WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

# Commission Teleconference Meeting
# July 28, 2022
# PowerPoint Presentations and Handouts

| | | |
|---|---|---|
| **Agenda Item 5:** | •Handout: | Presenter Bio - Keris Myrick |
| | •Presentation: | CARE ACT/ SB 1338 |
| | •Handout: | Letter from NAMI California |
| | • Link: | Additional Letters Gathered by NAMI California |
| **Agenda Item 7:** | •Presentation: | Multi-County Full Service Partnership (FSP) Innovation Project |
| **Agenda Item 8:** | • Presentation: | MHSOAC Budget Overview and Expenditure Plan |
| **Agenda Item 9:** | •Handout: | Article – emPATH Units as a Solution for ED Psychiatric Patient Boarding |
| **Miscelleneous:** | •Handout: | Innovation Dashboard |

Bio-

Keris Jän Myrick is a leading mental health advocate and executive, known for her innovative and inclusive approach to mental health reform and the public disclosure of her personal story with over 15 years of experience in mental health services innovations, transformation, and peer workforce development. Myrick is an in-demand national trainer and keynote speaker, authored several peer reviewed journal articles and book chapters and in June 2021, was the recipient of Mental Health America's highest honor the Clifford W. Beers Award.

Ms. Myrick's personal story was featured in the New York Times series: Lives Restored, which told the personal narratives of several professionals living with mental health issues. Myrick is also known for her collaborative style and innovative "whole person" approach to mental health care and is a podcast host of "Unapologetically Black Unicorns" which centers on lived experience, race equity and mental health change agents.

Ms. Myrick is Vice President of Partnerships at Inseparable and most recently was the Co-Director of The Mental Health Strategic Impact Initiative (S2i). She is on the board of directors for Mental Health of America (MHA) and National Association of Peer Supporters (N.A.P.S.) as their policy liaison. Myrick previously held positions as the Chief, Peer and Allied Health Professions for the Los Angeles County Department of Mental Health, the Director of the Office of Consumer Affairs for the Center for Mental Health Services (CMHS) of the United States Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), President and CEO of Project Return Peer Support Network, a Los Angeles-based, peer-run nonprofit and the Board President of the National Alliance on Mental Illness (NAMI).

Ms. Myrick a Certified Personal Medicine Coach and Certified Therapeutic Game Master; has a Master of Science degree in industrial organizational psychology from the California School of Professional Psychology of Alliant International University. Her Master of Business Administration degree is from Case Western University's Weatherhead School of Management.

# MHSOAC Meeting
# CARE ACT/ SB 1338
# July 28, 2022

***Stephanie Welch, Deputy Secretary of Behavioral Health, MSW***

California Health & Human Services Agency

***Person Centered. Equity Focused. Data Driven.***

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Healthy CALIFORNIA ALL

# Systemic Change to Behavioral Health Care

- This **Administration**, like the leadership demonstrated in the **Legislature**, is deeply committed to transforming the Behavioral Health Care System.
- Transforming the behavioral health system will ultimately create **generational change** so **ALL Californians** have access to high quality, culturally responsive and easily accessible behavioral health care.
- **Critical investment** is needed to **build new behavioral health capacity** and **reduce fragmentation** in the behavioral health system - both for mental health and substance use disorders. Much of this is driven by **decades of stigma,** where behavioral health was not considered a core component of the health system.

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# Systemic Change to Behavioral Health Care

Behavioral Health Assessment confirmed that there are capacity challenges across the continuum. The report calls out the **NEED** for

- A **comprehensive** approach to **crisis services**
- More **community-based living options**, from housing to long-term residential, for people living with serious mental illness and/or a substance use disorder
- More **treatment options for children and youth** with significant needs as well as efforts to prevent behavioral health conditions
- Services and strategies that **advance equity** and address disparities
- Addressing related **housing, economic and physical health issues** especially for individuals who are **justice-involved**

Assessing the Continuum of Care for Behavioral Health Services in California Data, Stakeholder Perspectives, and Implications

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# Systemic Change to Behavioral Health Care

- **California Advancing and Innovating Medi-Cal (CalAIM)**
  - Modernizes, improves, and simplifies Medi-Cal's BH system and the **CalAIM Justice Package**
  - **CalAIM and Providing Access and Transforming Health (PATH)**
  - **Medi-Cal Community-Based Mobile Crisis Services**

- **Children and Youth**
  - **The Children and Youth Behavioral Health Initiative (CYBHI)-** reimagining behavioral health system for children and youth
  - **Youth Suicide Prevention and Behavioral Health -** Investment in **youth suicide prevention** and behavioral health to ensure rapid and timely investment in resources to support youth behavioral health needs

- **Preventing and Addressing Crisis:**
  - **Established an Office of Suicide Prevention, CalHHS** is developing a comprehensive **Crisis Care Continuum Plan, DHCS is managing CalHOPE -** a crisis counseling assistance and training program, support for the **CA Peer-Run Warm Line**, and prepping for **9-8-8** implementation.

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# Systemic Change to Behavioral Health Care

## Substance Use

- **California Medicated Assisted Treatment (MAT) Expansion Project**, pilot **Contingency Management** in outpatient treatment settings, **Diversion and Community-Based Restoration Program, Expanding Access to MAT**

## Housing

- **Behavioral Health Bridge Housing -** address the **immediate housing and treatment** needs of **people experiencing or at eminent risk of homelessness** with serious behavioral health conditions, funding can be used to purchase and install tiny homes and to **provide time-limited operational supports** in these tiny homes or in other **bridge housing settings** including existing assisted living settings.

## Care Economy Workforce Development

- Create innovative and accessible opportunities to **recruit, train, hire, and advance an ethnically and culturally inclusive health and human services workforce,** with improved diversity, compensation, and health-equity outcomes.

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# Preventing Long-term Institutionalization

- **Behavioral Health Continuum Infrastructure Program**
  - The Behavioral Health Continuum Infrastructure Program (BHCIP) and the Community Care Expansion (CCE) Program provide $3B to build out community based care, including residential placements.

- **Solutions to Address the Incompetent to Stand Trial (IST) Crisis:**
  - Investing in Department of State Hospitals, namely expansions of Community Based Restoration (CBR) and Diversion, but also through upstream efforts to avoid individuals becoming IST in the first place.

- **CARE Court**
  - Department of Health Care Services, California Health and Human Services Agency and Judicial Branch all help to implement CARE. DHCS will evaluate the program and will provide training and technical resources with CalHHS providing initial implementation coordination. The Judicial Branch will conduct hearings and provide resources.

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# CARE
(Community Assistance, Recovery and Empowerment) **Court**

# CARE Court Overview

# Community Assisted Empowerment and Recovery (CARE) Court

- **CARE** is a new pathway to access much needed comprehensive treatment and services.
- **CARE** aims to deliver behavioral health services to the **most severely ill and vulnerable individuals,** while supporting **self-determination** to the greatest extent possible and community living.
- **CARE** is an **upstream diversion to prevent** more restrictive **conservatorships or incarceration.**
- **CARE** is based on **evidence** which demonstrates that many **people can stabilize,** begin healing, and **exit homelessness in less restrictive, community-based care settings.**
- **CARE** seeks both **participant** and **system success.**
- **CARE Court is NOT** for everyone experiencing **homelessness or mental illness**.

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# Community Assisted Empowerment and Recovery (CARE) Court is Different

- **CARE** is fundamentally different from **LPS Conservatorship** in that it **does not include custodial settings** or **long-term involuntary medications**
- **CARE is different than LPS/Laura's Law in several important ways:**
  - **May be initiated by a petition to the Court** from a variety of people known to the participant (family, clinicians/ physicians, first responders, etc.) and **only credible petitions are pursued**
  - **Multiple** negative outcomes **(incarceration, hospitalizations, etc.)** are not required to be considered
  - **Local government and participants work together** and are both held to the CARE plan
  - Client may have a **Supporter** to assist in **identifying, voicing, and centering the individual's care decisions** in their CARE plan and graduation plan, including preparing **a Psychiatric Advanced Directive, if desired.**

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# Criteria for CARE Respondent

- The person must be 18 years or older
- The person is experiencing severe mental illness and has a diagnosis of schizophrenia spectrum other psychotic disorder
- The person must not be clinically stabilized in on-going treatment
- CARE Court is the least restrictive alternative
- The person will benefit from CARE proceedings
- The person meets one of the following:
  - The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.
  - The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined in Section 5150.

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# CARE Pathways – Petition

- Petition is filed by spouse/family members/ friends, providers/clinicians, county BH, first responders, and others as specified in law
- Petition is promptly reviewed by the court. If it does not meet criteria it is dismissed. If criteria is met the court orders the county to investigate, and file a written report.
- The county agency will submit the written report to the court with findings and conclusions of the investigation, along with any recommendations.
- **If the county is making progress with engagement, an additional 30 days can be provided to continue support enrolling the individual in services**.

