon request. To ensure availability of services, please make your request at least three business days (72 hours) prior to the meeting by contacting Lester Robancho at (916) 445-8774 or by email at mhsoac@mhsoac.ca.gov.

Khatera Tamplen
Chair

AGENDA
April 25, 2019

Lynne Ashbeck
Vice Chair

Approximate Times

9:00 AM **Convene and Welcome**
Chair Khatera Tamplen will convene the Mental Health Services Oversight and Accountability Commission meeting and will introduce the Transition Age Youth representative, Matthew Diep. Roll call will be taken.

9:10 AM **Announcements**

9:20 AM **Consumer/Family Voice**
Jason Robison will open the Commission meeting with a story of recovery and resilience.

9:40 AM **Action**
1: Approve March 28, 2019 MHSOAC Meeting Minutes.

The Commission will consider approval of the minutes from the March 28, 2019 meeting.

- Public Comment
- Vote

9:45 AM **Action**
2: Butte County Innovation Plan
Presenters:

- Heather Senske, Director of Child Development Programs and Services (CDPS), Butte County Office of Education
- Holli Drobny, Community Services Program Manager, Butte County Behavioral Health
- Yvonne McQuaid, Director, First 5 Butte County Children and Families Commission
- Shelley Hart, PhD, NCSP, Member, Planning and Development Committee for The Center

The Commission will consider approval of $1,671,031 to support Butte County's Center CARE (Collective Action for Resiliency and Education) Innovation Project.

- Public Comment
- Vote

10:25 AM **Action**

3: Alameda County Innovation Plan

Presenters:

- Tracy Hazelton, MPH, Division Director MHSA, Alameda County Behavioral Health
- Mary Skinner, J.D., Innovations Coordinator, MHSA, Alameda County Behavioral Health

The Commission will consider approval of $2,040,120 to support Alameda County's Mental Health Technology 2.0 Innovation Project.

- Public Comment
- Vote

11:05 AM **Action**

4: Awarding of the Immigrant and Refugee Stakeholder Contracts

Presenters:

- Norma Pate, Deputy Director, MHSOAC
- Tom Orrock, Chief of Commission Operations and Grants, MHSOAC

The Commission will consider awarding stakeholder contracts to five organizations for a total amount of $2,012,500 to the highest scoring applicants for the Immigrant and Refugee Stakeholder Request for Proposal.

- Public Comment
- Vote

11:45 AM **Action**

5: Legislative and Budgetary Priorities

Presenter:

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

The Commission will consider legislative and budget priorities for the current legislative session, including consideration of the following bills: SB 66 (Atkins) – Medi-Cal: federally qualified health center and rural health clinic services; AB 512 (Ting) – Medi-Cal: specialty mental health services; and AB 1352 (Waldron) – Community mental health services: mental health boards.

- Public Comment
- Vote

12:25 PM **Lunch Break**

1:30 PM **Information**

6: Executive Director Report Out

Presenter:

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

Executive Director Ewing will report out on projects underway and other matters relating to the ongoing work of the Commission.

- Public comment

1:45 PM **Information**

7: Strategic Planning

Presenters:

- Susan Brutschy, President, Applied Survey Research
- Lisa Colvig-Niclai, Vice President of Research, Applied Survey Research

The Commission will continue its Strategic Planning process facilitated by Applied Survey Research. The Commission will engage in a facilitated discussion around the organizational roadmap and results-based-planning.

- Public Comment

4:15 PM **General Public Comment**

Members of the public may briefly address the Commission on matters not on the agenda.

4:30 PM **Adjourn**

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AGENDA ITEM 1

Action

April 25, 2019 Commission Meeting

Approve March 28, 2019 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the March 28, 2019 Commission 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 (1): (1) March 28, 2019 Meeting Minutes.

Handouts: None.

Proposed Motion: The Commission approves the March 28, 2019 meeting minutes.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM
Governor

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
March 28, 2019

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

866-817-6550; Code 3190377

Members Participating:

Khatera Tamplen, Chair
Lynne Ashbeck, Vice Chair
Reneeta Anthony
Ken Berrick
John Boyd, Psy.D.
Sheriff Bill Brown
Mara Madrigal-Weiss
Gladys Mitchell
Tina Wooton

Members Absent:

Mayra Alvarez
Senator Jim Beall
Keyondria Bunch, Ph.D.
Assemblymember Wendy Carrillo
Itai Danovitch, M.D.
David Gordon

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

CONVENE AND WELCOME

Chair Khatera Tamplen called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:06 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and announced a quorum was not yet present. A quorum was achieved after Commissioner Mitchell arrived.

Chair Tamplen reviewed the meeting protocols.

Youth Participation

Chair Tamplen stated the Commission made a commitment to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. Marisol Beas introduced herself.

Consumer/Family Voice

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

Meghan Stanton, Executive Director, Consumers Self-Help Center, which operates two wellness recovery centers in the county and provides patient rights advocacy to four counties, shared the story of her struggle with depression, having a positive hospitalization experience, and wanting to help others have positive experiences. She stated, however, she did not receive any follow-up counseling or support upon discharge and had to look for support on her own. She stated she eventually found cognitive behavioral therapy (CBT). CBT helped her change the way she thought about things and that, in turn, changed her mood, which helped her to make better decisions, to think about how her decisions affect depression, and to begin to structure her life in a way that supports mental health rather than deteriorates it. She stated there are things she personally cannot do that other people can get away with. She stated she has to be very conscious and manage those things to keep her from relapsing. She shared how she continued to work in the mental health field and today she operates two wellness recovery centers.

ACTION

1: Approve February 28, 2019, MHSOAC Meeting Minutes

Chair Tamplen asked to change the term “Fleet model” to “LEAP model” at the top of page 20.

Commissioner Anthony asked to switch the chair/vice chair positions for the Client and Family Leadership Committee appointments on page 2.

Action: Vice Chair Ashbeck made a motion, seconded by Commissioner Brown, that:

The Commission approves the February 28, 2019, Meeting Minutes as amended.

Motion carried 7 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Berrick, Boyd, Brown, Madrigal-Weiss, and Mitchell, Vice Chair Ashbeck, and Chair Tamplen.

The following Commissioners abstained: Commissioners Anthony and Wooton.

ACTION

2: Mono County Innovation Plan (Extension)

Presenters:

- Robin K. Roberts, MFT, Director, Mono County Behavioral Health
- Rick Goscha, Ph.D., Senior Vice President, California Institute for Behavioral Health Solutions

Chair Tamplen stated the Commission will consider approval of Mono County's request for an additional four months and an additional $84,935 to support the Eastern Sierra Learning Collaborative: A County Driven Regional Partnership Innovation Plan previously approved by the Commission on September 28, 2017. She asked the representatives from Mono County to present this agenda item.

Robin Roberts, Director, Mono County Behavioral Health, shared what the county has learned from the Eastern Sierra Strengths-Based Learning Collaborative to date and the need to extend the project.

Rick Goscha, Ph.D., Senior Vice President, California Institute for Behavioral Health Solutions, stated the original Innovation plan focused on the training and skill development that staff receive as part of the learning collaborative. An important part of the Innovation plan is the work that is done between those learning sessions and focusing on what is happening in Mono County, much of which involves structural change. Staff combines multiple roles. A structural change is not just to think about how to work with the community but how to work within themselves so that they do not only respond reactively but think about how to help individuals.

Commissioner Questions

Chair Tamplen asked about scheduling for the proposed four-month extension.

Dr. Goscha stated there are tentative things that are ready to go such as skill development around motivational interviewing and beginning to do training with community partners.

Vice Chair Ashbeck asked what will happen at the end of the proposed four-month extension.

Ms. Roberts stated an infrastructure has been created in her department for clinical supervision and champions are trying to get individuals engaged and interested both inside and outside the department.

Commissioner Brown asked about the plan for future staff turnover and how the county plans to look at challenges prospectively.

Ms. Roberts stated the county has a low turnover. It is difficult to recruit and retain licensed individuals so individuals are brought in at the entry level and they are steeped in these new processes. The individuals the county is struggling with the most are individuals who have been in the county system and have only worked in Mono County for years and who do not have experience outside of that. The youngsters that are coming up are dedicated to the process.

Commissioner Mitchell asked if cultural competency is embedded in the learning collaborative.

Ms. Roberts stated whether or not it is a part of the learning collaborative, she and Dr. Goscha have strongly listened to where individuals need more education and also where they get stuck. There are several cultural competency trainings upcoming that will continue to build cultural humility.

Commissioner Wooton asked about outcomes that are in place to ensure that the staff is talking about recovery, housing, employment, community partners, etc.

Ms. Roberts stated the first thing staff does is listen carefully for the needs of individuals. If they need help with that, they are further trained in motivational interviewing and the strength-based collaborative.

Public Comment

Adrienne Shilton, Steinberg Institute, spoke in support of the proposed Innovation project extension.

Action: Commissioner Anthony made a motion, seconded by Vice Chair Ashbeck, that:

The MHSOAC approves Mono County's request for $84,935 additional Innovation funding and extension of time as follows:

Name: Eastern Sierra Strengths-Based Learning Collaborative (ESSBLC)

Additional Amount: $84,935 for a total Innovation project budget of $343,981

Additional Project Length: four (4) months for a total project duration of (28) months.

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

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Brown, Madrigal-Weiss, Mitchell, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

ACTION

3: San Mateo County Innovation Plan (Extension)

Presenters:

- Dave Pine, Supervisor, San Mateo County, District 1
- Lisa Putkey, MA, Program Director, San Mateo County Pride Center
- Andres Loyola, Peer Support Worker, San Mateo County Pride Center
- Ryan Fukumori, Ph.D., Research Associate, Resource Development Associates
- Scott Gilman, MSA, CBHE, Director, San Mateo County Health, Behavioral Health and Recovery Services

Chair Tamplen stated the Commission will consider approval of San Mateo County's request for an additional two years and an additional $1,550,000, to support the LGBTQ Behavioral Health Coordinated Services (The Pride Center) Innovation Plan previously approved by the Commission on July 28, 2016. She asked the representatives from San Mateo County to present this agenda item.

Andres Loyola, Peer Support Worker, San Mateo County Pride Center, provided an overview, with a slide presentation, of the need for the Innovation project.

Lisa Putkey, Program Director, San Mateo County Pride Center, continued the slide presentation and discussed the accomplishments of the Innovation project.

Ryan Fukumori, Ph.D., Research Associate, Resource Development Associates, continued the slide presentation and discussed the learning goals and evaluation of the project.

Scott Gilman, MSA, CBHE, Director, San Mateo County Health, Behavioral Health and Recovery Services, continued the slide presentation and discussed the extension request and sustainability of the project.

Dave Pine, Supervisor, San Mateo County, District 1, stated the Board of Supervisors and the Mental Health Steering Committee unanimously approve this project. He asked that the Commission approve the county's two-year extension request.

Commissioner Questions

Chair Tamplen asked to include the Mental Health Services Act (MHSA) logo in The Pride Center's flyers.

Vice Chair Ashbeck asked if the integration of physical health will be included in the proposed project.

Scott Gilman stated it will. San Mateo Health operates a hospital in a primary care system. The current model being considered is behavioral health homes so primary care will be wrapped around with mental health services.

Commissioner Mitchell asked if cultural competency is embedded in the Innovation project.

Lisa Putkey stated it is; cultural competency is important to the program.

Andres Loyola shared the names of some of the county's programs and initiatives that have cultural competency embedded in them.

Commissioner Madrigal-Weiss asked about the trainings the project offers to schools and if more engagement and inclusive school climates are a result.

Lisa Putkey stated all San Mateo School District High School teachers, staff, and administrators receive training, as well as high school and middle school students. Examples of the trainings are LGBTQ 101, how to create affirming school campuses, and other best practice trainings that are tailored to the community being presented with the training. A youth survey that was done in 2017 by the LGBTQ Commission and also the Healthy Kids Survey will be used as baselines.

Marisol Beas asked how the county works with LGBTQ families to reduce stigma and create support.

Andres Loyola stated the county's Parent Project contracts with The Pride Center to talk to parents in multiple languages about LGBTQ issues to help parents better understand their children.

Lisa Putkey stated the county holds an annual eight-week psychoeducation class for parents of LGBTQ teens.

Marisol Beas asked if the county works with undocumented LGBTQ.

Andres Loyola stated it does. The Pride Center offers translation services to undocumented individuals for programs and to help them get their IDs and driver's licenses at the DMV.

Lisa Putkey stated The Pride Center offers therapy sessions on a sliding scale to help undocumented individuals.

Marisol Beas asked for examples of collaborations that are envisioned for the future.

Lisa Putkey stated there is great need in San Mateo County. The hope is to work with additional school districts, elementary schools, the criminal justice system, and the county's Human Resource Department.

Andres Loyola stated the need to consider that collaboration extends beyond the county because there are many individuals who come from outside San Mateo County for San Mateo County programs. There are discussions about doing a symposium of all The Pride Centers in the Bay Area on gaps and impacts on the larger Bay Area.

Scott Gilman stated the Stanford Center for Social Innovation is partnering with The Pride Center on a sustainability plan.

Public Comment

Mandy Taylor, California LGBT Health and Human Services Network, spoke in support of the proposed Innovation project extension.

Smitha Gundavajhala, Youth Leadership Institute, spoke in support of the proposed Innovation project extension.

Fen Schubert, San Mateo Pride Center, spoke in support of the proposed Innovation project extension.

Katherine Relf-Canas, San Mateo Pride Center, spoke in support of the proposed Innovation project extension.

Leo Canas, San Mateo Pride Center, spoke in support of the proposed Innovation project extension.

Lyssett Sanchez, San Mateo Pride Center, spoke in support of the proposed Innovation project extension.

Dawn Davidson, San Mateo Pride Center, spoke in support of the proposed Innovation project extension.

Jeannine Meanger, San Mateo County LGBTQ Commission, spoke in support of the proposed Innovation project extension.

Craig Weisner, San Mateo County LGBTQ Commission, spoke in support of the proposed Innovation project extension.

Rory O'Brien, LGBTQ Program Coordinator, Mental Health America of Northern California (NorCal MHA), Project Coordinator, #Out4MentalHealth, spoke in support of the proposed Innovation project extension.

Lexi Shimmers, San Mateo Pride Center, spoke in support of the proposed Innovation project extension.

Reverend Terri Echelbarger, Many Journeys Metropolitan, spoke in support of the proposed Innovation project extension.

Andrew Longworth, San Mateo Pride Center, spoke in support of the proposed Innovation project extension.

Action: Commissioner Berrick made a motion, seconded by Vice Chair Ashbeck, that:

The Commission approves San Mateo County's request for $1,550,000 additional Innovation funding and extension of time as follows:

Name: LGBTQ Behavioral Health Coordinated Services (The Pride Center)

Additional Amount: $1,550,000 for a total Innovation project budget of $3,750,000

Additional Project Length: Two (2) years for a total project duration of five (5) years

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Brown, Madrigal-Weiss, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

ACTION

4: <u>Tulare County Innovation Plans)</u>

Presenters for the Metabolic Syndrome Pilot Project:

- Alisa L. Huff, Psy.D., Lead Psychologist

- Lester E. Love, M.D., Medical Director
- Sander Valyocsik, M.A., Consultant, Societas, Inc.

Presenters for the Connectedness 2 Community Project:

- Carol Davies, Consultant, Davies and Associates, Inc.
- Michele Cruz, Mental Health Services Act Manager

Chair Tamplen stated the Commission will consider approval of $1,610,734 to support the Addressing Metabolic Syndrome and Its Components in Consumers Taking Antipsychotic Medication Plan, and $1,320,684 to support the Connectedness 2 Community Innovation Plan. She asked the representatives from Tulare County to present this agenda item.

Michele Cruz, Mental Health Services Act Manager, Tulare County Health and Human Services Agency, Mental Health Branch, introduced the representatives who will present Tulare County's two Innovation plans.

Metabolic Syndrome Pilot Project

Sander Valyocsik, Consultant, Societas, Inc., provided an overview, with a slide presentation, of the background, community planning process, and learning objectives and outcomes of the Metabolic Syndrome Pilot Project.

Alisa L. Huff, Psy.D., Immigrant Services Manager, Lead Psychologist, continued the slide presentation and discussed the history of mental and physical health integration, pilot project implementation, treatment protocol, and added interventions of the Metabolic Syndrome Pilot Project.

Lester Love, M.D., Medical Director, continued the slide presentation and discussed metabolic syndrome and its connection to mental health, local psychiatric hospital study, and how the proposed Metabolic Syndrome Pilot Project is innovative.

Commissioner Questions

Chair Tamplen asked for more detail about the program starting in 2018 with community services and supports (CSS) funding.

Ms. Cruz stated this project was started out of the great collaboration between the mental health and public health branches. They developed the examination rooms and then realized it could be funded through Innovation funding. After speaking with Commission staff, it was determined that adding interventions would satisfy the Innovative requirement.

Commissioner Anthony asked how the county will incorporate the project team, which includes consumers and family members, to engage the participants and how to ensure through corrective action that participants will be engaged.

Dr. Huff stated participant engagement is a concern and noted that the population being served by the mental health clinic often does not want to go to the health clinic, even with serious health issues, because they consider the mental health clinic their family. This is why the county chose to bring exam rooms to the clients.

Dr. Love stated another thing this project does is bring in cutting-edge technology so all treatment and diagnostic decisions can be made on sight in the mental health clinic.

Michele Cruz, Mental Health Services Act Manager, in response to Commissioner Madrigal-Weiss' question, stated that it is correct that the program is already being paid for through CSS funding. The personnel costs currently being paid through CSS funding will be shifted to the

Innovation funding, which would allow additional supports to be added within the CSS programs.

Mr. Valyocsik stated the intention was always to use Innovation funds for this program. Even without the three additional interventions, the base program is innovative.

Commissioner Wooton asked whether peers will be hired as a part of the proposed Innovation project and how the project team and oversight that is part of the county mental health board will be helping with the program.

Dr. Huff stated this program runs one afternoon per week and borrows existing peer support specialists from the clinic. She stated the desire to hire peer support specialists who are dedicated to the program as they are not always available from the clinic.

Commissioner Wooton asked how many peer support specialists will be hired for the proposed Innovation project.

Ms. Cruz stated the number of peer support specialists to be hired is not yet known.

Mr. Valyocsik in response to Commissioner Wooton's question stated that the three new interventions will be implemented on July 1st of this year, depending on funding.

Vice Chair Ashbeck asked what was learned during the past year of running the project and how three new interventions are worth an extra $1 million in MHSA funding.

Dr. Love stated the data over the past year indicated that significant changes were not being made in morbidity and mortality and part of that was that the interventions were too few and not intense enough.

Vice Chair Ashbeck asked if voluntary weekly group visits to a gym, voluntary weekly cooking classes, and the provision of healthy snacks during clinic appointments were the three more frequent, more intense interventions that the county identified.

Ms. Cruz stated those three identified interventions would allow the program to be expanded beyond the one-half day per week. The county will support the program with the cost to attend the gyms and the cost of the food. How these interventions will lift the program to a higher level is, in addition to the fact that those costs can be shifted from CSS, which is almost at its maximum with additional programs the county has planned, personnel costs will be shifted over to the Innovation funding, and additional funding will be available to support consumers. The three interventions will occur more often with additional time with the public health branch staff at the clinic.

Vice Chair Ashbeck stated her struggle is with the cost shift.

Marisol Beas stated the model is heavily based on lifestyle changes. She asked if the county will address possible food deserts and food insecurities, or access to safe parks and roads.

Ms. Cruz stated the county has not looked at these issues. She stated she was unaware of nutritional deserts within the rural county.

Marisol Beas stated many individuals with serious mental illness end up in jails or prisons. She asked if there are efforts to provide services there.

Dr. Huff stated other services are provided in the local jails. The purpose of the proposed Innovation project was to have it in the local mental health clinic where consumers are currently coming in.

Public Comment

Ms. Cruz, on behalf of Darlene Prettyman, Commissioner Emeritus, read a letter from Ms. Prettyman in support of the proposed project.

Pete Lafollette spoke in support of the proposed project.

Mandy Taylor stated concern that the proposed Innovation project is based on a foundation of the medical and public health models. There is nothing wrong with these models, but the recovery and resilience model mandated with the MHSA needs to be clearly articulated. The speaker was not interested in metabolic syndrome interventions for mental health, but was interested in interventions that help create recovery, community, and mental wellness. Also, the mental health interventions could be provided to all mental health consumers and done by peers who have experience in recovery and wellness as a result of engaging in these healthy activities.

Mandy Taylor suggested that the objective needs to be helping people feel better, not the objectives listed on the slides. The speaker was also concerned about the selected outcomes. Body shaming and measuring body circumference is not beneficial to mental health. The selected outcomes need to be based on how people feel about their mental health and wellness, how able they feel to engage in their daily activities, and how much their isolation has been reduced by engaging in these programs. It is possible that this program could do those things but there needs to be a fundamental shift that this program addresses mental health. Physical and public health can be awesome side outcomes but not the main objective.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke in support of the proposed project.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, stated it does not sound like the individuals who would benefit from this program had a voice within this program and there is no funding being set aside for peer providers.

Tiffany Carter, Assistant Statewide Advocate, ACCESS California, NorCal MHA, stated the MHSA calls for peer roles to be elevated. It is important to ensure that the population that the program is serving is at the table throughout the process to ensure its effectiveness and that it is meeting the needs of those who the services are being provided for.

Tiffany Carter stated there is a need to have a distinct difference between groups being facilitated by case managers or peer support specialists. They are both meaningful, but the peer support specialist is what the MHSA calls for. The speaker asked to identify who participated in the surveys and focus groups, particularly if participants included consumers of mental health services who had taken anti-psychotic medications.

Commissioner Discussion

Chair Tamplen asked Executive Director Ewing to address Commissioners' questions.

Executive Director Ewing stated the Commissioners asked about the parameters for the use of Innovation funds. He stated the Commission has considerable discretion in determining what is innovative and what is approved. He used the example that the MHSA encourages the role of peers but it is not a requirement that everything innovative must have a peer component.

Executive Director Ewing stated he is unaware of anything in the law about shifting program dollars between a CSS fund and Innovation fund but the Commission has supported using Innovation funds in the past to adapt or evolve a practice that had previously been funded with CSS funds. He stated the Commission has the discretion to interpret whether the proposal is an innovation program that is worth investing in.

Commissioner Anthony stated community planning, community involvement from the beginning, and peers to implement and carry out activities is important. Change in organizational culture is necessary and needed. Everything needs to include change in organizational culture. She stated she will vote in support of the proposed project but stated the project is significantly lacking.

Commissioner Wooton stated the MHSA states the need to promote the employment of consumers and family members.

Connectedness 2 Community Project

Michele Cruz provided an overview, with a slide presentation, of the background, need, and community planning process of the Connectedness 2 Community Project.

Carol Davies, Consultant, Davies and Associates, Inc., continued the slide presentation and discussed learning objectives and outcomes and how the proposed project is innovative.

Commissioner Anthony asked how the cultural change will be measured from the top down.

Ms. Cruz stated she will answer those questions during her discussion on the evaluation of the project. She continued her slide presentation and stated the number of clinicians who attend cultural sessions with cultural brokers and community leaders is being measured.

Commissioner Questions

Commissioner Anthony asked what the county will do to build trust in the county through cultural change monitoring.

Ms. Cruz stated it would be part of the numbers of clinicians who are attending the cultural sessions.

Ms. Davies stated a lot has to happen in the first year and it requires organizations that have a level of readiness and are already identified as a spiritual center for the target population.

Marisol Beas asked if there are efforts toward staffing people of color.

Ms. Cruz stated those efforts are ongoing in the county. This program intends to onboard cultural brokers from the target communities.

Vice Chair Ashbeck asked why this is unique and innovative for Tulare County when it seems like fundamental behavioral health work.

Ms. Cruz stated communities in Tulare County are conservative and isolated. They have a need for mental health services but they do not seek services; however, those communities ask the county for help. A deeper connection and a community tie are required. This project is a great way to reach those populations by being inserted and impacted into the communities to understand deeper what the needs are and how to reach them.

Vice Chair Ashbeck stated her understanding that the proposed project is not to provide services but is just to make that connection over a five-year period of time.

Ms. Cruz stated it is and also to educate the clinical staff as to how those communities' needs can be best addressed.

Chair Tamplen asked about the role of the Ethnic Services Manager and what the cultural competency plan includes.

Ms. Cruz stated the Ethnic Services Coordinator was heavily involved in bringing the community to the table. His involvement was key but he has since moved on to another employment

opportunity. The cultural competence plan has done many different kinds of trainings not specifically targeted towards these groups.

Commissioner Anthony made a motion to approve the proposed Addressing Metabolic Syndrome and its Components in Consumers Taking Antipsychotic Medication project. Commissioner Wooton seconded.

Vice Chair Ashbeck made a friendly amendment to include conditions that the county work with staff to strengthen the three new interventions and the evaluation.

Commissioner Wooton agreed and added a friendly amendment that consumers and/or family members are employed in the program.

Commissioner Anthony agreed to accept the friendly amendments.

Ms. Yeroshek restated the motion that the Commission approves Tulare County's Innovation plan with the conditions that the county works with staff to strengthen the three new interventions and the evaluation and that consumers and/or family members are employed in the program.

Chair Tamplen asked Tulare County if they agreed with the conditions.

Ms. Cruz agreed with the Commission's conditions.

Public Comment

Rory O'Brien spoke in support of the proposed Connectedness 2 Community Project.

Mandy Taylor spoke in support of the proposed Connectedness 2 Community Project.

Brian Poth, Executive Director, theSOURCE LGBT+Center, spoke in support of the proposed Connectedness 2 Community Project.

Stacie Hiramoto stated this would not be the first time this Commission approved an Innovation plan that was not completely innovative.

Action: Commissioner Anthony made a motion, seconded by Commissioner Wooton, that:

The Commission approves Tulare County's Innovation plan with the conditions that the county work with staff to strengthen the new interventions and the evaluation and that consumers and/or family members are employed in the program as follows:

> *Name: Addressing Metabolic Syndrome and its Components in Consumers Taking Antipsychotic Medication*
>
> *Amount: $1,610,734*
>
> *Project Length: Five (5) years*

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Brown, Madrigal-Weiss, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

Commissioner Discussion

Commissioner Wooton made a motion to approve the proposed Connectedness 2 Community project. Commissioner Madrigal-Weiss seconded.

Commissioner Ashbeck stated this proposed project needs more work on outcome measurements and the depth of the target population.

Commissioner Anthony made a friendly amendment that the county looks at their existing organizational culture and makes changes in how they value clients because clients are not coming back to the MHSA programs.

Executive Director Ewing stated staff would be happy to work with the county on their evaluation. He suggested that staff engage other counties that are also struggling with the issue of trust and engagement. He suggested facilitating a multicounty learning opportunity with Tulare County taking the lead.

Commissioner Wooton amended her motion to include Commissioner Anthony's friendly amendment for staff to work with the county on evaluation and organizational culture within the department to strengthen their ability to help the community.

Commissioner Madrigal-Weiss agreed.

Chair Tamplen asked Tulare County if they agreed with the conditions.

Ms. Cruz agreed with the Commission's conditions.

Action: Commissioner Wooton made a motion, seconded by Commissioner Madrigal-Weiss, that:

The Commission approves Tulare County's Innovation plan with the conditions that the county work with staff on strengthening the evaluation and organizational culture within the department to strengthen their ability to help the community as follows:

Name: Connectedness 2 Community

Amount: $1,320,684

Project Length: Five (5) years

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Berrick, Brown, Madrigal-Weiss, and Wooton, Vice Chair Ashbeck, and Chair Tamplen.

GENERAL PUBLIC COMMENT

Pete Lafollette stated multiple-million dollars in contracts were approved at the February meeting. It feels like there is a pattern for administrative awards versus awards for recovery services. As a voting Commission, it gives the appearance of practicing a business model rather than demonstrating recovery evidence-based practice to prove outcomes. The speaker stated concern that discussions are not in-depth enough and are not about whether programs are delivering services to the underserved and the severely mentally ill. The peer support and engagement model is the original design in keeping with the MHSA.

Theresa Comstock, Executive Director, California Association of Local Behavioral Health Boards and Commissions (CALBHBC), distributed the CALBHBC's spring newsletter to Commissioners. The speaker stated the newsletter includes the duties of boards and commissions and the components of the MHSA and legislative advocacy. The speaker stated training funding to the CALBHBC through the Department of Health Care Services (DHCS) has stopped. The speaker stated the need for a partnership between the MHSOAC, the California Behavioral Health Planning Council, and the DHCS.

Stacie Hiramoto stated Assembly Bill 43 by Assembly Member Gloria to ensure transparency, accountability, and client-driven policies in the MHSA was recently amended and will now focus on improving and strengthening the community planning process. It would be great for the Commission and the community to work jointly on this bill.

Andrea Crook stated the Commission will meet in Anaheim for the April meeting but will be reviewing Butte County's Innovation plan. The speaker requested reviewing Innovation projects from the southern counties when meetings are held in the south to make it more accessible to stakeholders. The speaker suggested pushing the Anaheim meeting to May where the agenda will be more appropriate.

LUNCH BREAK

(Closed Session – Government Code Section 11126(a) related to personnel)

Chair Tamplen explained that the Commission will be going into closed session during the lunchbreak as listed on the agenda as part of the Commission's normal annual Executive Director performance review.

REPORT BACK FROM CLOSED SESSION

Chair Tamplen reconvened the meeting and stated the Commission took no reportable action in closed session.

