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Mental Health Services
Oversight & Accountability Commission

Meeting Materials Packet

Commission Meeting
July 25, 2024
9:00 AM – 3:30 PM

MHSOAC
Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING NOTICE & AGENDA

July 25, 2024

NOTICE IS HEREBY GIVEN that the Commission will conduct a meeting on July 25, 2024, at 9:00 a.m.

This meeting will be conducted via teleconference pursuant to the Bagley-Keene Open Meeting Act according to Government Code sections 11123, 11123.5, and 11133. The location(s) from which the public may participate are listed below. All members of the public shall have the right to offer comment at this public meeting as described in this Notice.

DATE	July 25, 2024
TIME	9:00 a.m.
LOCATION	1812 9th Street, Sacramento, CA 95811 and Virtual

COMMISSION MEMBERS:
Mara Madrigal-Weiss, *Chair*
Mayra E. Alvarez, *Vice Chair*
Mark Bontrager
Bill Brown, *Sheriff*
Keyondria D Bunch, Ph.D.
Wendy Carillo, *Assemblymember*
Steve Carnevale
Rayshell Chambers
Shuonan Chen
Dave Cortese, *Senator*
Itai Danovitch, MD
Dave Gordon
Gladys Mitchell
James L. Robinson III, Psy.D., MBA
Alfred Rowlett

EXECUTIVE DIRECTOR:
Toby Ewing

ZOOM ACCESS
Zoom meeting link and dial-in number will be provided upon registration.
Free registration link:
https://mhsoac-ca-gov.zoom.us/meeting/register/tZcvdOirpz8iEtQdBKMRwIzvIIQ5pMjAbR_F

Public participation is critical to the success of our work and deeply valued by the Commission. Please see the detailed explanation of how to participate in public comment after the meeting agenda.

Our Commitment to Excellence

The Commission's 2024-2027 Strategic Plan articulates four strategic goals:

- Champion vision into action to increase public understanding of services that address unmet mental health needs.
- Catalyze best practice networks to ensure access, improve outcomes, and reduce disparities.
- Inspire innovation and learning to close the gap between what can be done and what must be done.
- Relentlessly drive expectations in ways that reduce stigma, build empathy, and empower the public.

Meeting Agenda

It is anticipated that all items listed as "Action" on this agenda will be acted upon, although the Commission may decline or postpone action at its discretion. Items may be considered in any order at the discretion of the Chair. Public comment is taken on each agenda item. Unlisted items will not be considered.

9:00 a.m. **1. Call to Order & Roll Call**

Chair Mara Madrigal-Weiss will convene the Commission meeting and a roll call of Commissioners will be taken.

9:05 a.m. **2. Announcements and Updates**

Information

Chair Mara Madrigal-Weiss, Commissioners and Staff will make announcements and updates.

9:20 a.m. **3. General Public Comment**

Information

General Public Comment is reserved for items not listed on the agenda. No discussion or action will take place.

9:40 a.m. **4. May 23, 2024 Meeting Minutes**

Action

The Commission will consider approval of the minutes from the May 23, 2024 Commission Meeting.

- Public Comment
- Vote

9:50 a.m. **5. Consent Calendar**

Action

All matters listed on the Consent Calendar are routine or noncontroversial and can be acted upon in one motion. There will be no separate discussion of these items prior to the time that the Commission votes on the motion unless a Commissioner requests a specific item to be removed from the Consent Calendar for individual action. The following items are coming forward for consideration on consent:

- Innovation: Electronic Health Records Multi-County Collaborative: Sierra County
- Resolution: Workers Compensation Insurance for Volunteers

- Public Comment
- Vote

10:00 a.m.

6. State Budget and Expenditure Update

Action

The Commission will hear a presentation on the newly signed State Budget for Fiscal Year 2025-2026 and consider approval of expenditures; presented by Norma Pate, Deputy Director

- Public Comment
- Vote

10:30 a.m.

7. Transformational Change in Behavioral Health: Transparency and Accountability

Action

The Commission will hear from a panel of speakers on opportunities for improved accountability and transparency under behavioral health transformation; *presented by Melissa Martin-Mollard, Ph.D., Chief of Research and Data*

Amendment: Panelists added to Agenda on July 19, 2024:

- Lishaun Francis, Senior Director of Behavioral Health, Children Now
- Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency
- Ryan Quist, Ph.D., Behavioral Health Services Director, Sacramento County
- Sergio Aguilar-Gaxiola, MD, Ph.D., Founding Director, Center for Reducing Disparities, UC Davis
- Debra Oto-Kent, Founder and Executive Director, Health Education Council

- Public Comment
- Vote

12:30 p.m. **8. Lunch**

1:00 p.m.

9. Proposition 1 Implementation: Exploring Commission Opportunities

Action

The Commission will hear an overview of Proposition 1 reforms that impact the Commission and its operations; *presented by Kendra Zoller, Legislative Deputy Director*

- Public Comment
- Vote

2:30 p.m. **10. Early Psychosis Strategic Plan Draft**

Action

The Commission will hear an update on the efforts to draft a strategic plan for Early Psychosis intervention; presented by Toby Ewing, Executive Director

- Public Comment
- Vote

3:30 p.m. **11. Adjournment**

Our Commitment to Transparency

In accordance with the Bagley-Keene Open Meeting Act, public meeting notices and agenda are available on the internet at www.mhsoac.ca.gov at least 10 calendar days prior to the meeting. Further information regarding this meeting may be obtained by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov

Our Commitment to Those with Disabilities

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability need special assistance to participate in any Commission meeting or activities, may request assistance by calling (916) 500-0577 or by emailing mhsoac@mhsoac.ca.gov. Requests should be made one (1) week in advance, whenever possible.

Notes for Participation

For Public Comments: Prior to making your comments, please state your name for the record and identify any group or organization you represent.

Register to attend for free here:
https://mhsoac-ca-gov.zoom.us/meeting/register/tZcvdOirpz8iEtQdBKMRwIzvIIQ5pMjAbR_F

Email Us: You can also submit public comment to the Commission by emailing us at publiccomment@mhsoac.ca.gov. Emailed public comments submitted at least 72 hours prior to the Commission meeting will be shared with Commissioners at the upcoming meeting. Public comment submitted less than 72 hours prior to the Commission meeting will be shared with Commissioners at a future meeting. Please note that public comments submitted to this email address will not receive a written response from the Commission. **Emailing public comments is not intended to replace the public comment period held during each Commission Meeting and in no way precludes a person from also providing public comments during the meetings.**

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

of the public to comment. Please see additional instructions below regarding public participation procedures.

The Commission is not responsible for unforeseen technical difficulties that may occur. The Commission will endeavor to provide reliable means for members of the public to participate remotely; however, in the unlikely event that the remote means fail, the meeting may continue in person. For this reason, members of the public are advised to consider attending the meeting in person to ensure their participation during the meeting.

Public participation procedures: All members of the public have a right to offer comment at the Commission's public meeting. The Chair will indicate when a portion of the meeting is open for public comment. Any member of the public wishing to comment during public comment periods must do the following:

→ If joining in person. Complete a public comment request card and submit to Commission staff. When it is time for public comment, staff will call your name and you will be invited to the podium to speak. Members of the public should be prepared to complete their comments within 3 minutes or less, unless a different time allotment is needed and announced by the Chair.

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

→ If joining by computer, press the raise hand icon on the control bar. Pressing the raise hand will notify the meeting host that you wish to comment. You will be placed in line to comment in the order in which requests are received by the host. When it is your turn to comment, the meeting host will unmute your line, announce your name, and ask if you'd like your video on. The Chair reserves the right to limit the time for comment. Members of the public should be prepared to complete their comments within 3 minutes or less time if a different time allotment is needed and announced by the Chair.

In accordance with California Government Code § 11125.7(c)(1), members of the public who utilize a translator or other translating technology will be given at least twice the allotted time to speak during a Public Comment period.

AGENDA ITEM 4

Action

July 25, 2024 Commission Meeting

May 23, 2024 Meeting Minutes

Summary:
The Mental Health Services Oversight and Accountability Commission will review the minutes from the May 23, 2024 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.

Enclosures (2): (1) May 23, 2024 Minutes; (2) May 23, 2024 Motions Summary

Handouts: None

Proposed Motion: That the Commission approves the May 23, 2024 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Commission Meeting Minutes

Date May 23, 2024

Time 9:00 a.m.

Location MHSOAC
1812 9th Street
Sacramento, California 95811

Members Participating:

Mara Madrigal-Weiss, M.Ed., Chair
Mayra Alvarez, M.A., Vice Chair*
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Steve Carnevale
Rayshell Chambers, M.P.A.
Itai Danovitch, M.D., M.B.A.*
David Gordon, Ed.M.
Gladys Mitchell, M.S.W.
Alfred Rowlett, M.B.A., M.S.W.

*Participated remotely

Members Absent:

Mark Bontrager, J.D., M.S.W.
Assembly Member Carrillo, M.A.
Shuo Chen
Senator Dave Cortese, J.D.
Jay Robinson, Psy.D., M.B.A.

MHSOAC Meeting Staff Present:

Toby Ewing, Ph.D., Executive Director
Sandra Gallardo, Chief Counsel
Maureen Reilly, Staff Counsel
Tom Orrock, Deputy Director, Program Operations
Norma Pate, Deputy Director, Administration and Performance Management
Kendra Zoller, Deputy Director, Legislation
Riann Kopchak, Chief, Community Engagement and Grants
Amariani Martinez, Administrative Support
Lester Robancho, Health Program Specialist
Cody Scott, Meeting Logistics Technician

1: Call to Order and Roll Call

Chair Mara Madrigal-Weiss called the Meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:05 a.m. and welcomed everyone.

Chair Madrigal-Weiss introduced new Chief Counsel Sandra Gallardo and welcomed her to the Commission. She thanked Maureen Reilly, Assistant Chief Counsel, for supporting the Commission as Interim Chief Counsel as staff worked to fill the gap left by Geoff Margolis's passing.

Chair Madrigal-Weiss stated the Commission's Strategic Plan for 2024-27 was approved at the January Commission meeting. She reviewed a slide about how today's agenda supports the Commission's Strategic Plan Goals and Objectives, and noted that the meeting agenda items are connected to those goals to help explain the work of the Commission and to provide transparency for the projects underway.