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# CARE Pathways – Petition to Initial Hearing

- The court will review the report within 5 days
  - If the court determines that **voluntary engagement is effective**, and that the individual has enrolled in behavioral health treatment, the **court shall dismiss the matter**.
  - If the court determines that the respondent meets and **engagement is not effective**, the court shall set an **initial hearing within 14 days**.
- The court provides notice of the hearing to the petitioner and others as specified by law.
- At the initial hearing, the court determines whether the respondent meets the CARE criteria. If so, the **court orders the county behavioral health agency to work with the respondent, the respondent's counsel, and the CARE supporter to engage in behavioral health treatment.**
- The court will set a case management hearing within 14 days.

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# CARE Pathways – Case Management Conference to Care Agreement

- If the court finds that **the parties have agreed to a CARE agreement**, and the court approves, the court will set a **progress hearing for 60 days.**
- If the court finds that the parties have **not reached a CARE agreement,** the court will order a **clinical evaluation** of the respondent.
- The court will order the county behavioral health agency, through a **licensed behavioral health professional, to conduct the evaluation.**
- The court shall set a **clinical evaluation hearing within 14 days.**

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# CARE Pathways – Clinical Evaluation to Care Plan

- If at the **clinical evaluation hearing** the court finds that the respondent meets the CARE criteria, the **court will order the development a CARE plan. If not, the court shall dismiss the petition**.
- **Care Plan** is developed **with the respondent, supporter, counsel and county behavioral health**. The hearing to review and consider approval of the proposed CARE plan will occur in 14 days.
- After reviewing the proposed CARE plan, the **court may issue any orders necessary** to support the respondent in accessing appropriate services and supports, **including prioritization for those services and supports**.
- The issuance of the order approving the CARE plan begins the **up-to-one-year CARE program timeline.** At intervals of not less than 60 days during CARE plan implementation, the court will have a status review hearing.

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# CARE Pathways – Care Plan to Graduation

- In the 11th month of the program, the court will hold a one-year status hearing where the court will determine whether to **graduate the respondent** from the program or **reappoint the respondent** to the program for another term, not to exceed one year.
- A **respondent may also voluntarily request reappointment** to the CARE program.
- The court will review the **voluntary agreement for a graduation plan** to support a successful transition out of court jurisdiction and **may include a psychiatric advance directive.**
- A **court may refer an individual from assisted outpatient treatment and conservatorship proceedings** to CARE proceedings.
- A **court may refer an individual from misdemeanor proceedings** pursuant to Section 1370.01 of the Penal Code, in which case the prosecuting attorney may be the petitioner.

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# Accountability

# Individual Accountability

- If the Court determines at any time during the proceeding that the participant is **not participating in CARE proceedings**, the **Court may terminate** the respondent's participation in the CARE program.
- The Court may utilize **existing authority** to ensure an individual’s safety. To ensure the respondent’s safety. The court shall provide notice to the county behavioral health agency and the Public Conservator/Guardian if the court utilizes that authority.
- **Subsequent proceedings** may use the CARE proceedings as a **factual presumption** that no suitable community alternatives are available to treat the individual.

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# Government Accountability

- The court can fine a county or other local government entity if it is not complying with CARE.
- The fines will be used to establish the CARE Act Accountability Fund.
  - *All moneys in the fund shall be used, upon appropriation, by the State Department of Health Care Services to support local government efforts that will serve individuals who have schizophrenia or other psychotic disorders and who experience, or are at risk of, homelessness, criminal justice involvement, hospitalization, or conservatorship.*

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# Reporting and Evaluation

- DHCS will develop, in consultation with county behavioral health agencies, other relevant state or local government entities, disability rights groups, individuals with lived experience, families, counsel, racial justice experts, and other appropriate stakeholders, an annual CARE Act report.
- DHCS will provide information on the populations served and demographic data, stratified by age, sex, race, ethnicity, languages spoken, disability, sexual orientation, gender identity, health coverage source,  and county, to the extent statistically relevant data is available.

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# Reporting and Evaluation

- An independent, research-based entity will conduct an evaluation of the effectiveness of the CARE Act.
- The independent evaluation shall highlight racial, ethnic, and other demographic disparities, and include causal inference or descriptive analyses regarding the impact of the CARE Act on disparity reduction efforts.
- A preliminary report to the Legislature is due three years after the implementation date of the CARE Act with a final report due in five years.

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# Community Partner Engagement & Feedback

To date we have received significant feedback on:

- Opportunity for early services and supports engagement
- Voluntary services should be prioritized
- Importance of the supporter role (supported decision-making model) as well as the role of peer support as part of the ongoing Care Plan
- Trauma informed policy and practices, addressing racial bias
- Need for housing resources to meet the needs of the participant
- Despite significant recent investments in the behavioral health continuum, concerns over service capacity, including workforce
- Concern that narrow eligibly criteria misses other high need, high vulnerability populations
- Concern over the implementation timeline in general, especially for small counties

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# Summary of Legislative Changes
# June 30 2022 Version

# Key Changes

- Court directed county behavioral health engagement process
- 2-Phase County Implementation Process
- ~~The Supporter role is housed at DHCS and can be family, friends, and peers~~
- DHCS will provide optional training and technical resources with CalHHS providing initial implementation coordination.
- Legal representation is provided by local qualified legal services project (i.e. Legal Aid)
- Creates the CARE Act Accountability fund at State Treasury
- Includes significant evaluation of CARE Court by requiring DHCS to produce a robust CARE Act report annually
- Includes an emphasis on trauma-informed care and addressing racial bias

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# FAQs

# Why Doesn’t CARE Include All Behavioral Health Conditions?

- **CARE is for people with a focused diagnosis** that is both severely impairing and also **highly responsive to treatment,** including stabilizing medications**.**
- **Broader behavioral health redesign i**s being led by the Administration through to **create generational change** so all Californians have access to high quality, culturally responsive and easily accessible behavioral health care.
- **Critical investments** include **building new behavioral health capacity** through treatment and workforce infrastructure and **reducing fragmentation** in the behavioral health system--**both for mental health and substance use disorders.**

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# Does CARE Guarantee Housing?

- **Housing is an important component of CARE** —finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle.
- **Care Plans will include a housing plan.** Individuals who are served by CARE Court will have diverse housing needs on a continuum ranging from clinically enhanced interim or bridge housing, licensed adult and senior care settings, supportive housing, or housing with family and friends.
- **Governor's proposed 2022-2023 budget includes $1.5 billion for Behavioral Health Bridge Housing,** which will fund clinically enhanced bridge housing settings that are well suited to serve CARE Court participants.
- **2021 Budget Act made a historic $12 billion investment to prevent and end homelessness.**

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# Why Courts?

- The courts are often in the **crosshairs of the lives of those suffering** from severe, decompensated mental illness.
- **Often it's the criminal courts not the civil courts**. By going upstream, CARE Court aims to **serve individuals before** the end up in the **criminal court system or conservatorship**.
- The **CARE courts are a vehicle for collaboration and coordination not compliance**. The CARE court process can be a supportive place that will start with a period of engagement, recently amendment.
- In the case, the **client can't participate** or **the government entities can't implement** an appropriate, person-centered plan, **then the court will deepen its engagement** and oversight.

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# Does CARE Perpetuate Stigma?

- There are **well documented inequities** in clinical diagnosis and the court systems we have today. These are issues not to be taken lightly. We must **acknowledge these realities** and **address them in the formative design of the program**.

- Recent amendments ensure **standardized tools for assessment and evaluation** are reviewed by many with an **eye for ameliorating the features that drive inequity**.

- We can **train individuals participating in CARE court processes** to ensure they have keen awareness of these **drivers of inequity and their own role in perpetuating them**.

- We can **engage communities and stakeholders** not just in these formative days of the Care Court proposal, but **regularly as the program develops** over the next few years.

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# How is Self-Determination supported in the CARE Court model?

- Supporting a self-determined path to recovery and self-sufficiency is core to CARE Court
- Each participant is offered a Legal Aid counselor and may choose a CARE Supporter in addition to their full clinical team
- The CARE Plan ensures that supports and services are coordinated and focused on the individual needs of the person it is designed to serve

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# Next Steps and Questions

**Resources**

CARE Court - California Health and Human Services

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NAMI California
National Alliance on Mental Illness



July 20, 2022

The Mental Health Services Oversight & Accountability Commission
1812 9th Street
Sacramento, CA 95811

Re: SB 1338 (Umberg and Eggman) Community Assistance, Recovery, and Empowerment (CARE) Court Program – **SUPPORT**

Dear Commissioners:

NAMI-CA supports SB 1338 (Umberg and Eggman), which aims to deliver services to Californians with a serious mental illness or substance use disorder who too often languish – suffering in homelessness or incarceration – without the treatment they desperately need.