ACTION

5: Legislative and Budgetary Priorities

Presenters:

- Sarah Couch, Legislative Director, Office of Senator Bates
- Toby Ewing, Ph.D., Executive Director; Norma Pate, Deputy Director

Chair Tamplen stated the Commission will consider legislative and budget priorities for the current legislative session. In addition, the Commission has been asked by the authors to consider taking a position on the following bills: Senate Bill 582 (Beall) and Senate Bill 604 (Bates). She asked Executive Director Ewing to introduce this agenda item.

Senate Bill 604 (Bates) MHSA: centers of excellence

Executive Director Ewing reviewed how staff represents the Commission in the legislative process based on the Rules of Procedure. Director Ewing stated that the rule authorized staff to advocate on legislation (1) when the legislation is consistent with an officially approved position of the Commission or (2) at the direction of the chair and when, the legislation furthers the interest of the Commission.

Sarah Couch, Legislative Director, Office of Senator Bates, reviewed Senate Bill (SB) 604, authored by Senator Bates, which requires the Commission to establish centers of excellence to provide counties with technical assistance to implement best practices related to elements of the MHSA. The centers will be established with state administrative funds. SB 604 is set for hearing in the Senate Health Committee on April 3rd.

Ms. Couch asked for the Commission's support on behalf of Senator Bates and asked to work together to better craft the language of the bill to suit the needs of the Commission and the work that it is doing. She stated it seems that every individual who has come into the office lately has been very interested in the mental health bills that are coming through the Legislature.

Executive Director Ewing stated counties have shared with staff that they often struggle with the issues of community trust and Theresa Comstock shared today that the local boards often struggle to understand what their roles are and how to be effective in those roles. There is tremendous need for technical assistance and an opportunity through the budget process as well as the bill process to find solutions. The general sense is that there are areas of fundamental priority such as criminal justice and mental health and schools and mental health, and also that the Commission will need discretion over time to focus technical assistance based on issues of high-priority statewide needs.

Commissioner Questions

Commissioner Wooton asked if suicide prevention will be one of the centers of excellence since it is one of the Commission's policy projects.

Executive Director Ewing stated it will. The Legislature is identifying their priorities and will leave room for the Commission to prioritize based on its policy projects and emerging trends.

Vice Chair Ashbeck stated she understood that the centers of excellence would focus on the issues of regional alignment, leveraging regional work, and aligning existing work, but the presentation today was more about focusing the centers of excellence on topics. She asked if it could be both.

Executive Director Ewing stated it is intended to be both. Some centers will be regional models and others will be statewide models.

Commissioner Berrick stated Assembly Member Wilk has legislation that would create a policy working group around children's issues and mental health funding. He asked if those efforts will potentially be folded into this bill.

Ms. Couch stated she was unfamiliar with that bill but stated Senator Bates's office will reach out to Assembly Member Wilk's office to discuss possibilities.

Chair Tamplen suggested including a peer-led peer services center of excellence.

Commissioner Mitchell asked if the centers will be regionally located.

Executive Director Ewing stated the way that the bill is currently drafted states that the Commission will determine the number and locations of the centers based on funding availability.

Ms. Couch stated Senator Bates's office is discussing adding language that the Commission shall consider data on unmet needs in areas of service delivery to determine where the centers should be. She stated it was Senator Bates's opinion to make the bill as broad as possible in order to let the professionals determine the needs and where the centers should be located.

<u>Senate Bill 582 (Beall) School-based mental health partnerships</u>

Executive Director Ewing reviewed SB 582, authored by Senator Beall, which focuses on schools, keeps a 50 percent set-aside for children, and reestablishes the $12 million in funding that was cut from the triage program last year. In fact, this bill will put $15 million back into triage to support primarily school mental health programs. Executive Director Ewing testified in favor of SB 582 yesterday on behalf of the Commission.

Assembly Bill (AB) 43 (Gloria) MHSA funding

Staff is looking to take a support position on this bill based on the fiscal transparency work the Commission did three years ago. This bill asks the Commission to continue doing that work and to do it more thoroughly.

AB 1443 (Maienschein) Mental Health: technical assistance centers

This bill is consistent with SB 604 and is in response to policy offices listening to the work that the Commission is doing and asking the Commission to help them understand the needs.

AB 1126 (O'Donnell) Pupil Health: mental health services

The author's office intends to amend this bill to direct the Commission to do the transparency work to support more Innovation and to provide technical assistance with an emphasis on school mental health.

Executive Director Ewing stated these are the bills that staff is actively engaged on that are aligned with the Commission's priorities. Staff is pushing for support for the Commission's ability to tell the data story around the dollars, programs, and outcomes to try to make funding available for technical assistance, support for the Innovation Incubator, and support for SB 82 Triage funding that the Commission can use to support counties addressing issues that are of statewide concern.

Executive Director Ewing stated the challenge is there are significant staff limitations. As these bills move forward, there will be conversations with the Administration and the Legislature about what it would take for the Commission to be successful if one or more of these bills moves forward.

Commissioner Questions

Commissioner Wooton stated there is a bill on page 5 that would require that the Commission create a grant program for the College Mental Health Services Program. She stated this would be a good bill to watch.

Executive Director Ewing stated the Rules of Procedure state that, if the Commission takes a formal position on a topic and a bill reflects that position, then staff can advocate on the Commission's behalf for that. Many of the bills listed on the Legislation Tracking Report, which was included in the meeting packet, are important and useful but the Commission has not taken a formal position on them. Staff cannot take a support position until it has been agendized.

Commissioner Anthony asked how the Commission can help staff move things along.

Executive Director Ewing stated it is easy for staff to take a support position when the Commission has established the position that guided the legislation. In the case of legislation where the Commission has not taken a position, the intent is to work with the Chair to build out the agenda including having those offices come and present so Commissioners can formally discuss the bill and potentially take a position. He asked Commissioners to advise him of bills that the Commissioners are interested in.

Marisol Beas referred to AB 512 on page 2 of the Legislation Tracking Report and asked the Commission to put AB 512 on next month's agenda.

Public Comment

Theresa Comstock stated CALBHBC is in support of SB 582.

Rory O'Brien stated #Out4MentalHealth is in support of AB 43 and would like to see the Commission engaged in the process for AB 512.

Stacie Hiramoto stated REMHDCO would have concerns about the Commission taking positions based on the approval of the chair alone. Stakeholders should have the opportunity to share concerns on bills prior to the Commission taking a position. The speaker suggested running bills through a legislative committee prior to the full Commission taking a position. The speaker spoke in support of AB 512 and asked the Commission to put it on the next meeting agenda to take a position on.

Jane Adcock, Executive Officer, California Behavioral Health Planning Council (CBHPC), stated the CBHPC is the sponsor and is in support of SB 539.

Andrea Crook stated NorCal MHA and ACCESS California are sponsoring and are in support of AB 43.

INFORMATION

6: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director

Executive Director Ewing presented his report as follows:

Fiscal Reversion

The counties are facing fairly tight deadlines around reversion. Under the terms of AB 114, which identified unspent funds that had not been reverted, the state determined that counties could keep the unspent funds as long as they were spent by June 30, 2020. Staff is trying to be accommodating to counties that are trying to get their requests funded by the deadline.

Speaking Engagements

Staff is introducing themselves to appointees as the new administration makes appointments to let them know about the Commission and what it does.

Staff has been engaging and giving presentations with a number of organizations.

Strategic Planning

Half of the April Commission meeting will be set aside for strategic planning.

Commissioner Questions and Discussion

Commissioner Wooton asked if contracted service agency survey feedback is considered to use as guidance during the strategic planning process.

Executive Director Ewing stated the strategic planning consultants have reached out to many stakeholders through surveys and one-on-one interviews. That can be strengthened. Mechanisms are being developed to incorporate the feedback from stakeholder groups into the strategic planning work.

Vice Chair Ashbeck stated the strategic planning consultants have reached out but she was unsure if they asked the contracted service agencies to share the feedback from their surveys to be used in the Commission's strategic planning process. She stated she will look into it.

GENERAL PUBLIC COMMENT

Stacie Hiramoto stated, at the last Cultural and Linguistic Competence Committee, many members of the California Reducing Disparities Project (CRDP) Phase 2 were present to ask for Commission support in a variety of ways including consideration in the state budget process. The CRDP pilot projects, which are community-defined practices, are coming close to the end of the three-year program. They would like funding for more than three years. The Commission originally set aside the funding for this project along with suicide prevention, school-based projects, and stigma and discrimination reduction. These projects take longer than three years to pilot due to the complexity and new nature of them. The speaker stated the hope that the CRDP will present at a future meeting.

Rory O'Brien discussed #Out4MentalHealth's current activities. Each year the program produces an annual report on LGBTQ communities across the state. The first 200-page report has been published. Hard copies have been produced in limited supply but the report can be downloaded online. #Out4MentalHealth is already planning for the next report and has sent out surveys with questions that have never been asked before at a population level. The local task forces have been holding strategic planning meetings and discussing how to build engagements with their counties to bring trainings in their areas to build resources up through Innovations and through Prevention and Early Intervention. There is wonderful work being done at the statewide advocacy level through #Out4MentalHealth. The speaker thanked the Commission for making that possible.

ADJOURN

There being no further business, the meeting was adjourned at 3:33 p.m.

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AGENDA ITEM 2

Action

April 25, 2019 Commission Meeting

Butte County Innovation Plan

Summary: The Mental Health Services Oversight and Acc ountability Commission (MHSOAC) will consider approval of Butte County's request to fund a new Innovative project:

(A) **Center Care Project: $1,671,031**

- Butte County is proposing to establish a technical assistance center and learning collaborative to serv e young children (ages 0-5), their parents and caregivers. The collaborative will facilitate: expansion of access to specialized, trauma- informed, multi-generational, and cross-sector treatment modalities offering community level education and system collaboration. The innovation is the integration of these approaches (Mental Heal th Consultation Model, Family Resource Centers, and community center collaborations) in a rural county where they do not exist.

The Mental Health Services Act (MHSA) requires that an INN project does one of the following: (a) introduces a new mental health practice or approach, including but not limited to prevention and early intervention; (b) makes a change to an existing ment al health practice or approach, including, but not limited to, adaptat ion for a new setting or community; (c) introduces to the mental health system a promising community-driven practice/approach, that has been successful in non-mental health contexts or settings; or (d) participates in a housing program designed to stabilize a person's living situation while also providing supportive services on site. The law also requires that an INN projec t address one of the following as its primary purpose: (1) increase acce ss to underserved groups, (2) increase the quality of services including measurable outcomes, (3) promote interagency and community collaboratio n, or (4) increase access to services.

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Presenters for Butte County's Innovation Project:

- Heather Senske, Director of Child Development Programs and Services (CDPS), Butte County Office of Education
- Holli Drobny, Community Services Program Manager, Butte County Behavioral Health
- Yvonne McQuaid, Director, First 5 Butte County Children and Families Commission
- Shelley Hart, PhD, NCSP, Member, Planning and Development Committee for The Center

Enclosures (3): (1) Biographies for Butte County's Innovation Presenters; (2) Center Care Staff Analysis; (3) Center Care Project Brief.

Handouts (2): (1) PowerPoint will be presented at the meeting; (2) Letters from stakeholders will be provided at the meeting.

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following URL: http://mhsoac.ca.gov/sites/default/files/documents/2019-04/ButteCounty_INNPlan_OurCenter_2019_Final.pdf

Proposed Motion: The Commission approves Butte County's Innovation plan as follows:

Name: Center Care Project
Amount: Up to $1,671,031 in MHSA Innovation funds
Project Length: Three (3) years, two (2) months

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Mental Health Services
Oversight & Accountability Commission

Biographies for Butte County Presenters

Heather Senske, as Director of Child Development Programs and Services (CDPS), Heather is responsible for the all aspects of Butte County Office of Education's Early Learning programs and systems. CDPS is charged to provide high quality early learning services for nearly 500 children and families at 10 preschools across Butte County, and integrating Support Services, including social emotional and mental health supports. CDPS' professional services includes the Butte Quality Early Learning Initiative and Local Child Care Planning Council providing professional development, training and technical assistance and planning for early learning and child care programs. CDPS aligns high quality services for early learners and quality enhancement training and technical assistance to educational and community based organizations within Butte and the north state region, resulting in professional and quality enhancement outcomes. Heather has engaged in community based, local, regional and CA state systems development for the past 30 years through various roles in child care, early childhood education and early learning systems development and implementation.

Holli Drobny is a Community Services Program Manager at Butte County Behavioral Health. Her position encompasses three different roles; MHSA Coordinator, Cultural Competency Coordinator, and Public Information Officer. Holli began her career at Behavioral Health in the Systems Performance, Research and Evaluation Unit as an Administrative Analyst where she gained experience as a key part of the implementation and evaluation team for various projects, including the Investment in Mental Health Wellness Act of 2013. Holli is passionate about contributing to the behavioral health system of care because of her lived experience as a family member of someone living with a severe mental health diagnosis. Holli holds a Bachelor's degree in Communication Studies with an emphasis on Organizational Communication from California State University, Chico.

Shelley Hart, PhD, NCSP earned her BA in Psychology from the University of California (UC), Santa Cruz in Psychology, her MA in Education (specialization school psychology) from California State University (CSU), Sacramento, and her doctorate in Clinical, Counseling, and School Psychology from UC, Santa Barbara. Following attainment of her PhD, she completed a National Institute of Mental Health (NIMH) Postdoctoral Fellowship in the Psychiatric Epidemiology Training Program at Johns Hopkins University, Department of Mental Health, Bloomberg School of Public Health. She has worked in various capacities in the mental health arena, such as locked psychiatric facilities, juvenile hall, and schools. Her scholarship centers on individuals with emotional and behavioral challenges, suicide prevention, and adverse childhood experiences.

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Yvonne McQuaid has been the Director of the First 5 Butte County Children and Families Commission since 2014. Prior to becoming the Director, she served as a volunteer Commissioner for 12 years. Before assuming the First 5 Directorship, Yvonne trained and individually coached numerous nonprofits and family resource centers (FRCs) throughout the North State in organizational and leadership development, strategic planning, sustainability, and community engagement. She has co-authored two monographs on promising practices within family resource centers. Yvonne earned her Masters degree in Public Administration.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS – BUTTE COUNTY

Innovative (INN) Project Name: Center Care Project

Extension Funding Requested for Project: $1,671,031

Duration of Project: 3 years, 2 months

Review History:

Approved by the Board of Supervisors: April 9, 2019
County Submitted Innovation (INN) Project: March 20, 2019
MHSOAC Consideration of INN Project: April 25, 2019

Project Introduction:

Butte County is proposing to establish a technical assistance center and learning collaborative to serve young children (ages 0-5), their parents and caregivers. The collaborative will facilitate: expansion of access to specialized, trauma-informed, multi-generational, and cross-sector treatment modalities offering community level education and system collaboration. The innovation is the integration of these approaches (Mental Health Consultation Model, Family Resource Centers, and community center collaborations) in a rural county where they do not exist.

In the balance of this brief we address specific criteria that the Commission looks for when evaluating Innovation Plans, including:

- What is the unmet need that the county is trying to address?
- Does the proposed project address the need?
- Are there clear learning objectives that link to the need?
- Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives?

In addition, the Commission checks to see that the Innovation meets regulatory requirements, that the proposed project aligns with the core MHSA principles, promotes learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and

increases access to services, including, but not limited to, services provided through permanent supportive housing.

The Need

Butte County identifies that there is a need for more innovative and specialized mental health and therapeutic services for young children, as well as a trauma-informed system of support for those caring for young children in Butte County. Driving these needs include: a countywide high prevalence of trauma, poverty and displacement from the Camp Fire.

As a result, the County explains that their residents live with the highest prevalence of one or more Adverse Childhood Experiences (ACEs) in California (76.5 percent of residents, with 30.3 percent having experienced four or more ACEs).

Butte County states that they lack the resources to support the mental health of young, developing children (0 to five-years old) in their natural environment and in their service delivery systems. An example of this is children who are being expelled from preschool due to lack of teacher training on behavioral health.

When children are referred to clinical services, they are not receiving developmentally appropriate treatment. This is partly because there are no more than five (5) clinicians trained in specialized mental health treatment for young children within the community.

The Response

To address these needs, Butte County proposes to increase the quality of, and access to, mental health services through a collaborative innovation project bringing together the Butte County Office of Education, Child Development Programs and Services Department, California State University, Chico and Butte County Behavioral Health.

The Collaborative proposes to establish an integrated care center which provides a technical assistance center and learning collaborative where multi-disciplinary teams can learn from and support each other to provide developmentally appropriate support services for children (ages 0-5), their families and caregivers. Care Center services will be provided both at the center, a family-friendly location in Chico, and will provide transportation and community-based services to reach rural parts of the county.

The Center Care Project will build on the research-based Infant Early Childhood Mental Health Consultation Model (IECMHC) to bring specialized mental health support to young children in (1) natural learning and play environments and (2) at a centrally located

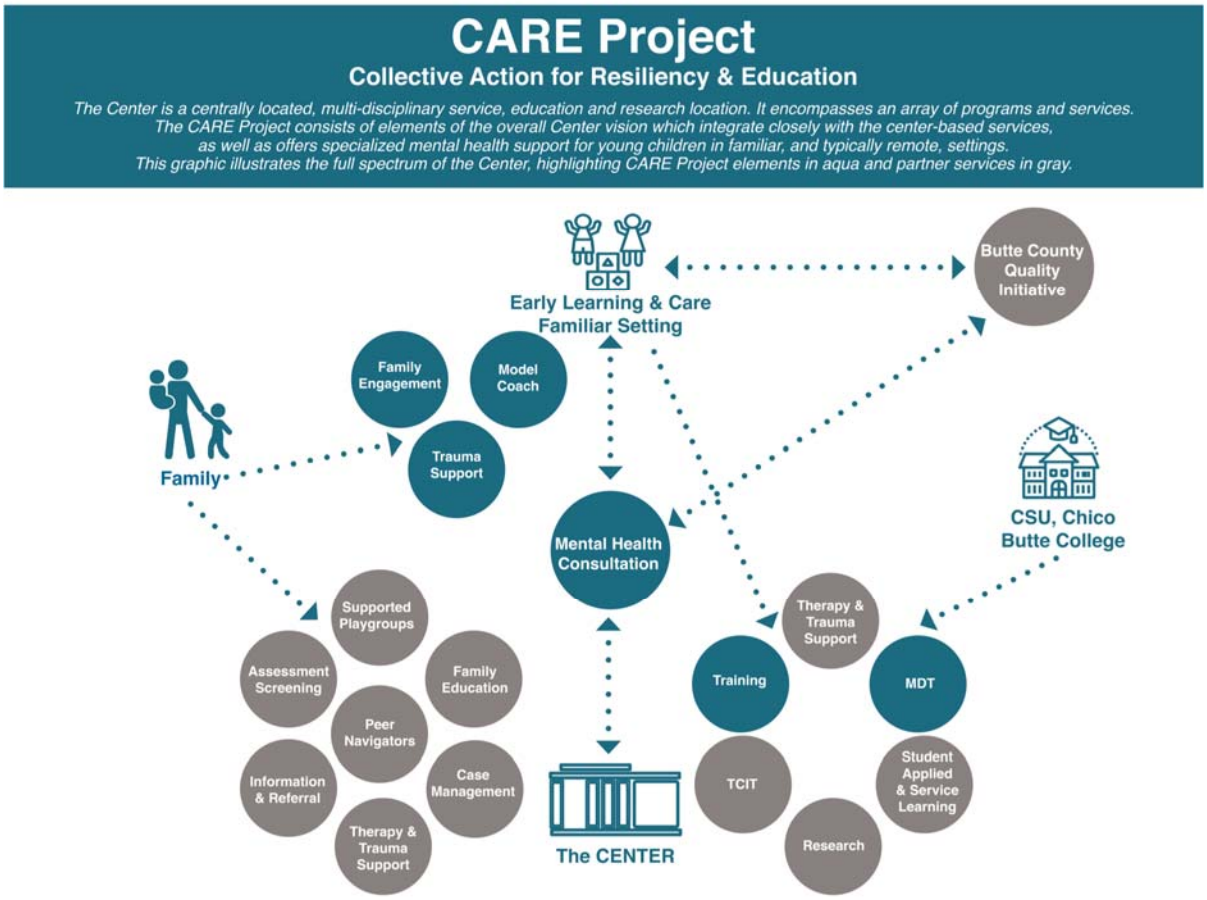
service, education, and research center. The IECMHC model is a best practice approach for early childhood to address trauma.

The County explains that IECMHC consultants provide tools so caregivers can support healthy growth and development in children. By building the capacity of the adults in children's lives, children are supported in all of their natural settings (home, preschool, day care, etc.). This can help promote positive social interactions, increase emotional wellbeing and resilience, and reduce challenging behavior. The Center will also provide support for caregivers and teachers to help reduce stress and compassion fatigue.

Butte County will also use the Pyramid Model (promotes social emotional competence in young children). The Pyramid Model is designed to provide multi-tiered systems of support within the educational context. These systems include social-emotional learning and prevention strategies for all children, more targeted early intervention strategies for some children who need more support, and increased intervention for a few children who need treatment. This model will be used to screen and identify children who need treatment and will inform a child-centered plan developed by a multidisciplinary team. Butte County's innovation proposal aims to establish the wide base of an effective workforce in a rural county where they lack providers who are specially trained to work with 0-5 year olds.

PEI programs in Marin, Alameda and San Francisco all use a version of the Early Childhood Consultation Model to provide support to children (ages 0-5), their parents and caregivers. Butte County proposes to use this best practice but plans to combine it with two additional delivery models to create an integrated technical assistance center and learning collaborative.

See below for a diagram highlighting Center components:



The County is encouraged to include family partners, navigators and Child Welfare (CPS) in the collaboration, if not yet considered.

<u>The Community Program Planning (CPP) Process</u>

The County presents evidence of a thorough CPP process, which included developing a Center Planning and Development Committee, made of 25 cross-sector county leaders, agencies and consumers. The County supported the Committee through a design thinking process accomplished in 4 phases (**please see pages 19-25 for a complete description of the extensive planning process**).

In addition, the County made presentations, conducted surveys and held consumer interviews or focus groups with the African American Family Cultural Center, the Hmong Cultural Center, Stonewall Alliance, ACCESS Consumer Advocacy and several tribal groups in order to learn how the Center might best serve their communities and integrate the strategies and approaches into the implementation plan. In general, the community was highly involved in the planning for this program. This project was shared with the Commission stakeholders on February 11, 2019; Commission staff received no letters of support or opposition. The County will submit letters they received from their community as part of their presentation to the Commission.

Learning Objectives and Evaluation

Butte County plans on implementing a project that will target children from ages 0 to 5, families, and mental health professionals in a learning collaborative project aimed at increasing access to- and the quality of- mental health services. Upwards of 230 children will be served by the Center CARE project annually as well as 20 parents of young children, 20 mental health professionals, and 15 early care education providers (**see pg. 10 of County plan**).

To guide their project, the County has identified several goals and outcomes centered on improving child social emotional outcomes, increasing the capacity of clinicians with specialized training, and decreasing work related stress experienced by mental health professionals. Additionally, the County seeks to increase expertise on interagency collaboration.

The County will gather a myriad of information from several different sources, including:

- Child Assessments, such as, the Ages & Stages Questionnaires: Social Emotional (ASQ-SE); the Devereaux Early Childhood Assessment: Infant/Toddler (DECA-I/T) or Preschool (DECA-P)
- Early Care Education Program Assessments, such as: the Infant Toddler Environment Racing Scale (ITERS); the Early Childhood Environment Rating Scale (ECERS); and the Classroom Assessment Scoring System (CLASS PreK)
- Teacher Assessments, such as: Student Teacher Relationship Scale (STRS); and the Child Care Worker Job Stress Inventory (CCWJSI)
- Tracking referrals, services provided, and registration/attendance records
- Case notes
- Clinician evaluation training surveys
- Collaborative practices assessment, and others (**see pgs. 17-18 of County plan**).

While the methods and measures that will be utilized for evaluation meet the proposed learning goals, **The County may wish to clarify the timing in which assessments will be administered**. Additionally, in order to garner more information relative to burnout experienced by both families and clinicians, **the County may wish to consider measuring for compassion fatigue, and a caregiver stress index that can be administered to families**. Further, to address one of the needs stated in the plan, **the County may wish to consider tracking preschool expulsion rates to determine impact of the Center CARE Project**.

The County will contract with the Butte County of Education, as well as the Child Development Programs and Services Department to conduct the evaluation. In order to disseminate lessons learned, the County will provide updates quarterly and will hold an annual symposium that will be open to stakeholders. Additionally, the County will share successes and lessons learned on the center's website.

The Budget

The majority of the budget ($937,199 total) is invested in "developing a professional infrastructure" including 2 FTE Mental Health Consultants ($397,215) who are considered the hub of the CARE project; a 0.5 FTE Center Director; 0.25 Clinical Director; 0.5 FTE Program Manager; 0.25 Admin Support; and 0.25 Admin Analyst.

The County will spend $376,000 to hire consultant architects and designers to develop a center to meet the cultural and trauma sensitive needs of diverse families and professionals. Consultant costs also include an evaluation and training consultant.

Operational costs total $236,354 and include curriculum and materials with indirect costs totaling $121,478. Evaluation is budgeted at $228,626 (13%).

The County addresses sustainability through multiple funding sources including: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) match for Medi-Cal, state preschool add on, managed care system, Help Me Grow, grants, donations and several others (**see page 29 of the full plan**).

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations**.**

Full project proposal can be accessed here:

http://mhsoac.ca.gov/sites/default/files/documents/2019-04/ButteCounty_INNPlan_OurCenter_2019_Final.pdf

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Butte County Innovation Brief: The CARE Project

The Need

Young children (age 0-5) in Butte County are facing significant trauma and disconnects in social-emotional development that are leading to challenging behaviors, interfering in their ability to learn and develop. As of 2013, Butte County had the highest prevalence of residents living with one or more Adverse Childhood Experiences (ACEs) in California at 76.5 percent of residents, and with 30.3 percent having experienced four or more ACEs (ranked third). Compounding this urgent issue is the lack of mental health providers with expertise serving youth aged 0-5, and a lack of funding to serve this vulnerable population; particularly those in rural and remote areas.

Butte County is considered a low-income county faced with many socio-economic burdens. The lower socio-economic status is commonly generational, and families often also struggle with higher rates of unemployment, financial instability, food insecurity, mental health issues, and substance abuse and dependence. Approximately 28 percent of residents are enrolled in Medi-Cal, compared to roughly 18 percent of Californians, and the foster care rates in the county are nearly twice that of the state as of January 1, 2018. California's poorest areas often have the highest rates of mental illness with the fewest mental health professionals to provide treatment. This is certainly the case in Butte County which possesses a high poverty rate, high percent of people living with a serious mental illness, and a low number of psychiatrists.

Rural communities such as Butte County face distinct challenges in connecting services to children and families. Barriers include the distance, time, and difficult terrain between localities; lack of an efficient, effective, or far-reaching public transit system; families living in geographically-isolated micro-communities; social stigma attached to seeking services; difficulty in finding services for people experiencing mild to moderate mental health symptoms; and a limited number of qualified specialists available to cover the vast majority of the county territory.

In addition to these significant statistics and characteristics, in early November 2018, Butte County communities were decimated by the Camp Fire, the largest and most destructive wild fire in California history, displacing nearly 50,000 residents, including approximately 5,000 school-age children and 1,000 children in childcare settings into surrounding towns. Families have lost homes, jobs, businesses, child care, medical and mental health care, family strengthening and support systems, and a sense of community. The community of Magalia is now separated from services and amenities for basic needs by a 45-minute drive through the rubble and destruction of Paradise, re-traumatizing and excessively burdening families with young children. Families are doubled up and co-housed with multiple families and in temporary housing trailers in new communities, adding to the day-to-day-living stressors which research associates with increases in mental health conditions, drug and alcohol use, family violence and crime. It is yet known the true long-term impact of a fire with such unprecedented devastation, but research indicates that there is a predicted spike in mental health issues two to five years after a disaster.

Planning and Development Committee

Butte 2-1-1
Butte College
Education, Child & Family Studies
Butte Thrives: County ACEs Coalition*
Child Abuse Prevention Council*
County Department
of Behavioral Health*
County Department
of Employment & Social Services
County Department of Public Health
County First 5 Commission*
County Office of Education
Child Development Programs & Services
Special Education
California State University Chico,
Child Development Department*
Civic Engagement
Education Department
Psychology Department
Rural School Collaborative
Social Work Department
Far Northern Regional Center
Head Start/Early Head Start*
Northern Valley Catholic Social Service*
Parent/Family Consumers
State Preschools
Student Consumers
Trauma Consultants
Workforce Development
Youth For Change*

**obtained letter of intention to collaborate*

Additional Letters of Intention to Collaborate

Butte Quality Early Learning Initiative
Butte County Children's Services
Coordination Council
Butte County Local Child Care
Planning Council

The Creation of The Center and the CARE Project

The Center for Learning & Resilience (The Center) is a trauma-responsive, innovative, community-based, research-driven approach to services and learning. Young, developing children and the adults who impact their lives are at the heart of The Center. The Center building itself is a place for children, families and community to feel like they belong and that they will receive the support they need to heal and thrive. The framework for The Center includes five tiers: Community Development, Research, Organizational & Systems Capacity, Integrated Education, and Direct and Coordinated Services. The proposed MHSA Innovation, The CARE (Collective Action for Resiliency & Education) Project, is an essential piece of the Center as it links all five tiers.