Sandra Gallardo, Chief Counsel, called the roll and confirmed the presence of a quorum. Attending In-Person: Chair Madrigal-Weiss, Commissioner Brown, Commissioner Bunch, Commissioner Carnevale, Commissioner Chambers, Commissioner Gordon, Commissioner Mitchell and Commissioner Rowlett attended in person. Attending Remotely: Vice Chair Alvarez and Commissioner Danovitch

Amariani Martinez, Commission staff, reviewed the meeting protocols.

2: Announcements and Updates

Chair Madrigal-Weiss gave the announcements as follows:

Mental Health Awareness Month

May is Mental Health Awareness Month. Since its inception in 1949, Mental Health Awareness Month has been a cornerstone of addressing the challenges faced by millions of Americans living with mental health conditions. This national movement is dedicated to eradicating stigma, extending support, fostering public education, and advocating for policies that prioritize the well-being of individuals and families affected by mental illness.

Across the state, there have been events held this month to provide a voice to those facing mental illness and recognize the importance of access to mental health services for all Californians. Commission staff participated in the mental health awareness activities held at the Capitol last week to bring awareness to the Commission's work to transform the behavioral health system.

The Association of California State Employees with Disabilities (ACSED) has selected the Commission as the recipient of the 2023 ACSED Adverse Childhood Experiences (ACES) Award for Small Departments. This marks the second consecutive year that the Commission has received this award, which recognizes a department's outstanding contributions to advancing disability employment within state government.

Commission Meetings

- There will be no Commission meeting in June. The next MHSOAC meeting is scheduled for Thursday, July 25th in Sacramento, where the Commission will continue the discussion on transformational change in behavioral health with a focus on fiscal transparency, accountability, and substance use disorder integration.
- The April 2024 Commission meeting recording is now available on the website. Most previous recordings are available upon request by emailing the general inbox at mhsoac@mhsoac.ca.gov.

New Staff

Chair Madrigal-Weiss asked Riann Kopchak to share recent staff changes.

Riann Kopchak, Chief, Community Engagement and Grants, introduced Danielle Fischer, Assistant Chief, Community Engagement and Grants, and welcomed her to the Commission.

On behalf of the Commission, Chair Madrigal-Weiss welcomed Danielle Fischer to the Commission.

Legislation

The Legislature considered all legislation with a fiscal impact last week. Four bills the Commission supports passed the review and will continue their way through the process:

- Assembly Bill (AB) 2161 on early psychosis intervention.
- AB 2352 on psychiatric advance directives.
- AB 2711 on a public health approach to suspensions in schools.
- Senate Bill (SB) 1318 related to youth crisis responses in schools.
- Although AB 2411 and SB 1472 did not pass the review, the Commission looks forward to pursuing these important issues in future years.

Committee Meetings

The Commission's Client and Family Leadership Committee (CFLC) and Cultural and Linguistic Competency Committee (CLCC) held their first meeting of the year earlier this month. Under the leadership of Commissioner Chambers and Commission Vice Chair Alvarez, Committees have an enhanced role of supporting implementation of the Commission's strategic goals and objectives.

Chair Madrigal-Weiss asked the chairs of the Committees to provide updates on the meeting.

Vice Chair Alvarez, Chair of the CLCC, stated the CFLC and CLCC met jointly on May 8th to discuss the strategic plan and the work the Committees can undertake in support of the Commission and in support of the state's modernization process under the implementation of Proposition 1, Behavioral Health Transformation. She stated the Commission has acknowledged the importance of leveraging the expertise and

experience of Committee members; this meeting helped begin that process, particularly under the direction of the new strategic plan.

Vice Chair Alvarez stated, although Committee members' commitment to the work continues, there are vacancies in the Committees due to shifting job responsibilities. More than half of the members indicated that they plan to stay on the Committees through the end of their term in June of 2025.

Vice Chair Alvarez stated the joint meeting was a powerful indicator of the intersection of many challenges between clients and family members and marginalized communities, recognizing that these are the same communities the Commission is advocating on behalf of. She stated a second joint meeting is being explored for the future, but it is expected that the CFLC and CLCC will meet separately in the future with the CLCC focusing on how the strategic plan addresses the needs of marginalized and underserved communities.

Commissioner Chambers, Chair of the CFLC, acknowledged the synergy between the Committees and the intersection between culture, families, and consumers. She stated she looks forward to additional joint Committee meetings in the future.

Commissioner Chambers stated Deputy Director Norma Pate provided an overview of the strategic plan, followed by a robust conversation about how to engage individuals on the ground. She stated Committee members and the public discussed the importance of reaching individuals who have not been reached, elevating the diverse perspectives of communities, and utilizing traditional matrixes while transforming the system in ways to better capture community voice and the work on the ground. Meeting participants also discussed the importance of community engagement, how it should be defined, how to incentivize the work already being done, and how the Commission can identify impacts achieved and the small wins in communities.

Vice Chair Alvarez stated the conversation challenged how to measure progress and accountability. The Committees are planning to meet every two months. The next CLCC meeting will be held on June 12th and the next CFLC meeting will tentatively be held on July 17th. She thanked Committee members for their continued commitment and thanked Commissioner Rowlett for his participation in the May 8th Joint Committee meeting. She stated she looks forward to continuing the conversation.

Chair Madrigal-Weiss thanked Vice Chair Alvarez and Commissioner Chambers for their leadership and commitment to this work.

Art With Impact Event

Since 2012, the Commission has supported Art With Impact's mission of promoting mental wellness by creating space for young people to learn and connect on mental health themes through art and media. In addition to their arts-based workshops for college students, Art With Impact has built the largest and most diverse collection of mental health-themed short films in the world through their annual film production grant program which funds 10 filmmakers each year to create short films on underrepresented mental health narratives. Space is still available for Commissioners to attend this year's premiere film festival, Voices With Impact, online and in person at the San Francisco LGBT Center on June 6th at 6:30 pm.

MHSOAC Podcast

Based on feedback from community engagement with transition age youth (TAY), the Commission will pursue the development of a Podcast. The accessibility of this new communications channel represents another opportunity for the Commission to put its work in front of a targeted audience in a digestible format. The focus will be on highlighting the Commission's portfolio, mental health research, and policy work, animated by testimonials from experts, consumers with lived experience, and other internal and external partners, including Commissioners. This new communication channel will support the Commission's strategic plan goals of elevating the perspective of diverse communities, disseminating learnings from innovation and best practices, and growing public interest and awareness in the Commission's mission.

3: General Public Comment

Hector Ramirez, consumer and advocate, stated the need for trauma-informed practices and culturally-responsive language. They spoke as a person with a psychiatric disability, and noted that the language used is important so it does not further traumatize and stigmatize people, particularly young people. It is important that young people do not come away from meetings feeling worse about themselves having been described as mentally ill. The speaker encouraged the Commission to be conscious about the way it interacts with the community so it does not further traumatize and harm the individuals coming to the Commission for help.

Hector Ramirez suggested that, when evaluating county innovation proposals, the Commission look closely at how accessibility has been implemented and the way that the community has an opportunity to interact with counties to develop county plans. The speaker stated disappointment that Los Angeles County failed to provide the needed and requested disability accommodations for individuals to access meetings and materials in the necessary and requested disability format. The speaker asked the Commission to develop metrics and procedures that focus on accountability.

Hector Ramirez noted that the current Los Angeles County two-year Mental Health Services Act (MHSA) recommendation that the Department of Mental Health and the Commission represented to the board of supervisors is inaccessible to the disability community, so the community has been unable to review or evaluate the plan. This is unacceptable. The speaker noted that it is not in compliance with county, state, and federal regulations requiring accessibility to county and state process. There are new disability laws at the state level because of these issues. The speaker encouraged the Commission to become aware of and align with these new statutes.

Hector Ramirez stated they were glad to see Jonathan Sherin, M.D., Ph.D., former Director of the Los Angeles County Department of Mental Health, in attendance. They noted that the accessibility work that Dr. Sherin advanced during his time with Los Angeles County has been sabotaged by current staff. This is a significant concern, particularly during the current transformational change in behavioral health. The speaker stated the need to ensure that the same mistakes in the system do not continue to perpetuate and harm communities.

Vanessa Ramos, Advisor, Investigations Unit, Disability Rights California, and Member of the CFLC, stated they recently traveled throughout the state hosting community conversations. The speaker requested that the Commission spend time in the Bay Area meeting with individuals connected to the Center for Empowering Refugees and Immigrants (CERI) and the Korean Community Center of the East Bay (KCCEB). These organizations have large older adult populations who have concerns, due to funding changes brought on by the current transformational change in behavioral health, that programs like CERI will be cut. The speaker volunteered to work with the Commission on strategizing how to reach populations that are forgotten.

Vanessa Ramos suggested that the Commission review the procurement process at the county level. County mental health systems often have limitations that do not allow them to provide services in the way that the community best receives them. One of the reasons counties do not contract services out is the stringent procurement process. The speaker asked that the Commission create a subgroup to focus on the procurement process to ensure that peer-run organizations that are truly peer-run delivering authentic peer services are not limited in access to county contracts.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), echoed the comments of the previous speaker. She stated she had a delightful meet-and-greet with Jigna Shah, Chief, Innovation and Program Operations. Ms. Shah is a wonderful addition to Commission staff.

Stacie Hiramoto suggested that the Commission form an Innovations Committee to advise and help with the Commission's increased responsibility outlined in Proposition 1. She noted that the second-best opportunity to get Community-Defined Evidence Practices (CDEPs) funded, after the prevention component being handled by the California Department of Public Health (CDPH), is through innovation funding that the Commission will be in charge of.

Stacie Hiramoto stated the Governor's May Revise budget included cuts to the Children and Youth Behavioral Health Initiative (CYBHI). The components that were cut are the ones that fund CDEPs and serve LGBTQ and Black, Indigenous, and people of color (BIPOC) communities.

4: <u>April 25, 2024, Meeting Minutes</u>

Chair Madrigal-Weiss stated the Commission will consider approval of the minutes from the April 25, 2024, Commission meeting. She stated meeting minutes and recordings are posted on the Commission's website.

Commissioner Brown referred to the last paragraph on page two and asked to change "staff-to-client ratio" to "client-to-staff ratio."

Public Comment

There was no public comment.