NAMI-CA is the statewide affiliate of the country's largest mental health advocacy organization, the National Alliance on Mental Illness. Our over 110,000 active advocates and 62 affiliates include many people living with serious mental illnesses, their families, and supporters. NAMI-CA advocates on their behalf, providing education and support to its members and the broader community.

NAMI-CA believes that all people should have the right to make their own decisions about medical treatment. However, we are aware that there are individuals with serious mental illnesses such as schizophrenia and bipolar disorder who, at times, due to their illness, lack insight or good judgment about their need for medical treatment. In cases like this, a higher level of care may be necessary, but must be the last resort. Our members have been calling for reform for their loved ones for years.

NAMI-CA understands that the Commission is in a

For these reasons, NAMI-CA supports SB 1338. I may be reached at jessica@namica.org or (916) 567-0163. Thank you.

Sincerely,

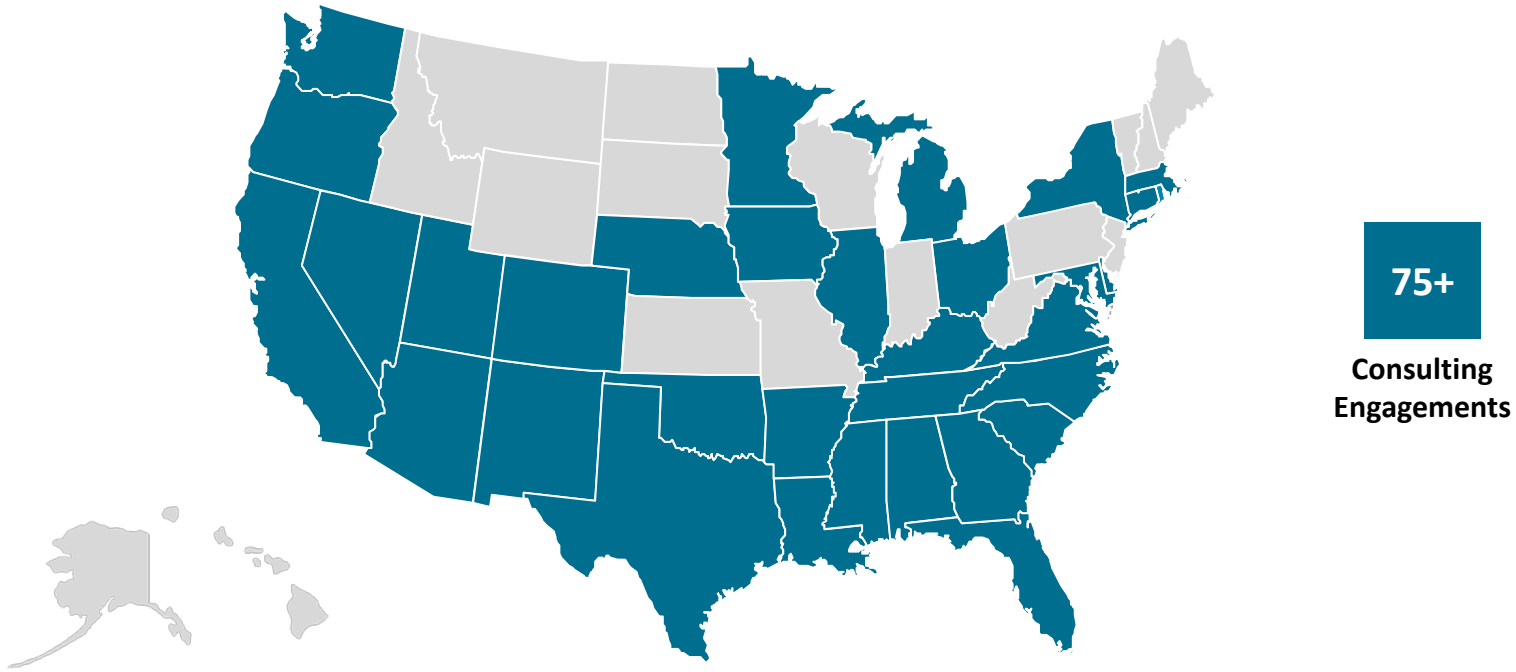
Jessica Cruz,
MPA/HS
Chief Executive Officer

# Multi-County Full Service Partnership (FSP) Innovation Project

## Project Summary and Lessons Learned: Years 1 & 2

July 28, 2022

# Third Sector helps government and communities use data and lived experience to strengthen human services and improve lives




Since 2011, Third Sector has worked with 50+ communities to deploy more than $1.2 billion in government resources toward improved outcomes

# Agenda

Project Overview

Project Timeline & Activities

- Landscape Assessment
- Community Engagement
- Design & Implementation: Cohort and County-level Solutions
- Sustainability Planning and Evaluation Period

Lessons Learned

# Full Service Partnerships (FSP) deliver comprehensive, community-based mental health services using a "whatever it takes" approach

## Population

**FSP serves over 60,000 individuals across California** experiencing severe emotional disturbances or serious mental illness. The highest intensity form of outpatient care, FSPs represent a $1 billion annual investment in public funds.

## Services

**FSP providers deliver a diverse range of evidence-based services** including therapy, psychiatric services, peer supportive services, housing services, and a wide range of case management services geared towards developing life skills and coping mechanisms.

## Outcomes

**FSPs provide consumer-centric services** to help individuals achieve the recovery goals identified in their Individual Services and Supports Plans, as stipulated in the Mental Health Services Act.

Counties are provided **substantial flexibility** in FSP operations, data collection, and approaches. While this local control has supported innovative, community-responsive services, **counties have different operational definitions and inconsistent data processes**, making it **challenging to understand and tell a statewide impact story**.

# Origins of the Multi-County FSP Innovation Project

### The Opportunity for Improvement

California has made significant strides since the creation of the Mental Health Services Act (MHSA). However, client data and concerns raised by county mental health directors suggest that counties still struggle to achieve and understand the impact of the intended outcomes for Full Service Partnership (FSP) programs.


### An Initial County Pilot

From 2018 – 2021, the Los Angeles County Department of Mental Health partnered with Third Sector to transform FSPs into more outcomes-oriented and data-informed programs that reflect the spirit of doing “whatever it takes.”

### The Multi-County FSP Collaboration

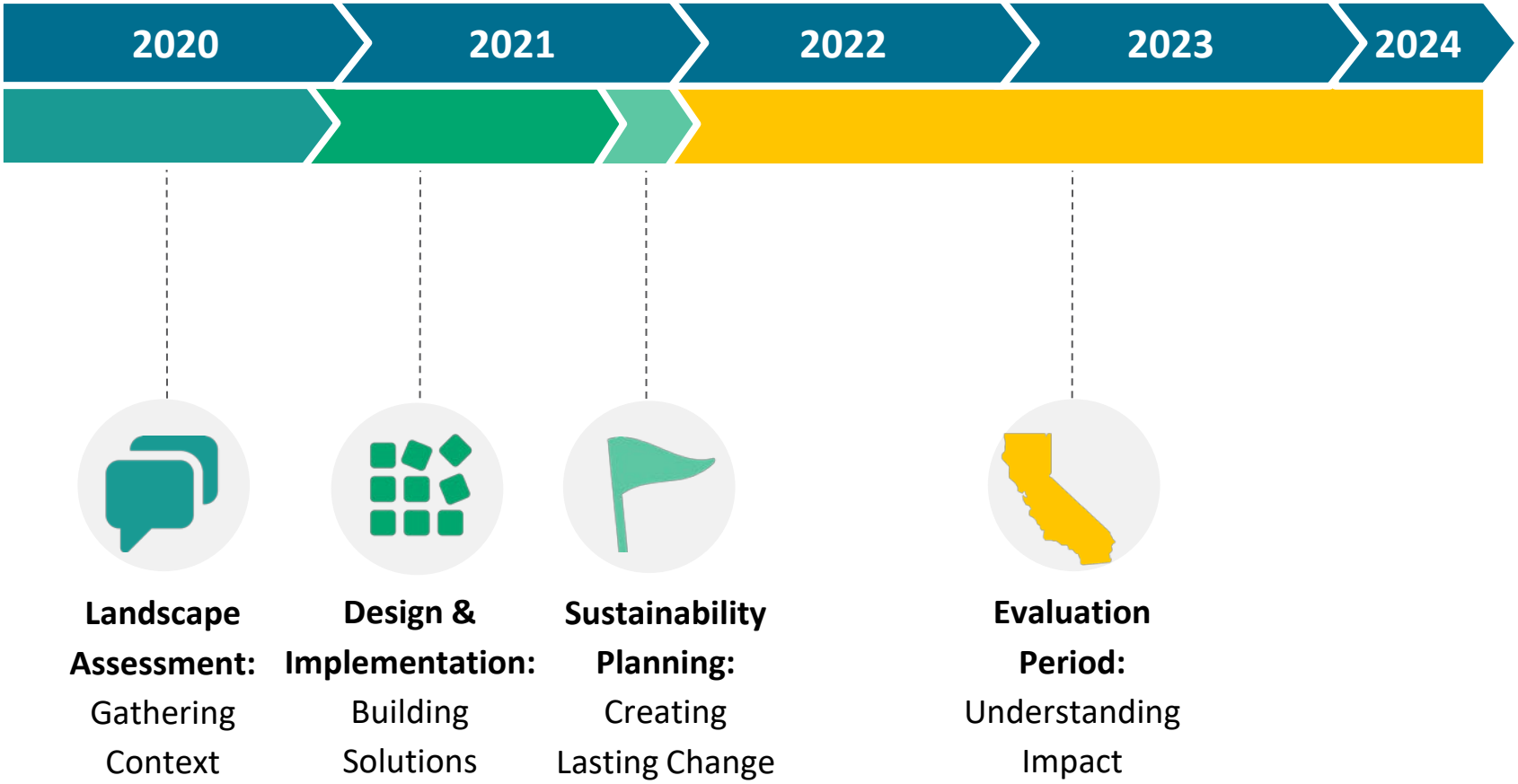
In 2020, six counties – Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura – in partnership with the MHSOAC and CalMHSA, launched the Multi-County FSP Innovation Project to leverage their collective resources and experiences to transform how data is used to continuously innovate and improve FSPs across California. In the fall of 2021, two additional counties – Lake and Stanislaus – joined the project.