Planning for The Center began in January 2018. A group of 25 seasoned, multi-disciplinary stakeholders (see side bar) convened to bring the Center vision to fruition. The CARE Project was born from the collective expertise of this group during the Development Phase of the process, which involved ideation of services, approaches and systems based on the understanding of the diverse planning committee.

After ten months of planning for the creation of The Center, Butte County was suddenly faced with further trauma and grief with the Camp Fire for which the unprecedented recovery needs now top the list of burdens the county faces. The need for the Center, and the community transformation that it represents, has changed from vital to dire. The current planning phase for The Center involves a comprehensive community input process in which eight different stakeholder groups have an opportunity to offer feedback about the Center ideation. The stakeholders include families, professional county-wide leaders, social service professionals, mental health therapists, education professionals, college professors and faculty, field study/workforce coordinators, and college student consumers. Each strategy for information collection is uniquely considered and implemented. Individuals and groups who are often dis-empowered and disenfranchised in developing programs to meet their family needs have been involved in the planning and strategic evaluation, specifically our African American, foster, grandparents raising grandchildren, Hmong, Indigenous, Latino, LGBTQI+, and single parent families.

In addition to the calculated and thoughtful planning and development activities from the Planning and Development Committee, The CARE Project was vetted through the 2019 MHSA Annual Update Community Input Process. A survey distributed to the community through the Community Input Process

featured eight strategies in the CARE Center application. Seventy percent considered those strategies an ***extremely important*** or ***very important*** use of public county funds. These included the following:

- Mental health support for young children and their families who have experienced trauma due to the Camp Fire
- Strategies that address generational community trauma and Adverse Childhood Experiences
- Counselors and mental health professionals that are trained in specialized ways to help young children with trauma
- Child care providers and preschool teachers, who see children every day in group settings, who are trained in specialized ways to help children with trauma and social and emotional skills
- Education and modeling for parents of young children on how to care for the emotional needs of their children
- A group of experts from different fields who work together to teach each other, do screenings, and consult on treatment for young children
- A family-friendly location for sensitive family services
- A research-driven, state of the art institute that leads the North State in trauma responsive practices.

The Innovation

The CARE Project will build on the Infant Early Childhood Mental Health Consultation Model (IECMHC) to bring specialized mental health support to young children in natural learning and play environments. **The innovative CARE Project brings IECMHC's research-based urban model to rural, remote communities and integrates it into a multi-disciplinary trauma-responsive service system.** The IECMHC model is a best practice approach for early childhood to address trauma. This model promotes positive mental health outcomes, allows for prevention and management of early childhood trauma, and utilizes intervention strategies that are effective in supporting young children. Yet, this model is wholly untested in rural settings. The CARE Project not only pilots IECMHC is rural settings, but some of the most isolated, remote, and pioneer frontier areas in the state.

The CARE Project is a multi-faceted, intensive-intervention, and research-based project. It builds mental health professional capacity and service access at target locations that are most accessible to children, families, and professionals in need. The Mental Health Consultant will be referred to Early Learning and Care sites to support identified young children who have either experienced early trauma or exhibit behavior challenges in the child care, preschool, or family child care home settings. This strategy brings services and support to convenient, familiar, and sustained locations. The Consultant will be integrated into the child's natural setting to support the child's healthy development, emphasize social emotional skills in a community setting, and nurture responsive relationships. The Consultant will also model and coach the Early Learning and Care professionals in trauma-informed approaches and practices, and social and emotional development instruction, as well as support the staff through their own secondary trauma.

Fundamental to the CARE Project is decreasing challenging behaviors and increasing access to mental health services for young children. This is done not only through the IECMHC, but by increasing the number of clinicians in Butte County who have completed adequate training to effectively serve young children and their specific and unique needs. The CARE Project will allow comprehensive training to be brought to the county

so that overloaded mental health providers can gain expertise in mental health modalities for young children, in trauma recovery support, and culturally humble approaches.

Innovative to the IECMHC rural-pilot is its context within a multi-disciplinary service support system. The Mental Health Consultant, as well as early care and education teacher, peer navigators, and families will participate in a multi-disciplinary team (MDT) as case plans are developed, implemented, and evaluated. Others slated for this team include Inclusion Specialists, Early Care and Education Specialists, Occupational Therapist, Mental Health Clinicians, Home Visitors, Pediatricians, Child Psychiatrists, College Faculty and College Students. Many of the MDT members and agencies will be housed in the Center to both formally and informally support each other through trauma-responsive professional work, secondary trauma, and compassion fatigue. This MDT collaboration enhances the resource and referral system, child screening and assessment, case and care management, and builds capacity and expertise through cross-training in a community with an extremely limited workforce.

Evaluation and Research

The Center CARE Project details the evaluation associated with four overarching goals. The following clarifies the timing of the evaluation:

- Goal 1 – Improve child social emotional outcomes through **access to specialized mental health services** by IECMHC at Early Learning and Care settings.
  Child screening and assessment tools will be administered at the beginning of the academic year or when referred to the program if the site does not automatically complete the specific tool. The post-test will be administered at the end of the academic year or completion of the treatment plan.
- Goal 2 – Increase the **capacity of Butte County clinicians** to offer specialized, therapeutic care for young children by completing a professional development series, consisting of instruction, modeling, and observation.
  Clinician completion and evaluation of the training will be document at the time of the training. The rubric will be used at the end of the modelling and observation period.
- Goal 3 – Increase **interagency collaboration and expertise** related to mental health services through multidisciplinary co-location, cross-training, collaborative screen and assessments, joint case planning and collective evaluation.
  Professional record keeping will be monitored on an on-going basis and documented for completion at the end of each academic year. Pre-assessments for reflective practices will be administered within one month of the program starting, and annually at the end of the academic year.
- Goal 4 – Decrease **work related stress** by increasing professional development and trauma support to ECE caregivers.
  Pre-tests will be administered within two months beginning the academic year. Post-tests will be administered at the end of the academic year. Trainings will be monitored at the time of completion.

The CARE Project will not be including the administration of a family caregiver fatigue assessment as it is not associated with the four stated goals.

Local statistics on preschool expulsion are not readily available due to the fact that there is no industry monitoring system to collect the data. Nevertheless, anecdotal data through the Butte County Local Child Care Planning Council supports the claim that there has been a sizable increase in expulsions for young children.

Reversion Considerations

Pending DHSC approval, Butte plans to spend all MHSA funding subject to reversion first. This may result in FY 2015-16 and FY 2016-17 funding being spent prior to funding identified as AB 114 funding.

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AGENDA ITEM 3

Action

April 25, 2019 Commission Meeting

Alameda County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of Alameda County's request to fund the following Innovative project:

(A) **Mental Health Technology 2.0: $2,040,120**

- Alameda County is proposing to utilize a technology based approach to support the wellness of consumers and/or family members who are experiencing situational induced trauma by bringing together community based providers and web developers to create the web-based mental health application.

The Mental Health Services Act (MHSA) requires that an INN project does one of the following: (a) introduces a new mental health practice or approach, including but not limited to prevention and early intervention; (b) makes a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; (c) introduces to the mental health system a promising community-driven practice/approach, that has been successful in non-mental health contexts or settings; or (d) participates in a housing program designed to stabilize a person's living situation while also providing supportive services on site. The law also requires that an INN project address one of the following as its primary purpose: (1) increase access to underserved groups, (2) increase the quality of services including measurable outcomes, (3) promote interagency and community collaboration, or (4) increase access to services.

Presenters for Alameda County's Innovation Project:

- Tracy Hazelton, MPH, MHSA Division Director, Alameda County Behavioral Health
- Mary Skinner, J.D., MHSA Innovations Coordinator, Alameda County Behavioral Health

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Enclosures (3): (1) Biographies for Alameda County's Innovation Presenters; (2) Mental Health Technology 2.0 Staff Analysis; (3) Mental Health Technology 2.0 Project Brief.

Handout (1): PowerPoint will be presented at the meeting.

Additional Materials (1): A link to the County's Innovation Plan is available on the Commission website at the following URL:

http://mhsoac.ca.gov/sites/default/files/documents/2019-04/Alameda%20County_INN%20Plan_Mental%20Health%20Technology_4.4.2019_FINAL_corrected%20budget.pdf

Proposed Motion: The Commission approves Alameda County's Innovation Project, as follows:

Name:	**Mental Health Technology 2.0**
Amount:	**Up to $2,040,120 in MHSA Innovation funds**
Project Length:	**2.5 years**

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Biographies for Alameda County Presenters

INN Project: Mental Health Technology 2.0

Tracy Hazelton, MPH
Division Director MHSA
Alameda County Behavioral Health

Ms. Hazelton is currently a Division Director for Alameda County Behavioral Health focusing on the oversight of the Mental Health Services Act (Prop 63) funding stream. She has extensive experience in the areas of project development and implementation, evaluation, and community engagement/support with a special emphasis in prevention and early intervention services. Before coming to Behavioral Health, Ms. Hazelton spent a number of years conducting social science research and managing evaluations of various sizes. She earned her Master's degree in Public Health from the University of California Los Angeles with a focus on community health and planning. Tracy was also a Peace Corps volunteer in Ghana, West Africa where she taught high school science.

Mary Skinner, J.D.
Innovations Coordinator, MHSA
Alameda County Behavioral Health

Ms. Skinner is currently Innovations Coordinator for Alameda County Behavioral Health focusing on the Innovations component of the Mental Health Services Act (Prop 63) funding stream. She has comprehensive experience in the areas of legal research; project management; administration and evaluation of community based organizations programs; and contracts including providing oversight, analysis, evaluation, and technical assistance. Prior to Behavioral Health, Ms. Skinner was in the legal field performing research and drafting legal documents for presentation to the Board of Immigration Appeals, the Ninth Circuit Court of Appeals, and the Supreme Court of the United States. She earned her J.D. from San Francisco Law School, and holds a Bachelor's in Sociology from the University of Wisconsin-Madison.

STAFF ANALYSIS - ALAMEDA COUNTY

Innovation (INN) Project Name:	**Mental Health Technology 2.0**
Total INN Funding Requested:	**$2,040,120**
Duration of Innovative Project:	**2.5 Years**

Review History:

Approved by the County Board of Supervisors:	April 8, 2018
County submitted INN Project:	March 27, 2019
MHSOAC consideration of INN Project:	April 25, 2019

Project Introduction:

Alameda County developed this innovation project in January 2010 (Innovative Grant Program) and obtained approval by their Board of Supervisors. During the Commission staff's review of the County's Annual Revenue and Expenditure reports, it came to the staff's attention that Alameda County continued to expend funds on this project after the approved timeline and had not sought approval for new expenditures in the program.

In July 2018, Commission staff met with Alameda County and suggested conducting appropriate community program planning activities to support the work previously initiated, and provided the option to bring these projects to the Commission for consideration. As a result of that work, Alameda County is proposing the Mental Health Technology 2.0 Innovation Project which plans to establish a competitive bid process for community based organizations and software developers to work in tandem to develop mental health mobile applications to support four specific populations; caregivers of family members who suffer from a serious mental illness, youth and transition aged youth who are victims of trauma, attempted suicide survivors and immigrants, asylees and refugees who are particularly isolated in the County and who may have a set of barriers (i.e. stigma, knowledge, language) that prevent them from seeking services.

In the balance of this brief we address specific criteria that the Commission looks for when evaluating Innovation Plans, including:

- *What is the unmet need that the county is trying to address?*
- *Does the proposed project address the need?*
- *Are there clear learning objectives that link to the need?*
- *Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives?*

In addition, the Commission checks to see that the Innovation meets regulatory requirements, that the proposed project aligns with the core MHSA principles, promotes learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four (4) allowable primary purposes: increases access to mental health services to underserved groups; increases the quality of mental health services, including better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing.

The County states this innovation project meets the primary purpose of increasing access to mental health services to County residents who are experiencing situational trauma (page 1). Further, they believe that mobile apps can be creatively used to engage the hard to reach populations (page 2).

The Need

The County has identified four populations experiencing situational trauma who are in need of mental health services and not presently accessing services due to a sense of isolation or lack of anonymity. Further, these populations have been specifically identified by stakeholders as being of importance to them, during the County's CPP process and in the months during the development of this proposal.

The first of these populations, caregivers of family members who suffer from a serious mental illness (SMI) or serious emotional disturbance (SED), represents an increasingly growing group of individuals who may or may not see themselves as caregivers, (i.e. parents of SED children, spouses of aging or ill partners), resulting in isolation and lack of self-care strategies. Data obtained by the County suggests that between 40-70% of caregivers have symptoms of clinical depression and approximately 25-50% of them meet the criteria for major depression. Locally, the County estimates that there are about 50,000 caregivers who are not receiving any services. In part, this may be due to their not believing they are "caregiving" as opposed to parenting or being a supportive partner but in large part the County believes that they just are not aware that there is some relief for them through behavioral health services and now with this Innovation, mobile apps which can provide a platform for better engagement. According to the County, caregivers themselves face burnout and heightened stress and are not provided with care and ways to address these issues, which affects the level of care they are able to provide. The

County is in need of a resource that addresses burnout and other burdens the caregivers face, which will improve their own lives, and in turn, impact those that they care for/serve.

The second population is the youth and transition age youth who have been exposed to or who are victims of violence. Alameda County reports that 44.5% of households in the county have experienced between 1 to 3 Adverse Childhood Experiences (ACEs). Using 2017 census data, this represents 253,236 households. Since census data also estimates there are approximately 2.8 persons per household, over 700,000 people or 42% of Alameda County residents are/could be coping with or are victims of some form of trauma.

Although the County indicates that they have a number of ACEs curricula for staff and providers and services for TAY and children through its other behavioral health programs, addressing the trauma at its onset or during the acute phase is the best strategy to deal with trauma as a result of being exposed to violence (SAMHSA). The County believes "a mobile app may serve as the most prudent alternative because of its immediate availability to anyone," as well as provide a degree of anonymity for the user who may not feel comfortable with a face to face meeting (page 6). **The County may wish to explain why current strategies are not sufficient to serve this population in a timely manner.**

The third population is attempted suicide survivors. In 2018, the County reported 158 suicides per year during the years 2014 to 2016. The majority of these deaths, according to the County were male and suicide ranks in the top 20 leading cause for death in the County.

Although the county reports they have suicide prevention centers, hotlines to assist persons who are thinking of committing suicide, teen text lines, community gatekeepers, crisis de-briefers and counseling services for suicide prevention, the County feels they do not have sufficient methods to address risk factors for attempted suicide survivors. The County believes that a mobile app will help reduce isolation, reduce stigma around suicidal thoughts and in general create a safe place for survivors who may feel blame, fear, disgrace, or have possible disfigurements from their attempted suicide. Since "history of suicide attempts is one of the highest risk factors for suicide" (page 7), the County hopes that this app will succeed where so many of its other prevention programs have not. Here, however, **County may wish to describe requirements for engagement activities from the developers to ensure that the target population is being sufficiently served.**

The final population is the immigrants, asylees and refugees in the County. The County reports that it is the fourth most diverse county (page 8) in the United States with nearly 1 in 3 (32%) residents being an immigrant. In fact, according to 2017 census data nearly 45% of Alameda County households report speaking a language other than English in the home.

The County also reports that second to Los Angeles, they are the "home to the highest number of unaccompanied immigrant youth" (page 8) coming to the United States. Because of the varying degrees of trauma associated with migration (separation from

family, violence, persecution), and the "dire" (page 8) and often substandard living conditions (before and after immigration), all of which exacerbate isolation and distress, the County believes that a mobile app to help with the acculturation and socialization processes.

The County reports that while they have a number of cultural and linguistically competent staff and programs to cover the needs of the populations in the six (6) threshold languages, they do not have adequate staff to cover the 39 languages spoken in the County or to address the multi-lingual and cultural needs of its immigrant/refugee/aslyee populations. This lack of ability to connect with this population leads to further isolation for them and an increase in mental health needs not being addressed. While the development of applications are yet to be established, **the County may wish to describe their intended strategies to ensure that applications are translated into the appropriate languages to meet the needs of the targeted populations.**

The Response

To meet these needs, the County proposes that mobile apps will be developed in collaboration with local community based organizations for four vulnerable populations. Each of these populations are identified by stakeholders as not having sufficient ability to obtain mental health services resources to services either because of lack of information or because of stigma associated with receiving or seeking services.

The County is proposing to award eight (8) grants of not more than $230,000 each to local non-profit, community-based organizations (CBOs) who will work with application/web designers/developers to meet the technology needs of targeted populations, described above. The term of the grant will be 24 months. The requirements for the grants will include that the developer and CBO develop, test, launch, host, and evaluate aspects of the app, as well as meet specific Health Insurance Portability and Accountability Act (HIPAA) and confidentiality requirements related either to their population, specific use of their app or the nature of the data on the app. No app will have text or email features. **The County may wish to describe whether contractors will need approval with a local Institutional Review Board to review plans and confidentiality requirements.**

The County is aware that there are some similarities of this innovation project to that of the multi-county Innovation Technology Suite project as need-specific apps are being designed. They feel however that their model of addressing these specific populations, who are or have experienced some form of trauma, separates their technology project from that of the other Tech Suite project. In their review of what has been done previously they also looked at apps for health related/caregivers. Only 44 of the 200,000 available app are directly related to caregivers, however none of those have been tested to see if they specifically are addressing caregiver needs or use an evidence based approach.

According to the County there are no specific apps for TAY and youth. There are apps for bullying, Help Kids Cope, etc., a veterans' app which may have some applicability for children and TAY but is not designed specifically for them, and an app for locating specific types of law enforcement help that can support a person after a crime (AVIATOR). Again, because the County intends to have an app developed for TAY youth who have experienced a recent trauma, the County believes that their population is unique.

For survivors of attempted suicide the County's research indicates that there are no apps for persons who have made suicide attempts. The county indicates that an app has been developed by a 15 year old for persons who are *thinking* about suicide (Anxiety Helper), as well as apps for depression, panic attacks, stress and suicide prevention/ideation. (page 7)

Currently there are only a few apps for immigrants/aslyees and refugees and most of these are related to emergency, legal and logistical services. There are no apps for this population that address mental health issues or mental health issues associated with the stressors, trauma and isolation of being forced to leave their known connections, country and family.

The Community Planning Process

When the County was not able to go forward with the granting process in 2017-18 the County indicated that there was an "outpouring of public support" (page 15), including public comment at the October 2018 Commission meeting, requesting that the project be developed. The County indicates that as of January 2019, they continued to receive calls from their constituents about the project. The revised plan went out for public comment February 8, 2019 through March 8, 2019. One comment was received from the public. Although the feedback was supportive of the project, a suggestion to increase the amount allocated for the grants was indicated. As a result of that suggestion, the County has increased the budgeted amount for the technology developments.

The County also reports that it currently has an open survey for the technology project and is receiving feedback on its two questions:

1. In your experience, how can mobile technology improve outreach and engagements with consumers who are isolated, underserved, and/or inappropriately served?

2. Is there anything else you would like to share about how mobile technology can support mental health?

It is anticipated that responses from this survey may inform the requirements of the RFPs.

This project was shared with the Commission stakeholders on February 11, 2019 and there were no letters of support or opposition received.

Learning Objectives and Evaluation

Alameda County seeks to utilize a technology based approach as a means of increasing access to mental health care for individuals in the county experiencing situational induced trauma. Specifically, the County will address the needs of four target populations:

- Caregivers of family members who suffer from a serious mental illness or serious emotional disturbance
- Youth/Transition Age Youth who are victims of Trauma
- Attempted suicide survivors, and
- Immigrants, asylum seekers, and refugees.

The overall evaluation will be refined as grantees enter into contracts with evaluators, however, the County has identified both individual level and agency level learning goals that will guide the overall project (**see pg. 13 of County plan**).

Both active and passive data will be collected according to the design of the applications to establish a baseline for further evaluation. Examples of sources of information include: completing a health quiz or assessment, self-reported mental health status and/or a mood scale all within the application. **Because this data will potentially contain personal health information, the County may wish to further describe how protections of PHI will be maintained—or more important—how the County will ensure that technology grantees will meet these protections.**

Though the data that will be collected may presumably measure what is needed to meet the learning goals and outcomes proposed, the **County may wish to clarify how baseline data relative to increases in access to services will be established.**

Specifics to evaluation will be vary by each technology grantee, and will be a requirement of the RFP process. At the completion of the project, the County will utilize evaluation results and lessons learned to potentially link with the Technology Suite Collaborative Project and expand on the statewide learning, or continue the project utilizing Capital Facilities & Technological Need funding.

The Budget

The County is seeking authorization to spend $2,040,120 for this Innovation over a 2.5 year period. Personnel costs in the amount of $567,624 represent 28% of the total budget. These salary costs will support County staff responsible for managing the RFP process.

Contract (grants) in the amount of $880,000 represent 43% of the total budget. Each grant is additionally allocated $35,000 for a total of $280,000 or 14% of the total budget for evaluation. **The County may wish to clarify if the grants will include any direct service provisions.**

The Innovation dissemination plan includes a half day learning conference to "showcase" (page 22) each of the mobile applications, budgeted at $75,000 represents 4% of the total budget. Other costs and indirect costs totaling $237,496 represent 12% of the total budget.

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

References

https://www.census.gov/quickfacts/fact/table/alamedacountycalifornia/PST045217

Full project proposal can be accessed here:

http://mhsoac.ca.gov/sites/default/files/documents/2019-04/Alameda%20County_INN%20Plan_Mental%20Health%20Technology_4.4.2019_FINAL_corrected%20budget.pdf

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Project Summary

County: **Alameda County**
Date submitted: 4/11/2019
Project Title: **Mental Health Technology 2.0**
Total amount requested: $2,040,120
Duration of project: 2 years and 5 months

General Requirement	Introduces a new practice or approach to the overall mental health system, including, but not limited to prevention and early intervention.
Primary Purpose	Utilize a technology based approach in order to increase access to mental health care and support for individuals in Alameda County who are experiencing situational induced trauma.

> ***"I can honestly say that technology has saved my life. When I found something greater than myself, I realized that I am not just a person with a life. I am a person who has something to contribute."*** *Amanda Southworth, Founder and Executive Director of Astra Labs and survivor of seven suicide attempts.*

Problem

SAMHSA describes individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." (https://www.samhsa.gov/trauma-violence) Trauma is boundless with its cultural competencies because it has complete disregard for race, ethnicity, gender identity or age. It has no sense of how affluent or impoverished an individual may be. Trauma cuts through every line that society draws. Alameda County is no exception to trauma's rules.

The research on the effects of trauma is extensive, showing the oppressive nature of traumatic experiences. Trauma can shatter one's sense of security creating symptoms that can include fear, anxiety, sadness, guilt, anger, and grief. These feelings can then lead to withdrawal, isolation, and self-harm. Even when there are resources of support to address traumatic effects, the feelings of isolation and withdrawal may be too overwhelming for some individuals and prevents them from seeking assistance.

Alameda's Community Planning Process (CPP) revealed that suicide prevention, community violence, and trauma were identified as priorities throughout CPP outreach events held during June – October 2017 for the MHSA Three Year Plan. During these events, mental health technologies was a suggested method to reach populations that are experiencing trauma because of stigmatization, culture, and language barriers or in respect to the caregiver population, the feeling that if they leave the house, their loved one will fall to harm.

Within the field of MH applications there remains an issue regarding baseline data and measurement of change, and for this project in particular, there are issues with baseline caregiver demographic data that Alameda is in the process of collecting through conversations with the four Alameda County NAMI affiliations.

All grantees will be required to submit demographic data with their MH Technology bids as well as describe a process for collecting baseline data so that change information will be able to be reported. This will be an item that the local community-based organizations (CBO) and the tech developer will need to develop as part of their grant and report on in regular intervals. The evaluation consultant hired for each grant will also be able to assist with this process.

The prospects in mental health solutions using innovative technologies is ripe for exploration to reduce prolonged suffering, which is one of the MHSA seven negative outcomes "that may result from untreated, undertreated or inappropriately treated mental illnesses".

Solution

Technology brings anonymity for the stigmatized, and more importantly a source of outreach that *doesn't* sleep, become tired or irritable, and is literally available with a touch of a finger. Anyone with a smartphone is able to access technology, and able to maintain their anonymity due to advanced encryption methods. The user can thus feel less lonely, less isolated, doesn't feel judged, and in the end, feels supported, receiving a reduction in distress, anxiety, and fatigue.

As a stand-alone treatment modality, there has only been a fraction of research done on mental health apps and the body of evidence was of very low quality. It also can be argued that the mental health apps currently on the market have an implied message of you're on your own because the apps existence implies that you and the app can, together, solve your problems. Nonetheless, digging through product liability disclaimers you may find the app stating, "We give no representation or warranties about the accuracy, completeness, or suitability for any purpose [of our] advice." This leaves the responsibility on the user which is a lot for someone seeking help. (https://vitals.lifehacker.com/how-mental-health-apps-are-messing-with-our-heads-1827727989)

However, research of mental health apps and their efficacy in behavioral health *when used in conjunction with traditional treatment modalities* continues to grow and shows great promise. The possibilities of the inclusion of this type of technology as an additional platform to traditional services, resources, and support brings an opportunity for synergy between technology and tradition.

This is the path that Alameda would like to explore through this Innovation project, i.e. the combination of technology being embedded with local community-based organizations for the dual goal of increasing access to mental health services, resources and supports *and* learning how technology can not only help different communities but how can it also help change or

reimagine the work and direction of the community-based organization.

Project

Community based providers will collaborate with web developers to create an innovative web-based mental health technology application to support the wellness of consumers and/or family members who are experiencing situational induced trauma[1]. This project intends to provide a platform for individuals who reside in isolation, anonymity, or feel they have no place to go because of their situation. This project offers new opportunities for outreach, and engagement, and support to these communities by testing a technology based delivery system for mental health solutions. The targeted populations have been identified because of the County's interest in the situational trauma being created by a number of specific factors that are affecting its residents.

These factors include:

1) The role of caregivers due to a result of an increasing shift of psychiatric care to the community supplemented by an ever aging population – [*Target Populations* are *caregivers* of family members who suffer from a Serious Mental Illness or a Serious Emotional Disturbance.]
Data is not specifically available to accurately gauge the number of caregivers of family members because of a lack of research[2];

- Anecdotal evidence from stakeholders indicates an increase in unchecked stressors due to a burdening aging population;
- Applying national data to Alameda suggests an estimated 50,000 residents are caregivers during any 12 month period;
- In 2020, the County will have 260,000 adults over the age of 65; by 2030, 1 in 5 will be 65 plus; and by 2040, older adults will be substantially more than number of children under 18;

2) Physical violence and gun violence – [*Target population* is youth/transition age youth who are *victims of trauma* induced by multiple forms of violence, particularly gun violence.]

- Alameda County's violent crime rate is twice as high as that of California;
- City of Oakland continues to account for a disproportionate amount of the County's total violent crime at 69%;
- Alameda County has the 4th highest youth homicide rate of all California counties at 20.86 per 100,00;

[1] Here, the County is defining trauma as having been induced by a recent situation rather than a long term trauma.

[2] The County is in an outreach process with the four NAMI chapters in Alameda County to conduct some additional research in order to better determine the estimated number of the current caregiver population.

3) The rising rate of suicide especially in youth, transitional age youth, and older men – [*Target population* is *attempted* suicide survivors.]

- Suicide rates for teens ages 10 to 17 have risen 70% between 2006-2016;
- Alameda County averaged 158 suicides per year between 2014-2016, a rate of 9.0 per 100,00 with a majority of these being males aged 45-64;
- Suicide has ranked in the top 20 causes of death in Alameda County since 2000, and currently ranks 19th;

4) The influx of immigrants, asylees, and refugees into the County – [*Target populations* are immigrants, asylees, and refugees.]

- Alameda County is the 4th most diverse county in the United States;
- 1 in 3 County residents is an immigrant (current estimated County population is 1.6 million);
- Alameda County has a very low penetration rate of mental health services for Asian identified Medi-Cal beneficiaries who comprise the highest number of incoming migrants.

Evaluation

This Innovation project aims to tailor a mobile application to the mental health field to assess the following items at two different levels:

Individual/Client Level Questions

1. Can a mobile app that's tailored to recent trauma victims improve mental, and functional outcomes?
2. Can a mobile app assist in reducing barriers to accessing mental health treatment?
3. Can a mobile app have an effect on a person feeling "less alone"?
4. What virtual strategies contribute most significantly to increasing an individual's capacity/willingness to reach out for in-person support?
5. What is the level of user engagement by target population and understanding the reasons for engagement or lack of it?

CBO/Agency Level

1. What type of difference does it make to develop and implement an app at the local level as compared to adopting a ready-made app off of Google Play and/or Apple iTunes?
2. What changes occur at the CBO level for the awarded CBO in terms of new or different practices/policies, outreach efforts, activities, etc.?
3. How are these new practices/policies being employed as a result of receiving and implementing this Mental Health Technology grant?

Additional Information:

Alameda County previously had an Innovation (INN) Project called the Innovative Grant Program that had multiple rounds of short term grant projects with different themes per round based on various community planning processes (CPPs). Under this INN Project, in FY 16/17, Alameda developed a grant round for the development and implementation of mental health technology applications. The overview of this round of grants was included in Alameda's FY 16/17 Plan Update and the MHSA Three Year Plan 17/18-19/20. Only an overview was provided in these Plans since Alameda understood this grant round was under the umbrella of their approved original Innovative Grant Program. Unfortunately, due to an administrative error on Alameda's behalf, this grant round couldn't be included under their original INN project due to the regulatory time limitations of an INN project.

There has been an outpouring of ongoing public support for this INN project around mental health technology. Therefore, the County is reviving this project idea of mental health technology through a new INN proposal: Mental Health Technology 2.0.