<u>Action</u>: Chair Madrigal-Weiss asked for a motion to approve the minutes. Commissioner Brown made a motion, seconded by Commissioner Carnevale, that:

- *The Commission approves the April 25, 2024, Meeting Minutes, as modified.*

Motion passed 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Brown, Bunch, Carnevale, Chambers, Danovitch, Gordon, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioner abstained: Commissioner Mitchell.

5: Transformational Change in Behavioral Health: Full-Service Partnerships Panel

Chair Madrigal-Weiss stated the Commission will focus on transformational change in behavioral health with a panel on Full-Service Partnerships (FSPs). The Commission heard a presentation in April of last year about the history and promise of FSPs and heard an overview of efforts to establish best practices for the model. The goal of this agenda item is to continue the conversation around the Commission’s efforts to drive improvements in FSP service delivery, opportunities that Behavioral Health Transformation establishes for FSPs, and how the Commission can be a collaborative partner for FSPs. She introduced the members of the panel and asked them to give their presentations.

Emily Melnick

Emily Melnick, Director, Third Sector Capital Partners, Inc. (Third Sector), stated Third Sector recently completed a 10-month community engagement project to learn more about how to support FSPs across California. She provided an overview, with a slide presentation, of the project background, methodology, demographics, key findings, and recommended next steps for better supporting FSPs.

- Third Sector recommendations on FSP service delivery are to provide increased guidance on a common set of FSP service requirements and to support communities to increase availability and access to lower-tier supports.
- Third Sector recommendations on disparities and equity are to support FSPs to build partnerships with local cultural and community organizations, to support FSP providers to address challenges with data entry systems, and to provide guidance and resources to improve Americans with Disabilities Act (ADA) compliance.
- Third Sector recommendations on data and outcomes are to streamline data collection and usage for FSPs and align on five common outcomes to track.
- Third Sector recommendations on funding and statewide changes are to provide support and guidance to counties as they navigate funding and billing changes and help counties understand and adapt to statewide changes.

Ms. Melnick stated counties are open to capacity-building assistance. She suggested creating spaces for cross-county peer learning. She stated the need to ensure that technical assistance from the Commission is concrete and specific with actionable tools or guidelines. She suggested pacing technical assistance with sensitivity to counties’ limited capacities so they can meaningfully engage.

Ms. Melnick stated the Commission and Third Sector are currently planning additional community engagement in 2024-25 to collect and share best practices in FSP service delivery.

Tyler Sadwith

Tyler Sadwith, State Medicaid Director, Department of Health Care Services (DHCS), provided an overview, with a slide presentation, of the Behavioral Health Transformation goals, current and future states of FSPs, key opportunities for the Commission, and next steps. He stated FSP improvement opportunities are to standardize FSP practices across the state, overcome data collection challenges, and provide step-down options out of FSPs.

Mr. Sadwith reviewed the Behavioral Health Transformation FSP goals to build upon the success of proven FSP interventions; standardize and scale evidence-based service models; improve financial, performance, and outcomes data collection; and maximize resources for behavioral health care and services. He stated FSPs will evolve under Behavioral Health Transformation by standardizing evidence-based practices, including substance use disorder (SUD) treatment, and using CDEPs.

Mr. Sadwith stated the core focus of lifting, standardizing, and scaling evidence-based service models that are known to fundamentally work for individuals is not limited to Behavioral Health Transformation or FSPs but is strategically aligned in other ongoing initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) 1115 Waiver Demonstration.

Mr. Sadwith stated the DHCS submitted a Section 1115 Waiver to the Centers for Medicare and Medicaid Services (CMS) last October that is expected to be approved by the end of this year to do transformations that would expand the continuum of outpatient behavioral health care across the state, including a number of evidence-based service models that are also explicitly called out in Behavioral Health Transformation. By establishing coverage for these evidence-based service models, counties can opt in to cover those services, the majority of which will be reimbursed by federal funding.

Mr. Sadwith stated BH-CONNECT and Behavioral Health Transformation are strategically interwoven to ensure there are Centers of Excellence that will be available for these evidence-based service models to provide free training and fidelity monitoring to counties and providers.

Mr. Sadwith stated key opportunities for the Commission with FSPs are to map out and design what FSPs look like within the continuum of care levels and standards, research and evaluate key submissions to promote transformational change for FSPs, provide real-time technical assistance and training to support learning and diffusion within FSPs and more broadly, and leverage the annual $20 million innovation funding to drive FSPs.

Mr. Sadwith stated the DHCS will consult with the Commission on developing a biennial list of early intervention evidence-based practices, building FSP levels of care, developing statewide outcome metrics, and determining statewide behavioral health goals and outcome measures. He stated the DHCS will continue its community engagement process to inform the design of the bond funding opportunity for behavioral

health facility expansion and policy development under Behavioral Health Transformation.

Mr. Sadwith stated a phased rollout of draft policy guidance for Three-Year County Integrated Plans for Behavioral Health Services and Outcomes will begin in early 2025 to guide how the Behavioral Health Services Act (BHSA) strategies are developed locally. He stated the DHCS will be seeking input and feedback on many upcoming materials.

Richard Johnson

Richard Johnson, CEO, Healthy Brains Global Initiative (HBGI), stated the Commission contracted with HBGI to review FSPs and make recommendations for how to increase the impact of these programs for the state's most vulnerable populations by drawing upon HBGI's global experience reengineering government contracting, research, and engagement with behavioral health leadership in six counties, who provided feedback on the draft report. The final version of the report *Towards a New Contracting Model For Full-Service Partnerships*, which focused on adult FSPs, was published in December 2023.

Mr. Johnson provided an overview, with a slide presentation, of the findings from HBGI's consultations with state and county partners, including how county and state partners define and measure success, use data to track and report FSP performance, currently base their contracts for service delivery, and currently execute contract and service management. He stated the success of a program depends on the ability to build it around the individual who is receiving or accessing that service, and the ability to ensure that that individual's progress towards outcomes addresses the needs that are meaningful and relevant to them.

Mr. Johnson stated observations in the Report include the following:

- FSPs are highly professional and operated by hugely dedicated staff who save lives each year.
- FSPs are running at approximately 70 percent capacity in large part because of staffing morale issues and because there is a lack of drive, incentive, and systems to maximize performance.
- FSPs are often inaccessible to new clients because program graduation is not emphasized as one of the keys to promoting and supporting an ongoing recovery journey for clients.
- Reports on annual impact focus on population level metrics that largely ignore individual outcomes, particularly in relation to clients establishing healthy relationships ('people') and community participation ('purpose').
- The current system is focused on 'billing' as its performance focus, not outcomes.
- With limited performance reporting/management, it is difficult to determine which organizations are providing the best care and achieving the best outcomes (there is weak accountability).

- Previous attempts at outcomes-focused contracts have been largely unsuccessful.

Mr. Johnson stated the Report makes three key recommendations: implement new performance-based pilot programs, develop new performance management practices, and build market capacity. The Report also describes three possible pilot programs: a new purpose-led outcomes contract, an FSP follow-on program, and two new place-based outcomes contracts. He stated, if more meaningful services are delivered for more individuals and they bring more individuals to achieve outcomes that are relevant to them, the billing will look after itself.

Jonathan Sherin

Jonathan Sherin, M.D., Ph.D., Chief Medical Officer, HBGI, and former Director of the Los Angeles Department of Mental Health, stated some of the things that clearly must happen to help lift up individual clients and families in FSPs did not happen because certain things were not billable. He stated billability cannot drive the system; outcomes and human beings must drive the system. One of the things that is problematic and heard across the board is data, data collection, analysis of data – the systems are disparate and fragmented. This is a problem politically, financially, and in terms of tracking. He stated data cannot continue to be collected without being shareable between counties and providers. The state has not clearly identified how data should be centralized or who should be responsible for it. This is an area for significant investment.

Dr. Sherin stated the California Mental Health Services Authority (CalMHSA) is in the process of developing a shared electronic medical record and is doing billing. He stated, as Director of the Los Angeles Department of Mental Health, he learned that frontline providers spent most of their time doing paperwork, taking care of medical charts, and billing. This not only takes time, but it also takes energy and motivation; it is demoralizing as a frontline provider to spend so much time dealing with administrative tasks over clinical and human service-oriented tasks. He stated the need for the state to develop a hub, a repository that will collect information that can inform on current issues while taking the burden of off frontline providers in terms of billing.

Dr. Sherin stated one of the things about outcomes that is fundamental is the outcome for the individual. Top-down solutions never work. He stated grass roots must inform and drive the grass tops; the same is true for individuals getting care. A framework and system need to be provided, such as the People, Place, and Purpose Framework, that will allow providers to understand what that means for each person getting care. This needs to be a benchmark in FSP Programs. FSPs that are performance-based and highlight the voice of consumers is the most important data piece that must be incorporated.

Dr. Sherin stated, in order to become accountable to outcomes, the Commission needs to look at what is incentivizing the work. Shifting billing to outcomes, not paying for services that qualify, will reform the system from the ground up. This requires cultural transformation that moves from billability to accountability for achieving outcomes. Paying for outcomes is the ultimate solution to drive reform and get workers in the

trenches to do what is important, not what they can get paid for. He stated the need to empower the front lines to do the work.

Susan Holt

Susan Holt, Director, Fresno County Department of Behavioral Health, stated the county mission and goals emphasize quality of care because it is a primary driver that is embedded in the county's 11 guiding principles. She stated FSPs are often the highest level of outpatient care in communities. She provided an overview, with a slide presentation, of FSPs in Fresno County, partnering with the Third Sector project, standardization and step-downs, monitoring FSP level of care and contracts, and data opportunities for the future.

Ms. Holt stated standardization works best when grounded in clinical research through the lens of equity to address health disparities. She agreed with incentivizing quality of care and a well-trained workforce to stay within the public sector, while ensuring appropriate monitoring, controls, and fiscal sustainability. She stated the need for a sufficient housing inventory with an adequate array of housing options for individuals with numerous, complex needs.

Ms. Holt stated individuals should not lose their housing because they get better. She stated the need to disentangle funding for housing from FSP services and for rates to be sufficient to support intensive engagement activities.

Ms. Holt noted that the analysis of outcomes is greater than just looking within the FSP program; it is necessary to also determine how additional services that individuals participate in complement and advance their recovery, including services rooted in culture. Effective outreach and engagement are critical for a person who needs an FSP level of care.