# Project Vision and Shared Goals

When the Multi-County FSP Innovation Project is complete, counties will have an improved ability to collect and use data that illuminates **who FSP is serving, what services they receive, and what outcomes are achieved**. Findings from each county will contribute to **statewide recommendations to create more consistent FSPs** that deliver on FSP's "whatever it takes" promise.

1. Develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework
2. Increase the clarity and consistency of enrollment criteria, referral, and graduation processes through developing and disseminating clear tools and guidelines across stakeholders
3. Improve how counties define, track, and apply priority outcomes across FSP programs
4. Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools
5. Develop new and/or strengthen existing processes for continuous improvement that leverage data to foster learning, accountability, and meaningful performance feedback

# Project Timeline*




*Project timeline for original six counties. Lake and Stanislaus counties began work in the fall of 2021 and will follow a similar process.

# *Landscape Assessment:* Counties began by gathering context about their FSP programs, then prioritized changes

## PROGRAMMATIC LANDSCAPE

Map current FSP programmatic landscape, including practices for referral, enrollment, services, stepdown, and data collection

## IMPLEMENTATION ACTIVITY SELECTION

Facilitate provider and county conversations to choose activities to implement at both a local level and statewide

**Impact:** Counties developed a comprehensive understanding of their similarities and differences across FSP programs and practices, leading to clear next steps for piloting change.

# *Community Engagement:* Project activities were rooted in client and staff feedback and experiences

The Multi-County FSP Innovation Project engaged a diverse range of community voices, including FSP clients, caregivers, peer advocates, and providers—**centering the knowledge and expertise of individuals with lived experience**.

**179**

**Individual interviews**
with current or former FSP clients or their caregivers

**39**

**Provider focus groups**
with participation from 195 FSP staff

**123**

**Survey responses**
from county and provider staff

Counties and Third Sector launched two iterative community engagement initiatives:

- One to learn about overall experiences in FSP and prioritize challenges to address
- Another to inform changes to implement at a county and cohort level, translating community needs into tangible solutions

# For example, client goals served as the basis for developing consistent FSP outcomes across counties

**Clients hoped to achieve many of the same goals in FSP** despite their different geographies, including increased independence, coping skills, housing, employment, education access, and sense of meaning and connectedness—goals that the six-county cohort used as the basis for **shared outcomes, process measures, and metrics**.

> Social isolation is a problem for me in a small town with nowhere to go. This has made getting kind of meaningful social interaction really difficult to acquire. —Siskiyou County client

> Recovery to me looks like happiness. I want to wake up happy and trust the world. I want small things – happiness, freedom, and to keep my life. Now I have good reasons to stay alive and active. — San Bernardino County client

> Success would be for me, at least a semester of school, getting my own apartment. And feeling like less of a mental health case, and more of a, I guess, normal person. —Fresno County client

# Client transition needs also informed FSP stepdown guidelines in several counties

**Clients had a range of reactions to stepping down from FSP**, including pride in the progress it represented and anxiety about losing support. They requested slow transition processes with warm handoffs, celebratory gestures, and open doors for continued communication—principles that five counties used to design **recovery-oriented guidelines and processes**.

> Talking about [leaving FSP] and having that communication where we're on the same page. I don't staff to pop out and say, We're done with your services as of today.
> —San Mateo County client

> I would want my next program to have the same kind-hearted type of people that truly care about what happens to you, where you go, and what you accomplish. —Ventura County client

> We still do baby steps to make sure they're comfortable with stepping down to a lower level. We don't want them to feel abandoned.
> —Sacramento County provider

# *Design & Implementation:* Counties created shared definitions and metrics as a cross-county cohort

## FSP POPULATION DEFINITIONS

Standardize definitions of FSP populations (e.g., homeless, justice-involved, high utilizer of psychiatric facilities, etc.)

## OUTCOME & PROCESS METRICS

Identify priority outcomes and process measures to track what services FSP clients receive and the success of those services

## STATEWIDE DATA RECOMMENDATIONS

Develop recommendations for revising Data Collection & Reporting (DCR) forms, metrics, and/or data reports to increase the utility of state data

**Impact:** Counties developed a shared understanding of who FSP serves, what outcomes it achieves, and how these outcomes should be measured.

# Counties defined key FSP outcomes and a measurement plan

| | |
|---|---|
| **Increased stable housing** [Source: DCR] | **A)** The number of days that each FSP participant experienced (i) stable housing, (ii) temporary housing, and (iii) unstable arrangements during the previous 12-month period [See Slide 2 for housing arrangement classifications].<br>**B)** The number of times that each FSP participant experienced unstable housing/homelessness during the previous 12-month period. |
| **Reduced justice involvement** [Source: DCR] | **A)** Whether each FSP client was incarcerated (yes/no) over the previous 12 months<br>**B)** The number arrests that each FSP client experienced during the previous 12 months |
| **Reduced utilization of psychiatric facilities** [Source: EHR systems] | ***Measure #1: Reduced Psychiatric Admissions***<br>**A)** The number of days hospitalized that each FSP participant experienced during the previous 12-month period—in both psychiatric hospitals and general hospitals receiving psychiatric care.<br>**B)** The number of psychiatric admissions that each FSP participant experienced during the previous 12-month period—in both psychiatric hospitals and general hospitals receiving psychiatric care.<br>***Measure #2: Reduced CSU Admissions***<br>The number of Crisis Stabilization Unit admissions that each FSP participant experienced during the previous 12-month period. |
| **Increased social connectedness** [Source: DCR] | 1-item measure “How often do you get the social and emotional support that you need?”<br>Response options: always, usually, sometimes, rarely, never. |

# Counties also pursued their own local implementation activities

| Implementation Activity | Participating Counties |
|---|---|
| Stepdown (Graduation) Guidelines | Sacramento, San Mateo, Ventura, San Bernardino, Siskiyou |
| Service Requirements | San Mateo, Ventura, Siskiyou |
| Reauthorization Process | Fresno, Sacramento |
| Eligibility Guidelines | San Mateo, Ventura |
| Improved Data Collection Processes | Fresno, San Bernardino |
| Referral Guidelines | San Bernardino |
| Referral and Enrollment Process | Fresno |

# Fresno County used staff feedback and community engagement to prioritize three collaborative county-specific initiatives