The following chart outlines the variances that exist between CalMHSA's Technology Suite and Alameda County's proposed Mental Health Technology Application:

Alameda's Targeted Population	**Identified Issues to Resolve**	**Technology Suite Overlap**
Caregivers of SMI and SED Family Members	Outreach Engagement and Education for emotional support	***No populations of caregivers identified in suite.***
Youth/TAY Victims of Trauma by Multiple Forms of Violence	Early intervention after trauma Prevention of further trauma Promote mental health wellness in youth and TAY	Youth/TAY are identified as identified demographics, ***trauma induced by violence is not a topic in the suite.***
Attempted Suicide Survivors	Reduce Isolation and Stigmatization surrounding suicidal thoughts; Prevention	Suicide prevention is identified by Riverside, Santa Barbara and Tehama county as a targeted demographic. ***Alameda's is specifically targeting survivors of suicide attempts.***
Immigrants, Asylees, and Refugees	Reduce Stigma Increase Access Reduce Isolation and Fear	Only Tehama County specifies an immigrant population: migrant workers. ***Alameda is the only county targeting immigrants, asylees, and refugees***.

B. New Innovative Project Budget By FISCAL YEAR (FY)*					
EXPENDITURES					
PERSONNEL COSTS (salaries, wages, benefits)		**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**Total**
1	Salaries	$ 145,562	$ 257,031	$ 165,031	**$ 567,624**
2	Direct Costs				**$ -**
3	Indirect Costs	$ 21,834	$ 38,555	$ 24,755	**$ 85,144**
4	Total Personnel Costs	**$ 167,396**	**$ 295,586**	**$ 189,786**	**$ 652,768**
OPERATING COSTS					**Total**
5	Direct Costs	$ 27,600	$ 66,240	$ 38,640	**$ 132,480**
6	Indirect Costs	$ 4,140	$ 9,936	$ 5,796	**$ 19,872**
7	Total Operating Costs	**$ 31,740**	**$ 76,176**	**$ 44,436**	**$ 152,352**
NON RECURRING COSTS (equipment, technology)					**Total**
8					**$ -**
9					**$ -**
10	Total Non-recurring costs				**$ -**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)					**Total**
11	Direct Costs	$ 241,667	$ 580,000	$ 338,333	**$ 1,160,000**
12	Indirect Costs				
13	Total Consultant Costs	**$ 241,667**	**$ 580,000**	**$ 338,333**	**$ 1,160,000**
OTHER EXPENDITURES (please explain in budget narrative)					**Total**
14	INN Technology Conference		**$75,000**		**$ 75,000**
15					**$ -**
16	Total Other expenditures				**$ -**
BUDGET TOTALS					
Personnel (line 1)		**$ 145,562**	**$ 257,031**	**$ 165,031**	**$ 567,624**
Direct Costs (add lines 2, 5 and 11 from above)		**$ 269,267**	**$ 646,240**	**$ 376,973**	**$ 1,292,480**
Indirect Costs (add lines 3, 6 and 12 from above)		**$ 25,974**	**$ 48,491**	**$ 30,551**	**$ 105,016**
Non-recurring costs (line 10)		**$ -**	**$ -**		**$ -**
Other Expenditures (line 16)		**$ -**	**$ -**		**$ -**
TOTAL INNOVATION BUDGET		**$ 440,803**	**$ 1,026,762**	**$ 572,555**	**$ 2,040,120**

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AGENDA ITEM 4

Action
April 25, 2019 Commission Meeting
Awarding of the Immigrant and Refugee Stakeholder Contracts

Summary: The Mental Health Services Oversight and Accountability Commission will consider awarding five stakeholder contracts in the amount of $402,500 each to the highest scoring applicants in response to the Request for Proposals for mental health advocacy on behalf of Immigrants and Refugees and authorizing the Executive Director to act in accordance with the Commission's decision.

At its January of 2019 meeting the Commission approved the scope of work and minimum qualifications for the Request for Proposal and authorized the Executive Director to initiate a competitive bid process to make one award available in each of the five California regions (Superior, Bay Area, Central, Southern California, and Los Angeles) for five awards of $402,500 for a total of $2,012,500.

The Request for Proposals were released on February 15, 2019. They were posted on Cal eProcure, the MHSOAC website, and were advertised through an email notification to the MHSOAC listserv.

Scope of Work
Proposers were asked to develop deliverables in response to the scope of work as outlined in the Request for Proposal in the following three priority areas:

- Advocacy
- Training and Education
- Outreach and Engagement

RFP Timeline

- February 15, 2019: RFP released to the public
- April 5, 2019: Deadline to submit proposals
- April 8-18: Multiple stage evaluation process to review and score proposals
- April 25, 2019: Results presented to the Commission

RFP Evaluation Process
The entire scoring process from receipt of proposals to posting of the Notice of Intent to Award is confidential. In accordance with the State of California standard competitive selection process, all proposals were evaluated in a multiple stage process.

- **Stage 1: Administrative Submission Review**
  Each proposal was reviewed by Commission staff for the presence of all required documents including certification that the proposer met all minimum requirements as listed in the RFP. This first Stage was scored on a pass/fail basis. Proposals that passed the requirements of Stage 1 moved to Stage 2. Proposals that did not meet the requirements of Stage 1 were deemed non-compliant and are not eligible to receive an award.

- **Stage 2: Technical Review**
  Proposals were scored by a review panel comprised of state agency subject matter experts during the Stage 2 evaluation. The panel reviewed and scored proposals on the following requirements:
    - Background
    - Work Plan
    - References

  The maximum points possible for this stage was 800 points.

- **Stage 3: Interviews**
  Interviews, where needed, were conducted with the top 2 highest scoring proposals per designated region based on the Total Technical Evaluation Score of each designated region. Interviews were used to validate the information in the proposal as another means to provide assurance to the Commission that the Proposer has the capability and capacity to perform the work required by the RFP.

  The maximum points possible for this stage was 200 points.

- **Stage 4: Combining Proposer's Scores**
  Commission staff combined the points from Stage 2 and Stage 3 to determine the total scores for each qualifying proposer.

Final selection is determined on the basis of the highest overall point score. The recommended awards are to be made to the proposers receiving the highest overall point score within their region.

In the event that there are no compliant bidders for the Request for Proposal the Commission will have the option to consider amending the Request for Proposal or closing the solicitation and re-issuing a new Request for Proposal.

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RFP Award and Protest Process

Within five working days of the Commission's vote to award the contracts, unsuccessful proposers, wishing to protest the decision, must submit to the Commission an Intent to Protest letter. Within five working days after the Commission receives the Intent to Protest letter, the protesting proposer must submit a Letter of Protest detailing the grounds for protest. The Letter of Protest must describe the factors that support the protesting Proposer's claim that:

1. The protesting proposer would have been awarded the contract had the Commission correctly applied the prescribed evaluation rating standards in the RFP; or
2. The protesting proposer would have been awarded the contract had the Commission followed the evaluation and scoring methods in the RFP.

As outlined in the RFP, the MHSOAC Executive Director reviews the grounds for protest and renders a final decision.

Presenters:

- Norma Pate, Deputy Director, MHSOAC
- Tom Orrock, Chief of Commission Operations and Grants, MHSOAC

Enclosures: None

Handout: A Power Point presentation will be made available at the Commission meeting.

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AGENDA ITEM 5

Action

April 25, 2019 Commission Meeting

Legislative and Budgetary Priorities

Summary: The Commission will consider legislative and budget priorities for the current legislative session, including consideration of the following bills: SB 66 (Atkins) – Medi-Cal: federally qualified health center and rural health clinic services; AB 512 (Ting) – Medi-Cal: specialty mental health services; and AB 1352 (Waldron) – Community mental health services: mental health boards.

- **Senate Bill 66 (Atkins):** This bill will facilitate the ability to seamlessly transition patients from primary care to an onsite mental health specialist on the same day, to ensure that a patient receives needed care and follows through with treatment. An efficient transition is important for disadvantaged patients for whom taking time off work and arranging transportation to and from a health center can be extraordinarily difficult. Right now, California is one of only a handful of states that does not allow health centers to provide and bill for mental and physical health visits on the same day. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit.

- **Assembly Bill 512 (Ting):** Current law requires the State Department of Health Care Services to implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans, and requires mental health plans to be governed by various guidelines, including a requirement that a mental health plan assess the cultural competency needs of the program. This bill would require each mental health plan to prepare a cultural competency assessment plan to address specified matters, including disparities in access, utilization, and outcomes by various categories, such as race, ethnicity and immigration status.

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- **Assembly Bill 1352 (Waldron):** The Bronzan-McCorquodale Act governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Current law generally requires each community mental health service to have a mental health board consisting of 10 to 15 members who are appointed by the governing body, and encourages counties to appoint individuals who have experience with and knowledge of the mental health system. This bill would require a mental health board to report directly to the governing body, and to have the authority to act, review, and report independently from the county mental health department or county behavioral health department, as applicable.

Presenter:
- Toby Ewing, Executive Director, MHSOAC

Enclosures (9):
(1) SB 66 (Atkins) Fact Sheet
(2) SB 66 Bill Text – Amended 3/21/19
(3) AB 66 Analysis – Senate Committee on Health
(4) AB 66 Analysis – Senate Committee on Appropriations
(5) AB 512 (Ting) Fact Sheet
(6) AB 512 Bill Text – Amended 4/2/19
(7) AB 512 Analysis – Assembly Committee on Health
(8) AB 1352 (Waldron) Fact Sheet
(9) AB 1352 Bill Text – Amended 3/25/19

Handout: None

SB 66 – Improved Access to Mental Health Services in Primary Care

IN BRIEF

SB 66 dismantles barriers that mental health patients in California face when attempting to access comprehensive health services by allowing their local community health center to bill Medi-Cal for mental health services and other medical services in the same day.

BACKGROUND

There are 1,300 community health centers in California providing an array of primary care, podiatry, optometry, dental care and mental health services to 6.5 million patients. The vast majority of these patients live at or below the poverty line, and a substantial share are uninsured or enrolled in Medi-Cal.

Multiple studies have underscored the benefits of integrated health care, particularly when it comes to mental health. According to the Department of Psychiatry and Behavioral Sciences at UC Davis, as many as 40% of patients seen in a primary care setting on any given day have an active psychiatric condition. The ability to seamlessly transition a patient from primary care to an on-site mental health specialist on the same day has proven highly effective in ensuring a patient accesses needed care and follows through with treatment regimens. This is especially true in impoverished communities, where taking time off work and arranging transportation to and from a health center can become an insurmountable challenge.

THE ISSUE

In California, if a patient receives treatment through Medi-Cal at a community health center from both a medical provider and a mental health specialist on the same day, the State Department of Health Care Services will only reimburse the center for one "visit", meaning it can't be adequately reimbursed for its services. A patient must seek mental health treatment on a subsequent day in order for that treatment to be reimbursed as a second "visit."

This statute creates an undue financial barrier for community centers, known as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), preventing them from treating their patients in a comprehensive manner in the same day.

Notably, this barrier doesn't exist for similar health services. The federal Medicare program allows for same-day billing of behavioral health and medical services and California allows FQHC and RHCs to bill for two separate Medi-Cal "visits" if a patient sees both a primary care provider and a dental provider on the same day. In addition, the federal government encourages states to allow FQHCs and RHCs to bill for care provided by a primary care specialist and mental health specialist in the same day as two separate visits in recognition of the value comprehensive care generates.

Inexplicably, California has refused to change its Medi-Cal billing statute to align with federal policy and its own state policy regarding dental care. Emergency rooms are too often a costly point of entry for mental health services, and we see the fallout of untreated mental illness on our streets, our jails, and our communities.

THE SOLUTION

SB 66 would require the state to allow FQHCs and RHCs to bill Medi-Cal for two visits if a patient is provided mental health services on the same day they receive other medical services.

Allowing health centers to access the same-day billing statute already in place in other public programs will ensure more early intervention in mental illness and guarantee that we are using the integrated health services available to our communities at their full potential.

SUPPORT

- California Health+ Advocates (cosponsor)
- The Steinberg Institute (cosponsor)
- California Association of Public Hospitals and Health Systems (cosponsors)
- Local Health Plans of California (cosponsor)

- National Union of Healthcare Workers

OPPOSITION

- None

FOR MORE INFORMATION

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Senator Mike McGuire
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AMENDED IN SENATE MARCH 21, 2019

SENATE BILL No. 66

Introduced by Senators Atkins and McGuire
(Coauthors: Senators Bates, Beall, Chang, Dodd, Galgiani, Hertzberg, Jones, Nielsen, Portantino, Wiener, and Wilk)
(Coauthors: Assembly Members Aguiar-Curry, Berman, Carrillo, Dahle, Frazier, Gallagher, Eduardo Garcia, Gray, Maienschein, Mathis, Robert Rivas, and Wood)

January 8, 2019

An act to amend Section 14132.100 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 66, as amended, Atkins. Medi-Cal: federally qualified health center and rural health clinic services.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a ~~physician.~~ *physician and marriage and family therapist.* Under existing law, "physician," for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist.

This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit for purposes of establishing the FQHC's or RHC's rate to apply for an adjustment to its per-visit rate, and after the department has approved that rate adjustment, to bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits, in accordance with the bill.

This bill would also ~~make an FQHC or RHC visit to a licensed acupuncturist reimbursable on a per-visit basis. The~~ *include a licensed acupuncturist within those health care professionals covered under the definition of "visit." The* bill would require the department, by July 1, 2020, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services to reflect certain changes described in the bill, and to seek necessary federal approvals. The bill would also make conforming and technical changes.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d(a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accordance with the definition of "visit" set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1 thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall

be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accordance with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of service provided by the FQHC or RHC. Rate changes based on a change in the scope of service provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivision (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Services Administration (HRSA).

(3) No change in costs shall, in and of itself, be considered a scope of service change unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of service defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75-percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope of service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope of service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope of service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of service provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall

submit a scope of service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope of service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope of service change, the adjusted reimbursement rate for that scope of service change shall be made retroactive to the date the scope of service change was initially implemented. Scope of service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to "fiscal year" shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope of service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include both of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant, two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less.

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) (1) An FQHC or RHC "visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, "physician" shall be interpreted in a manner consistent with the federal Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a medical doctor, osteopath, podiatrist, ~~licensed acupuncturist,~~ dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(2) (A) A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, ~~or~~ a marriage and family ~~therapist.~~ *therapist, or a licensed acupuncturist.*

(B) Notwithstanding subdivision (e), if an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, the FQHC or RHC shall apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, shall bill these services as a separate visit. However, multiple encounters with dental professionals or marriage and family therapists that take place on the same day shall constitute a single visit. The department shall develop the appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates. An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this subparagraph shall not constitute a change in scope of service within the meaning of subdivision (e). An FQHC or RHC that applies for an adjustment to its rate pursuant to this subparagraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment for visits between an FQHC or RHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist has been approved. Any approved increase or decrease in the provider's rate shall be made within six months after the date of receipt of the department's rate adjustment forms pursuant to this subparagraph and shall be retroactive to the beginning of the fiscal year in which the FQHC or RHC submits the request, but in no case shall the effective date be earlier than January 1, 2008.

(C) An FQHC or RHC that does not provide dental hygienist, dental hygienist in alternative practice, or marriage and family therapist services, and later elects to add these services and bill these services as a separate visit, shall process the addition of these services as a change in scope of service pursuant to subdivision (e).

(3) Notwithstanding any other provision of this section, by July 1, 2018, a visit shall include a marriage and family therapist.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity, as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code, the Medicare Program, or the Child Health and Disability Prevention (CHDP) Program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) Provided that the following entities are not operating as intermittent clinics, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, each entity shall have its reimbursement rate established in accordance with one of the methods outlined in paragraph (2) or (3), as selected by the FQHC or RHC:

(A) An entity that first qualifies as an FQHC or RHC in 2001 or later.

(B) A newly licensed facility at a new location added to an existing FQHC or RHC.

(C) An entity that is an existing FQHC or RHC that is relocated to a new site.

(2) (A) An FQHC or RHC that adds a new licensed location to its existing primary care license under paragraph (1) of subdivision (b) of Section 1212 of the Health and Safety Code may elect to have the reimbursement rate for the new location established in accordance with paragraph (3), or notwithstanding subdivision (e), an FQHC or RHC may choose to have one PPS rate for all locations that appear on its primary care license determined by submitting a change in scope of service request if both of the following requirements are met:

(i) The change in scope of service request includes the costs and visits for those locations for the first full fiscal year immediately following the date the new location is added to the FQHC's or RHC's existing licensee.

(ii) The FQHC or RHC submits the change in scope of service request within 90 days after the FQHC's or RHC's first full fiscal year.

(B) The FQHC's or RHC's single PPS rate for those locations shall be calculated based on the total costs and total visits of those locations and shall be determined based on the following:

(i) An audit in accordance with Section 14170.

(ii) Rate changes based on a change in scope of service request shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successors.

(iii) Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(C) Except as specified in subdivision (j), this paragraph does not apply to a location that was added to an existing primary care clinic license by the State Department of Public Health, whether by a regional district office or the centralized application unit, prior to January 1, 2017.

(3) If an FQHC or RHC does not elect to have the PPS rate determined by a change in scope of service request, the FQHC or RHC shall have the reimbursement rate established for any of the entities identified in paragraph (1) or (2) in accordance with one of the following methods at the election of the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, ~~healthcare~~ *health care* and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected

allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(4) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(5) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its new FQHC or RHC provider number, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) (1) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, or at the election of the FQHC or RHC and

subject to paragraph (2), a location added to an existing primary care clinic license by the State Department of Public Health prior to January 1, 2017, shall be billed by and reimbursed at the same rate as the FQHC or RHC that either established the intermittent clinic site or mobile unit, or that held the clinic license to which the location was added prior to January 1, 2017.

(2) If an FQHC or RHC with at least one additional location on its primary care clinic license that was added by the State Department of Public Health prior to January 1, 2017, applies for an adjustment to its per-visit rate based on a change in the scope of service provided by the FQHC or RHC as described in subdivision (e), all locations on the FQHC or RHC's primary care clinic license shall be subject to a scope of service adjustment in accordance with either paragraph (2) or (3) of subdivision (i), as selected by the FQHC or RHC.

(3) Nothing in this subdivision precludes or otherwise limits the right of the FQHC or RHC to request a scope of service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope of service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope of service adjustments as provided in subdivision (e).

(*l*) (1) For purposes of this subdivision, the following definitions apply:

(A) A "mental health visit" means a face-to-face encounter between an FQHC or RHC patient and a psychiatrist, clinical psychologist, licensed clinical social worker, or marriage and family therapist.

(B) A "dental visit" means a face-to-face encounter between an FQHC or RHC patient and a dentist, dental hygienist, or registered dental hygienist in alternative practice.

(C) "Medical visit" means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, or a

comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services.

(2) A maximum of two visits, as defined in subdivision (g), taking place on the same day at a single location shall be reimbursed when one or both of the following conditions exists:

(A) After the first visit the patient suffers illness or injury requiring additional diagnosis or treatment.

(B) The patient has a medical visit and a mental health visit or a dental visit.

(3) (A) Notwithstanding subdivision (e), an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as constituting a single visit for purposes of establishing its FQHC or RHC rate may elect to apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, the FQHC or RHC shall bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits.

(B) The department shall develop and adjust all appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates.

(C) An FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this paragraph shall not constitute a change in scope of service within the meaning of subdivision (e).

(D) An FQHC or RHC that applies for an adjustment to its rate pursuant to this paragraph may continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment has been approved.

(4) The department, by July 1, 2020, shall submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting the changes described in this subdivision.

(m) Reimbursement for Drug Medi-Cal services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC may elect to have Drug Medi-Cal services reimbursed directly from a county or the department under contract with the FQHC or RHC pursuant to paragraph (4).

(2) (A) For an FQHC or RHC to receive reimbursement for Drug Medi-Cal services directly from the county or the department

under contract with the FQHC or RHC pursuant to paragraph (4), costs associated with providing Drug Medi-Cal services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing Drug Medi-Cal services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering Drug Medi-Cal services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver Drug Medi-Cal services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering Drug Medi-Cal services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing Drug Medi-Cal services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the Drug Medi-Cal services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope of service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering Drug Medi-Cal services outside of the PPS rate. Notwithstanding subdivision (e), the scope of service change request shall include a full fiscal year of activity that does not include Drug Medi-Cal services costs.

(B) An FQHC or RHC may submit requests for scope of service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope of service change request under this subdivision approved by the department shall be retroactive to the first day that Drug Medi-Cal services were rendered and reimbursement for Drug Medi-Cal services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for Drug Medi-Cal services outside of the PPS rate when the FQHC or RHC obtains approval as a Drug Medi-Cal provider and enters into a contract with a

county or the department to provide these services pursuant to paragraph (4).

(D) Within 90 days of receipt of the request for a scope of service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope of service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For purposes of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and Drug Medi-Cal services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate and the FQHC or RHC is approved as a Drug Medi-Cal provider, an FQHC or RHC shall not bill the PPS rate for any Drug Medi-Cal services provided pursuant to a contract entered into with a county or the department pursuant to paragraph (4).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope of service adjustments as provided for in subdivision (e).

(4) Reimbursement for Drug Medi-Cal services shall be determined according to subparagraph (A) or (B), depending on whether the services are provided in a county that participates in the Drug Medi-Cal organized delivery system (DMC-ODS).

(A) In a county that participates in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county or county designee and the FQHC or RHC. If the county or county designee refuses to contract with the FQHC or RHC, the FQHC or RHC may follow

the contract denial process set forth in the Special Terms and Conditions.

(B) In a county that does not participate in the DMC-ODS, the FQHC or RHC shall receive reimbursement pursuant to a mutually agreed upon contract entered into between the county and the FQHC or RHC. If the county refuses to contract with the FQHC or RHC, the FQHC or RHC may request to contract directly with the department and shall be reimbursed for those services at the Drug Medi-Cal fee-for-service rate.

(5) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments for Drug Medi-Cal services made pursuant to this subdivision.

(6) For purposes of this subdivision, the following definitions shall apply:

(A) "Drug Medi-Cal organized delivery system" or "DMC-ODS" means the Drug Medi-Cal organized delivery system authorized under the California Medi-Cal 2020 Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services and described in the Special Terms and Conditions.

(B) "Special Terms and Conditions" shall have the same meaning as set forth in subdivision (o) of Section 14184.10.

(n) Reimbursement for specialty mental health services shall be provided pursuant to this subdivision.

(1) An FQHC or RHC and one or more mental health plans that contract with the department pursuant to Section 14712 may mutually elect to enter into a contract to have the FQHC or RHC provide specialty mental health services to Medi-Cal beneficiaries as part of the mental health plan's network.

(2) (A) For an FQHC or RHC to receive reimbursement for specialty mental health services pursuant to a contract entered into with the mental health plan under paragraph (1), the costs associated with providing specialty mental health services shall not be included in the FQHC's or RHC's per-visit PPS rate. For purposes of this subdivision, the costs associated with providing specialty mental health services shall not be considered to be within the FQHC's or RHC's clinic base PPS rate if in delivering specialty mental health services the clinic uses different clinical staff at a different location.

(B) If the FQHC or RHC does not use different clinical staff at a different location to deliver specialty mental health services, the FQHC or RHC shall submit documentation, in a manner determined by the department, that the current per-visit PPS rate does not include any costs related to rendering specialty mental health services, including costs related to utilizing space in part of the FQHC's or RHC's building, that are or were previously calculated as part of the clinic's base PPS rate.

(3) If the costs associated with providing specialty mental health services are within the FQHC's or RHC's clinic base PPS rate, as determined by the department, the specialty mental health services costs shall be adjusted out of the FQHC's or RHC's per-visit PPS rate as a change in scope of service.

(A) An FQHC or RHC shall submit to the department a scope of service change request to adjust the FQHC's or RHC's clinic base PPS rate after the first full fiscal year of rendering specialty mental health services outside of the PPS rate. Notwithstanding subdivision (e), the scope of service change request shall include a full fiscal year of activity that does not include specialty mental health costs.

(B) An FQHC or RHC may submit requests for a scope of service change under this subdivision only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any scope of service change request under this subdivision approved by the department shall be retroactive to the first day that specialty mental health services were rendered and reimbursement for specialty mental health services was received outside of the PPS rate, but in no case shall the effective date be earlier than January 1, 2018.

(C) The FQHC or RHC may bill for specialty mental health services outside of the PPS rate when the FQHC or RHC contracts with a mental health plan to provide these services pursuant to paragraph (1).

(D) Within 90 days of receipt of the request for a scope of service change under this subdivision, the department shall issue the FQHC or RHC an interim rate equal to 90 percent of the FQHC's or RHC's projected allowable cost, as determined by the department. An audit to determine the final rate shall be performed in accordance with Section 14170.

(E) Rate changes based on a request for scope of service change under this subdivision shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(F) For the purpose of recalculating the PPS rate, the FQHC or RHC shall provide upon request to the department verifiable documentation as to which employees spent time, and the actual time spent, providing federally qualified health center services or rural health center services and specialty mental health services.

(G) After the department approves the adjustment to the FQHC's or RHC's clinic base PPS rate, an FQHC or RHC shall not bill the PPS rate for any specialty mental health services that are provided pursuant to a contract entered into with a mental health plan pursuant to paragraph (1).

(H) An FQHC or RHC that reverses its election under this subdivision shall revert to its prior PPS rate, subject to an increase to account for all Medicare Economic Index increases occurring during the intervening time period, and subject to any increase or decrease associated with the applicable scope of service adjustments as provided for in subdivision (e).

(4) The department shall not reimburse an FQHC or RHC pursuant to subdivision (h) for the difference between its per-visit PPS rate and any payments made for specialty mental health services under this subdivision.

(o) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope of service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(p) The department shall promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid Services for any waivers that would be necessary to implement this section.

(q) The department shall implement this section only to the extent that federal financial participation is available.

(r) Notwithstanding any other law, the director may, without taking regulatory action pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, implement, interpret, or make specific subdivisions (m) and (n) by means of a provider bulletin or similar instruction. The department shall notify and consult with interested parties and appropriate stakeholders in implementing, interpreting, or making specific the provisions of subdivisions (m) and (n), including all of the following:

(1) Notifying provider representatives in writing of the proposed action or change. The notice shall occur, and the applicable draft provider bulletin or similar instruction, shall be made available at least 10 business days prior to the meeting described in paragraph (2).

(2) Scheduling at least one meeting with interested parties and appropriate stakeholders to discuss the proposed action or change.

(3) Allowing for written input regarding the proposed action or change, to which the department shall provide summary written responses in conjunction with the issuance of the applicable final written provider bulletin or similar instruction.

(4) Providing at least 60 days advance notice of the effective date of the proposed action or change.

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SENATE COMMITTEE ON HEALTH

Senator Dr. Richard Pan, Chair

BILL NO: SB 66
AUTHOR: Atkins
VERSION: January 8, 2019
HEARING DATE: March 20, 2019
CONSULTANT: Kimberly Chen

SUBJECT: Medi-Cal: federally qualified health center and rural health clinic services

SUMMARY: Requires a federally qualified health center and a rural health center to receive Medi-Cal reimbursement for two visits on the same day at the same location if after the first visit the patient suffers from illness or injury that requires additional treatment and diagnosis, or if the patient has a medical visit and a mental health or dental visit in the same day.

Existing federal law: Establishes the definition of services of a federally qualified health center (FQHC) and the services of a rural health clinic (RHC). [42 U.S. Code §1396d]

Existing state law:

1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which low-income individuals are eligible for medical coverage. [WIC §14000 et seq.]

2) Requires FQHC and RHC services to be covered benefits under the Medi-Cal program and these services be reimbursed on a per-visit basis, as defined. [WIC §14132.100]

3) Defines "visit" as a face-to-face encounter between a patient of an FHQC or RHC and a specified health care professional, including a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse, podiatrist, dentist, optometrist, chiropractor, comprehensive perinatal services practitioner providing comprehensive perinatal services, a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist, a four-hour day of attendance at an Adult Day Health Care Center; and, any other provider identified in the state plan's definition of an FQHC or RHC visit. [WIC §14132.100]

4) Requires FQHC and RHC per-visit rates to be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in federal law. [WIC §14132.100]

5) Authorizes an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Requires rate changes based on a change in the scope of services provided by an FQHC or RHC to be evaluated in accordance with Medicare reasonable cost principles. [WIC §14132.100]

6) Authorizes an FQHC or RHC that currently includes the cost of services of a dental hygienist in alternative practice, or a marriage and family therapist in establishing its FQHC or RHC rates to bill those services as separate services. Requires an FQHC or RHC seeking to bill those services as separate visits to apply and receive approval by DHCS for an adjustment to its per-visit rate. [WIC §14132.100]

This bill:

1) Requires a maximum of two visits taking place on the same day at a single location to be reimbursed if one or both of the following conditions are met:

    a) After the first visit, the patient suffers illness or injury that requires additional diagnosis or treatment; and,
    b) In addition to a medical visit, the patient has a mental health or a dental visit.

2) Authorizes an FQHC or RHC that currently includes the cost of services of a medical visit and mental health visit as a single visit in establishing its FQHC or RHC rates to bill those services as separate visits. Requires an FQHC or RHC seeking to bill a medical visit and a mental health visit as separate visits to apply for an adjustment to its per-visit rate and receive approval by DHCS in order to receive reimbursement for those services as two visits.

3) Defines "mental health visit," "dental visit," and "medical visit" for purposes of this bill.