Ms. Holt stated counties and providers are delivering meaningful services and demonstrating unrelenting dedication to the persons served. Fresno County remains committed to continuing to advance improvements and looks for opportunities to be included and engaged in the conversation on how to set standards and measurements across California.

Commissioner Comments & Questions

Commissioner Brown referred to Mr. Sadwith's Strategic Alignment slide and asked if Medication-Assisted Treatment (MAT) will be included in the BH-CONNECT, Behavioral Health Transformation, or CYBHI initiatives.

Mr. Sadwith stated he had a separate slide on MAT but removed it in the interest of time. He stated the Department and the Administration are using every lever available to increase access to medications for addiction treatment.

Commissioner Bunch asked when counties will begin to be trained on evidence-based practices.

Mr. Sadwith stated the Department will put out a Request for Information (RFI) soon around the Centers of Excellence platform. The Centers of Excellence are designed to be organizations that have experience with providing training on evidence-based practices that are called out in the BHSA and in BH-CONNECT. The Department will

fund the Centers of Excellence. He stated it is important that the Centers of Excellence are offering training in a way that reflects not only the standard model of care but also local experience of counties that have done this and have developed tailored approaches to ensure that diverse communities are successfully engaged and welcomed into care.

Commissioner Chambers stated her assumption that Behavioral Health Transformation will leverage existing dollars to draw down federal dollars. She asked how that aligns with the proposed pilot program that focuses on incentives and how that would fit into the model based on what can be billed and not on outcomes that was discussed in the presentation.

Mr. Sadwith stated Behavioral Health Transformation does not require everything that is funded by the BHSA to be billed to Medi-Cal. The goal in the statute is that, if there is a service that a county is delivering using BHSA funding, then that service could be billed to that person's health plan. He stated the idea is to leverage all funding sources so that the MHSA is not the backbone holding up the world of mental health – commercial health care plans, Medi-Cal Managed Care, and the federal government for Medi-Cal should pay their fair share.

Mr. Sadwith stated pay-for-performance initiatives, such as the California Advancing and Innovating Medi-Cal (CalAIM) Behavioral Health Payment Reform Initiative, intersect with Behavioral Health Transformation. Providers are now able to receive a reimbursement with the Fee-for-Service Model. CalAIM Behavioral Health Payment Reform provides the authority necessary for counties to develop value-based payment models.

Commissioner Bunch asked how that would work when the programs will be required to use evidence-based practices. She asked how the Fee-for-Service Model will be used as well as using a specific form of treatment that does not appear to be outcomes-based.

Mr. Sadwith stated it can be both. A provider can deliver one of the service models and be paid not just for delivering the service but based on outcomes.

Commissioner Chambers asked how commercial health care plans are being held accountable.

Dr. Sherin stated parity laws have existed since they were passed as federal law in 2008, but there has been no ability to hold private insurers accountable and they are using a lot of public money to deliver care. This is unconscionable. He agreed with Mr. Johnson in that, if the quantity and quality of the work is going up and achieving outcomes, the billing will take care of itself. It is important not to lose sight of the fact that the MHSA keeps things together. It is special funding and must be used to do those things that are required for cohesion.

Mr. Johnson stated there is a clear observation that within this service there is currently a deep level of inefficiency because time is not maximized in focusing on the needs of individuals in the program and progressing those needs. Instead, much time is spent on administration, paperwork, and billing, but this concept needs to be proved. A two-year pilot that demonstrates success in focusing on outcomes that are meaningful for

individuals as opposed to focusing on billing will change the system. He stated doubling the face-to-face time with individuals and being 10 times more responsive will increase billability, but it must be proved.

Commissioner Chambers stated it is encouraging that the Centers of Excellence will support the existing workforce and providers. She asked if current providers will test the new models or if new providers will be brought in as part of the procurement process to test models for program improvement. She stated the provider pool needs to be widened.

Mr. Johnson stated this conversation has been ongoing for the past year or more. He acknowledged that procurement is a barrier. Individuals are reluctant to engage in this because it will require engaging in a 6- to 12-month process of a lot of work. The concept needs to be proven, but an easier procurement process needs to be developed. He stated part of challenging the culture to shift services from process to product must include bringing in individuals and organizations that think and do things differently.

Commissioner Danovitch asked the panel to prioritize one or two things that the Commission can do to help them fulfil some of what they are proposing.

Mr. Sadwith responded to Commissioner Danovitch's question to the panel. He suggested that the Commission help the Administration and that everyone collectively determine what the continuum of care looks like in FSPs, the standards, and the intensive levels of care. The statute directs that FSPs shall include certain specified evidence-based service models, CDEPs, and other behavioral health services. It also directs that there should be levels of care for individuals to step down. He noted that Ms. Holt demonstrated in her presentation how Fresno County has already done this and stated this is a blank-slate opportunity. He stated it would be helpful for the state of California to have an informed discussion about what the levels of FSPs and step-downs look like based on what is known to work today in communities, in counties, and in research.

Ms. Melnick responded to Commissioner Danovitch's question to the panel. She stated Third Sector also asks the Commission to help build out the different levels of care. She agreed with Dr. Sherin that the Commission is a conduit between different programs in the state. She asked the Commission to help build out Third Sector's accounting of who is doing this work, what they are doing, and how linkages can be built between different providers and staff members across the state to begin having conversations about best practices.

Dr. Sherin responded to Commissioner Danovitch's question to the panel. He stated there are opportunities for innovation money that is still in place – not just for money that has not been committed, but for money that has not been spent that can pivot towards FSPs, which is the fundamental fabric of community mental health. He suggested that the Commission approve innovation programs that focus on using innovation funding that allow for incentive for payment for achieving outcomes for individuals.

Mr. Johnson responded to Commissioner Danovitch's question to the panel. He stated one of the challenges with FSPs is defining measurable standardized outcomes

because individual outcomes are completely different. He suggested that the Commission talk to individuals on FSPs to create a list of a dozen potential outcomes for people, a dozen for place, and a dozen for purpose, and then use those to pay the service provider for achieving the outcomes that the individual on the program selects from a drop-down menu.

Mr. Johnson suggested that the Commission run the proof-of-concept idea to see what happens when people and their potential are focused on to see what billing follows. He suggested asking counties to opt in to this and the Commission to develop a facilitated process to enable them to do that easily.

Mr. Johnson suggested thinking about transparency across the system. Questions must be answered about who is doing it well and who is doing it badly so they can be learned from.

Ms. Holt stated, in the interest of time, she can send her response to Commissioner Danovitch's question to the panel to staff.

Commissioner Danovitch asked what the state is doing to facilitate developing greater substance use specialization within FSPs and what the Commission can do to accelerate the process or to ensure that it becomes a reality.

Mr. Sadwith stated this is even more of a blank-slate opportunity with more potential for innovation. SB 326 mandates that FSPs shall include assertive field-based initiation for SUD treatment including medications for addiction treatment. This language reveals the fact that there is no defined model or standards for SUD like there is for Assertive Community Treatment (ACT).

Mr. Sadwith stated, in Medi-Cal, the DHCS has issued guidance on street medicine and medications for addiction treatment being billable at any site in the community. It is removing barriers and providing tools for providers and counties to cover and deliver SUD treatment wherever individuals are, but the questions are what that looks like as a service model, how to identify best practices in improving outcomes and engaging individuals, and what the training and qualifications look like to connect individuals to clinics and the California Bridge to Treatment (CA Bridge) Program. This is a massive opportunity. He stated the DHCS will be looking to the Commission, counties, and providers that are doing this today to help define those service models for assertive SUD treatment.

Commissioner Brown asked about workforce challenges. He stated he sees parallels with law enforcement workforce challenges in terms of hiring and keeping the right individuals on the job. He stated he sees many individuals going into the field as a second or third career. They want to work in the field but not necessarily to work 24 hour/7 days per week kinds of shifts, around the clock, in encampments or in neighborhoods that are not like theirs, and other challenges. They would prefer to work in telehealth over in-person health care.

Commissioner Brown asked if the members of the panel are seeing the same things. He stated law enforcement is trying to rethink where individuals are being recruited from. Traditional candidate pools are no longer as successful as they used to be, particularly for custody staff. He stated law enforcement is looking at branching out to students who

are studying subjects other than criminal justice and to different fields like education and counseling. He asked how to increase the recruiting pool to attract the right kinds of individuals. He asked, once individuals are hired, how to keep them in their role and how to help them avoid compassion fatigue and burnout.

Ms. Melnick responded to Commissioner Brown's question to the panel. She stated the permanent supportive housing workforce experiences similar issues. One of the things seen in the field is balancing the fact that FSP services are best provided in person in the field with other aspects of FSP jobs that do not need to happen in person. She suggested thinking innovatively about shifts or work arrangements where, for a certain number of days, staff is in the field but Fridays are when staff works on paperwork at home, or staff works a certain amount of time mainly with more high-acuity or high-stress cases or situations and another period of time working in less stressful situations to balance their compassion load and have time for self-recovery.

Ms. Melnick stated Third Sector recommends further exploring leveraging peers in extensive ways by looking at a workforce made up of individuals who have graduated from FSP programs or participated in other parts of the behavioral health ecosystem as potential partners, and working across the allied health professions, particularly social work schools, looking at internships and pipeline programs, and considering ways to incentivize participating in FSP.

Mr. Johnson responded to Commissioner Brown's question to the panel. He emphasized that it is not the same everywhere. Many assumptions are being made about the reasons for workforce issues. He provided the example of two service providers in a town, where one seems unable to recruit workers while the other has no problem with recruitment. He stated the need to learn what is happening in those instances.

Mr. Johnson stated the more a high-fidelity model is moved toward, the more this will become a problem because the service provider is now required to deliver a particular model with a particular sort of person with a particular set of qualifications. Their hands are being tied. He stated, with all the things Commissioner Brown described that law enforcement is trying, the service providers need to be liberated to try those things, to innovate, to bring in different people, and to use different delivery models. He stated the only way to do that is to shift from heavily-prescribed inputs, which the payments are attached to, to outcomes and enabling and freeing providers to focus on the needs of the individual so together they can figure out a service that best fits.

Mr. Johnson stated the need to take the billing job away from providers. Providers did not join the service to tick boxes and submit claims to Medi-Cal.