## Fresno County Implementation Activities

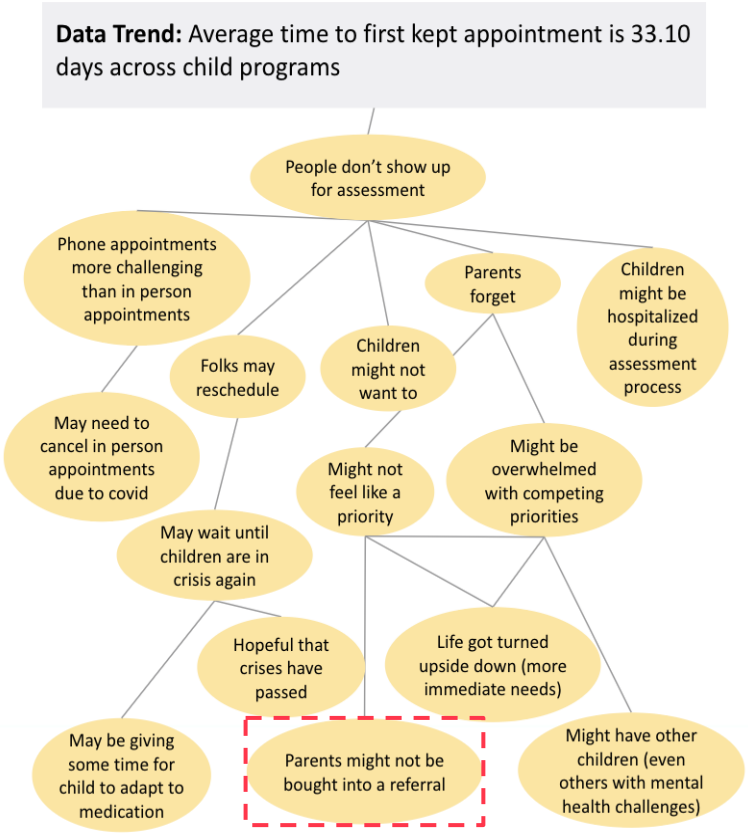
**Reauthorization**
Develop a process in which FSP providers communicate at regular intervals where FSP clients are in their treatment plans in order to better assess reauthorization needs

**Child Referral & Enrollment**
Develop a standardized Child FSP referral and enrollment process to enhance communication between county and providers and reduce waitlists

**Data Collection & Reporting**
Update existing or develop new data practices to enable county and providers to more effectively collect, access, and utilize FSP data to inform care

***Today's presentation will further highlight this initiative***

# As a result of this project, Fresno County is implementing new tools and meetings to discuss data with 7 contracted FSP providers




## Interactive Data Dashboards:

- **Metrics such as engagement** in services, timeliness to services, self-reported feelings of safety, etc.
- Accessed in **real-time** by providers
- **Filter by demographic** variables (e.g. race, zip code)

## Dedicated Data Meetings:

- **Existing 1-on-1 monthly** meetings to discuss provider-specific data trends
- **New quarterly** meetings with all providers to discuss trends across system, using Root Cause Analysis

# *Sustainability Planning:* Counties dedicated the final months of Third Sector's TA to planning for the future

## EVALUATION DATA

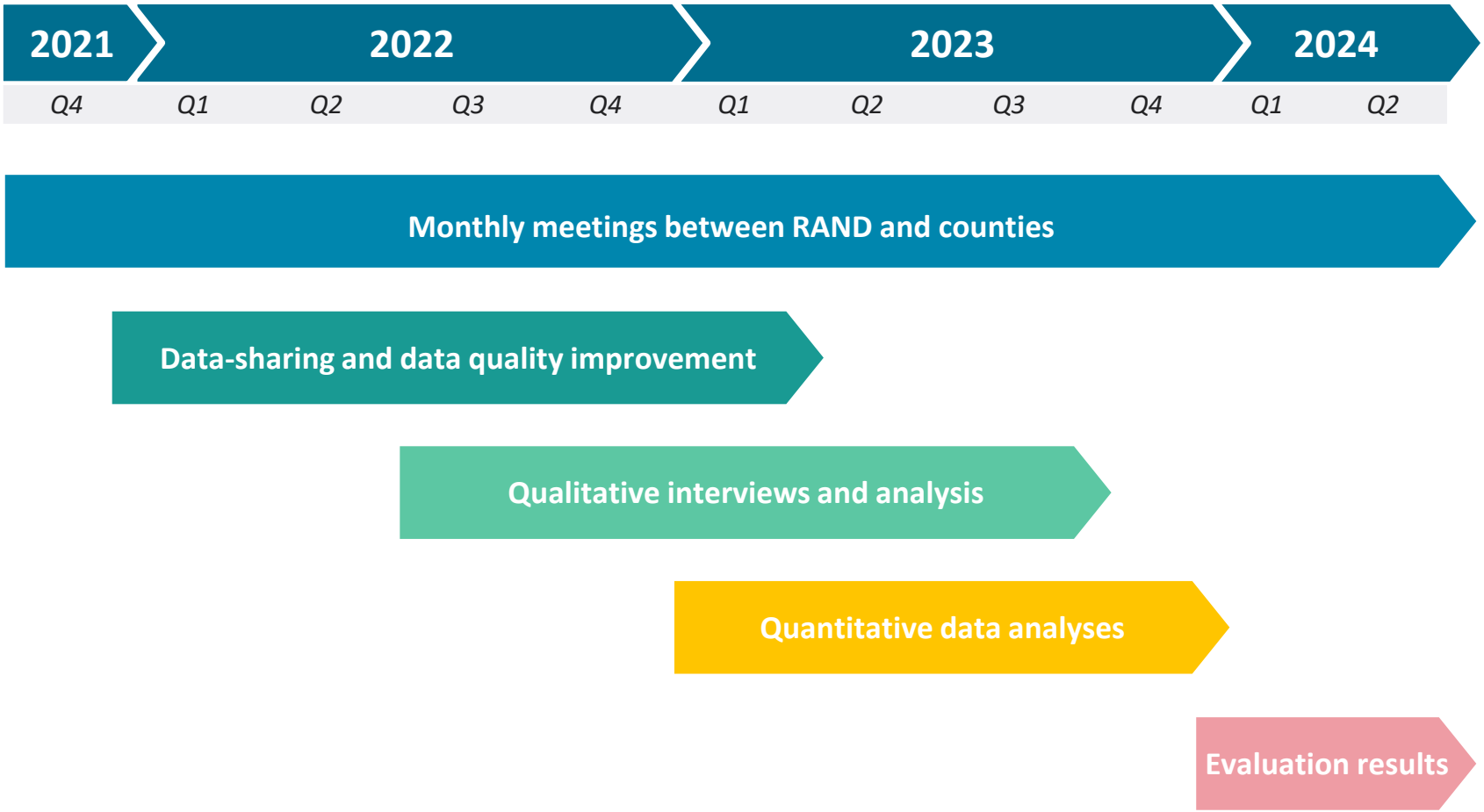
Confirm evaluation plan and data-sharing format for RAND's ongoing analysis, in order to understand client and project impact

## CONTINUOUS IMPROVEMENT PLAN

Develop an ongoing cadence to share outcomes data, identify best practices, and strategize new operational improvements to pilot

**Overarching Impact:** Counties have tools and processes to share data, understand outcomes, and investigate trends to continue improving FSPs statewide, beyond Third Sector's technical assistance.

## *Evaluation Period:* Over the next 2.5 years, RAND will continue meeting with counties in ongoing evaluation and continuous improvement forums



# Lessons Learned: Project insights on multi-county collaborations

**Pursue a shared vision with flexible approaches tailored to individual county needs.** State collaborations inevitably draw counties of varying sizes, structures, and resources. Recognizing and responding to these differences in workplanning, meeting cadence, communication, and process implementation can help mitigate challenges.

**Consider which activities are appropriate for statewide standardization vs. local customization.** Some activities are appropriate for state collaboration; others should be customized to the county context. Both can create efficiencies through shared resources and learnings while honoring counties' distinct geographies, populations, and histories.

**Value informal learning as highly as formal meetings and project structures.** In addition to structured forums for designing and delivering on project activities, the six counties had the opportunity to compare notes and exchange informal learning about best practices for topics ranging from flex funding to data reporting practices.

# Lessons Learned: Project insights on community engagement

**Ground decisions about policies and operational practices in client experience,** including data reporting and outcomes measurement.

**Engage community early and often** in order ensure their voices are included in both the design of the solution and the articulation of the challenge.

**Compensate clients** to recognize the value of their time and contributions.

**Train staff in cultural competency,** equipping them with language and tools to facilitate discussions about identity and culturally-specific needs with clients.

**Leverage both county advocates and third-party facilitators** as necessary to surface deeper insights and bridge potential trust gaps.

**Use trauma-informed and healing-centered techniques** to reduce harm and avoid retraumatization, especially when discussing sensitive topics.

# Creating a statewide vision for Full Service Partnerships

**Add New Counties to the Innovation Project**

Lake and Stanislaus Counties have joined the Multi-County FSP Innovation Project to build upon existing cohort work while examining initiatives for their local context.

**Grow Statewide Learning Communities**

Counties can utilize forums developed during the project to continue sharing learning, evaluating results, and collaborating across the state more broadly.

**Explore Opportunities for Statewide Change**

Participating counties will continue to explore collaborative, innovative opportunities to drive changes to policies and practices.