4) Requires DHCS to develop and adjust all appropriate forms to determine which FQHCs or RHCs rates are adjusted, and to facilitate the calculation of the adjusted rates.

5) Prohibits an FQHC or RHC application for, or DHCS' approval of, a rate adjustment from constituting a change in scope of service within the meaning of existing law.

6) Authorizes an FQHC or RHC that applies for a rate adjustment under this bill to continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment has been approved.

7) Requires DHCS, by July 1, 2020, to submit a state plan amendment (SPA) to the federal Centers for Medicare and Medicaid Services reflecting the changes described in this bill.

8) Codifies the addition of licensed acupuncturists to the list of health care providers who are billable on a face-to-face per visit basis by FQHCs and RHCs.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, community health centers are an essential component of our Medi-Cal primary care network. Sixty percent of their revenue comes from the Medi-Cal program. The author states that according to the California Future Health Workforce Commission Report, February 2019, approximately 25% of all people seen in primary care have diagnosable mental disorders and the prevalence varies by income with much higher rates at lower income levels for both children and adults. The report points out that primary care providers generally receive limited formal psychiatric education or experience during their training, but are often the first point of contact for detection and treatment. This bill will facilitate the ability to seamlessly transition patients from primary care to an onsite mental health specialist on the same day, a proven way to ensure that a patient receives needed care and follows through with treatment. An efficient transition is even more important for disadvantaged patients for whom taking time off work and arranging transportation to and from a health center can be extraordinarily difficult. Right now, California is one of only a handful of states that does not allow health centers to provide and bill for mental and physical health visits on the same day.

2) *Background*. FQHCs and RHCs are clinics that meet federally defined qualifications and furnish federally specified services. FQHCs provide preventive and primary health care services to medically underserved populations. RHCs also provide outpatient primary care services and must be located within a designated medically underserved area. There are 1,040 FQHCs and 283 RHCs in California. The number of FQHCs has grown significantly—from 476 FQHCs in 2006 to 1,007 in 2015.

3) *Prospective Payment System.* Payment rules for FQHCs and RHCs differ from those for other providers. State and federal law requires that FQHCs and RHCs are paid for each patient visit, a cost-based per-visit rate known as the prospective payment system (PPS). Medi-Cal managed care plans, which must make FQHCs and RHCs available to their members, makes its payment to the FQHC and RHC. DHCS also makes a "wrap around" payment that makes up the difference between the managed care plan payment and the FQHC or RHC's full per-visit PPS rate.

   The PPS is composed of a base rate, which includes a combination of allowable capital costs and allowable operating costs per visit, and a cost-of-living adjustment determined by the Medicare Economic Index (MEI). The adjustments based on the MEI are mandated under state and federal law. FQHCs and RHCs may opt to forgo a base rate established based on projected costs and elect for a rate that is comparable to clinics providing similar services in the same geographic area with similar caseloads. An FQHC and RHC may also request an adjustment to its PPS rate based on a scope of its services, which may include the addition of new services, an increase in service intensity attributed to patients served, changes in operating costs or other changes defined in state law. DHCS is required to evaluate the request in accordance with federal regulations, which may result in increase or decrease in the PPS rate.

4) *DHCS policy on qualifying visits.* Federal law offers states flexibility in defining which services are included in a visit and establishing limits on the number of visits an FQHC can bill per member per day. According to the Medicaid and CHIP Payment and Access Commission, Hawaii allows FQHCs to bill for one medical or optometry visit, one behavioral health visit and one dental visit per day, while Oklahoma allows for more than one visit per day within the same category of service as long as it is for an unrelated diagnosis.

   DHCS specifies that encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. The exception is that two visits may be billed in the following instances:

   a) When a patient, after the first visit, suffers illness or injury that requires another health diagnosis or treatment; and,
   b) When a patient is seen by a health professional or a perinatal practitioner and also receives dental services on the same day.

5) *Medi-Cal acupuncture benefit codification.* In January 2018, DHCS announced outpatient acupuncture services for FQHCs and RHCs were restored as benefits provided to Medi-Cal recipients, effective retroactively for dates of service on or after July 1, 2016. This bill codifies acupuncture visits to an FQHC or RHC as billable under the PPS rate system.

6) *Related legislation.* AB 769 (Smith) requires licensed professional clinical counselors to be included as an eligible billable provider within the definition of a "visit," which establishes when an FQHC or RHC may be reimbursed for services under the PPS rate. *AB 769 is pending the Assembly Health Committee.*

   AB 770 (E. Garcia) requires exclusions to the adjusted PPS rate methodology, authorizes an FQHC or RHC to apply for a scope of service change when updating or implementing a certified electronic health record system, expands the definition of "visit" to include services rendered outside the facility location, as specified, and extends the time frame for which an FQHC or RHC may request a scope of service rate change. *AB 770 is pending the Assembly Health Committee.*

7) *Prior legislation.* SB 1125 (Atkins of 2018) is substantially similar to this bill. *SB 1125 was vetoed by the Governor Brown, who stated the bill required "significant, ongoing general fund commitments" and "should be considered as part of the budget process."*

   SB 323 (Mitchell, Chapter 540, Statutes of 2017) authorized FQHCs and RHCs to provide Drug Medi-Cal services pursuant to the terms of a mutually agreed upon contract entered into between the FQHC or RHC and the county or county designee, or DHCS, as specified, and would set forth the reimbursement requirements for these services.

   SB 1150 (Hueso and Correa of 2014) would have required Medi-Cal reimbursement to FQHC and RHCs for two visits taking place on the same day at a single location when the patient suffers illness or injury requiring additional diagnosis or treatment after the first visit, or when the patient has a medical visit and another health visit with a mental health provider or dental provider. *SB 1150 was held on the Senate Appropriations suspense file.*

   AB 1445 (Chesbro of 2010) was substantially similar to SB 1150. *AB 1445 was held on the Senate Appropriations suspense file.*

   SB 260 (Steinberg of 2007) would have authorized FQHCs and RHCs to bill separately for same day medical and mental health visits. *SB 260 was vetoed by Governor Schwarzenegger.*

8) *Support.* This bill is co-sponsored by the California Association of Public Hospitals and Health Systems, Californiahealth+ Advocates, and the Steinberg Institute. Californiahealth+ Advocates state that patients qualify for Medi-Cal based on having low-income and often come from a background of economic hardship that makes getting to a health center difficult in the first place. They argue that by requiring a 24 hour gap in services between referral from primary care and being seen by a mental health provider, many of these patients are not able to follow through and receive care, resulting in costly visits down the line. The Steinberg Institute states the ability to seamlessly transition a consumer from primary care to an on-site mental health specialist on the same day is highly effective in ensuring that patients have timely access to services and follow through with treatment regimens. The California Association of Public Hospitals and Health Systems writes that the existing billing rules have historically limited the capacity of their clinics to provide behavioral health services on a co-located basis. They contend that the flexibility created by this bill would enable public health care systems and other clinic partners to expand mental health and other services, more effectively meeting the needs of their patient populations.

9) *Technical amendments.* The author proposes technical amendments to move "licensed acupuncturist" to the appropriate subparagraph and to add co-authors.

SUPPORT AND OPPOSITION:

Support: California Association of Public Hospitals and Health Systems (co-sponsor)
CaliforniaHealth+ Advocates (co-sponsor)
Local Health Plans of California (co-sponsor)
ACCESS California
Alameda Health Consortium
Alameda Health System
Alliance of Catholic Health Care
AltaMed Health Services Corporation
American Academy of Pediatrics, California
American College of Obstetricians and Gynecologists
APLA Health
Arroyo Vista Family Health Center
Asian Health Services
Association of California Healthcare Districts
Behavioral Health Services, Inc.
Blue Shield of California
California Alliance of Child and Family Services
California Hospital Association
California Pan - Ethnic Health Network
California Podiatric Medical Association
California Professional Firefighters
California Psychiatric Association
California Psychological Association
California School-Based Health Alliance
California School Employees Association, AFL-CIO
California Society of Addiction Medicine
California State Association of Counties
Center for Family Health & Education
Central City Community Health Center
Clinica Romero
Clinica Sierra Vista
Coalition of Orange County Community Health Centers
Coastal Health Alliance
CommuniCare Health Centers
Community Clinic Association of Los Angeles County
Community Clinic Consortium of Contra Costa and Solano Counties
Community Health Alliance of Pasadena (ChapCare)
Community Health Systems, Inc.
Contra Costa County
County Behavioral Health Directors Association of California
County Health Executives Association of California
County of Santa Clara
Disability Rights California
Desert AIDS Project
El Dorado Community Health Centers
Essential Access Health

Golden Valley Health Centers
Harbor Community Clinic
HealthRIGHT 360
Health Alliance of Northern California
Health Center Partners of Southern California
Kedren Community Health Center
La Clinica de La Raza, Inc.
Latino Coalition for a Healthy California
LifeLong Medical Care
Local Health Plans of California
Los Angeles Christian Health Centers
Marin Community Clinics
Mendocino Community Health Clinics, Inc.
National Union of Healthcare Workers
Neighborhood Healthcare
North Coast Clinics Network
North East Medical Services
Northeast Valley Health Corporation
OLE Health
Omni Family Health
One Community Health
Open Door Community Health Centers
Peach Tree Health
Planned Parenthood Affiliates of California
QueensCare Health Centers
Redwood Community Health Coalition
Redwoods Rural Health Center
Riverside County Board of Supervisors
SAC Health System
San Francisco Community Clinic Consortium
San Fernando Community Health Center
San Ysidro Health
Santa Barbara Neighborhood Clinics
Santa Rosa Community Health
SEIU California
Silicon Valley Leadership Group
Southside Coalition of Community Health Centers
Steinberg Institute
The Children's Clinic
The Children's Clinic, Serving Children & Their Families
T.H.E. Health and Wellness Centers
UMMA Community Clinic
Valley Community Healthcare
Vista Community Clinic
Western Center on Law and Poverty
White Memorial Community Health Center

Oppose: None received

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SENATE COMMITTEE ON APPROPRIATIONS

Senator Anthony Portantino, Chair
2019 - 2020 Regular Session

SB 66 (Atkins) - Medi-Cal: federally qualified health center and rural health clinic services.

Version: March 21, 2019
Urgency: No
Hearing Date: April 8, 2019

Policy Vote: HEALTH 8 - 0
Mandate: No
Consultant: Samantha Lui

Bill Summary: Requires Medi-Cal reimbursement to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for two visits taking place on the same day at a single location when the patient suffers illness or injury requiring additional diagnosis or treatment after the first visit, or when the patient has a medical visit and another health visit with a mental health or dental provider.

Fiscal Impact: Staff notes the following estimate reflects figures provided in a Department of Finance estimate, dated August 7, 2018, for a substantively similar bill (Senate Bill 1125, Atkins, 2018):

- $272.7 million ($109.1 million General Fund), assuming that 50 percent of clinics would request a rate adjustment, there will be a 25-percent increase for the number of eligible visits, and partially offset by an estimated 5-percent net decrease to the Prospective Payment System rate.

- $3.6 to $7.2 million ($1.8 to $3.6 million General Fund), the equivalent of 25 to 50 limited-term auditor positions, to implement the provisions of this bill.

- DOF notes “increased reimbursement costs for clinics and state operations costs are highly variable and depended on clinic behavior and timing of rate adjustment requests.”

For more information about assumptions, please see Staff Comments.

Background: The Department of Health Care Services (DHCS) administers Medi-Cal, the state’s Medicaid program, which provides comprehensive health care coverage for low-income individuals. Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services are covered benefits under the Medi-Cal program, and current law requires visits, as defined, be reimbursed on a per-visit basis. Current law defines a “visit” as:

> A face-to-face encounter between an FQHC or RHC patient and the following health care providers: a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, visiting nurse, podiatrist, dentist, optometrist, chiropractor, comprehensive perinatal services practitioner providing comprehensive perinatal services, a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist, a four-hour day of attendance at an Adult Day Health Care Center; and, any other provider identified in the state plan’s definition of an FQHC or RHC visit.

FQHCs and RHCs are federally designate clinics that furnish federally specified services, and provide preventive and primary health care services to medically underserved populations. RHCs also provide outpatient primary care services and must be located within a designated medically underserved area. In 2018, there were 1,061 FQHCs and 279 RHCs in California. A FQHC or RHC can apply for an adjustment to its per-visit rate based on a change the scope of services provided by the FQHC or RHC, and any rate changes based on a change must be within the scope of services provided by an FQHC or RHC to be evaluated in accordance with Medicare reasonable cost principles.

Medi-Cal reimbursement to FQHCs and RHCs is governed by state and federal law. FQHCs and RHCs are reimbursed by Medi-Cal on a cost-based per-visit rate under what is known as the prospective payment system (PPS). For Medi-Cal managed care plan patients, DHCS reimburses FQHCs and RHCs for the difference between its per-visit PPS rate and the payment made by the plan. This payment is known as a "wrap around" payment. The Medi-Cal managed care wrap-around rate was established to reimburse providers for the difference between their PPS rate and their Medi-Cal managed care reimbursement rate. The rationale for the enhanced reimbursement is to ensure that FQHCs and RHCs do not use federal grant funds intended for uninsured and special needs populations to back-fill for potentially below-cost Medicare or Medi-Cal rates.

Billing for same day visits. DHCS' policy on same day visits at FQHCs and RHCs is in California's Medicaid State Plan. It states that encounters with more than one health professional and/or multiple encounters with the same health professional, which take place on the same day and at a single FQHC or RHC location, constitute a single visit, except that more than one visit may be counted on the same day in the following circumstances:

- When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment; or,
- When the clinic patient has a face-to-face encounter with a dentist or dental hygienist and then also has a face-to-facet encounter with another health professional or comprehensive perinatal services practitioner on the same date.

The PPS is composed of a base rate, which includes a combination of allowable capital costs and allowable operating costs per visit, and a cost-of-living adjustment determined by the Medicare Economic Index (MEI). FQHCs and RHCs may opt to forgo a base rate established based on projected costs and elect for a rate that is comparable to clinics providing similar services in the same geographic area with similar caseloads. A FQHC and RHC may also request an adjustment to its PPS rate based on a scope of its services, which may include the addition of new services, an increase in service intensity attributed to patients served, changes in operating costs or other changes defined in state law. DHCS is required to evaluate the request in accordance with federal regulations, which may result in increase or decrease in the PPS rate.

Chapter 540, Statutes of 2017 (SB 323, Mitchell), allows federally qualified health centers or rural health clinics to elect to be reimbursed for Drug Medi-Cal or specialty mental health services separately from their standard per-visit rates. These can be

services billed separately and on the same day as other medical services provided that clinics go through a rate adjustment process with DHCS.

Proposed Law: Senate Bill 66 includes the following provisions:

- Requires a maximum of two visits, as defined, taking place on the same day at a single location, to be reimbursed when one or both of the following conditions exist:
  - After the first visit, the patient suffers illness or injury requiring additional diagnosis or treatment;
  - The patient has a medical visit, and a mental health or dental visit.

- Authorizes a FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as constituting a single visit for purposes of establishing its FQHC or RHC rate to apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the DHCS, the FQHC or RHC must bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits.

- Requires the DHCS to develop and adjust all appropriate forms to determine which FQHC's or RHC's rates shall be adjusted and to facilitate the calculation of the adjusted rates.

- Specifies that an FQHC's or RHC's application for, or the department's approval of, a rate adjustment pursuant to this paragraph must not constitute a change in scope of service, as defined.

- Authorizes a FQHC or RHC that applies for an adjustment to its rate to continue to bill for all other FQHC or RHC visits at its existing per-visit rate, subject to reconciliation, until the rate adjustment has been approved.

- Requires the DHCS, by July 1, 2020, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting the changes described in this subdivision.

- Adds "visit to a licensed acupuncturist" to the existing definition of an FQHC or RHC visit

- Defines key terms, such as "mental health visit," "dental visit," and "medical visit." Makes other conforming changes.

Related Legislation:

- AB 769 (Smith) requires licensed professional clinical counselors to be included as an eligible billable provider within the definition of a "visit," which establishes when an FQHC or RHC may be reimbursed for services under the PPS rate. AB 769 is pending the Assembly Health Committee.

- AB 770 (E. Garcia) requires exclusions to the adjusted PPS rate methodology, authorizes an FQHC or RHC to apply for a scope of service change when updating or implementing a certified electronic health record system, expands the definition of "visit" to include services rendered outside the facility location, as specified, and extends the time frame for which an FQHC or RHC may request a scope of service rate change. AB 770 is pending in the Assembly Health Committee.

- SB 1125 (Atkins of 2018) is substantially similar to this bill. Governor Brown vetoed SB 1125 citing "significant, ongoing General Fund commitments."

- SB 323 (Mitchell, Chapter 540, Statutes of 2017) authorized FQHCs and RHCs to provide Drug Medi-Cal services pursuant to the terms of a mutually agreed upon contract entered into between the FQHC or RHC and the county or county designee, or DHCS, as specified, and would set forth the reimbursement requirements for these services.

- SB 1150 (Hueso and Correa of 2014) would have required Medi-Cal reimbursement to FQHC and RHCs for two visits taking place on the same day at a single location when the patient suffers illness or injury requiring additional diagnosis or treatment after the first visit, or when the patient has a medical visit and another health visit with a mental health provider or dental provider. SB 1150 was held on the Senate Appropriations suspense file.

- AB 1445 (Chesbro of 2010) was substantially similar to SB 1150. AB 1445 was held on the Senate Appropriations suspense file.

- SB 260 (Steinberg of 2007) would have authorized FQHCs and RHCs to bill separately for same day medical and mental health visits. SB 260 was vetoed by Governor Schwarzenegger.

Staff Comments: The DHCS fiscal estimate assumes about 50 percent of clinics would request a rate adjustment. However, a survey conducted of 170 clinic corporations in August 2018, found approximately 20 percent of respondents would rebase their PPS rate to implement same day visits. Staff notes the significant difference in assumptions. To the extent that assumptions are not realized, and actual numbers of clinics that file are lower than anticipated, staff notes the fiscal estimate would differ.

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AB 512 (Ting): Cultural Competence in Mental Health

(Co-Authors: Assemblymembers E. Garcia, Reyes, Senator Portantino)

Background

Mental health is a critical component of health, yet California's diverse communities face myriad challenges accessing care and maintaining wellbeing. Asian and Pacific Islander communities have among the lowest rates of mental healthcare utilization. While Latinos have higher utilization rates, those who visit a mental health practitioner often do not return for subsequent visits. Black communities are too often served through emergency and non-voluntary mental health treatment due to a lack of culturally appropriate prevention and early intervention. And LGBTQ communities have historically encountered a biased mental health system that failed to recognize their humanity.

Issue/Current Law

The Mental Health Services Act (MHSA), passed by California voters in 2004, specifically identified improved access to and quality of care for racial and ethnic communities as a primary goal and dedicated resources for this purpose. Since that time, California counties have been tasked with designing mental health programs and services that meet the needs of diverse local communities. In addition, Medi-Cal provides mental health care to low-income consumers through both health plans and counties.

Under existing regulation, county mental health programs are required to develop and submit cultural competency plans to the Department of Healthcare Services (DHCS) every three years. However, these plans do not set forward-looking goals for disparities reduction or hold counties accountable for improving care. In addition, DHCS has neither reviewed these plans nor enforced existing regulations to reduce county mental health disparities put forth in the cultural competence plans. Although some county mental health plans have made efforts towards developing culturally and linguistically competent services, it is imperative that all counties be supported in this critical effort.

This Bill

Requires counties to report on additional criteria in their cultural competency plans and requires DHCS to annually review and monitor quality improvement and mental health disparities reduction. In addition, the bill requires counties, DHCS, and stakeholders to develop performance targets that reduce disparities and improve mental health quality, transforming the public mental health system to focus on outcomes rather than solely utilization.

Specifically, this bill would require that every county's cultural competency plan includes the following:

- Disparities in access, utilization, and outcomes by race, ethnicity, language, disability status, sexual orientation, gender identity, and immigration status to the extent data is available and can be reported with individual identification.
- Annual performance targets for reduction in disparities in access, utilization, and outcomes.

This bill would require each county to:

- Convene a stakeholder committee monthly to provide feedback on the plan.
- Make annual updates to the cultural competence plans to reflect population changes.
- Submit plans to the Department of Health Care Services for review every three years.

The bill would also require DHCS to:

- Consult with the Office of Health Equity to review county assessments and statewide performance on disparities reduction.
- Require counties to meet specified performance and disparities reduction goals and develop a protocol for monitoring this.
- Publish cultural competency plans on its website.

Support

California Pan-Ethnic Health Network (sponsor)
The Steinberg Institute (sponsor)
Latino Coalition for a Healthy California (sponsor)
Southeast Asia Resource Action Center (sponsor)
California Black Health Network

Contact:
Linda Tenerowicz, California Pan-Ethnic Health Network (CPEHN)
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916-447-1299

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AMENDED IN ASSEMBLY APRIL 2, 2019

AMENDED IN ASSEMBLY MARCH 14, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 512

Introduced by Assembly Member Ting
(Coauthors: Assembly Members Boerner Horvath, Eduardo Garcia, and Reyes)
(Coauthor: Senator Portantino)

February 13, 2019

An act to amend Sections 14684 and 14717.5 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 512, as amended, Ting. Medi-Cal: specialty mental health services.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans, and requires mental health plans to be governed by various guidelines, including a requirement that a mental health plan assess the cultural competency needs of the program. Existing law requires mental health plan reviews to be conducted by an external quality review organization (EQRO) on an annual basis, and requires those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, such

as the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year.

This bill would require each mental health plan to prepare a cultural competency assessment plan to address specified matters, including disparities in access, utilization, and outcomes by *various categories, such as* race, ethnicity, ~~language, sexual orientation, gender identity,~~ and immigration status. The bill would require a mental health plan to convene a committee for the purpose of reviewing and approving the cultural competency assessment plan, to annually update its cultural competency plan and progress, to post this material on its internet website, and to submit its cultural competency assessment plan to the department every 3 years for technical assistance and implementation feedback. The bill would require the department to *develop at least 8 statewide disparities reduction targets, to* post the cultural competency assessment plan submitted by each mental health plan to its internet website, and to consult with the Office of Health Equity *and the office of the state Surgeon General* to review and implement county assessments and statewide performance on disparities reductions. The bill would require the department to direct the EQRO to develop a protocol for monitoring performance of each mental health plan, and to report on statewide disparities reduction ~~targets, progress related to disparities reduction, and outcomes.~~ *targets and statewide progress related to the disparities reduction targets.* The bill would require the mental health plan to meet specified disparities reduction targets every 3 years.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Mental health is a vital aspect of an individual's overall well-being.

(b) Disparities in access to mental health services vary across demographic groups, including race, age, gender, income level, and immigration status.

(c) Immigrant communities across California have experienced heightened levels of stress and anxiety in light of today's political climate, which has resulted in reduced utilization of state

administered assistance programs and reduced incidence of crime reporting by communities of color.

(d) Disparities in mental health services can be reduced or eliminated by addressing barriers to the mental health care system and improving outreach strategies.

(e) Investing in mental health services that are culturally and linguistically appropriate are crucial in identifying, preventing, and alleviating mental health conditions for historically disenfranchised groups, such as communities of color, the lesbian, gay, bisexual, and transgender community, and the undocumented.

(f) Early detection and intervention for mental health conditions among vulnerable communities is inherent to overall community wellness and safety.

SEC. 2. Section 14684 of the Welfare and Institutions Code is amended to read:

14684. Notwithstanding any other state law, and to the extent permitted by federal law, a mental health plan, whether administered by public or private entities, shall be governed by the following guidelines:

(a) State and federal Medi-Cal funds identified for the diagnosis and treatment of mental illness shall be used solely for those purposes. Administrative costs incurred by a county for activities necessary for the administration of the mental health plan shall be clearly identified and ~~shall be~~ reimbursed in a manner consistent with federal Medicaid requirements and the approved Medicaid state plan and waivers. Administrative requirements shall be based on and limited to federal Medicaid requirements and the approved Medicaid state plan and waivers, and shall not impose costs exceeding funds available for that purpose.

(b) The development of a mental health plan shall include a public planning process that includes a significant role for Medi-Cal beneficiaries, family members, mental health advocates, providers, and public and private contract agencies.

(c) A mental health plan shall include appropriate standards relating to quality, access, and coordination of services within a managed system of care, and costs established under the plan, and shall provide opportunities for existing Medi-Cal providers to continue to provide services under the mental health plan, as long as the providers meet those standards.

(d) Continuity of care for current recipients of services shall be ensured in the transition to managed mental health care.

(e) Medi-Cal covered specialty mental health services shall be provided in the beneficiary's home community, or as close as possible to the beneficiary's home community. Pursuant to the objectives of the rehabilitation option described in subdivision (a) of Section 14021.4, mental health services may be provided in a facility, a home, or other community-based site.

(f) Medi-Cal beneficiaries whose mental or emotional condition results or has resulted in functional impairment, as defined by the department, shall be eligible for covered specialty mental health services. Emphasis shall be placed on adults with serious and persistent mental illness and children with serious emotional disturbances, as defined by the department.

(g) A mental health plan shall provide specialty mental health services to eligible Medi-Cal beneficiaries, including both adults and children. Specialty mental health services include Early and Periodic Screening, Diagnosis, and Treatment Services to eligible Medi-Cal beneficiaries under 21 years of age pursuant to Section 1396d(a)(4) of Title 42 of the United States Code.

(h) A mental health plan shall include a mechanism for monitoring the effectiveness of, and evaluating accessibility and quality of, services available. The plan shall utilize and be based upon state-adopted performance outcome measures and shall include review of individual service plan procedures and practices, a beneficiary satisfaction component, and a grievance system for beneficiaries and providers.

(i) A mental health plan shall provide for culturally competent and age-appropriate services, to the extent feasible. A mental health plan shall assess the cultural competency needs of the program, and prepare a cultural competency assessment plan, as specified in this subdivision. A mental health plan shall include, as part of the quality assurance program required by Section 14725, a process to accommodate the significant needs with reasonable timeliness. The department shall provide demographic data and technical assistance. Performance outcome measures shall include a reliable method of measuring and reporting the extent to which services are culturally competent and age-appropriate.

(1) (A) The cultural competency assessment plan shall address, but not be limited to, all of the following:

(i) Disparities in access, utilization, and outcomes by race, ethnicity, language, sexual orientation, gender identity, *age, disability status,* and immigration status, to the extent data is available.

(ii) Annual *statewide* performance targets for reducing disparities in access, utilization, and ~~outcomes.~~ *outcomes, as determined by the department pursuant to subparagraph (C) of paragraph (6). A mental health plan may include additional performance targets, as appropriate.*

(iii) Designated strategies for reaching performance targets, including the mental health plan's rationale for each strategy.

(iv) The mental health plan's performance on prior performance targets.

(v) The mental health plan's strategies for addressing trauma and developing trauma-informing services.

(vi) The process for community input, including a list of community entities participating.

(B) (i) For purposes of developing the cultural competency assessment plan, a mental health plan shall utilize available data and may solicit information from Medi-Cal beneficiaries who receive specialty mental health services from the mental health ~~plan.~~ *plan and recipients of other county mental health services.*

~~(ii) A mental health plan shall comply with the federal Medicaid program law and regulations and applicable state and federal privacy laws that govern medical information, including the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), and the federal Health Insurance Portability and Accountability Act of 1996.~~

(ii) Data reported pursuant to this section shall be collected, maintained, and kept confidential in a manner consistent with Sections 14100.2 and 17852, the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), and the federal Health Insurance Portability and Accountability Act of 1996.

(2) A mental health plan shall convene a committee, through open invitation to relevant stakeholders, including, but not limited to, agency and department representatives, consumer advocates, consumers, disparities reduction experts, and providers, for the purpose of reviewing and approving the cultural competency assessment plan. The committee shall convene monthly either in

person or through electronic means, and meetings shall be open and accessible to the public.

(3) (A) A mental health plan shall annually update its cultural competency assessment plan, in coordination with the committee, to reflect population changes, and shall include in the annual update a report on its progress toward achieving performance targets.

(B) A mental health plan shall post the material described in subparagraph (A) on its internet website.

(4) A mental health plan shall submit the cultural competency assessment plan to the department every three years for technical assistance and implementation feedback. The department, within 30 days of its receipt of this material, shall post the cultural competency assessment plan submitted by each plan to its internet website.

(5) (A) The department shall consult with the Office of Health Equity *and the office of the state Surgeon General* for purposes of reviewing county assessments and statewide performance on disparities reduction.

(B) The review specified in subparagraph (A) shall include an assessment about the extent to which strategies utilize both evidence-based and community-defined best practices, and shall address documented disparities, including progress ~~about~~ *in meeting* performance targets.

(6) (A) The department shall direct an external quality review organization, as described in Section 14717.5, to develop and implement a protocol for monitoring performance on established disparities reduction targets for each mental health plan.

(B) In ~~creating~~ *developing* and implementing this protocol, the department shall consult with consumer advocates, consumers, experts in disparities reduction, and providers.

(C) The department shall *develop, in consultation with stakeholders and the Office of Health Equity, at least eight statewide disparities reduction targets and* require each mental health plan to meet *the* specified disparities reduction targets every three years. *The disparities reduction targets shall include access and outcomes targets, and shall consider, at a minimum, metrics addressing disparities on the basis of race, ethnicity, language, sexual orientation, gender identity, age, disability status, and immigration status.*

SEC. 3. Section 14717.5 of the Welfare and Institutions Code is amended to read:

14717.5. (a) A mental health plan review shall be conducted annually by an external quality review organization (EQRO) pursuant to Section 438.350 et seq. of Title 42 of the Code of Federal Regulations. Commencing July 1, 2018, the review shall include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including all of the following:

(1) The number of Medi-Cal eligible minor and nonminor dependents in foster care served each year.