Dr. Sherin responded to Commissioner Brown's question to the panel. He agreed that medical billing is difficult to understand. There is important, consistent messaging here – the workforce needs to be reconsidered. Half of the problem in this space is initial and ongoing engagement; it is not about clinical degrees. In many ways, it is about lived experience, shared understanding, respect, and sensibility. The workforce needs to be reconsidered.

Dr. Sherin stated, if providers are being paid for outcomes and they are liberated to do the work that they came to do, they will stay.

Ms. Holt responded to Commissioner Brown's question to the panel. She agreed with comments made about workforce. She stated Fresno County was in a workforce shortage long before workforce shortages were being discussed statewide. Counties in the Central Valley share the struggles that Fresno County does. It is important to think about retention of the workforce in similar ways as the FSP programs – connection to meaning and purpose. This is not only good for the individuals being served, it is good for team members.

Ms. Holt stated, although clinicians, doctors, and nurses are focused on, there are passionate administrative staff who are also burned out. These individuals also have expertise that needs to be retained. She stated the system is burning and churning – people need to be connected to purpose. Leaders need to be able to slow down enough to focus on organizational wellbeing, which is different than individual humans having wellness. Organizational wellbeing requires investing in conversations that allow for truth to be lifted up and experiences to be shared openly without the fears and pressures of things such as productivity.

Ms. Holt stated the importance of connecting to purpose and figuring out not just recruitment but retention.

Commissioner Rowlett stated most FSP participants do not understand or appreciate the full utility of their Medi-Cal benefits. He asked what the Commission can do to engage Managed Care Plans around the state in helping improve or highlight this opportunity to enhance FSP.

Mr. Sadwith stated Behavioral Health Transformation not only calls out that Managed Care Plans and commercial plans have an obligation to reimburse and counties are expected to seek that reimbursement and leverage those funding sources, but it also states the process for evolving from a Three-Year MHSA Plan to a Three-Year County Integrated Plan for Behavioral Health Services and Outcomes, where the county not only looks at all sources of behavioral health funding but also takes into account the Managed Care Plan's Population Needs Assessment and the local public health department's Community Health Assessments.

Mr. Sadwith stated the goal is to break down silos and encourage cross-system coordination and alignment so that the Three-Year County Integrated Plan is inclusive of and informed by what the plans are identifying as needs in their assessment and vice versa – Managed Care Plans are required to coordinate their process for their Population Needs Assessment by considering the County's Integrated Three-Year Plan. These are high-level references for how Behavioral Health Transformation brings the Medi-Cal Managed Care Plans into the picture.

Mr. Sadwith stated the CalAIM Enhanced Care Management (ECM) benefit is a powerful tool that is designed to be in-person, high-touch, in the community, meeting people where they are, and delivered by community-based organizations. Many if not most individuals in FSP programs are likely to meet one of the ECM populations of

focus. The benefit includes a lead care manager who is tasked with driving engagement with medical benefits and social services. This is a key opportunity.

Mr. Sadwith suggested that the Commission can help by inviting Medi-Cal Managed Care Plans and plan associations to present at Commission meetings on how they are engaging populations and leveraging ECM as an opportunity to engage with the FSP population. These are conversations the DHCS actively has with plans. The Commission inviting Medi-Cal Managed Care Plan representation into the dialogue can be powerful.

Commissioner Rowlett asked staff to consider inviting Medi-Cal Managed Care Plan representatives to present at a future Commission meeting.

Commissioner Bunch stated many times staff leave their clinical positions not because they decide it is not a good fit, but because they get frustrated with the inability to provide quality care under the constraints of the system. She asked if Third Sector's outcomes considered staff turnover and if there are current metrics that look at positive events.

Ms. Melnick stated some counties are currently integrating positive events in their metrics. Third Sector learned that, while there are bright spots around the state, it is not happening consistently. Some counties include metrics from consumers for increased social connectedness as a positive outcome to focus on. Another metric can be what a positive outcome looks like in someone's lived experience, such as being released from the hospital or jail. Part of the outcomes conversations that Third Sector hopes to have across the state is tracking and framing to understand what positive events and outcomes look like at a human level to experience both affirmatively positive outcomes and lack of negative outcomes.

Commissioner Bunch stated this would need to come from the clients because positive events vary widely per individual. Minute changes make big differences to clients on an individual basis.

Mr. Johnson stated, although the list of 12 potential outcomes for people, place, and purpose informed by individuals in FSP programs has not yet been created, the performance management pilot in Sacramento and Nevada Counties includes a case manager who will ask three questions of each person they work with every month about the quality of their experience in that month and whether they are progressing.

Mr. Johnson stated HBGI is currently going through the process of determining the three questions to be tracked over time, which must be accessible, meaningful to the individual, and asked to all participants every month. Asking these questions also urges the case manager to be engaging in a different sort of conversation. He stated the three questions might be as follows: Has the month been better, worse, or the same? Are you looking forward to your next meeting here? Did you do something new this month? He stated HBGI will also ask service providers three questions to be tracked over time to try to understand their experience, motivation, and morale.

Dr. Sherin stated the Veterans Administration developed the Root Cause Analysis (RCA), which is usually used to figure out what happened in a sentinel event. He

suggested applying the RCA to recovery cases to help learn about the root cause in the recovery process.

Commissioner Mitchell stated appreciation for the panel presentations. She agreed with developing FSPs by measuring outcomes on the individual and the improvement in their life. She stated individuals seek services because they need help. This is a simple concept and yet the system is complex. A system needs to be built with measurements of the outcomes of that system on the purpose and goodness of the individual who is seeking service. Incentivizes for counties and individuals need to be based upon the improvements in that individual's life.

Commissioner Mitchell stated clients have the answers. They know what they need. They just need to be taught how to use the tools that providers are trained to utilize to help them make better choices so they have better outcomes. She stated she would love to see a system that is built on a standardization of measuring the improvement in a person's life. She stated the need not to ignore the experience of the individual in the system and how each person is impacted, acknowledging that each population has a different experience.

Commissioner Mitchell asked if the child welfare system is included in this discussion because many of those individuals end up with behavioral health issues.

Commissioner Carnevale stated, as a business representative, he thinks of this more on a system level. He stated this is like the plumbing in a house that is never considered unless it is broken. He stated the system is broken in so many ways that it makes the "house" unlivable. He noted that all big businesses struggle with this too but business seems to come more naturally to solutions. Management 101 books are all about outcome-based management. Outcome-based management makes better organizations. Organizations that thrive do this and ones that do not go bankrupt. It is as simple as that.

Commissioner Carnevale stated Dr. Sherin stated performance-management systems, a robust data system, and payment and billing innovations are the three steps to transforming a whole system. This discussion is essential. He asked why government does not naturally come to these processes. He asked why do we have to fight so hard to get to them ourselves? Is this truly what will transform the system? How long can it take? How long should it take? How long will it take so we can fix this plumbing issue so we can get focused on the real issues of prevention and early intervention?

Dr. Sherin stated well-intended efforts at the grass tops level have led to a significantly fragmented system of programming, data collection, and funding. Only when focusing on the consumer and how their needs can be attended to and building the system around that will success be seen. Structures are in place that must be dismantled carefully.

Dr. Sherin stated the way to get that alignment straight up from grass roots to grass tops is to determine the outcomes and pay providers for those outcomes, then ask the Administration to facilitate the success of achieving those outcomes. He noted that pushing the system to do more of the same thing is a big mistake. There is a window in time to reverse some of the things that might happen with Proposition 1 and CalAIM

under the same rubric of legal language to drive it from the bottom up, based on taking care of customers and letting them define and drive the system.

Commissioner Gordon stated a lot of finding and keeping employees is based on culture. He stated services for individuals are based on trust and access. Managed Care does not give much hope on either of those. Someone working in the field is looking backwards from the service they are providing and asking if help is on the way in terms of prevention and early intervention. Sacramento has four separate Managed Care Plans, but the clients are randomly distributed among them and there is no plan to reach down particularly into the underserved areas. The problems now just replicate themselves because there is not enough, if anything, going on there.

Commissioner Gordon stated the need for a strategy alongside the strategy to intervene with the people who need the most services. That is something that the Commission is uniquely positioned to try to think through: how to reorganize that service based on data and accomplishment.

Commissioner Gordon stated some of the First 5 Commissions are currently doing that around the state. They have lots of data. He stated there is a problem there but there is great promise in conjunction with amping up the quality of the downstream types of services.

Chair Madrigal-Weiss thanked the panel members for their presentations and sharing their knowledge with the Commission. She stated the Commission looks forward to continuing conversations on this going forward. She stated, for children and youth, considering schools as partners is important.

Chair Madrigal-Weiss agreed with Ms. Holt's candid conversation about leaders in the community needing to be thoughtful about their organizational wellbeing. She stated, if this is not being addressed, no matter what system, measurements, and outcomes put out there, there will not be a workforce that is healthy enough to do the work. She also agreed with Ms. Holt about the need to have workers in the field talking with consumers and family members. She stated human beings do not need a sterile environment; they need workers who are willing to meet them where they are.

Public Comment

Steve Leoni, consumer and advocate, stated they were encouraged by the powerful panel presentations, particularly the HBGI presentations. The speaker stated concern with Proposition 1 around FSPs that could undermine a lot of this. The step-down within the FSPs means stepping down or out of FSPs. San Francisco does a lot of things with step-downs so it is not surprising that the Governor, who was Mayor of San Francisco, is bringing the San Francisco system to the state. Oftentimes, in the city, step-downs mean cheaper beds. The issue is that the support system around an individual keeps shifting.

Steve Leoni stated the law states that the step-down shall be based on acuity. The speaker stated the issue is that the stepping down in Proposition 1 is stepping out of FSPs, which is based on Milestones of Recovery and possibly other instruments. Being based in recovery means determining whether a person has begun to look after themselves, wants to take their medication for their own reasons, and is willing and able

to make connections to keep a support system around themselves. This is not based on acuity, which means that a patient has been stabilized on medication.

Steve Leoni stated once the patient is stabilized, they are moved to a lower environment. The issue is, if the person does not like their medication, they may not take it, which sends the person back to the higher level of care. This has happened before where patients go around and around the levels of care. The speaker stated concern about basing the step-downs on acuity. Whatever the step-down means will be contrary to doing it, as Richard Johnson stated, for individuals' own benefit for what they need and want, which is the cornerstone of the original FSP in the MHSA.