# THANK YOU!

**For more resources and information:**
Multi-County FSP Project website: https://www.thirdsectorcap.org/Multi-County-CA-FSP-INN

**For additional questions please contact:**
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Marissa Williams, Manager (mwilliams@thirdsectorcap.org)

## Disclosure



Third Sector Capital Partners, Inc.
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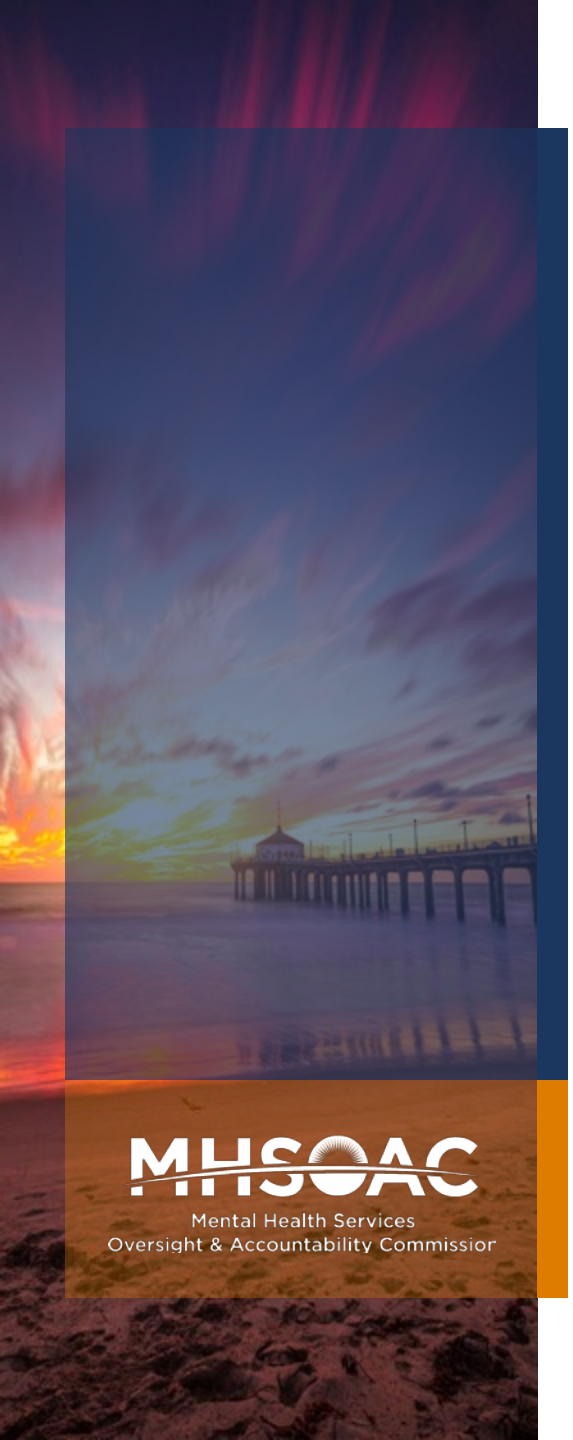
MHSOAC
Mental Health Services
Oversight & Accountability Commission

# MHSOAC Budget Overview and Expenditure Plan

July 28, 2022

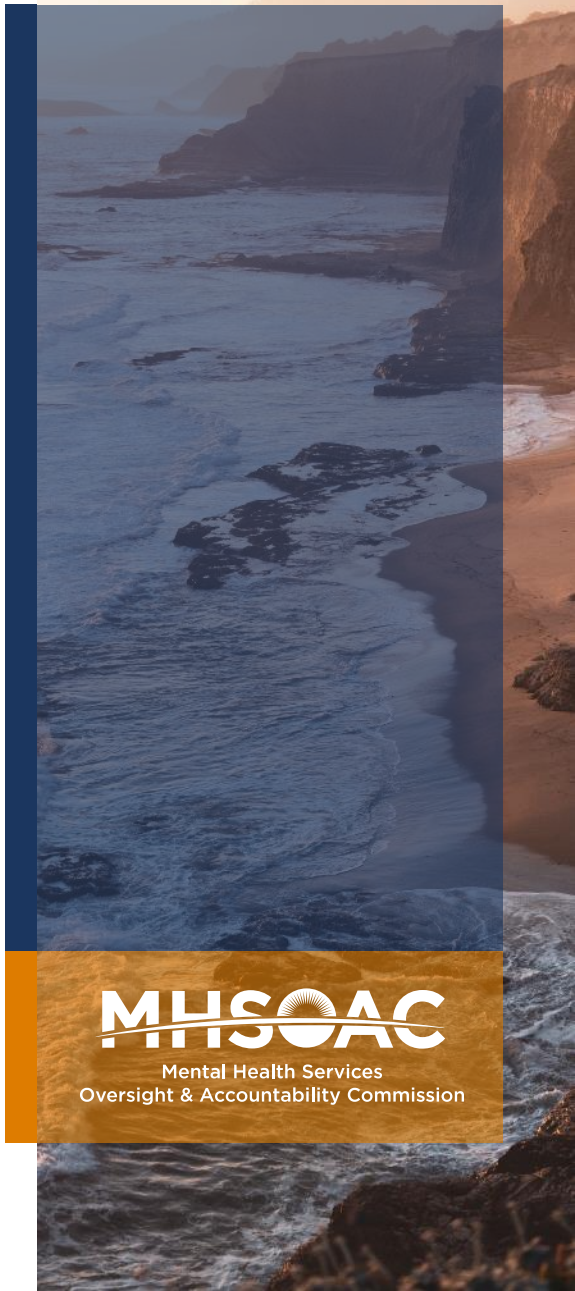



# MHSOAC Budget Overview

| 2021-22 | 2022-23 |
|---|---|
| $255 Million | $111.7 Million |

# MHSOAC Budget Overview – 2021/22

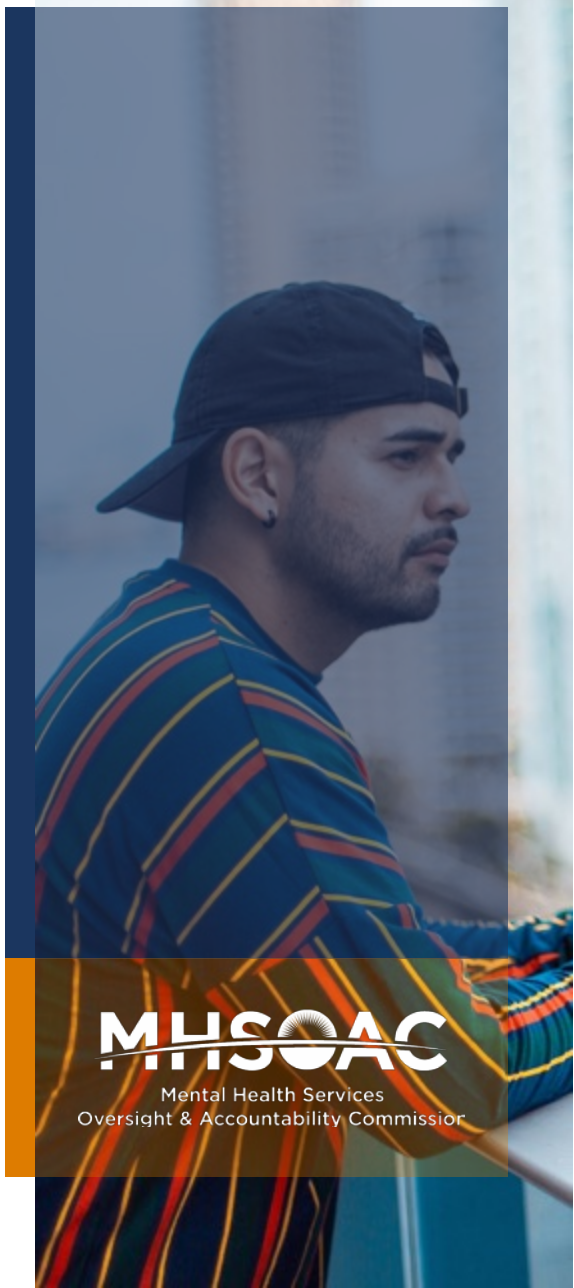
- **Fiscal Year 2021-22**
- Commission Approved on August 26, 2021
- Mid-year update on February 24, 2022
- Fiscal Year 2020-21 Final Report on July 28, 2022



| | FY 21/22 Budget | FY 21/22 Actuals (To Date) |
|---|---|---|
| **Operations** | | |
| Personnel | $6,720,000 | $6,664,867 |
| Core Operations | $1,720,442 | $2,053,428 |
| **Commission Priorities** | | |
| Communications | $509,880 | $518,008 |
| Innovation | $462,500 | $162,500 |
| Research | $1,197,178 | $1,210,990 |
| **Budget Directed** | | |
| Anti-Bullying Campaign | $5,000,000 | $5,000,000 |
| MHSSA Administration Augmentation | $15,000,000 | $110,050 |
| MHSSA Admin/Evaluation | $10,000,000 | $97,214 |
| **Local Assistance** | | |
| Triage | $20,000,000 | |
| MHSSA | $188,830,000 | $138,793,497 |
| Community Advocacy | $5,418,000 | $5,418,000 |
| Suicide Prevention Voluntary Tax | $239,000 | |
| **TOTAL** | **$255,097,000** | **$160,028,554** |