(2) Details on the types of mental health services provided to children, including prevention and treatment services. The types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, day treatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services.

(3) Access to, and timeliness of, mental health services, as described in Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in foster care.

(4) Quality of mental health services available to Medi-Cal eligible minor and nonminor dependents in foster care.

(5) Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in foster care.

(6) Performance data for Medi-Cal eligible minor and nonminor dependents in foster care.

(7) Utilization data for Medi-Cal eligible minor and nonminor dependents in foster care.

(8) Medication monitoring consistent with the child welfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:

(A) Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD).

(B) Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC).

(C) Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP).

(D) Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM).

(b) (1) The department shall post the EQRO data disaggregated by Medi-Cal eligible minor and nonminor dependents in foster care on the department's internet website in a manner that is publicly accessible.

(2) The department shall review the EQRO data for Medi-Cal eligible minor and nonminor dependents in foster care.

(3) If the EQRO identifies deficiencies in a mental health plan's ability to serve Medi-Cal eligible minor and nonminor dependents in foster care, the department shall notify the mental health plan in writing of identified deficiencies.

(4) The mental health plan shall provide a written corrective action plan to the department within 60 days of receiving the notice required pursuant to paragraph (3). The department shall notify the mental health plan of approval of the corrective action plan or shall request changes, if necessary, within 30 days after receipt of the corrective action plan. Final corrective action plans shall be made publicly available by, at minimum, posting on the department's internet website.

(c) To the extent possible, the department shall, in connection with its duty to implement Section 14707.5, share with county boards of supervisors data to assist in the development of mental health service plans, such as data described in Section 438.350 et seq. of Title 42 of the Code of Federal Regulations, subdivision (c) of Section 16501.4, and paragraph (1) of subdivision (a) of Section 1538.8 of the Health and Safety Code.

(d) The department shall annually share performance outcome system data with county boards of supervisors for the purpose of informing mental health service plans. Performance outcome system data shared with county boards of supervisors shall include, but not be limited to, the following disaggregated data for Medi-Cal eligible minor and nonminor dependents in foster care:

(1) The number of youth receiving specialty mental health services.

(2) The racial distribution of youth receiving specialty mental health services.

(3) The gender distribution of youth receiving specialty mental health services.

(4) The number of youth, by race, with one or more specialty mental health service visits.

(5) The number of youth, by race, with five or more specialty mental health service visits.

(6) Utilization data for intensive home services, intensive care coordination, case management, therapeutic behavioral services, medication support services, crisis intervention, crisis stabilization, full-day intensive treatment, full-day treatment, full-day rehabilitation, and hospital inpatient days.

(7) A unique count of youth receiving specialty mental health services who are arriving, exiting, and continuing with services.

(e) The department shall ensure that the performance outcome system data metrics include disaggregated data for Medi-Cal eligible minor and nonminor dependents in foster care, and the data shall be in a format that can be analyzed.

(f) *(1)* Commencing January 1, 2020, the EQRO shall ensure that the annual review that it performs of each mental health plan, as specified in subdivision (a), includes a report on ~~statewide disparities reduction targets,~~ progress related to ~~disparities reduction, and outcomes.~~ *the statewide disparities reduction targets established pursuant to subparagraph (C) of paragraph (6) of subdivision (i) of Section 14684.*

(2) The EQRO shall publish statewide progress related to the statewide disparities reduction targets in the annual detailed technical report as required by Section 438.364 of Title 42 of the Code of Federal Regulations.

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Date of Hearing: March 26, 2019

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 512 (Ting) – As Amended March 14, 2019

SUBJECT: Medi-Cal: specialty mental health services.

SUMMARY: Codifies a requirement that county mental health plans (MHPs) prepare a cultural competency assessment plan, expands the required elements to be included in the plan, and requires counties to convene a committee to review and approve the plan. Requires the Department of Health Care Services (DHCS) to direct an external quality review organization (EQRO) to develop a protocol for monitoring performance on established disparities reduction targets for each MHP. Requires the EQRO to ensure that the annual review that it performs of each MHP includes a report on statewide disparities reduction targets, progress related to disparities reduction, and outcomes. Specifically, **this bill**:

1) Requires a MHP to prepare a cultural competency assessment plan, which addresses, but is not limited to, all of the following:
   a) Disparities in access, utilization, and outcomes by race, ethnicity, language, sexual orientation, gender identity, and immigration status, to the extent data is available;
   b) Annual performance targets for reducing disparities in access, utilization, and outcomes;
   c) Designated strategies for reaching performance targets, including the MHP's rationale for each strategy;
   d) The MHP's performance on prior performance targets;
   e) The MHP's strategies for addressing trauma and developing trauma-informing services; and,
   f) The process for community input, including a list of community entities participating.

2) Requires a MHP, for purposes of developing the cultural competency assessment plan, to utilize available data and may solicit information from Medi-Cal beneficiaries who receive specialty mental health services (SMHS) from the MHP.

3) Requires a MHP to comply with federal Medicaid program law and regulations and applicable state and federal privacy laws that govern medical information, including the state Confidentiality of Medical Information Act, and the federal Health Insurance Portability and Accountability Act of 1996.

4) Requires a MHP to convene a committee, through open invitation to relevant stakeholders, including, but not limited to, agency and department representatives, consumer advocates, consumers, disparities reduction experts, and providers, for the purpose of reviewing and approving the cultural competency assessment plan.

5) Requires the committee to convene monthly either in person or through electronic means, and requires meetings to be open and accessible to the public.

6) Requires a MHP to annually update its cultural competency assessment plan, in coordination with the committee, to reflect population changes, and to include in the annual update a report on its progress toward achieving performance targets. Requires a MHP to post this material on its Internet Website.

7) Requires a MHP to submit the cultural competency assessment plan to DHCS every three years for technical assistance and implementation feedback.

8) Requires DHCS, within 30 days of its receipt, to post the cultural competency assessment plan submitted by each plan to its Internet Website.

9) Requires DHCS to consult with the Office of Health Equity and the California Surgeon General for purposes of reviewing county assessments and statewide performance on disparities reduction. Requires the review to include an assessment about the extent to which strategies utilize both evidence-based and community-defined best practices, and to address documented disparities, including progress about performance targets.

10) Requires DHCS to direct an EQRO to develop and implement a protocol for monitoring performance on established disparities reduction targets for each MHP. Requires DHCS, in creating and implementing this protocol, to consult with consumer advocates, consumers, experts in disparities reduction, and providers.

11) Requires DHCS to require each MHP to meet specified disparities reduction targets every three years.

12) Requires, commencing January 1, 2020, the EQRO review required under state law, to ensure that the annual review that it performs of each mental health plan, includes a report on statewide disparities reduction targets, progress related to disparities reduction, and outcomes.

13) Makes legislative findings and declarations related to this bill, including that disparities in access to mental health services vary across demographic groups, including race, age, gender, income level, and immigration status, that disparities in mental health services can be reduced or eliminated by addressing barriers to the mental health care system and improving outreach strategies.

EXISTING LAW:

1) Designates DHCS as the state agency responsible for the development and implementation of, MHPs for Medi-Cal beneficiaries.

2) Requires DHCS to implement managed mental health care for Medi-Cal beneficiaries through contracts with MHPs. Permits MHPs to include individual counties, counties acting jointly, or an organization or nongovernmental entity determined by DHCS to meet MHP standards. Permits a contract to be exclusive and may be awarded on a geographic basis.

3) Requires, to the extent permitted by federal law, MHPs, whether administered by public or private entities, to be governed by specified guidelines, including the following:
   a) To provide SMHS to eligible Medi-Cal beneficiaries, including both adults and children. SMHS include EPSDT to eligible Medi-Cal beneficiaries under the age of 21;
   b) To provide for culturally competent and age-appropriate services, to the extent feasible;
   c) To assess the cultural competency needs of the program;

d) To include, as part of the quality assurance program, a process to accommodate the significant needs with reasonable timeliness, and requires DHCS to provide demographic data and technical assistance; and,
e) Requires performance outcome measures to include a reliable method of measuring and reporting the extent to which services are culturally competent and age-appropriate.

4) Requires MHPs, pursuant to regulation, to develop and implement a Cultural Competence Plan that includes specified components.

5) Requires, pursuant to federal Medicaid regulation, that each state that contracts with plans, to ensure (with exceptions) that a qualified EQRO performs an annual external quality review (EQR) for each such contracting plan.

6) Requires, under state law, a MHP review to be conducted annually by an EQRO pursuant to federal Medicaid regulations.

7) Requires, commencing July 1, 2018, the review to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care.

8) Requires, through an amendment to the State Constitution enacted by Proposition 30 of 2012, legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency (including MHPs) for programs or levels of service mandated by the 2011 Realignment Legislation (which includes Drug Medi-Cal (DMC) and Medi-Cal specialty mental health) to:

   a) Apply to local agencies only to the extent that the State provides annual funding for the cost increase; and,
   b) Prohibits local agencies from being obligated to provide programs or levels of service required by legislation above the level for which funding has been provided.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, the federal Patient Protection and Affordable Care Act (ACA) required nearly all health plans to provide mental health care for their members. Public mental health coverage is provided through state implementation of the ACA, which expanded the scope of Medi-Cal mental health coverage, and through California's county safety net programs. Despite tremendous gains in access to care, communities of color often experience suboptimal outcomes from mental health treatment. This results in great inequity as communities of color and other vulnerable populations who desperately need these services are often met with the greatest barriers to access them. In order to continue to strive for a more accessible system, there has to be an exact understanding of the disparities, data which currently is not reported. This bill is needed to start pinpointing the exact solutions and implementing them to strive for an accessible mental health care system.

2) BACKGROUND. Medi-Cal mental health benefits are delivered through two separate systems. MHPs provide a broad range of SMHS to individuals with more severe mental

illnesses, while Medi-Cal managed care (MCMC) plans provide non-SMHS. The delivery of SMHS through MHPs is commonly referred to as a "carve out," as is the coverage of anti-psychotic prescription medication through fee-for-service (FFS) Medi-Cal (described further below). A "carve out" is when services covered by the Medi-Cal program are delivered outside of a MCMC plan. Services for physical and behavioral health (which includes mental health and substance use disorders) historically have been financed and delivered under separate systems (the Drug Medi-Cal benefit is also delivered outside of MCMC plans).

MHPs are responsible for providing SMHS to Medi-Cal beneficiaries who meet SMHS medical necessity criteria. SMHS are delivered through 56 county mental health plans (Placer and Sierra Counties and Yuba and Sutter Counties operate two separate dual-county combined MHPs). Medi-Cal beneficiaries that meet medical necessity criteria for SMHS are entitled to receive medically necessary SMHS from their county MHP, regardless of whether or not they are enrolled in a MCMC plan.

MCMC plans are responsible for providing non-SMHS, and are responsible for prescription drug coverage for mental health conditions, except for approximately 40 anti-psychotic medications. These medications are contractually carved out of nearly all MCMC plan contracts and instead reimbursed through Medi-Cal FFS.

3) **CULTURAL COMPETENCE PLAN**. Existing regulations for county MHPs require each MHP to comply with cultural competence and linguistic requirements, the terms of the contract between the MHP and DHCS, and the MHP's Cultural Competence Plan. Under the regulation, each MHP is required to develop and implement a Cultural Competence Plan that includes the following components:

   a) A population assessment and an organizational and service provider assessment focusing on issues of cultural competence and linguistic capability;
   b) Objectives and strategies for improving the MHP's cultural competence based on the assessment, and the MHP's performance on the standards required by this bill;
   c) A listing of SMHS and other MHP services available for beneficiaries in their primary language by location of the services;
   d) A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing SMHS employed by or contracting with the MHP or with contractors of the MHP, and the persons employed by or contracting with the MHP or with contractors of the MHP to provide interpreter or other support services to beneficiaries.

   The regulation requires DHCS to establish timelines for the submission and review of the Cultural Competence Plan, either as a component of the Implementation Plan process or as a term of the contract between the MHP and DHCS. The MHP is required to submit the Cultural Competence Plan to DHCS for review and approval in accordance with these timelines, and the MHP is required to update the Cultural Competence Plan and submit these updates to DHCS for review and approval annually.

   DHCS indicates the Cultural Competence Plan Requirements establish standards and criteria for the entire County Mental Health System, including Medi-Cal services, Mental Health Services Act, and Realignment as part of working toward achieving cultural and linguistic competence.

4) **EQRO.** Federal Medicaid regulations require each State that contracts with Medicaid managed care plans to ensure that a qualified EQRO performs an annual external quality review (EQR) for each such contracting plan. EQROs must perform mandatory EQR-related activities, which include validation of performance improvement projects that were underway during the preceding 12 months, validation of plan performance measures, and validation of plan network adequacy during the preceding 12 months. EQRO optional activities include validation of encounter data reported by plans, administration or validation of consumer or provider surveys of quality of care, calculation of performance measures in addition to those reported by a plan, conduct of performance improvement projects in addition to those conducted by the plan, conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time, and assisting with the quality rating of plans. Federal regulations require states to ensure that the EQR results in an annual detailed technical report that summarizes findings on access and quality of care. This includes an assessment of each plan's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries, and recommendations for improving the quality of health care services furnished by each plan, including how the State can target goals and objectives in its quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. States are required to finalize the annual technical report by April 30th of each year, and post the most recent copy of the annual EQR technical report on the Website. Federal financial participation of 75% is available in expenditures for EQR (including the production of EQR results) and the EQR-related activities performed by plans that are conducted by EQROs and their subcontractors.

5) **DISPARITIES IN HEALTH CARE.** According to an August 2018 publication by the Kaiser Family Foundation, health and health care disparities refer to the differences in health and health care between populations. Disparities in "health" and "health care" are related, but not synonymous, concepts. A "health disparity" refers to a higher burden of illness, injury, disability, or mortality experienced by one group relative to another. A "health care disparity" typically refers to differences between groups in health insurance coverage, access to and use of care, and quality of care. Health and health care disparities often refer to differences that cannot be explained by variations in health needs, patient preferences, or treatment recommendations. Health inequality and inequity are also used to refer to disparities. There are multiple examples of health disparities and health care disparities in the broader mental health delivery system (including suicide rates are more than double in the Northern and Sierra regions) and the Medi-Cal mental health delivery system. For example, mental health utilization varies by race and region, and language. Lower service penetration rates for SMHS for Asian and Latino populations has been cited over many years, there are differences by race in receipt of services following an inpatient hospital stay for mental health (for example, blacks have the longest time frame from an outpatient visit following an in-patient hospitalization for mental illness.

6) **PREVIOUS LEGISLATION.** AB 470 (Arambula), Chapter 550, Statutes of 2018, requires DHCS to create a performance outcome report for SMHS, as specified, and to make it available to specified entities no later than December 31, 2018. Requires DHCS to consult with stakeholders, as specified, for purposes of creating the report, and to update the report, as specified.

SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012, among other provisions, requires DHCS, in collaboration with the California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission, to create a plan for a performance outcome system for EPSDT mental health services provided to eligible Medi-Cal beneficiaries under the age of 21. SB 1009 required DHCS to convene a stakeholder advisory committee, and in developing a plan for a performance outcomes system for EPSDT mental health services, to consider specified objectives, including: a) high quality and accessible EPSDT mental health services for eligible children and youth, consistent with federal law; b) information that improves practice at the individual, program, and system levels; c) reliable data that are collected and analyzed in a timely fashion; d) federal requirements; and, e) timelines for implementation at the provider, county, and state levels.

DHCS was required to provide the performance outcomes system plan, including milestones and timelines, for EPSDT mental health services to all fiscal committees and appropriate policy committees of the Legislature no later than October 1, 2013. Finally, SB 1009 required DHCS to propose how to implement the performance outcomes system plan for EPSDT mental health services described no later than January 10, 2014.

7) **SUPPORT.** This bill is jointly sponsored the California Pan-Ethnic Health Network, the Steinberg Institute, #Out4MentalHealth, the Southeast Asia Resource Action Center, and the Latino Coalition for a Healthy California to require counties to set forward-looking goals in their mental health cultural competence plans and to require DHCS to annually review and monitor their progress. The sponsors argue cultural competence plans are an important tool to address mental health disparities, particularly among historically underserved populations. However, under existing law, these plans lack goals to improve access and utilization of mental health services. Despite tremendous gains in mental health coverage, communities of color and LGBTQ+ communities continue to experience disparities in quality and access to mental health treatment. The sponsors conclude this bill would ensure that counties have the guidance, expertise, and assistance they need to realize the intended purpose of cultural competence plan requirements—to actively respond to and reduce disparities in mental health outcomes.

8) **PROPOSED AMENDMENTS**. Following discussions between supporters and staff, this bill will be amended to: a) require the cultural competency plan to also include age and disability status; b) to require DHCS to determine the performance targets in consultation with stakeholders and the Office of Health Equity; c) to require at least eight statewide disparities reduction targets that include access and outcome targets and include metrics addressing disparities on the basis of race, ethnicity, language, sexual orientation, gender identity, age, disability status, and immigration; d) to clarify that the cultural competency assessment plan solicits information from recipients of county mental health services; e) to require existing confidential protections for data reported under existing law to apply to data reported under this bill and to specifically reference federal and state privacy laws; f) to require DHCS to also consult with the Office of the Surgeon General for purposes of reviewing county assessments and statewide performance on disparities reductions; and, g) to clarify the EQRO annual review includes progress related to statewide disparities reduction targets established by this bill, and to clarify this information is published in the annual EQRO technical report required under existing federal regulation.

REGISTERED SUPPORT / OPPOSITION:

Support

California Pan-Ethnic Health Network (cosponsor)
Steinberg Institute (cosponsor)
#Out4MentalHealth (cosponsor)
Latino Coalition for a Healthy California (cosponsor
Southeast Asia Resource Action Center (cosponsor)
Access Women's Health Justice
American Federation of State, County And Municipal Employees, AFL-CIO
API Equality-LA
Asian Americans Advancing Justice - California
Asian Health Services
Asian Pacific Islander Forward Movement
California Immigrant Policy Center
California Latinas for Reproductive Justice
California LGBTQ Health and Human Services Network
California School Employees Association
California School-Based Health Alliance
CaliforniaHealth+ Advocates
Center For Empowering Refugees And Immigrants
Community Clinic Association of Los Angeles County
Disability Rights California
Equality California.
Fathers And Families of San Joaquin
Fresno Interdenominational Refugees Ministries
Khmer Girls in Action
Latino Coalition For a Healthy California
Little Manila Rising
Maternal Mental Health Now
Mid-City Community Advocacy Network
Racial and Ethnic Mental Health Disparities Coalition
Southeast Asia Resource Action Center
Stone Soup Fresno
The Cambodian Family
Union of Pan Asian Communities
Vietnamese Youth Development Center
Western Center on Law & Poverty

Opposition

None on file.

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MARIE WALDRON
ASSEMBLY REPUBLICAN LEADER
ASSEMBLYMEMBER, SEVENTY-FIFTH DISTRICT

AB 1352: LOCAL MENTAL HEALTH BOARDS

IN BRIEF:
AB 1352 is intended to revitalize, strengthen and empower local mental health boards, and clarify their position as independent advisors to both the Boards of Supervisors and county mental/behavioral health departments.

BACKGROUND:
The Bronzan-McCorquodale Act (Act) defines California's county mental health system, and requires those systems to provide mental health services to children and adolescents who have a serious emotional disturbance, and adults and older adults who have a serious mental illness. The Act also created local mental health boards, which are responsible for reviewing community mental health needs, services, facilities, and special problems. In an advisory capacity, these boards were intended to provide checks and balances on the mental health system by connecting family members, consumers, and the community to county Boards of Supervisors and local mental/behavioral health directors.

THE ISSUE:
Every county is different. The composition, focus, participation, and structure of local mental health boards vary widely by county. Some counties have the resources to establish nonprofit organizations to manage the duties of the local boards, while others heavily rely on meager funding and bare-minimum participation to "rubber stamp" whatever mental health service plan is handed to them mental/behavioral health department.

Regardless of county size (geographically or financially), local mental health boards are supposed to be co-equal partners with the elected officials and the local mental/behavioral health programs, to ensure that the community meets the needs of seriously mentally ill individuals.

THE SOLUTION:
AB 1352 would affirm the independence of local mental health boards and clarify their responsibilities, encourage Boards of Supervisors to allocate a budget for the boards that would allow them to meet independently, establish goals for additional membership partners, and require local mental/behavioral health departments to explain to the public why recommendations from the local boards are, or are not, included in the county's final mental health plan or updates.

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AMENDED IN ASSEMBLY MARCH 25, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 1352

Introduced by Assembly Member Waldron

February 22, 2019

An act to amend ~~Section 5604~~ *Sections 5604, 5604.2, 5604.3, 5604.5, and 5848* of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1352, as amended, Waldron. Community mental health services: ~~board.~~ *mental health boards.*

Existing law, the Bronzan-McCorquodale Act, governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law generally requires each community mental health service to have a mental health board consisting of 10 to 15 members who are appointed by the governing body, and encourages counties to appoint individuals who have experience with and knowledge of the mental health system. Existing law specifies the duties of mental health boards, including, among other things, reviewing specified county agreements. Existing law requires a local mental health board to develop bylaws to be approved by the governing body to establish the specific number of members on the mental health board and to ensure that the composition of the mental health board represents the demographics of the county as a whole.

This bill would require a mental health board to report directly to the governing body, and to have the authority to act, review, and report independently from the county mental health department or county

behavioral health department, as applicable. The bill would require a local mental health board to develop bylaws to establish the goal of appointing up to ⅓ of the board membership from public, private, and nonprofit entities that engage with seriously mentally ill individuals in the course of daily operations. The bill would revise the duties of mental health boards by, among other things, authorizing the mental health boards to make recommendations to the governing body regarding concerns with the above-described county agreements. By imposing new duties on county mental health boards, the bill would impose a state-mandated local program. The bill would encourage counties to provide a budget for the mental health board that is sufficient to ensure that board meetings may be held and administered independently from the county mental health department or county behavioral health department, as applicable.

Existing law, the Mental Health Services Act, an initiative statute enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The act provides that the Legislature may amend that act through a bill passed by a ⅔ vote of the Legislature if the amendments are consistent with, and further the intent of, that act. The act authorizes the Legislature to add provisions to clarify its procedures and terms by majority vote.

The act requires each county mental health program to prepare a 3-year program and expenditure plan and annual updates, and requires the local mental health board to review the adopted plan or update and make recommendations to the county mental health department for revision.

This bill would require the county mental health department to provide written explanations for any recommendations from the mental health board that are not included in the final plan or update. By requiring county mental health departments to provide a higher level of service with regard to existing duties, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state,

reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

This bill would declare that it clarifies procedures and terms of the Mental Health Services Act.

~~Existing law, the Bronzan-McCorquodale Act, governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law generally requires each community mental health service to have a mental health board consisting of 10 to 15 members who are appointed by the governing body, and encourages counties to appoint individuals who have experience with and knowledge of the mental health system.~~

~~This bill would make technical, nonsubstantive changes to those provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. Section 5604 of the Welfare and Institutions Code is amended to read:

5604. (a) (1) Each community mental health service shall have a mental health board consisting of 10 to 15 members, depending on the preference of the county, appointed by the governing body, except that boards in counties with a population of less than 80,000 may have a minimum of five members. ~~One~~ *The board shall report directly to the governing body, and one* member of the board shall be a member of the local governing body. ~~Any~~ *A* county with more than five supervisors shall have at least the same number of members as the size of its board of supervisors. ~~Nothing in this section shall be construed to~~ *This section does not* limit the ability of the governing body to increase the number of members above 15. Local mental health boards may recommend appointees to the county supervisors. Counties are encouraged to appoint individuals who have experience with and knowledge of the mental health system. The board membership should reflect the ethnic diversity of the client population in the county.

(2) Fifty percent of the board membership shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.

(3) (A) In counties ~~under 80,000 population,~~ *with a population that is less than 80,000,* at least one member shall be a consumer, and at least one member shall be a parent, spouse, sibling, or adult child of a consumer, who is receiving, or has received, mental health services.

(B) Notwithstanding subparagraph (A), a board in a county with a population ~~under~~ *that is less than* 80,000 that elects to have the board exceed the five-member minimum permitted under paragraph (1) shall be required to comply with paragraph (2).

(b) The mental health board shall have the authority to act, review, and report independently from the county mental health department or county behavioral health department, as applicable.

~~(b)~~

(c) The term of each member of the board shall be for three years. The governing body shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

~~(c)~~

(d) If two or more local agencies jointly establish a community mental health service ~~under~~ *pursuant to* Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 of Title 1 of the Government Code, the mental health board for the community mental health service shall consist of an additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.

~~(d)~~

(e) (1) Except as provided in paragraph (2), ~~no~~ *a* member of the board or ~~his or her~~ *the member's* spouse shall *not* be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.

(2) A consumer of mental health services who has obtained employment with an employer described in paragraph (1) and who

holds a position in which ~~he or she does~~ *the consumer does* not have any interest, influence, or authority over any financial or contractual matter concerning the employer may be appointed to the board. The member shall abstain from voting on any financial or contractual issue concerning ~~his or her~~ *the member's* employer that may come before the board.

~~(e)~~

(f) Members of the board shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

~~(f)~~

(g) If it is not possible to secure membership as specified in this section from among persons who reside in the county, the governing body may substitute representatives of the public interest in mental health who are not full-time or part-time employees of the county mental health service, the State Department of Health Care Services, or on the staff of, or a paid member of the governing body of, a mental health contract agency.

~~(g)~~

(h) The mental health board may be established as an advisory board or a commission, depending on the preference of the county.

SEC. 2. Section 5604.2 of the Welfare and Institutions Code is amended to read:

5604.2. (a) The local mental health board shall do all of the following:

(1) Review and evaluate the community's mental health needs, services, facilities, and special problems. *This includes the authority to review and report on needs, services, or special problems that have been identified in the community or any facility within the county where mental health evaluations and services are being provided.*

(2) Review any county agreements entered into pursuant to Section 5650. *The local mental health board may make recommendations to the governing body regarding concerns identified within these agreements.*

(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program. *Local mental health boards are encouraged to request assistance from the grand jury when reviewing issues related to the provision of mental health services within county jails.*

(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning ~~process.~~ *process by all citizens, including individuals with lived experience and their families, professionals representing a variety of organizations, and community members.*

(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.

(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

(7) Review and comment on the county's performance outcome data and communicate its findings to the California Behavioral Health Planning Council.

(8) ~~Nothing in this part shall be construed to~~ *This part does not* limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.

SEC. 3. Section 5604.3 of the Welfare and Institutions Code is amended to read:

5604.3. *(a)* The board of supervisors may pay from any available funds the actual and necessary expenses of the members of the mental health board of a community mental health service incurred incident to the performance of their official duties and functions. The expenses may include travel, lodging, ~~child care,~~ *childcare,* and meals for the members of an advisory board while on official business as approved by the director of the local mental health program.

(b) Counties are encouraged to provide a budget for the mental health board that is sufficient to ensure that board meetings may be held and administered independently from the county mental health department or county behavioral health department, as applicable.

SEC. 4. Section 5604.5 of the Welfare and Institutions Code is amended to read:

5604.5. The local mental health board shall develop bylaws to be approved by the governing body which ~~shall:~~ *shall do all of the following:*

(a) Establish the specific number of members on the mental health board, consistent with subdivision (a) of Section 5604.

(b) Ensure that the composition of the mental health board represents the demographics of the county as a whole, to the extent feasible.

(c) Establish that a quorum be one person more than one-half of the appointed members.

(d) Establish that the chairperson of the mental health board be in consultation with the local mental health director.

(e) Establish that there may be an executive committee of the mental health board.

(f) Establish the goal of appointing up to one-third of the board membership from public, private, and nonprofit entities that engage with seriously mentally ill individuals in the course of daily operations, including, but not limited to, representatives of the city police, county sheriffs, large and small business owners, hospitals, hospital districts, emergency departments, and county offices of education.

SEC. 5. Section 5848 of the Welfare and Institutions Code is amended to read:

5848. (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program

and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions. *The county mental health department or county behavioral health department, as applicable, shall provide written explanations for any recommendations made by the mental health board that are not included in the final plan or update.*

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California.

(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) shall be included in the review of program performance by the California Behavioral Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

(e) The department shall annually post on its ~~Internet Web site~~ *internet website* a summary of the performance outcomes reports submitted by counties if clearly and separately identified by counties as the achievement of performance outcomes pursuant to subdivision (c).