Steve McNally, family member and Member, Orange County Behavioral Health Advisory Board, speaking as an individual, stated, the further the conversation gets from the state of California, the closer it gets to community members and the end user. Recovery is based on willingness to change, trust, honesty, and openness. The speaker stated the panel members are simplifying what is required, which is a culture change. Everyone must come to grips with this because families have been distanced from the system.

Steve McNally stated there are discussions about what is wanted for peers and yet the 3,300 Certified Peer Specialists in the state have not been consulted for feedback. It comes back to accountability and oversight. Even in CalAIM, while the aspirations are incredible, the implementation has not been easy.

Steve McNally stated Executive Director Ewing once made a comment about data to the California Behavioral Health Planning Council (CBHPC) that there is lots of data but there is no appetite to look at it. The speaker suggested using the Open Data Portal to create county-level data. The DHCS has over 600 data sets. These may not be the right data sets but they can be used for comparison.

Steve McNally stated issues in California are chronic; this comes from not listening from the bottom up. The speaker stated focusing on people and relationships one connectivity point at a time is what moves people. This is lost sight of when only considering increasing billing.

Kalene Gilbert, MHSA Coordinator, Los Angeles County Department of Mental Health, stated appreciation for the Commission bringing this conversation to the table. The speaker stated Los Angeles County implemented its incentives program for FSPs in Fiscal Year 2021-22, under Dr. Sherin's leadership for engagement, retention, and outcomes. The speaker stated the county is looking to grow the program but has learned that careful thought must go into the determination of the incentive criteria. The county has learned that it takes time to develop and put in place the dedicated resources needed to ensure that those robust incentive systems allow providers to monitor performance and adjust along the way. The speaker stated incentivization programing is a useful tool particularly as counties move toward the BHSA ACT standards and levels of care.

6: Lunch

The Commission took a short break and returned for a working lunch.

7: Innovation Proposals

Chair Madrigal-Weiss stated this agenda item is on the topic of innovation and how it will change under the BHSA. She reminded everyone that at the April Commission meeting she gave direction to staff to work with Commissioner Rowlett to identify recommendations on how the Commission can support counties in ensuring that innovations that come to the Commission for approval support the spirit of the BHSA and are sustainable, given revised BHSA funding streams.

Chair Madrigal-Weiss asked Commissioner Rowlett to share his recommendations on supporting counties as they transition to the BHSA and utilizing their innovation dollars to plan for behavioral health reform.

Commissioner Rowlett thanked the Chair for charging him with this task. He acknowledged the unique attributes and wonderful skill of the Commission staff. He thanked them for their support and commitment to innovations and the work of the Commission. He shared his recommendations:

- That counties include information on how their project aligns with the BHSA, including sustainability, given the new funding categories for the BHSA.
- That the Commission consider how innovation funding can be used to provide services to individuals who do not meet FSP criteria, such as those through adequate step-down services.
- That specific information be provided to the Commission on how the project will be sustained, given the new funding allocations of the BHSA.

Commissioner Rowlett stated the end of the fiscal year always brings up the topic of reversion, or unencumbered funds. Staff has calculated through estimates from county data that will help the Commission get a snapshot of innovation funds for the end of the fiscal year that are unencumbered. The estimated unencumbered funds should be considered by the Commission as they should be a part of not only a discussion but an ongoing presentation by staff to help the Commission chart what will ensure that innovation accomplishes the most important goals it was designed to accomplish in the beginning and the new goals under Proposition 1.

Commissioner Rowlett stated, out of the four innovation projects being heard today, two are to join previously-approved multi-county learning collaboratives, one is an extension of a previously-approved project, and one is a new proposal. He stated staff has worked with the counties to ensure that BHSA alignment and sustainability have been considered. This work includes meetings and feedback on all areas of the proposals, including areas of need within the county community engagement and areas of learning through this innovation proposal.

Commissioner Rowlett stated, based on his discussions with staff and his review of the four innovation projects, he recommended approval of these projects. He stated, as the Commission begins to think about the BHSA going forward, he urged Commissioners to hone in on those key questions that Commissioners should always ask about any innovation proposal being presented to the Commission for approval.

Chair Madrigal-Weiss stated the Commission will hear brief presentations from counties on their innovation proposals and will learn more about sustainability and how these proposals align with the BHSA and county-level planning for the BHSA. She introduced the county representatives and asked them to present their innovation plans.

Ventura County

Tara Niendam, Ph.D., Executive Director, UC Davis Early Psychosis Programs and the California Early Psychosis Intervention (EPI-CAL) Project, stated Ventura County is interested in joining the Early Psychosis Learning Health Care Network Collaborative. She provided an overview, with a slide presentation, of the purpose, data collection, and evaluation of the Early Psychosis Learning Health Care Network Collaborative.

Julie Glantz, Senior Manager, Ventura County, continued the slide presentation and discussed how Ventura County's Power over Psychosis (VCPOP) Program will expand and join the learning collaborative project with the goals of increasing the number of clients to be served countywide, increasing the number of staff positions, and lowering the age eligibility to 12. She stated Ventura County plans to gather service-user-level outcomes to incorporate into direct care and program-level decision making.

Fresno County

Ahmad Bahrami, Equity Services Manager, Fresno County Department of Behavioral Health, stated the county is asking for a two-year extension of the CRDP Evolutions Project to explore a model for sustainable CDEPs. He provided an overview, with a slide presentation, of the changes with the BHSA, extension plan, BHSA alignment, and budget of the CRDP Evolutions Extension Plan. He stated the extension will allow adding experienced technical assistance via Third Sector specifically on options for funding and billable services.

Mendocino County

Rena Ford, Staff Services Administrator, Mendocino County, stated the county is home to ten federally-recognized Native American tribes often in geographically isolated regions. She noted that drive times around the county can exceed two hours for one direction. She provided an overview, with a slide presentation, of the underserved Native American population, high suicide rates among Native communities, historic trauma, ongoing barriers within isolated Native communities, stigma, reasons Native communities tend not to utilize crisis services, alignment with the BHSA, and sustainability of the Mendocino Native American Peer Crisis Line Collaboration.

Shasta and Fresno Counties

Kiran Sahota, Contractor, Concepts Forward Consulting, the Project Director for the multi-county project, provided an overview, with a slide presentation, of the Digital Psychiatric Advanced Directives (PADs) Project phase one goals, digital categories, phase two, alignment with the MHSOAC and Proposition 1, and sustainability.

Mr. Bahrami continued the slide presentation and discussed Fresno County's involvement with the Multi-County Digital PADs Project.

Ashley Saechao, Community Development Coordinator, Shasta County, continued the slide presentation and discussed Shasta County's involvement with the Multi-County Digital PADs Project.

Commissioner Comments & Questions

Chair Madrigal-Weiss stated new research came out last year that associates chronic absenteeism with a 20 percent increase in suicidal ideation. She encouraged schools to increase engagement for absenteeism. She asked about the age of use for the warmline.

Ms. Ford stated the warmline is for anyone who can call.

Vice Chair Alvarez stated appreciation for the perspectives of the counties on their proposals and how they will be impacted by Proposition 1 and sharing some of their analyses, expectations, and speculations about what is to come. She stated appreciation to staff and the Commission for standing as a partner to the Department around implementation. She extended her gratitude for the counties, partners, and the team for putting in the work to think through what will happen to programs that support county population-specific needs as Proposition 1 moves forward and how to be good stewards of the resources while being responsive to community need. She stated she looks forward to being a partner to the Department to assess implementation. She noted that this is part of the work that Stephanie Welch talked about for the Commission.

Public Comment

Stacie Hiramoto stated she is also representing some of the community partners of the CRDP. She spoke in support of the Fresno County innovation extension proposal that would allow community-defined practices that have solid research evidence behind them to continue.

Marie Marks, Supervisor of Peer Support Specialists, Shasta County, read a comment from John Burgan (phonetic), Certified Medi-Cal Peer Support Specialist, who was unable to be in attendance. John Burgan wrote about the importance of a PAD for himself and the individuals he supports. He stated he values the idea of having an instrument that can speak on his behalf if he finds himself in a situation where he is unable to advocate for himself due to a mental health crisis or devastating incident. He ended his written comment with "my plan, my voice."

Commissioner Discussion

Action: Chair Madrigal-Weiss asked for a motion to approve Ventura County's Early Psychosis Learning Health Care Network Collaborative Innovation Project. Commissioner Rowlett made a motion, seconded by Commissioner Bunch, that:

- *The Commission approves Ventura County's Early Psychosis Learning Health Care Network Collaborative Innovation Project for up to $10,137,474.63.*

Motion passed 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Brown, Bunch, Carnevale, Chambers, Gordon, Mitchell, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

Action: Chair Madrigal-Weiss asked for a motion to approve Fresno County’s Extension of the California Reducing Disparities Innovation Project. Commissioner Gordon made a motion, seconded by Commissioner Rowlett, that:

- *The Commission approves Fresno County’s Extension of the California Reducing Disparities Innovation Project for up to $2,953,244.*

Motion passed 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Brown, Bunch, Carnevale, Chambers, Gordon, Mitchell, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

Action: Chair Madrigal-Weiss asked for a motion to approve Mendocino County’s Native American Crisis Line Innovation Project. Chair Madrigal-Weiss made a motion, seconded by Commissioner Brown, that:

- *The Commission approves Mendocino County’s Native American Crisis Line Innovation Project for up to $1,001,395.*

Motion passed 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Brown, Bunch, Carnevale, Chambers, Gordon, Mitchell, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

Action: Chair Madrigal-Weiss asked for a motion to approve Fresno County’s participation in the Psychiatric Advance Directive Collaborative Innovation Project. Commissioner Gordon made a motion, seconded by Commissioner Carnevale, that:

- *The Commission approves Fresno County’s participation in the Psychiatric Advance Directive Collaborative Innovation Project for up to $5,915,000.*

Motion passed 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Brown, Bunch, Carnevale, Gordon, Mitchell, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioners abstained: Commissioner Chambers.

Action: Chair Madrigal-Weiss asked for a motion to approve Shasta County’s participation in the Psychiatric Advance Directive Collaborative Innovation Project. Commissioner Rowlett made a motion, seconded by Commissioner Gordon, that:

- *The Commission approves Shasta County's participation in the Psychiatric Advance Directive Collaborative Innovation Project for up to $1,000,000.*

Motion passed 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Brown, Bunch, Carnevale, Gordon, Mitchell, and Rowlett, Vice Chair Alvarez, and Chair Madrigal-Weiss.