# MHSOAC Expenditure Plan – 2022/23

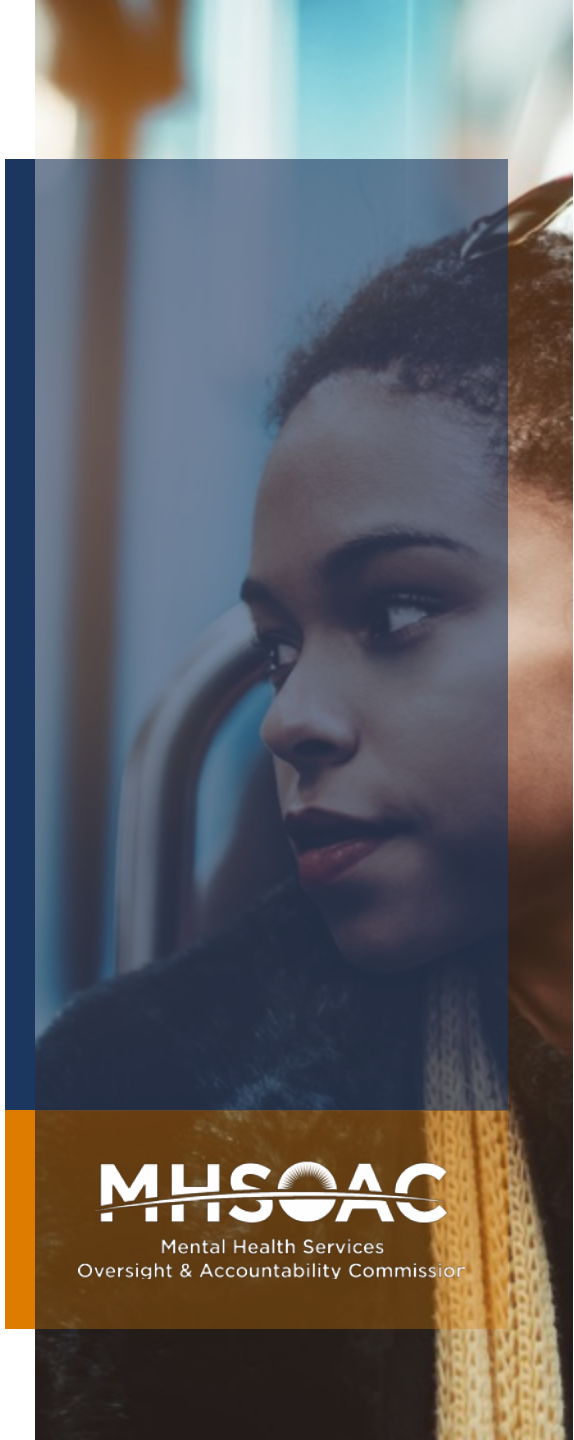
- **Fiscal Year 2022-23**
- Presented for approval on July 28, 2022
- Mid-year update scheduled for January 2023
- Fiscal Year 2022-23 Final Report scheduled for July 2023



| | FY 22/23 Budget | FY 22/23 Earmarked |
|---|---|---|
| **Operations** | | |
| Personnel | $8,100,000 | $8,100,000 |
| Core Operations | $1,484,552 | $1,425,685 |
| **Commission Priorities** | | |
| Communications | $467,448 | $467,448 |
| Innovation | $100,000 | |
| Research | $1,116,000 | $1,116,000 |
| **Budget Directed** | | |
| CA Behavioral Outcomes Fellowship | $5,000,000 | |
| Evaluation of FSP Outcomes | $400,000 | |
| MHSSA Eval/Admin | $16,646,000 | |
| **Local Assistance** | | |
| Triage | $20,000,000 | $20,000,000 |
| MHSSA | $8,830,000 | $8,359,048 |
| Community Advocacy | $6,700,000 | $4,690,000 |
| Reimbursement | $42,900,000 | |
| **TOTAL** | **$111,744,000** | **$44,158,181** |

# Motion

- The Commission approves the Fiscal Year 2022-23 expenditure plan.




Thank You
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Scott Zeller, MD

September 07, 2017

# emPATH Units as a Solution for ED Psychiatric Patient Boarding

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Patients with acute mental health issues stuck languishing for long hours, sometimes days, in medical emergency departments (ED) awaiting psychiatric disposition continue to be a major problem across the United States[1]. Many observers suggest the problem is due to a shortage of inpatient psychiatric beds. However, it should be noted that emergency psychiatric conditions may be the only cases presenting to EDs for which the default treatment is 'admit to inpatient', and if this were also true for any other emergency condition (such as chest pain), all medical beds of hospitals would likely be full as well. It has been demonstrated that the great majority of psychiatric emergencies, like other medical emergencies, can be resolved in less than 24 hours with prompt, appropriate intervention[2] — thus it would make sense to try to treat mental health crises in emergency settings as well.

emPATH units report substantial improvements in outcomes, as well as safety and patient satisfaction, while dramatically reducing the need for coercive measures.

However, resolving those symptoms in the standard ED can be a complicated task. The ED can be a frightening or agitating environment for patients in a mental health crisis, as they are often restrained to gurneys, or stuck in corners or cubicles guarded by a sitter, amid police and ambulance personnel, flashing lights, loud noises and hectic activity, and the cries of nearby others in pain. Paranoid or anxious patients, who might benefit from extra space or the ability to move about, may instead be restricted to a small, confined area. It has long been recognized that the standard ED setting may actually exacerbate the symptoms of a psychiatric crisis.[3]

Continue Reading Below

Those suffering from acute psychiatric conditions will understandably do better in more calming, supportive settings with trained psychiatric personnel. However, until recently in most parts of the country, such environments have only been possible within inpatient psychiatric wards (perhaps after a long wait in an ED) or in community-based crisis programs. The community crisis clinics, however, are typically limited to lower-acuity clients, and exclude patients with aggression, dangerousness, acute suicidality, substance intoxication or withdrawal, vital signs abnormalities or other medical concerns.

As a result, mental health patients with the most severe and urgent symptoms are, ironically, often the most under-served behavioral health population.

Fortunately, a new and effective model — the "emPATH unit" — has emerged nationally in recent years, now boasting state-of-the-art facilities in multiple states. Combining the soothing, home-like and supportive atmosphere of the community crisis clinic with the ability to accept even the most acute psychiatric patients, emPATH units report substantial improvements in outcomes, safety, and patient satisfaction, while dramatically reducing the need for coercive measures, decreasing episodes of agitation and physical restraints, and diverting unnecessary psychiatric hospitalizations, all at substantially lower costs than the status quo.[4]

emPATH unit stands for “emergency Psychiatric Assessment, Treatment & Healing unit,” and as the acronym implies, is modeled on empathetic, rather than coercive, care. These are hospital-based outpatient programs which can promptly accept all medically-appropriate patients in a psychiatric crisis, even those on involuntary psychiatric detention. Rather than being an alternative-to-inpatient destination for ED mental health patients, the emPATH unit is the destination for *all* the ED's acute mental health patients, a place where disposition decisions are typically not made until *after* a thorough psychiatric evaluation, treatment, and an observation period in the recuperative unit setting.

emPATH units can be widely diverse in their designs, staffing and floor plans, but all follow several basic tenets:

1.**The programs feature a large, comfortable central room or ‘milieu' where all patients are situated.** Rather than individual beds or rooms, in this short-term outpatient program each patient is provided their own recliner or ‘sleeper' chair, which can be positioned upwards for joining in socialization or group therapy, or folded flat if one wishes to take a nap. Recliners are arranged to maximize personal space, and there is also ample room on the unit for those patients who wish to walk about, pace or meditate; some units even feature a safe outdoor retreat. Stations with snacks, beverages, and linens are accessible to patients without needing to involve the staff. There are opportunities to read books or periodicals, watch TV, play board games, or chat privately with a therapist or peer support counselor.

The large milieu room is optimally airy, with high ceilings, windows, and ambient light. Soft colors and peaceful murals adorn the walls. The entire atmosphere is one of calming and healing, where needs can be met, frustrations are minimized, and therapeutic interventions can be allowed the time and space to be effective.

Some might question why patients would be all together in the milieu rather than the more traditional emergency psychiatry strategy of individual rooms, perhaps also wondering if highly-acute patients might be more likely to become combative when among other patients. But for a person in crisis, human interaction can be very beneficial, while an individual room can seem bleak and cell-like, with little hope for recovery.