SEC. 6. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 7. The Legislature finds and declares that this act clarifies procedures and terms of the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

~~SECTION 1. Section 5604 of the Welfare and Institutions Code is amended to read:~~

~~5604. (a) (1) Each community mental health service shall have a mental health board consisting of 10 to 15 members, depending on the preference of the county, appointed by the governing body, except that boards in counties with a population of fewer than 80,000 people may have a minimum of five members. One member of the board shall be a member of the local governing body. A county with more than five supervisors shall have at least the same number of members as the size of its board of supervisors. This section does not limit the ability of the governing body to increase the number of members above 15. Local mental health boards may recommend appointees to the county supervisors. Counties are encouraged to appoint individuals who have experience with and knowledge of the mental health system. The board membership should reflect the ethnic diversity of the client population in the county.~~

~~(2) Fifty percent of the board membership shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.~~

~~(3) (A) In counties with a population of fewer than 80,000 people, at least one member shall be a consumer, and at least one member shall be a parent, spouse, sibling, or adult child of a consumer, who is receiving, or has received, mental health services.~~

~~(B) Notwithstanding subparagraph (A), a board in a county with a population of fewer than 80,000 people that elects to have the board exceed the five-member minimum permitted under paragraph (1) shall be required to comply with paragraph (2).~~

~~(b) The term of each member of the board shall be for three years. The governing body shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.~~

~~(c) If two or more local agencies jointly establish a community mental health service under Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 of Title 1 of the Government~~

~~Code, the mental health board for the community mental health service shall consist of an additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.~~

~~(d) (1) Except as provided in paragraph (2), a member of the board or their spouse shall not be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.~~

~~(2) A consumer of mental health services who has obtained employment with an employer described in paragraph (1) and who holds a position in which the consumer does not have any interest, influence, or authority over any financial or contractual matter concerning the employer may be appointed to the board. The member shall abstain from voting on any financial or contractual issue concerning their employer that may come before the board.~~

~~(e) Members of the board shall abstain from voting on any issue in which the member has a financial interest, as defined in Section 87103 of the Government Code.~~

~~(f) If it is not possible to secure membership, as specified in this section, from among persons who reside in the county, the governing body may substitute representatives of the public interest in mental health who are not full-time or part-time employees of the county mental health service, the State Department of Health Care Services, or on the staff of, or a paid member of the governing body of, a mental health contract agency.~~

~~(g) The mental health board may be established as an advisory board or a commission, depending on the preference of the county.~~

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AGENDA ITEM 6

Information

April 25, 2019 Commission Meeting

Executive Director Report Out

Summary: Executive Director Ewing will report out on pr ojects underway and other matters relating to the ongoing work of the Commission.

Presenter: Toby Ewing, Executive Director

Enclosures (8): (1) Motions Summary from the March 28, 2019 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard; (4) Presentation Guidelines; (5) Calendar of Tentati ve Agenda Items; (6) Department of Health Care Services Revenue and Expenditure Reports Status Update; (7) Legislati ve Report to the Commission; (8) Legislative Tracking Report.

Handouts: None.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
March 28, 2019

Motion #: 1

Date: March 28, 2019 **Time:** 9:38AM

Motion:

The Commission approves the February 28, 2019 meeting minutes as amended.

Commissioner making motion: Vice-Chair Ashbeck
Commissioner seconding motion: Commissioner Brown

Motion carried 7 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☐	☐	☒
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☒	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☐	☐	☒
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 2

Date: March 28, 2019 **Time:** 10:07AM

Motion:

The Commission approves Mono County's request for $84,935 additional Innovation funding and extension of time as follows:

Name: Eastern Sierra Strengths-Based Learning Collaborative (ESSBLC)

Additional Amount: $84,935 for a total Innovation project budget of $343,981

Project Length: Four (4) months for a total project duration of 28 months

Commissioner making motion: Commissioner Anthony
Commissioner seconding motion: Vice-Chair Ashbeck

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 3

Date: March 28, 2019 **Time:** 11:05AM

Motion:

The Commission approves San Mateo County's request for $1,550,000 additional Innovation funding and extension of time as follows:

Name: LGBTQ Behavioral Health Coordinated Services (The Pride Center)

Additional Amount: $1,550,000 for a total Innovation project budget of $3,750,000

Project Length: Two (2) years for a total project duration of five (5) years.

Commissioner making motion: Commissioner Berrick

Commissioner seconding motion: Vice-Chair Ashbeck

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 4

Date: March 28, 2019 **Time:** 12:38PM

Motion:

The Commission approves Tulare County's Innovation plan with the conditions that the county work with Commission staff to strengthen the three new interventions, the evaluation and that consumers and/or family members are employed in the program, as follows:

Name: Addressing Metabolic Syndrome and its Components in Consumers Taking Antipsychotic Medication

Amount: $1,610,734

Project Length: Five (5) Years

Commissioner making motion: Commissioner Anthony

Commissioner seconding motion: Commissioner Wooton

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

Motion #: 5

Date: March 28, 2019 **Time:** 12:48PM

Motion:

The Commission approves Tulare County's Innovation plan with the conditions that the county works with staff on strengthening the evaluation and organizational culture within the department to strengthen their ability to help the community as follows:

Name: Connectedness 2 Community

Amount: $1,320,684

Project Length: Five (5) Years

Commissioner making motion: Commissioner Wooton

Commissioner seconding motion: Commissioner Madrigal-Weiss

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	☐	☐	☐
2. Commissioner Anthony	☒	☐	☐
3. Commissioner Beall	☐	☐	☐
4. Commissioner Berrick	☒	☐	☐
5. Commissioner Boyd	☐	☐	☐
6. Commissioner Brown	☒	☐	☐
7. Commissioner Bunch	☐	☐	☐
8. Commissioner Carrillo	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☐	☐
13. Commissioner Wooton	☒	☐	☐
14. Vice-Chair Ashbeck	☒	☐	☐
15. Chair Tamplen	☒	☐	☐

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MHSOAC Evaluation Dashboard April 2019
(Updated April 4th, 2019)

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Summary of Updates

Contracts
No Changes

Total Contracts: 4

Funds Spent Since the March Commission Meeting

17MHSOAC024	$13,200
17MHSOAC081	$0
17MHSOAC085	$0
18MHSOAC020	$0
Total	**$13,200**

Contracts with Deliverable Changes

17MHSOAC81

17MHSOAC85

The iFish Group: Hosting & Managed Services (17MHSOAC024)

MHSOAC Staff	Rachel Heffley
Active Dates	12/28/17 - 6/30/19
Total Contract Amount	$423,923
Total Spent	$352,073

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	12/28/17	No
Visualization Portal	Complete	12/28/17	No
Data Management Support Services	In Progress	06/30/19	No

MHSOAC Evaluation Dashboard Month April 2019

(Updated April 4th, 2018)

Regents of University of California, Los Angeles: Population Level Outcome Measures (17MHSOAC081)

MHSOAC Staff	Michelle Adams
Active Dates	7/1/2018-7/31/2020
Total Contract Amount	$1,200,000
Total Spent	$260,000

The purpose of this project is to develop, through an extensive public engagement effort and background research process, support for datasets of preferred (recommended) & feasible (delivered) measures relating to

1) negative outcomes of mental illness
2) prevalence rates of mental illness by major demographic categories suitable for supporting the evaluation of disparities in mental health service delivery & outcomes
3) the impact(s) of mental health & substance use disorder conditions (e.g., disease burden),
4) capacity of the service delivery system to provide treatment and support,
5) successful delivery of mental health services
6) population health measures for mental health program client populations.

Deliverable	Status	Due Date	Change
Work Plan	Complete	09/30/18	No
Survey Development Methodology/Survey	Complete	12/31/18	No
Survey Data Collection/Results/Analysis of Survey	In Progress	3/30/20	No
Summary Report (3 Public Engagements)	Under Review	3/30/19	Yes
Summary Report (3 Public Engagements)	Not Started	6/30/19	No

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MHSOAC Evaluation Dashboard Month April 2019

(Updated April 4th, 2018)

Outcomes Reporting Draft Report —3 Sections	Not Started	9/31/19	No
Outcomes Reporting Draft Report – 4 Sections	Not Started	12/31/19	No
Outcomes Reporting Final Report	Not Started	06/01/20	No
Outcomes Reporting Data Library & Data Management Plan	Not Started	06/01/20	No
Data Fact Sheets and Data Briefs	Not Started	06/01/20	No

Mental Health Data Alliance: FSP Pilot Classification & Analysis Project (17MHSOAC085)

MHSOAC Staff	Rachel Heffley
Active Dates	07/01/18 - 12/31/19
Total Contract Amount	$234,279
Total Spent	$50,200

The intention of this pilot program is to work with a four-county sample (Amador, Fresno, Orange, & Ventura) to collect FSP program profile data, link program profiles to the FSP clients they serve, & model a key outcome (early exit from an FSP) as a function of program characteristics, service characteristics, & client characteristics

Deliverable	Status	Due Date	Change
Final Online Survey	Complete	02/04/19	No
FSP Program Data Sets	Under Review	05/06/19	Yes
FSP Formatted Data Sets	Not Started	09/07/19	No
FSP Draft Report	Not Started	10/07/19	No
FSP Final Report	Not Started	12/09/19	No

MHSOAC Evaluation Dashboard April 2019
(Updated April 4th, 2019)

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The iFish Group: Hosting & Managed Services (18MHSOAC020)

MHSOAC Staff	Rachel Heffley
Active Dates	01/01/19 - 12/31/19
Total Contract Amount	$306,443
Total Spent	$261,443

To provide hosting & managed services (HMS) such as Secure Data Management Platform (SDMP) & a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, & other software products. Support services & knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, & curation of data from external sources.

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	01/01/19	No
Data Management Support Services	Not Started	12/31/19	No

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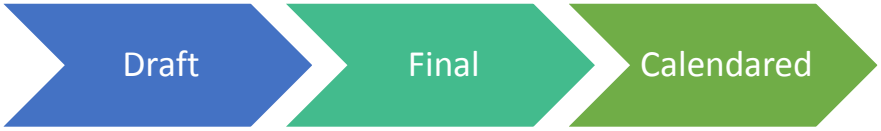
INNOVATION DASHBOARD

April 2019

	Number of Plans	Counties	Dollars Requested
Calendared*	5	5	$19,758,250
Draft Proposals Received	6	5	$8,245,996
TOTAL	11	10	$28,004,246

Average Time from FINAL to COMMISSION CALENDAR

52 days†

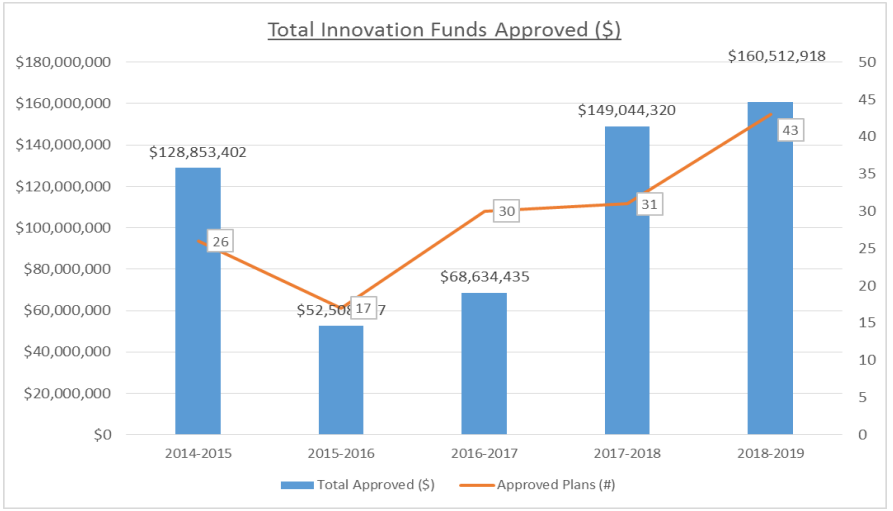


* **APRIL:** Butte (1), Alameda (1)
MAY: Ventura (1), Los Angeles (1), Orange (1)

† This excludes extensions of previously-approved projects, Tech Suite additions, and government holidays.

Previous Trends

	Fiscal Year				
	14/15	15/16	16/17	17/18	18/19 (to date)
APPROVED INN Dollars	$127,742,348	$46,920,919	$66,625,827	$143,871,714	$155,480,729
APPROVED Ext. Dollars	$1,111,054	$5,587,378	$2,008,608	$5,172,606	$5,032,189
Plans Received	N/A	N/A	33	34	43
Plans that Received Commission Vote	N/A	N/A	33	34	43
Plans APPROVED	26 N/A	17 N/A	30 91%	31 91%	43 100%
Participating Counties	16 27%	15 25%	18 31%	19 32%	28 47%



Number of Counties that have presented an INN Plan since 2013:	
55 Counties	93%

Number of Counties that have NOT presented an INN Plan since 2013:	
4 Counties	7%

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STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
CALENDARED	BUTTE	Center CARE Project	$1,671,031	3 Years 2 Months	2/4/2019	3/20/2019	**APRIL**
CALENDARED	ALAMEDA	Mental Health Technology 2.0	$2,040,120	2 Years 6 Months	2/8/2019	3/27/2019	**APRIL**
CALENDARED	VENTURA	Conocimiento - Addressing ACEs Through Core Competencies	$1,047,099	4 Years	2/26/2019	3/28/2019	**MAY**
CALENDARED	LOS ANGELES	Trieste to LA - Liberating the Recovery Angels in our Nature	Currently Unavailable	Currently Unavailable	Currently Unavailable	Expected 4/12/19	**MAY**
CALENDARED	ORANGE	Behavioral Health System Transformation Project	$15,000,000	2 Years	3/13/2019	Expected 4/12/19	**MAY**

CALENDARED: County has met all the minimum regulatory requirements for Innovation - Section 3580.010, and three (3) local approval

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	SISKIYOU	Integrated Care Project	$995,231	5 Years	2/14/2019	PENDING	PENDING
DRAFT	COLUSA	Social Determinants of Rural Mental Health Project	$403,419	3 Years	8/30/2018	PENDING	PENDING
DRAFT	GLENN	Access, Response, and Triage Team (ARTT)	$787,535	5 Years	3/26/2019	PENDING	Anticipated JULY
DRAFT	ALAMEDA	Supportive Housing Community Land Trust (CLT)	$5,000,000	5 Years	11/2/2018 and 2/8/19	PENDING	Anticipated AUGUST
DRAFT	SAN LUIS OBISPO	SLOTAP (San Luis Obispo Threat Assessment Program)	$559,811	4 Years	3/21/2019	PENDING	PENDING
DRAFT	SAN LUIS OBISPO	Holistic Adolescent Health	$500,000	4 Years	3/21/2019	PENDING	PENDING

DRAFT: A County plan submitted to the OAC that contains some of the regulatory requirements, including but not limited to a full budget

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MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING PRESENTATION GUIDELINES

These recommendations for innovation plan presentations have been developed to support the dialogue between the Commission and the counties. Please note that the recommendations below regarding length, the county brief, PowerPoint presentation and presenter information are to ensure that counties and the Commission have ample opportunity to engage in a dialogue to gain a better understanding of the needs in the county, how the innovation plan meets those needs, why it is innovative and how will it be evaluated to support shared learning.

1. **Length of Presentation**
   a. County presentations should be no more than 10-15 minutes in length
   b. The Commission will have received the Innovation Project Plan as well as the Staff Analysis prior to the meeting
   c. The remaining time on the agenda is reserved for dialogue with the Commission and for public comment

2. **County Brief**
   a. Recommend 2-4 pages total and should include the following three (3) items:
      i. Summary of Innovation Plan / Project
      ii. Budget
      iii. Address any areas indicated in the Staff summary

3. **PowerPoint Presentation**
   a. Recommend 5 slides and include the following five (5) items:
      i. Presenting Problem / Need
      ii. Proposed Innovation Project to address need
      iii. What is innovative about the proposed Innovation Project? How will the proposed solution be evaluated (learning questions and outcomes)?
      iv. Innovation Budget
      v. If successful, how will Innovation Project be sustained?

4. **Presenters and Biographies**
   a. We request no more than a few (2-4) presenters per Innovation Project
      i. If the county wishes to bring more presenters, support may be provided during the public comment period
   b. Recommend biography consisting of brief 1-2 sentences for individuals presenting in front of the Commission
      i. Include specific names, titles, and areas of expertise in relation to Innovation Plan / Project

Note: Due dates will be provided by Innovation Team upon Commission calendaring for the following items: Presenter Names, Biographies, County Brief, and PowerPoint presentation.

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Calendar of Commission Meeting Draft Agenda Items

Proposed 04/11/19

Agenda items and meeting locations are subject to change

May 23: Los Angeles, Ca

- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.
- **Transition Age Youth RFP Outline**
  The Commission will consider approval of an outline for a Transition Age Youth RFP.
- **Innovation Project: Ventura**
  Conocimiento - A program addressing Adverse Childhood Experiences through Core Competencies.
- **Innovation Project: Orange**
  Behavioral Health System Transformation – Be Well.
- **Innovation Project: Los Angeles**
  Trieste to Los Angeles-Liberating the Recovery of Angels in our Nature.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.
- **Data and Evaluation Contracts**
  The Commission will consider authorizing the Executive Director to enter into contracts to support data linkage efforts and ongoing transparency work.

June: No Meeting

- **No meeting planned for June**

July 25: TBD

- **Budget Overview**
  The Commission will consider approval of its Fiscal Year 2019-20 Operations Budget and will hear an update on expenditures.
- **Innovation Project: Glenn County**
  ARTT (Access, Response, and Triage Team): A project to address the needs of persons who are in crisis and/or at-risk of crisis.
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.
- **Awarding of the Transition Age Youth Stakeholder Contract**
  The Commission will consider awarding a stakeholder contract to in the amount of $2,010,000 to the highest scoring applicants for the Transition Age Youth Stakeholder RFP.
- **Use of County Innovation Funds**
  The Commission staff will provide an overview of county uses of Innovation funds outside of Innovation approval.

**Panel presentations for the Commission's SB 1004 project on statewide PEI prioritization, evaluation and technical assistance, and for the Commission's SB 1113 project on voluntary standards for Mental Health in the Workplace, will be scheduled contingent on further discussion with the Commission Chair and project chairs.*

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Calendar of Commission Meeting Draft Agenda Items

Proposed 04/11/19

Agenda items and meeting locations are subject to change

August 22: TBD

- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.
- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.
- **Suicide Prevention Strategic Plan**
  The Commission will be presented with the draft of the statewide Suicide Prevention Strategic Plan.

September 26: TBD

- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.
- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

October 24: San Diego, CA

- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.
- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **School Mental Health Policy Project**
  The Commission will be presented with the first read of the School Mental Health Policy Project findings.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.

November 21: TBD

- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Executive Director Report Out**
  The Executive Director will report out on projects underway and other matters relating to the ongoing work of the Commission.
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.

**Panel presentations for the Commission's SB 1004 project on statewide PEI prioritization, evaluation and technical assistance, and for the Commission's SB 1113 project on voluntary standards for Mental Health in the Workplace, will be scheduled contingent on further discussion with the Commission Chair and project chairs.*

Agenda Item 6, Enclosure 6: DHCS Status Chart of County RERs Received
April 25, 2019 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated April 11th, 2019.

This Status Report covers the FY 2012-13 through FY 2017-18 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx. Additionally, County RERs for reporting year FY 2016-17 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.aspx. County RERs for reporting year FY 2017-18 are not yet accessible through the Department's website.

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at http://mhsoac.ca.gov/fiscal-reporting for Reporting Years FY 2012-13 through FY 2016-17 and a data reporting page at http://mhsoac.ca.gov/documents?field_county_value=All&date_filter%5Bvalue%5D%5Byear%5D=&field_component_tid=46.

On July 1, 2018 DHCS published a report detailing MHSA funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). The report details all funds deemed reverted and reallocated to the county of origin for the purpose the funds were originally allocated. The report can be accessed at the following webpage:
http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/MHSA_Reversion_Funds_Report.pdf

DHCS MHSA Annual Revenue and Expenditure Status Update

	FY 14-15		FY 15-16		FY 16-17			FY 17-18		
County	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date
Alameda	9/14/2017	9/29/2017	9/29/2017	9/29/2017	1/2/2018		1/3/2018	3/25/2019	3/26/2019	
Alpine	6/26/2017	6/26/2017	11/22/2017	11/27/2017	7/23/2018		7/23/2018			
Amador	3/27/2017	3/27/2017	4/7/2017	4/10/2017	4/12/2018		4/13/2018	12/19/2018	12/19/2018	12/21/2018
Berkeley City	5/2/2016	7/26/2016	4/13/2017	4/13/2017	1/25/2018		2/1/2018	12/28/2018	1/2/2019	1/8/2019
Butte	4/4/2016	6/23/2016	4/17/2017	4/18/2017	5/4/2018		5/7/2018			
Calaveras	1/4/2016	1/13/2016	4/18/2017	4/19/2017	6/1/2018	6/14/2018	7/20/2018	1/10/2019		1/11/2019
Colusa	1/8/2016	2/10/2016	5/17/2017	5/17/2017	5/8/2018		5/9/2018	3/28/2019	4/2/2019	
Contra Costa	3/8/2016	3/14/2016	4/17/2017	4/18/2017	12/29/2017	1/5/2018	1/24/2018	12/31/2018	1/7/2019	1/22/2019
Del Norte	5/13/2016	5/16/2016	4/17/2017	5/19/2017	2/23/2018		2/26/2018	12/31/2018		1/2/2019
El Dorado	2/9/2016	2/11/2016	4/17/2017	4/19/2017	12/29/2017	1/5/2018	1/24/2018	12/28/2018	1/3/2019	1/25/2019
Fresno	12/14/2015	12/18/2015	4/17/2017	4/18/2017	12/29/2017	1/8/2018	5/7/2018	12/28/2018	1/2/2019	1/2/2019
Glenn	3/17/2016	3/24/2016	7/20/2017	7/20/2017	2/22/2018		2/22/2018	12/31/2018	1/7/2019	2/11/2019
Humboldt	9/30/2016	10/3/2016	4/13/2017	4/18/2017	12/21/2017	1/3/2018	4/25/2018	12/20/2018	12/21/2018	1/2/2019
Imperial	12/31/2015	1/4/2016	4/27/2017	4/27/2017	12/28/2017		1/9/2018	12/26/2018		1/2/2019
Inyo	2/24/2016	2/24/2016	5/9/2017	5/9/2017	7/6/2018		7/9/2018	3/19/2019	3/20/2019	3/22/2019
Kern	10/31/2016	10/31/2016	5/30/2017	2/7/2018	1/30/2018		2/7/2018	1/4/2019		1/7/2019
Kings	4/7/2016	5/2/2017	5/2/2017	5/24/2017	1/29/2018		1/29/2018	1/31/2019	2/4/2019	2/11/2019
Lake	7/25/2018	7/26/2018	7/25/2018	7/26/2018	9/12/2018	9/12/2018				
Lassen	9/21/2016	9/29/2016	5/18/2017	5/25/2017	5/14/2018	5/16/2018	7/23/2018	1/8/2019	1/14/2019	1/31/2019
Los Angeles	4/20/2017	4/21/2017	1/31/2018	2/1/2018	6/29/2018	7/2/2018	7/20/2018	12/31/2018	1/14/2019	1/29/2019
Madera	12/6/2016	12/7/2016	5/12/2017	6/13/2018	3/27/2018	6/14/2018	7/26/2018	12/31/2018	1/7/2019	2/4/2019
Marin	10/21/2016	10/21/2016	5/10/2017	5/11/2017	1/31/2018		2/1/2018	12/21/2018	12/21/2018	12/21/2018
Mariposa	9/23/2016	9/28/2016	5/18/2017	5/19/2017	3/14/2018		3/14/2018	12/20/2018	1/3/2019	1/31/2019
Mendocino	5/31/2017	5/31/2017	8/31/2017	8/31/2017	4/27/2018		4/30/2018	12/31/2018		1/3/2019
Merced	3/28/2017	3/29/2017	7/21/2017	7/21/2017	2/1/2018		2/1/2018	12/21/2018	12/21/2018	12/31/2018
Modoc	3/24/2016	3/25/2016	4/17/2017	4/19/2017	4/20/2018		4/23/2018	1/16/2019	1/16/2019	1/24/2019
Mono	3/30/2016	4/6/2016	4/25/2017	6/20/2017	5/18/2018	5/22/2018	6/13/2018	12/28/2018	1/3/2019	1/17/2019
Monterey	3/29/2018	4/23/2018	10/4/2018	10/4/2018	10/4/2018		10/4/2018	3/5/2019	3/6/2019	
Napa	8/18/2017	8/25/2017	11/9/2017	11/13/2017	5/15/2018		5/15/2018	12/28/2018	1/2/2019	1/4/2019
Nevada	6/21/2018	6/21/2018	7/20/2018	7/25/2018	8/13/2018		8/13/2018	12/21/2018		12/21/2018
Orange	12/30/2015	12/30/2015	12/27/2016	4/13/2017	12/29/2017	1/17/2018	1/25/2018	12/28/2018	1/2/2019	1/31/2019
Placer	11/15/2016	11/17/2016	4/14/2017	4/18/2017	12/22/2017		1/23/2018	1/18/2019		1/22/2019
Plumas	6/8/2017	6/23/2017	3/27/2018	3/28/2018	10/8/2018		10/15/2018			
Riverside	5/12/2017	5/15/2017	6/9/2017	6/12/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018		1/29/2019
Sacramento	5/8/2017	5/8/2017	6/19/2017	6/20/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018	1/2/2019	1/2/2019
San Benito	10/24/2016	3/8/2016	9/8/2017	9/12/2017	9/25/2018		9/27/2018	3/8/2019	3/8/2019	3/18/2019
San Bernardino	5/19/2016	5/19/2016	5/1/2017	5/1/2017	6/29/2018		7/2/2018	12/31/2018		1/2/2019
San Diego	12/18/2015	5/26/2017	5/26/2017	5/26/2017	5/11/2018		6/11/2018	12/26/2018		1/15/2019
San Francisco	3/4/2016	3/4/2016	7/5/2017	9/18/2017	3/21/2018		3/27/2018	12/31/2018	1/3/2019	1/30/2019
San Joaquin	6/8/2017	6/13/2017	10/3/2017	10/4/2017	12/29/2017	1/24/2018	1/25/2018	12/31/2018		1/7/2019
San Luis Obispo	1/15/2016	1/15/2016	5/12/2017	5/16/2017	2/15/2018		2/16/2018	12/14/2018	12/18/2018	12/28/2018
San Mateo	5/9/2017	5/9/2017	10/10/2017	10/18/2017	4/20/2018		4/30/2018	12/31/2018		1/2/2019
Santa Barbara	5/24/2017	6/20/2017	5/24/2017	6/20/2017	12/22/2017	1/22/2018	1/25/2018	12/21/2018	1/3/2019	1/14/2019
Santa Clara	5/5/2017	5/11/2017	12/18/2017	1/4/2018	4/20/2018		4/23/2018	12/27/2018		1/2/2019
Santa Cruz	4/5/2018	4/9/2018	7/19/2018	7/20/2018	8/15/2018		8/16/2018	12/31/2018	1/3/2019	1/7/2019
Shasta	10/7/2016	10/7/2016	4/14/2017	4/17/2017	3/29/2018		4/23/2018	12/13/2018	12/17/2018	1/2/2019
Sierra	10/17/2016	10/17/2016	8/16/2017	5/25/2018	6/28/2018	6/28/2018	7/23/2018	12/28/2018		1/2/2019
Siskiyou	6/30/2017	7/10/2017	6/30/2017	7/10/2017	7/27/2018		1/15/2019			
Solano	12/29/2015	12/30/2015	3/23/2017	4/4/2017	12/28/2017	1/23/2018	1/25/2018	12/31/2018	1/3/2019	2/21/2019
Sonoma	4/10/2017	4/10/2017	6/26/2017	6/27/2017	7/13/2018		7/23/2018	1/16/2019	1/29/2019	2/1/2019
Stanislaus	12/22/2015	12/22/2015	4/5/2017	4/5/2017	4/27/2018		4/30/2018	12/26/2018		1/3/2019
Sutter-Yuba	8/15/2018	8/17/2018	8/15/2018	8/17/2018	8/15/2018	5/1/2018	8/17/2018	1/7/2019	1/28/2019	1/31/2019
Tehama	4/29/2016	5/11/2017	5/8/2017	5/16/2017	7/25/2018		7/26/2018			
Tri-City	12/30/2015	2/3/2016	4/6/2017	4/6/2017	12/29/2017	1/24/2018	2/15/2018	12/31/2018	1/3/2019	1/30/2019
Trinity	9/19/2016	9/23/2016	7/14/2017	7/14/2017	6/29/2018		7/2/2018	1/30/2019		2/7/2019
Tulare	3/17/2016	3/22/2016	4/12/2017	4/12/2017	12/26/2017	1/22/2018	1/25/2018	12/19/2018	12/21/2018	12/26/2018
Tuolumne	12/23/2015	12/28/2015	4/10/2017	5/18/2017	2/16/2018		3/1/2018	12/11/2018	12/12/2018	12/12/2018
Ventura	12/31/2015	1/4/2016	4/14/2017	4/27/2017	4/27/2018		5/25/2018	12/20/2018		12/21/2018
Yolo	6/21/2017	6/21/2017	3/9/2018	3/12/2018	3/23/2018		3/26/2018	1/30/2019	1/31/2019	1/31/2019
Total	59	59	59	59	59		58	53	36	50

* FY 2005-06 through FY 2013-14, all Counties are current

Current Through: 04/11/2019

State of California
Mental Health Services Oversight and Accountability Commission
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2019 Legislative Report to the Commission
April 15, 2019

SPONSORED LEGISLATION

Senate Bill 10 (Beall)
Title: Mental health services: peer, parent, transition-age, and family support specialist certification.

Summary: Would require the State Department of Health Care Services to establish, no later than July 1, 2020, a statewide peer, parent, transition-age, and family support specialist certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program. The bill would include 4 certification categories: adult peer support specialist, transition-age youth peer support specialist, family peer support specialist, and parent peer support specialist.

Status/Location: 4/8/19 April 8 hearing: Placed on APPR. suspense file.

Co-Sponsors: Steinberg Institute

Senate Bill 11 (Beall)
Title: Health care coverage: mental health parity.