The following Commissioners abstained: Commissioner Chambers.

8: <u>May Revise Budget Update</u>

Chair Madrigal-Weiss stated the Commission will hear an update on the state budget and Governor's May Revise budget proposal. She asked staff to present this agenda item.

Norma Pate, Deputy Director of Administration and Performance Management, provided an overview, with a slide presentation, of the May Revise adjustments for Fiscal Year 2024-25 and the Commission's May Revise budget. She reviewed a side-by-side chart of the Governor's proposed budget and the May Revision for Fiscal Year 2024-25, which was included in the meeting materials. She stated the May Revision to the Governor's proposed budget includes several significant changes and updates related to behavioral health services:

- A reduction of $854.6 million will be made to health workforce initiatives over the next several years.
- An elimination of $189.4 million of the Mental Health Services Fund for programs proposed to be delayed until 2025-26.
- Reductions of $72.3 million in 2023-24 and $353.7 million over following years for the Children and Youth Behavioral Health Initiative (CYBHI).
    - These reductions do not impact grants the Commission is working on in collaboration with the DHCS.
    - The reduction for the evidence-based and community-defined grants will be for Round 6 that have not yet been awarded.
- An elimination of $450.7 million for the last round, while maintaining a $30 million one-time General Fund allocation for the Behavioral Health Continuum Infrastructure Program (BHCIP) in 2024-25.
- A reduction of $340 million over multiple years for the Bridge Housing Program, while maintaining $132.5 million General Fund allocation in 2024-25 and $117.5 million, of which $90 million is from the Mental Health Services Fund and $27.5 million is from the General Fund, in 2025-26.

Deputy Director Pate stated revisions to the Commission's budget include three additional staff positions to support Proposition 1 changes to the Commission, $100,000 for the next three years to facilitate the name change from the Mental Health Services Oversight and Accountability Commission to the Behavioral Health Services Oversight and Accountability Commission and legal support, and the Mental Health

Student Services Act (MHSSA) funds that will be transferred to the Mental Health Services Fund, reducing the Commission's budget by $7.6 million.

Deputy Director Pate stated, as a result of these budget changes, the Commission's current competitive bidding process will not be affected and the Commission will continue to award funds from Fiscal Year 2024 onward. The Commission will continue to prioritize mental health services for students and is committed to ensuring that the funds are allocated in the most effective ways possible. She stated the next budget update will be at the July Commission meeting.

Commissioner Comments & Questions

Commissioner Chambers asked about the Commission's three additional staff positions.

Deputy Director Pate stated the new positions will be a Health Program Specialist II, an Associate Government Program Analyst (AGPA) on the program side, and an AGPA to help with legislation and legal.

Commissioner Chambers asked which of those staff will coordinate with the new Commissioners, who will soon be appointed.

Deputy Director Pate stated that will most likely be absorbed internally. Staff is currently putting together an onboarding process for new Commissioners. The new AGPA may help with this process.

Vice Chair Alvarez stated it is a difficult budget year for the state of California with difficult decisions to make; however, the decisions made are choices that outline values. She stated disappointment in some of the budget cuts, particularly the cut to the CYBHI. The CYBHI was an incredible opportunity that the state of California put forward to take a stand on the youth mental health crisis that existed before the COVID-19 pandemic and was exacerbated as a result of it. She highlighted how connected that work is to the longstanding work of the Commission on student health, youth health, transition age youth, and other commitments to ensure the youngest people are the healthiest that they can be.

Vice Chair Alvarez suggested taking the opportunity to express concerns with those reductions, given the Commission's partnership role in implementing the CYBHI with longer-term commitments to being a good partner to the Administration in bringing the expertise of this Commission into the collective work to make California a better state for promoting the mental health of all who call it home. She stated she is not just expressing disappointment with the cuts, but she is also suggesting offering the Commission's partnership while moving forward and thinking through how community, community organizations, the Legislature, and other partners can ensure that everything possible is being done to address this crisis and ensure that the commitment remains as strong as ever.

Commissioner Gordon reiterated his earlier comment that, even separate from these cuts, there is still an opportunity to join with First 5's programs around the state and to push the notion of delivering much more preventive services. He stated some of the work being done to put clinicians in schools is designed to help reach down into the elementary grades and, from there, into preschools and child care programs, with family navigators and other personnel to focus the coverage that is there already for families

on these preventative services. Some of the funds would also have been directed at higher education, which is being put on hold. He stated the real progress long-term is in prevention and early intervention and making sure that the pipeline of severe issues in the future in elementary, middle, and high schools is stemmed.

Commissioner Carnevale pointed out that the economy is already recovering. It is doing well by all measures, even though the public sentiment does not always reflect that. He stated this budget deficit is a result of what happened last year. There is every reason to believe it should be better going forward. It is ridiculous that the state has a one-year budget process. No normal organization is run this way.

Commissioner Mitchell asked if the budget is adjusted when the economy improves.

Deputy Director Pate stated it can be. She stated there are currently adjustments to prior year budgets. Additional adjustments can also be made next year. She stated something she did not mention in her presentation is that there is also a proposal to reduce permanent positions within the state by 10,000. Direction has not yet been received from Finance or the Governor's Office on reductions to the Commission. No reductions to current positions are anticipated. In prior years, vacant or limited-term positions were eliminated first.

Chair Madrigal-Weiss stated the need to stay actively involved. She agreed with Vice Chair Alvarez that the CYBHI represents a historic investment in prevention and early intervention, which would result in long-term cost savings. She stated she is also concerned about the proposed budget cuts affecting children and families, particularly those that increase culturally relevant and linguistically appropriate behavioral health services aimed at addressing health disparities. She stated the Commission should stay actively involved in these budget discussions.

Chair Madrigal-Weiss asked Vice Chair Alvarez to work with staff to prioritize protecting children and youth, especially those from the most vulnerable communities, and to keep the Commission updated on progress made so it stays in the forefront of the Commission's work going forward. She asked Commissioners who would like to join Vice Chair Alvarez in this effort to contact staff.

Public Comment

Stacie Hiramoto thanked Vice Chair Alvarez for bringing up the cuts to the CYBHI. She stated REMHDCO and the CRDP were concerned, particularly because the cuts being made will affect communities of color and the LGBTQ community more. Unfortunately, it is last funded, first cut. One of the programs being cut is strictly for CDEPs, which have been proven to help communities.

Stacie Hiramoto commended Commission staff for their hard work with the Legislature, doing analyses, and participating in hearings.

Jazmin Estevez, Policy Associate, The Children's Partnership, stated The Children's Partnership and many other children, youth, and health equity advocates have significant concerns regarding proposed cuts for the CYBHI in the Governor's May Revision. The speaker stated these proposed cuts, particularly to the evidence-based and community-defined practices grants and the youth crisis response pilot, could

disproportionately affect youth of color and hinder access to culturally-responsive healing services.

Jazmin Estevez stated cuts to infant and early childhood mental health investments are concerning, given the critical impacts of preventative services on future mental health outcomes. Despite previous investments, these issues persist in providing mental health services to low-income children and youth. Rejecting these cuts is crucial to maintaining progress and addressing the mental health crisis among marginalized youth and ensuring equitable access to necessary care and support.

Jazmin Estevez stated The Children's Partnership urged the Commission to communicate to the Legislature the necessity of maintaining the CYBHI investments as essential to building a comprehensive mental health ecosystem of care for California's children.

9: Strategic Plan

Chair Madrigal-Weiss stated the Commission will hear an update on the 2024-27 strategic plan implementation efforts being used to accomplish the strategic plan goals and objectives. She stated, in adopting the strategic plan at the February Commission meeting, the Commission directed staff to develop a process for tracking and reporting progress against its strategic goals and objectives. She directed everyone's attention to the Strategic Plan Implementations questions document and the Strategic Plan Brochure, which were included in the meeting materials. She asked staff to present a draft of this process and proposed metrics.

Deputy Director Pate stated the purpose of this agenda item is to provide the Commission and the public with draft metrics, including aspirational metrics, in support of the Commission's goals. These metrics, which will provide the Commission with guidance and direction, are intended to be used as a framework for the Commission's ongoing evaluation of progress towards its goals. She stated the CLCC and CFLC held a joint meeting on May 8 to begin the discussion on how the Committees can assist the Commission's implementation of the strategic plan. The discussion produced several new metrics, including:

- Geographic distribution of engagements.
- Number of individuals from unserved or underserved populations who were not previously reached by Commission engagement.
- Number of cultural brokers with whom the Commission partnered.
- Number of individuals currently receiving behavioral health services.
- Number of individuals who benefited from incentives to participate in the engagement.
- Number of consumers and family members who engaged with decision makers.
- Percentage of follow-up responses or surveys returned post-engagement.

Deputy Director Pate provided an overview, with a slide presentation, of the strategic implementation plan with metrics for tracking and reporting progress against its strategic

goals and objectives. She stated the Commission's strategic plan consists of four key foundational goals: champion vision into action, catalyze best practice networks, inspire innovation and learning, and relentlessly drive expectations. She reviewed these goals and their objectives. She stated more information on the process to achieve the goals is included in the Appendix. A scorecard with the status of the goals and objectives will be included in the meeting materials each month.

Deputy Director Pate asked that the discussion and input center around the questions in the Strategic Plan Implementation Questions document.

Commissioner Comments & Questions

Commissioner Gordon suggested elevating and expanding the Commission's work done to listen to youth voice. He stated youth voice will be more important moving forward. He also suggested including youth voice in the Strategic Plan Brochure.

Chair Madrigal-Weiss suggested getting feedback from youth on the questions in the Strategic Plan Implementation Questions document.

Commissioner Carnevale stated the need for the strategic plan to be a dynamic, connected part of the Commission's work. He stated it would be helpful to create a map that maps the Commission's initiatives against this to show coverage, gaps, and other things the Commission is doing outside the boundaries of the strategic plan.

Commissioner Carnevale stated the need to model outcome contracting and include outcomes in the implementation plan and not just impacts and activities. There is always a way to quantify something; he recommended that the Commission move in that direction.