For example, a person who feels distraught and in despair might continue to harbor such feelings in a private room. In the ‘group campout' environment of the milieu, however, he or she might instead be able to speak with a nearby peer about their issues, make a new friend, or enjoy a game of dominoes, and then suddenly, things might not seem quite so bad. Similarly, even individuals with paranoia or hostile thoughts can be soothed by the collegiality and mutual respect of the patients in the milieu setting.

2. **All staff are intermingled with the patients on the milieu — there is no glass-enclosed ‘fishbowl' nursing station.** Nurses, social workers, therapists, and peer support counselors are always available and close by. Because of this of this set-up, any patient having difficulties or escalating symptoms can be quickly assisted in a supportive and non-coercive way. Unlocked enclosed areas are available should an individual need temporary privacy to decompress.

3. **All patients see a psychiatrist as quickly as possible, and have treatment implemented promptly.** It has been shown the more early the assessment in a mental health crisis setting, the better the outcome. [5] Similarly — especially given the fact that emPATH units, being outpatient, typically have a limit of 23 hours, 59 minutes — the best chances for a speedy recovery in the unit occur when treatment is employed as soon as possible.

The combination of a prompt assessment and treatment with a supportive, healing environment can lead to impressive results, especially in safety and symptom relief. emPATH units report the use of physical restraints and/or forced medications in less than 1% of patients, even when the majority of patients are on involuntary psychiatric holds, [6] an improvement over more traditional emergency psychiatry programs (one of which recently published physical restraint use at 14%).[7] Avoidance of inpatient hospitalization in highly-acute populations via treatment in an emPATH unit can be 75% or higher, sparing those available inpatient beds for those who truly have no alternative. [4]

emPATH units can help mental healthcare systems achieve the Triple Aim of health care —enhancing patient experience, improving population health, and reducing costs.[8] By minimizing boarding, which can cost EDs an average of $2264 per patient[8], and avoiding unnecessary hospitalizations, which can cost $8000 to$10,000 or even more, the financial benefits of an emPATH unit are clear; in addition, these units are often able to operate self-sufficiently at far less than the costs of the status quo. And moving crisis individuals out of the ED opens up ED beds for other medical emergency patients. Further enhancing the fiscal advantages, emPATH units can often be created in a cost-effective way by simply remodeling available, unused hospital spaces.

Best of all, emPATH units are truly a win for mental health patients, providing swift relief and recovery for those who traditionally have been under-served, and have too often been detained with minimal care in improper settings.

# References

1. Castellucci, M. ER wait times, length of stay far longer for psychiatric patients. *Modern Healthcare*. http://www.modernhealthcare.com/article/20161017/NEWS/161019918 October 17, 2016. Accessed August 30, 2017. .
2. Zeller SL. Treatment of psychiatric patients in emergency settings. *Primary Psychiatry*. 2010;17(6):41-47.
3. Garriga M, Pacchiarotti I, Kasper S, et al. Assessment and management of agitation in psychiatry: expert consensus. *World J Biol Psychiatry*. 2016; 17(2):86-128.
4. Zeller S, Calma N, Stone A. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *West J Emerg Med*. 2014; Feb;15(1):1-6.
5. Balfour M, Tannner K, Jurica PJ, Llewellyn D, Williamson RG, Carson CA. Using lean to rapidly and sustainably transform a behavioral health crisis program: impact on throughput and safety. *Jt Comm J Qual Patient Saf*. 2017;43(6):275-283.
6. Zeller, SL. Data presented at the American Psychiatric Association 2017 Annual Meeting; May 22, 2017; San Diego, California.
7. Simpson SA et al. Risk for physical restraint or seclusion in the psychiatric emergency service (PES). *Gen Hosp Psychiatry*. 2014; 36(1):113-8.
8. Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. Health Aff (Millwood). 2008. doi:10.1377/hlthaff.27.3.759
9. Nicks B, Manthey D. The impact of psychiatric patient boarding in emergency departments [published online July 22, 2012]. *Emerg Med Int*. 2012;2012:360308.

Mental Health Services
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# INNOVATION DASHBOARD

JULY 2022

| UNDER REVIEW | Final Proposals Received | Draft Proposals Received | TOTALS |
|---|---|---|---|
| Number of Projects | 0 | 6 | **6** |
| Participating Counties (unduplicated) | 0 | 6 | **6** |
| Dollars Requested | $0 | $28,088,796 | **$28,088,796** |

| PREVIOUS PROJECTS | Reviewed | Approved | Total INN Dollars Approved | Participating Counties |
|---|---|---|---|---|
| FY 2017-2018 | 34 | 33 | $149,548,570 | 19 (32%) |
| FY 2018-2019 | 53 | 53 | $304,098,391 | 32 (54%) |
| FY 2019-2020 | 28 | 28 | $62,258,683 | 19 (32%) |
| FY 2020-2021 | 35 | 33 | $84,935,894 | 22 (37%) |
| FY 2021-2022 | 21 | 21 | $50,997,068 | 19 (32%) |

| TO DATE | Reviewed | Approved | Total INN Dollars Approved | Participating Counties |
|---|---|---|---|---|
| 2022-2023 | | | | |

## INNOVATION PROJECT DETAILS

| DRAFT PROPOSALS | | | | | | |
|---|---|---|---|---|---|---|
| Status | County | Project Name | Funding Amount Requested | Project Duration | Draft Proposal Submitted to OAC | Final Project Submitted to OAC |
| Under Review | Santa Cruz | Healing The Streets | $5,843,551 | 5 Years | 12/9/2021 | Pending |
| Under Review | Orange | Clinical High Risk for Psychosis in Youth | $13,000,000 | 5 Years | 2/26/2022 | Pending |
| Under Review | Yolo | Crisis Now | $3,584,357 | 3 Years | 6/1/2022 | Pending |
| Under Review | Napa | Addressing MH Needs of American Canyon Filipino (Extension) | $138,425 | 1 Year | 6/14/2022 | Pending |
| Under Review | Shasta | Hope Park (Extension) | $107,360 | N/A | 6/17/2022 | Pending |
| Under Review | Sonoma | Semi-Statewide Electronic Health Record | $5,526,045 | 5 Years | 6/30/2022 | Pending |

| FINAL PROPOSALS | | | | | | |
|---|---|---|---|---|---|---|
| Status | County | Project Name | Funding Amount Requested | Project Duration | Draft Proposal Submitted to OAC | Final Project Submitted to OAC |
| Under Final Review | | | | | | |

| APPROVED PROJECTS (FY 21-22) | | | |
|---|---|---|---|
| County | Project Name | Funding Amount | Approval Date |
| Placer | 24/7 Adult Crisis Respite Center | $2,750,000 | 8/26/2021 |
| Marin | Student Wellness Ambassador Program | $1,648,000 | 9/23/2021 |
| Monterey | Residential Care Facility Incubator (Planning Dollars) | $792,130 | 11/1/2021 |
| Lake | Multi County FSP Collaborative | $765,000 | 11/2/2021 |

| APPROVED PROJECTS (FY 21-22) | | | |
|---|---|---|---|
| County | Project Name | Funding Amount | Approval Date |
| Shasta | Hope Park | $1,750,000 | 11/18/2021 |
| Alameda | Community Assessment Transportation Team (CATT) Extension | $4,759,312 | 11/18/2021 |
| Sonoma | Crossroads To Hope | $2,500,000 | 2/24/2022 |
| Stanislaus | CPP Planning Request | $425,000 | 3/3/2022 |
| Ventura | FSP Multi-County Collaborative-EXTENSION | $702,227 | 3/3/2022 |
| Kern | Mobile Clinic with Street Psychiatry | $8,774,098 | 3/24/2022 |
| Berkeley | Encampment -Based Mobile Wellness Center | $2,802,400 | 4/28/2022 |
| Butte | Resilience Empowerment Support Team (REST) at Everhart Village | $3,510,520 | 4/28/2022 |
| Orange | CPP Planning Request | $950,000 | 5/25/2022 |
| Modoc | Integrated Health Care for Individuals with SMI | $480,000 | 5/25/2022 |
| Orange | Young Adult Court | $12,000,000 | 5/26/2022 |
| Kern | Early Psychosis Learning Health Care Network | $1,632,257 | 5/26/2022 |
| Tri-Cities | PADs-Multi-County Collaborative | $789,360 | 5/26/2022 |
| Contra Costa | PADs-Multi-County Collaborative | $1,500,058 | 5/26/2022 |
| Ventura | Managing Assets for Security & Health (MASH) Senior Supports for Housing Stability | $966,706 | 6/20/2022 |
| Tulare | Semi-Statewide Enterprise Health Record System Improvement | $1,000,000 | 6/20/2022 |
| Yolo | Planning and Stakeholder Input Process for Crisis System Re-Design and Implementation (Extension) | $500,000 | 6/20/2022 |