Summary: Would require a health care service plan and a health insurer to submit an annual report to the Department of Managed Health Care or the Department of Insurance, as appropriate, certifying compliance with state and federal mental health parity laws, as specified. The bill would require the departments to review the reports submitted by health care service plans to ensure compliance with state and federal mental health parity laws, and would require the departments to make the reports and the results of the reviews available upon request and to post the reports and the results of the reviews on the departments' Internet Web site.

Status/Location: 3/22/19 Set for hearing April 24.

Co-Sponsors: The Kennedy Forum; Steinberg Institute

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SPONSORED LEGISLATION

Senate Bill 12 (Beall)

Title: Mental health services: youth.

Summary: This bill would require the commission, subject to the availability of funds for these purposes, to administer an Integrated Youth Mental Health Program for purposes of establishing local centers to provide integrated youth mental health services, as specified. The bill would authorize the commission to establish the core components of the program, subject to specified criteria, and would require the commission to develop the selection criteria and process for awarding funding to local entities for these purposes. The bill would authorize the commission to implement these provisions by means of an informational letter, bulletins, or similar instructions.

Status/Location: 4/8/19 April 8 hearing: Placed on APPR. suspense file.

Assembly Bill 46 (Carrillo)

Title: Individuals with mental illness: change of term.

Summary: Current law refers to an insane or mentally defective person in provisions relating to, among other things, criminal proceedings, correctional facilities, and property tax exemptions. This bill would state the intent of the Legislature to enact legislation to replace derogatory terms, including, but not limited to, “insane” and “mentally defective,” with more culturally sensitive terms when referring to individuals with mental illness.

Status/Location: 3/25/19 Re-referred to Com. on JUD.

Co-Sponsors: Disability Rights California

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SUPPORTED LEGISLATION

Senate Bill 582 (Beall)

Title: Youth mental health and substance use disorder services.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, when making grant funds available on and after July 1, 2021, to allocate at least 1/2 of those funds to local educational agency and mental health partnerships, as specified. The bill would require this funding to be made available to support prevention, early intervention, and direct services, as determined by the commission. The bill would require the commission, in consultation with the Superintendent of Public Instruction, to consider specified criteria when determining grant recipients.

Status/Location: 4/10/19 From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 0.) (April 10). Re-referred to Com. on APPR.

Senate Bill 604 (Bates)

Title: Mental Health Services Act: centers of excellence

Summary: Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish one or more centers of excellence to provide counties with technical assistance to implement best practices related to elements of the act. The bill would require those centers of excellence to be funded with state administrative funds provided under the act. In implementing these provisions, the bill would require the commission to determine the areas of focus for the centers of excellence, including, but not limited to, the areas of service delivery that need improvement.

Status/Location: 4/10/19 From committee with author's amendments. Read second time and amended. Re-referred to Com. on APPR.

Assembly Bill 713 (Mullin)

Title: Early Psychosis Intervention Plus (EPI Plus) Program

Summary: Current law establishes the Early Psychosis and Mood Disorder Detection and Intervention Fund, and authorizes the commission to allocate moneys from that fund to provide competitive grants to counties or other entities to create, or expand existing capacity for early psychosis and mood disorder detection and intervention services and supports. Current law requires the commission to adopt regulations to implement these provisions, but provide that the adoption of those regulations and the implementation of the grant program are contingent upon the deposit into the fund of at least $500,000 in nonstate funds for those purposes. This bill would delete the prohibition on General Fund moneys being appropriated for purposes of those provisions and would delete the requirement that the minimum $500,000 deposit be from nonstate funds.

Status/Location: 4/10/19 In committee: Set, first hearing. Referred to APPR. Suspense file.

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SUPPORTED LEGISLATION

Assembly Bill 1126 (O'Donnell)

Title: Early Psychosis Intervention Plus (EPI Plus) Program

Summary: Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish technical assistance centers and one or more clearinghouses to support counties in addressing mental health issues of statewide concern, with a focus on school mental health and reducing unemployment and criminal justice involvement due to untreated mental health issues.

Status/Location: 4/11/19 From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 6. Noes 0.) (April 10). Re-referred to Com. on HEALTH.

Assembly Bill 1443 (Maienschein)

Title: Early Psychosis Intervention Plus (EPI Plus) Program

Summary: Would require, subject to available funding, the Mental Health Services Oversight and Accountability Commission to establish one or more technical assistance centers to support counties in addressing mental health issues, as determined by the commission, that are of statewide concern and establish, with stakeholder input, which mental health issues are of statewide concern. The bill would require costs incurred as a result of complying with those provisions to be paid using funds allocated to the commission from the Mental Health Services Fund. The bill would state the finding and declaration of the Legislature that this change is consistent with and furthers the intent of the act.
Status/Location: 4/10/19 In committee: Set, first hearing. Referred to APPR. Suspense file.

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Mental Health Services
Oversight & Accountability Commission

LEGISLATION TRACKING REPORT

as of April 12, 2019

MENTAL HEALTH SERVICES ACT			
Bill No.	**Author**	**Title**	**Description**
AB 43	**Gloria**	MHSA Funding	Would clarify that the planning process for innovative programs is to be completed in collaboration with stakeholders and is to comply with open meetings laws.
AB 306	**Ramos**	Mental Health Services Fund	The act establishes the Mental Health Services Fund, which is continuously appropriated to, and administered by, the State Department of Health Care Services to fund specified county mental health programs.This bill would make technical, nonsubstantive changes to those provisions.
SB 389	**Hertzberg**	Mental Health Services Act	Would amend the Mental Health Services Act to authorize the counties to use MHSA moneys to provide services to persons who are participating in a presentencing or postsentencing diversion program or who are on parole, probation, postrelease community supervision, or mandatory supervision. By authorizing a new use of continuously appropriated moneys, this bill would make an appropriation. The bill would state the finding of the Legislature that this act is consistent with, and furthers the intent of, the Mental Health Services Act.
SB 539	**Caballero**	Mental Health Services Act: Workforce Education and Training	Would amend the Mental Health Services Act by requiring the Controller, in any fiscal year in which the Department of Finance estimates that the revenues to be deposited into the Mental Health Services Fund for the fiscal year will exceed the revenues deposited into the fund in the prior fiscal year, to, no later than the last day of each month and before any transfer or expenditure from the fund for any other purpose for the following month, set aside in the fund an amount that is equal to 25% of 1/12 of the estimated amount of increased revenue.
AB 563	**Quirk-Silva**	Mental Health Services Fund	Would appropriate $16,000,000 from the General Fund to the State Department of Health Care Services to distribute to the North Orange County Public Safety Task Force. The bill would require 1/2 of the moneys to be distributed on January 1, 2020, and 1/2 to be distributed on January 1, 2021, and would require the moneys to be used to provide a range of programs, services, and activities designed to assist individuals and families experiencing mental health crises.
SB 604	**Bates**	Mental Health Services Act: Centers of Excellence	Would require the Mental Health Services Oversight and Accountability Commission, by January 1, 2021, to establish one or more centers of excellence to provide counties with technical assistance to implement best practices related to elements of the act. The bill would require those centers of excellence to be funded with state administrative funds provided under the act. In implementing these provisions, the bill would require the commission to determine the areas of focus for the centers of excellence, including, but not limited to, the areas of service delivery that need improvement.

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GENERAL MENTAL HEALTH			
Bill No.	**Author**	**Title**	**Description**
AB 66	**Atkins**	Medi-Cal: federally qualified health center and rural health clinic services	This bill will facilitate the ability to seamlessly transition patients from primary care to an onsite mental health specialist on the same day, to ensure that a patient receives needed care and follows through with treatment. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit.
AB 480	**Salas**	Mental Health: Older Adults	Would establish within the California Department of Aging an Older Adult Mental Health Services Administrator to oversee mental health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and its responsibilities, including, but not limited to, developing outcome and related indicators for older adults for the purpose of assessing the status of mental health services for older adults, monitoring the quality of programs for those adults, and guiding decisionmaking on how to improve those services.
AB 512	**Ting**	Medi-Cal: specialty mental health services	Current law requires the State Department of Health Care Services to implement managed mental health care for Medi-Cal beneficiaries through contracts with mental health plans, and requires mental health plans to be governed by various guidelines, including a requirement that a mental health plan assess the cultural competency needs of the program. This bill would require each mental health plan to prepare a cultural competency assessment plan to address specified matters, including disparities in access, utilization, and outcomes by various categories, such as race, ethnicity and immigration status.
AB 577	**Eggman**	Medi-Cal: maternal mental health	Would extend Medi-Cal eligibility for a pregnant individual who is receiving health care coverage under the Medi-Cal program, or another specified program, and who has been diagnosed with a maternal mental health condition, for a period of one year following the last day of the individual's pregnancy if the individual complies with certain requirements. The bill would define "maternal mental health condition" for purposes of the bill.
AB 734	**Maienschein**	Resource families: supportive services pilot program	Would require the State Department of Social Services to establish and facilitate a pilot program, including, but not limited to, services similar to the Kinship Support Services Program, in up to 5 counties that voluntarily apply and are selected by the department, to increase placement stability for foster youth and facilitate greater resource family retention through the provision of community-based and family support services, including strengths-based, skills-based, trauma-informed coaching.

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GENERAL MENTAL HEALTH (Cont.)			
Bill No.	**Author**	**Title**	**Description**
AB 898	**Wicks**	Early and Periodic Screening Diagnosis, and Treatment services: behavioral health	Would require, by March 30, 2020, and monthly thereafter, the California Health and Human Services Agency, under the oversight of the Governor, to convene the Children's Behavioral Health Action Team, which would consist of no fewer than 30 individuals, including the Director of Health Care Services, Director of Social Services, the Director of Managed Health Care, and representatives from community-based behavioral health agencies, to maximize the well-being of children in California who receive EPSDT services and health care through the Medi-Cal program.
AB 1275	**Santiago**	Mental health services	Would require each county to establish an outreach team to provide outreach services to homeless and at-risk individuals with a history of mental illness or substance use disorders who are unable to provide for urgently needed medical care. The bill would require the outreach team to facilitate early intervention and treatment for these individuals in the least restrictive environment and to provide intensive outreach, case management, and linkage to services, including housing and treatment services.
AB 1352	**Waldron**	Community mental health services: mental health boards	The Bronzan-McCorquodale Act governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Current law generally requires each community mental health service to have a mental health board consisting of 10 to 15 members who are appointed by the governing body, and encourages counties to appoint individuals who have experience with and knowledge of the mental health system. This bill would require a mental health board to report directly to the governing body, and to have the authority to act, review, and report independently from the county mental health department or county behavioral health department, as applicable.
AB 1474	**Wicks**	Community mental health services: vocational rehabilitation systems	Current law sets forth the principles that should guide the development of community vocational rehabilitation systems, including that staffing patterns at all levels should reflect the cultural, linguistic, ethnic, racial, disability, sexual, and other social characteristics of the community the program serves. This bill would revise the principles regarding staffing patterns to also state that they should reflect the age and other demographic or social characteristics of the community the program serves.
AB 1676	**Mainschein**	Health care: mental health	Would require health care service plans and health insurers, by January 1, 2021, to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist, as specified, in order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness. The bill would require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing.

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GENERAL MENTAL HEALTH (Cont.)			
Bill No.	**Author**	**Title**	**Description**
AB 1634	**Gloria**	Mental health: community-based services	The Investment in Mental Health Wellness Act of 2013 requires funds appropriated by the Legislature to the California Health Facilities Financing Authority for the purposes of the act be made available to selected counties or counties acting jointly. The act authorizes the authority to consider making grant awards to private nonprofit corporations and public agencies in an area or region of the state if a county, or counties acting jointly, affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds. This bill would delete that limitation and authorize the authority to consider making grant awards to private nonprofit corporations and public agencies in an area or region of the state.
SB 640	**Moorlach**	Mental health services: gravely disabled	The Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of a person who is a danger to themself or others or who is gravely disabled. This bill would change the definition of “gravely disabled” for these purposes to read, in part, a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about, or providing for, the person’s own basic personal needs for food, clothing, or shelter without significant supervision and assistance from another person and, as a result of being incapable of making these informed decisions, the person is at risk of substantial bodily harm, dangerous worsening of a concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of the person’s essential needs that could result in bodily harm.

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EMPLOYMENT/WET			
Bill No.	**Author**	**Title**	**Description**
AB 565	**Mainschein**	Mental Health Workforce Planning: loan forgiveness, loan repayment, and scholarship programs	Current law establishes the Steven M. Thompson Physician Corps Loan Repayment Program (program) in the California Physician Corps Program within the Health Professions Education Foundation, which provides financial incentives, including repayment of educational loans, to a physician and surgeon who practices in a medically underserved area, as defined. Existing law establishes the Medically Underserved Account for Physicians, a continuously appropriated account, within the Health Professions Education Fund, to primarily provide funding for the ongoing operations of the program. Current law defines “practice setting,” for these purposes. This bill also would define “practice setting” to include a program or facility operated by, or contracted to, a county mental health plan.
AB 845	**Mainschein**	Continuing Education: physicians and surgeons: maternal mental health	By July 1, 2019, current law requires a licensed healthcare practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. Current law also requires a general acute care hospital or special hospital that has a perinatal unit to develop to implement, by January 1, 2020, a program relating to maternal mental health conditions including, but not limited to, postpartum depression. This bill would require the consider including a course in maternal mental health, addressing, among other provisions, the requirements described above. The bill would require the board to periodically update, in determining the continuing education requirements for physicians and surgeons, to consider including a course in maternal mental health, addressing, among other provisions, the requirements described above.
AB 1619	**Weber**	Mental Health Loan Assumption Program	Would appropriate $20,000,000 from the General Fund to the Office of Statewide Health Planning and Development for the purpose of reducing the shortage of, and disparity in, mental health services across the state by performing one or more of specified actions, including the recruitment and support of students enrolled in a postsecondary educational institution, who are from both an underrepresented group and a mental health professional shortage area, as defined, to pursue mental health careers.

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CHILDREN and SCHOOLS			
Bill No.	**Author**	**Title**	**Description**
AB 8	**Chu**	Pupil Health: mental health professionals	Would require, on or before December 31, 2022, a school of a school district or county office of education and a charter school to have at least one mental health professional, as defined, for every 400 pupils generally accessible to pupils on campus during school hours. The bill would require, on or before December 31, 2022, a school of a school district or county office of education and a charter school with fewer than 400 pupils to have at least one mental health professional generally accessible to pupils on campus during school hours, to employ at least one mental health professional to serve multiple schools, or to enter into a memorandum of understanding with a county agency or community-based organization for at least one mental health professional employed by the agency or organization to provide services to pupils.
AB 666	**Gabriel**	Pupil Mental Health: model referral protocols	Would require the State Department of Education to develop model referral protocols, as provided, for addressing pupil mental health concerns. The bill would require the department to consult with various entities in developing the protocols, including current classroom teachers and administrators. The bill would require the department to post the model referral protocols on its internet website. The bill would make these provisions contingent upon funds being appropriated for its purpose in the annual Budget Act or other legislation, or state, federal, or private funds being allocated for this purpose.
AB 826	**Reyes**	Medi-Cal: speciality mental health service: foster youth	Current law requires the State Department of Health Care Services to issue policy guidance concerning the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as prescribed. This bill would make those provisions for presumptive transfer inapplicable to foster youth placed in a short-term residential therapeutic program (STRTP) outside of their county of original jurisdiction, as specified.
AB 875	**Wicks**	Pupil health: in-school support services	The Healthy Start Support Services for Children Act establishes the Healthy Start Support Services for Children Program Council, specifies the members of the council, and provides for the duties of the council, which include assisting a local educational agency or consortium with local technical assistance, as provided. The act authorizes a local educational agency or consortium to contract with other entities, including county agencies and private nonprofit organizations or private partners, to provide services to pupils and their families. This bill would revise the list of entities that qualify for a grant and the eligibility criteria for a grant, as provided. The bill would rename the council to the Healthy Start Support Services for Children Initiative Council and would revise its membership.

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CHILDREN and SCHOOLS (cont.)			
Bill No.	**Author**	**Title**	**Description**
AB 895	**Muratsuchi**	School-based early mental health intervention and prevention services	The School-Based Early Mental Health Intervention and Prevention Services for Children Act of 1991, authorizes the Director of Health Care Services, in consultation with the Superintendent of Public Instruction, to provide matching grants to local educational agencies to pay the state share of the costs of providing school-based early mental health intervention and prevention services to eligible pupils at schoolsites of eligible pupils, subject to the availability of funding each year. This bill would enact a similar program to be known as the Pupil Mental Health Services Program Act.
AB 1546	**Kiley**	Pupil Health: mental health	Would authorize a county mental health plan to contract with a local educational agency (LEA) to provide EPSDT services, including mental health assessments, and mental health, social work, and counseling services, to Medi-Cal eligible pupils. The bill would require the department to permit an LEA to make claims for federal financial participation directly to the department for EPSDT services, to examine methodologies for increasing LEA participation in the Medi-Cal program, and to seek federal approval to implement these provisions.
AB 1547	**Kiley**	Special Education Funding: mental health services	Would express the intent of the Legislature to later enact legislation that would increase the flexibility of the use of funds appropriated in the Budget Act of 2011 for providing educationally related mental health services, including out-of-home residential services for emotionally disturbed pupils, required by an individualized education program.
SB 428	**Pan**	Pupil health: school employee training: youth mental health first aid	Would require the State Department of Education to identify an evidence-based training program for a local educational agency to use to train classified and certificated school employees having direct contact with pupils on youth mental health first aid, as specified. The bill would appropriate an unspecified sum from the General Fund to the department, for expenditure for the 2019–20 fiscal year to the 2021–22 fiscal year, inclusive, for purposes of these provisions.
SB 660	**Pan**	Postsecondary Education: mental health counseors	Would require the Trustees of the California State University and the governing board of each community college district to have one full-time equivalent mental health counselor with an applicable California license per 1,500 students enrolled at each of their respective campuses to the extent consistent with state and federal law. The bill would define mental health counselor for purposes of this provision. The bill would require those institutions, on or before January 1, 2021, and every 3 years thereafter, to report to the Legislature how funding was spent and the number of mental health counselors employed on each of its campuses, as specified.

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CRIMINAL JUSTICE/INCARCERATION			
Bill No.	**Author**	**Title**	**Description**
SB 433	**Monning**	Youth development and diversion	Would require the State Department of Social Services, in consultation with the State Department of Public Health to establish and oversee a 3-year pilot program known as the Office of Youth Development and Diversion (OYDD) Pilot Program. The purpose of the program would be to advance a comprehensive, coordinated, and expanded approach to youth diversion, with the goal of minimizing youth contact with the juvenile or criminal justice systems. The bill would require the department to award grants to up to 5 counties to establish a local OYDD.
SB 666	**Stone**	Mental Health Diversion	Current law authorizes a court to grant pretrial diversion, for a period no longer than 2 years, to a defendant suffering from a mental disorder, on an accusatory pleading alleging the commission of a misdemeanor or felony offense, in order to allow the defendant to undergo mental health treatment. Current law conditions eligibility on, among other criteria, a court finding that the defendant's mental disorder played a significant role in the commission of the charged offense. Current law makes defendants ineligible for the diversion program for certain offenses. This bill would make defendants ineligible for the diversion program for charges of robbery if the defendant was armed with a weapon at the time of the offense, assault with a deadly weapon, elder abuse, and child abuse, as defined.

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HOMELESSNESS			
Bill No.	**Author**	**Title**	**Description**
AB 14	**Caballero**	Multifamily Housing Prgram: homeless youths: homesless families	Would appropriate an unspecified sum from the General Fund into the Housing Rehabilitation Loan Fund to be expended under the Multifamily Housing Program to fund housing for homeless youths and homeless families in accordance with certain requirements, including that the department prioritize loans to housing projects in disadvantaged communities, as defined, and that unspecified amounts be set aside for both certain homeless youths and certain homeless families.
AB 1235	**Chu**	Homeless youth prevention centers	The California Community Care Facilities Act provides for the licensing and regulation of runaway and homeless youth shelters by the State Department of Social Services. Current law requires these shelters to offer short-term, 24-hour, nonmedical care and supervision and personal services to homeless youth and runaway youth, as those terms are defined, who voluntarily enter the shelter. Existing law defines “short-term” to mean no more than 21 consecutive days. This bill would rename these facilities “homeless youth prevention centers,” and would expand the categories of youth for which the center is required to provide services to also include youth at risk of homelessness and youth exhibiting status offender behavior, as those terms are defined by the bill.
AB 1295	**Quirk-Silva**	Mental Health: temporary housing and supportive services program	Current law prohibits the admission of a person to a developmental center except under certain circumstances, including when the person is experiencing an acute crisis and is committed by a court to the acute crisis center at the Fairview Developmental Center or the Sonoma Developmental Center. Current law requires the State Department of Developmental Services, on or before October 1, 2015, to submit to the Legislature a plan or plans to close one or more developmental centers, as provided. This bill, notwithstanding the provisions described above, would require the State Department of Developmental Services and the Department of General Services, in consultation with local cities, counties, and other relevant stakeholders, to establish a temporary mental health program on the premises of one currently operating developmental center on or before July 1, 2019, to assist individuals with severe mental illness in need of housing and supportive services.
SB 744	**Caballero**	No Place Like Home	Would require a lead agency to prepare concurrently the record of proceeding for a No Place Like Home project, as defined, with the performance of the environmental review of the project. Because the bill would impose additional duties on the lead agency, this bill would impose a state-mandated local program. The bill would require the lead agency to file and post a notice of determination within 2 working days of the approval of the project. The bill would require a person filing an action or proceeding challenging the lead agency’s action on the grounds of noncompliance with CEQA to file the action or proceeding within 10 days of the filing of the notice of determination.

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SUICIDE PREVENTION			
Bill No.	**Author**	**Title**	**Description**
AB 916	**Muratsuchi**	Suicide prevention	Thee California Suicide Prevention Act of 2000 authorizes the State Department of Health Care Services to establish and implement a suicide prevention, education, and gatekeeper program to reduce the severity, duration, and incidence of suicidal behaviors. Current law authorizes the department to contract with an outside agency to establish and implement a targeted public awareness and education campaign on suicide prevention and treatment. Existing law requires the target populations to include junior high and high school students. This bill would additionally require the target populations to include community college, 4-year college, and university undergraduate and graduate students.
SB 331	**Hurtado**	Suicide-prevention: strategic plans	The California Suicide Prevention Act of 2000 authorizes the State Department of Health Care Services to establish and implement a suicide prevention, education, and gatekeeper training program to reduce the severity, duration, and incidence of suicidal behaviors. This bill would require counties to create and implement, and update as necessary, a suicide-prevention strategic plan that places particular emphasis on preventing suicide in children who are less than 19 years of age and includes specified components, including long-term suicide prevention goals and the selection or development of interventions to be used to prevent suicide.

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IMMIGRATION			
Bill No.	**Author**	**Title**	**Description**
AB 1615	**Arambula**	Mental Health: anti-immigration activites and rhetoric	Current law governs the operation and financing of community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs.This bill would state the intent of the Legislature to enact legislation to mitigate the impact of anti-immigration activities and rhetoric on the mental health and well-being of children in immigrant families in California by, among other things, investing in community-based treatment modalities.

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AGENDA ITEM 7

Information

April 25, 2019 Commission Meeting

Strategic Planning

Summary: The Commission will continue its Strategic Planning process facilitated by Applied Survey Research. The Commission will engage in a facilitated discussion focusing on the organizational roadmap and will begin the conversation on the results framework.

Background: The Commission began a strategic planning process in the fall of 2018 with the help of Applied Survey Research, or ASR. With ASR's facilitation, the Commission held two public meetings, including breakout sessions with the public, and two half-day meetings with Commission staff to receive their feedback and input into the process. Additionally, ASR conducted personal interviews, focused conversations, and received over 400 online survey responses from consumers, providers, families, and stakeholders.

Presenters:

- Susan Brutschy, President, Applied Survey Research
- Lisa Colvig-Niclai, Vice President of Evaluation, Applied Survey Research

Enclosure (2): (1) Strategic Plan Process Map; (2) Organizational Roadmap.

Handouts (3): (1) Expanded Organizational Roadmap; (2) Draft Results Framework; (3) PowerPoint Presentation.

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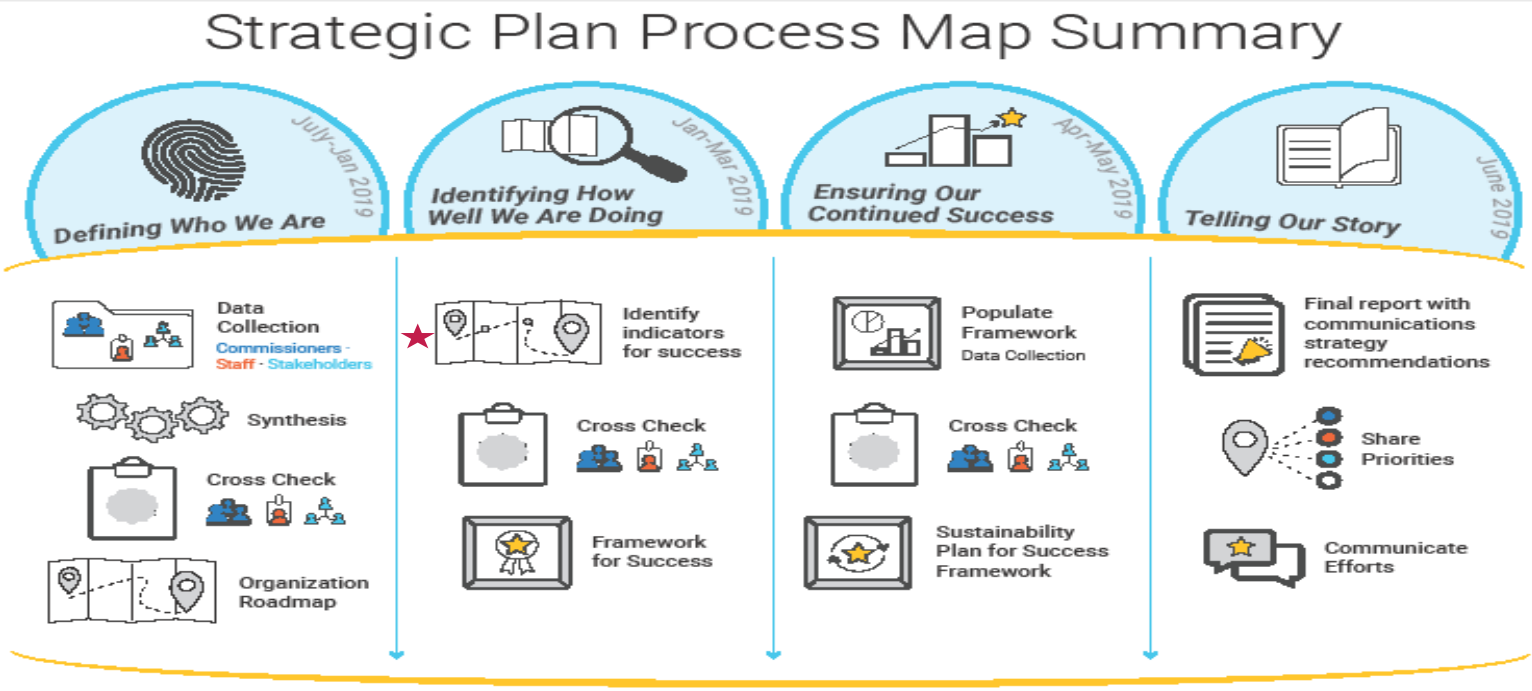
Helping People Build Better Communities

MHSOAC Results Based Strategic Plan 2018-19

Planning Update: April



Where We've Been

Since the fall of 2018, ASR has continued to work with the MHSOAC design team to further their efforts in the results based strategic planning process. The ASR team attended the Commission Meeting on February 28, 2019, to provide a project update, along with another opportunity for the Commission to view and provide feedback on the organizational roadmap. ASR has made necessary changes to this working document based on feedback from the Commissioners, as well as from input from the Commission staff. This document will be the foundation for the results framework moving forward.

Where We're Going

In spring 2019, the Commission will continue moving into results-based-planning and identifying indicators for success. This month, ASR will be discussing and soliciting feedback from the Commissioners on the working results framework. In early summer, the ASR team will present a draft of the Strategic Plan, in the form of a sustainability and communication plan, to the Commission at a regular Commission meeting, with opportunity for public comment and feedback.

If you have any questions, please email ASR President, Susan Brutschy, at susan@appliedsurveyresearch.org.

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Organizational Roadmap

Mental Health Services Oversight & Accountability Commission

The Commission pursues transformational change for California's mental health system by implementing these core functions and projects…	…to affect change in access, quality, and appropriateness of care in three arenas…	So that….

SET DIRECTION AND ESTABLISH PRIORITIES
- Policy projects
- Legislative positions
- Incentive funding
- Research and data analysis

IMPLEMENT PRIORITIES AND DRIVE CHANGE
- Regulations for PEI and innovation
- Technical Assistance
- Stakeholder Contracts
- Triage grants for crisis intervention
- Early Psychosis Plus
- Workplace mental health standards

MONITOR AND EVALUATE WHAT WORKS
- Transparency projects (fiscal, services, outcomes)
- Mental health metrics
- Evaluation

DISSEMINATE, COMMUNICATE, AND SUPPORT
- Communication

Public mental health system:
- Counties will continuously improve access, quality, and outcomes
- Scaling up of effective strategies across the state
- Policy, funding, and regulatory barriers are addressed

Population:
- Public will to support mental health as an essential part of overall health and wellbeing

The private sector:
- Private insurance market changes will change the way it supports mental health
- Employer standards & policies support mental health

Mental health system is transformed

Everybody who needs care gets care when they need it

Wellbeing for All