Commissioner Rowlett stated he liked what is written to be accomplished in the executive summary document. He referred to Question 8, Public Trust and Ownership, and stated what he often hears online is that the Commission is a place where there is a sentiment about public trust. He asked how that can be quantified in the strategic plan. He asked how to better engage the public in understanding and appreciating the value of the strategic plan. This is part of building public trust. He stated the Strategic Plan Brochure can be a vehicle to operationally do that.

Commissioner Rowlett suggested referencing the BHSA in the Strategic Plan Brochure.

Commissioner Chambers stated public trust came up in the Joint Committee meeting. She agreed that there is trust in the Commission. She suggested going into uncomfortable, nontraditional spaces to provide hope.

Commissioner Chambers referenced Goal 4, Objective 2, Develop a Behavioral Health Index, in the Strategic Plan Brochure and stated counties are working closely with the DHCS to talk about outcomes and key indicators for behavioral health. She asked how to align their efforts.

Commissioner Chambers referred to Question 6, Substance Use Disorder Integration, on the Strategic Plan Implementation Questions document and suggested hosting forums with traditional mental health and behavioral health providers to help break down silos.

Commissioner Danovitch stated the Strategic Plan Brochure is clear and succinct and accurately distills the values, principles, and purpose of the MHSA and the Commission, and the specific role of the Commission as a catalyst. The goals, objectives, and measures are relevant and achievable. The document will help the strategic plan to be used and not left to sit on a shelf.

Commissioner Danovitch suggested including the role of the Commission in generating access to data about individuals, programs, and systems. He quoted Mr. Johnson from his presentation earlier today about the need to measure inputs, outputs, outcomes, and impacts. These need to be tracked to hold the system accountable. Some of that should be the responsibility of the DHCS and other entities, but the question is if the Commission can do this.

Commissioner Danovitch suggested incorporating a weighting system to better understand the initiatives that should be prioritized.

Commissioner Danovitch stated the best measure of an effective strategic plan is that it is useful to staff in helping to prioritize the work and keep the Commission on track and effective. He asked if the strategic plan meets staff needs.

Executive Director Toby Ewing stated staff went into this looking for clear guidance from the Commission to ensure that they are tracking with the priorities of the Commission. He stated the direction received was to learn how to operationalize the strategic plan to ensure progress. Staff developed aspirational goals for the essential elements for each aspect of the strategic plan that would help develop metrics to reflect those goals. He stated the need for the Commission and others to recognize that staff is not in control of the budget and, as a result, is not in control of the ways to prioritize. There is a balance between what the Commission is required to do under the law and the budget and where there is flexibility.

Executive Director Ewing stated the strategic plan meets staff needs in the sense that staff can receive feedback and guidance from Commissioners. It also allows staff to have conversations with the Governor’s team and the Legislature about the budget and strategy. Everything in the strategic plan seems doable but not necessarily doable in the next six months. It is a multiyear plan that is intended to help staff communicate effectively with Commissioners, the public, and other partners about what the Commission is doing and why and how well progress is recognized. Each element is progress in driving transformational change in the system, including access to data. The Commission has elevated data for the past six to seven years.

Executive Director Ewing stated Proposition 1 has explicit language about establishing an outcome and accountability system that reflects the Commission’s work to talk about not just MHSA dollars but all the dollars that are available in the public mental health system and, increasingly, the non-public resources that are available to support robust behavioral health outcomes.

Executive Director Ewing stated the strategic plan allows staff to report back publicly to the Commission on the kinds of barriers being faced in trying to achieve the strategic plan goals, including barriers to access data.

Commissioner Carnevale stated two things are attempting to be accomplished in the strategic plan: measuring the Commission's goals and, in a broader sense, setting what should be the objectives of the whole system. He stated one of the things that is frustrating is not knowing how close the Commission is to reaching its objectives. He suggested establishing these goals quantitatively for the system and then measuring what the Commission is trying to accomplish to get to those but also measuring how well the system is doing in and of itself. It would be a huge accomplishment for the state to understand where it is succeeding and where it is failing.

Commissioner Gordon suggested, in addition to youth voice, adding prevention and early intervention. This is not just a mental health issue but is about general health as the child grows from birth. This would be a place to work with First 5 programs because many of the First 5's have good data on the penetration of healthy practices and if underserved communities get all checkups and other preventative care that they should be getting. This should be mentioned as an area that the Commission should be considering. The Commission may not have influence over this area, but it should consider advancing the issue to the public. He suggested working on this with Managed Care partners.

Chair Madrigal-Weiss agreed and stated the need for this to be considered in all cross-sections of the social determinants of health and mental health.

Commissioner Mitchell stated, if the Commission can do something like that as a strategic priority and measure it, it would impact all other areas of disproportionality downstream.

Executive Director Ewing stated staff envisions, within the different facets of the strategic plan, designing the "thermometer" to measure impact in some areas, moving the needle in other areas, and doing both in some cases. Staff will share updated infographics on the Commission's emphasis around prevention and early intervention and where FSPs, early psychosis intervention, and youth allcove® drop-in programs in school mental health connect at a future Commission meeting. To bring this update to the Commission, staff has spent the past four to five years working on a strategy to address what the elements of filling in that thermometer need to look like – financing workforce, technical assistance, accountability systems, research, and public engagement.

Executive Director Ewing reiterated the fact that the strategic plan is helpful to staff because it is staff's effort to operationalize the direction the Commission has given staff. The next step is to provide tools to make it easier to see the portfolio, which is one of the consistent comments in one-on-one interviews with Commissioners. The next step is also to see progress toward the goals. An initial step will be creating clarity of what staff thinks needs to happen, based on the work staff has been doing, to scale evidence-based practices so that standards are driven by the ability to respond effectively to and tailor to the needs of individuals communities, families, and individuals.

Executive Director Ewing stated the reality is, given the complexity in the behavioral health system, there are some components that are stable, evidence-based, and available, but there are other areas where there are conversations around how counties

spend innovation funds. Some counties are trying something for the first time, while other counties have been doing it for ten years. There are good reasons for that difference; the Commission is trying to understand and reflect that.

Vice Chair Alvarez stated the importance of ensuring that, as the Commission identifies indicators of success and interim progress outcomes, there is an opportunity that those indicators have buy-in from the community. The community engagement process to create this plan was a firm commitment of the Commission. She asked about opportunities to continue to use the Committee structure to create buy-in from communities in future discussion topics of the Committees and where it can be ensured that the Committees' input directly impacts what the Commission holds itself to as implementation moves forward.

Deputy Director Pate stated she would love that support. Support is needed from the Committees and everyone to make this strategic plan successful. She thanked her team for helping develop the metrics for her presentation and for putting together the Strategic Plan Brochure and the larger strategic plan that is listed on the website. She stated staff continues to work together to create community tools that are helpful to the Commission and the public.

Chair Madrigal-Weiss stated Commissioners look forward to working with the team and hearing updates as the progress moves forward.

Public Comment

There was no public comment.

10: Adjournment

Chair Madrigal-Weiss thanked everyone for their participation. She noted that the Commission historically does not have a June meeting and will resume meeting again in July. The next Commission meeting will be held on July 25th in Sacramento, where the Commission will continue the discussion on transformational change in behavioral health with a focus on fiscal transparency, accountability, and substance use disorder integration.

There being no further business, the meeting was adjourned at 3:01 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
May 23, 2024

Motion #: 1

Date: May 23, 2024

Proposed Motion:

The Commission approves the April 25, 2024 Meeting Minutes, as modified.

Commissioner making motion: Commissioner Brown

Commissioner seconding motion: Commissioner Carnevale

Motion carried 9 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Commissioner Bontrager	☐	☐	☐	☒	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☒	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☐	☐	☒	☐	☐
12. Commissioner Robinson	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
May 23, 2024

Motion #: 2

Date: May 23, 2024

Proposed Motion:

That the Commission approve Ventura County's Early Psychosis Learning Health Care Network Collaborative Innovation Project for up to $10,137,474.63.

Commissioner making motion: Commissioner Rowlett

Commissioner seconding motion: Commissioner Bunch

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Commissioner Bontrager	☐	☐	☐	☒	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☒	☐	☐	☐	☐
12. Commissioner Robinson	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

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Motions Summary
Commission Meeting
May 23, 2024

Motion #: 3

Date: May 23, 2024

Proposed Motion:

That the Commission approve Fresno County's Extension of the California Reducing Disparities Innovation Project for up to $2,953,244.

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Rowlett

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Commissioner Bontrager	☐	☐	☐	☒	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☒	☐	☐	☐	☐
12. Commissioner Robinson	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
May 23, 2024

Motion #: 4

Date: May 23, 2024

Proposed Motion:

That the Commission approve Mendocino County's Native American Crisis Line Innovation Project for up to $1,001,395.

Commissioner making motion: Chair Madrigal-Weiss

Commissioner seconding motion: Commissioner Brown

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Commissioner Bontrager	☐	☐	☐	☒	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☒	☐	☐	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☒	☐	☐	☐	☐
12. Commissioner Robinson	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
May 23, 2024

Motion #: 5

Date: May 23, 2024

Proposed Motion:

That the Commission approves Fresno County's participation in the Psychiatric Advance Directive Collaborative Innovation Project for up to $5,915,000.

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Carnevale

Motion carried 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Commissioner Bontrager	☐	☐	☐	☒	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☐	☐	☒	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☒	☐	☐	☐	☐
12. Commissioner Robinson	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

Motions Summary
Commission Meeting
May 23, 2024

Motion #: 6

Date: May 23, 2024

Proposed Motion:

That the Commission approve Shasta County's participation in the Psychiatric Advance Directive Collaborative Innovation Project for up to $1,000,000.

Commissioner making motion: Commissioner Rowlett

Commissioner seconding motion: Commissioner Gordon

Motion carried 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain	Absent	On Leave
1. Commissioner Bontrager	☐	☐	☐	☒	☐
2. Commissioner Brown	☒	☐	☐	☐	☐
3. Commissioner Bunch	☒	☐	☐	☐	☐
4. Commissioner Carnevale	☒	☐	☐	☐	☐
5. Commissioner Carrillo	☐	☐	☐	☒	☐
6. Commissioner Chambers	☐	☐	☒	☐	☐
7. Commissioner Chen	☐	☐	☐	☐	☒
8. Commissioner Cortese	☐	☐	☐	☒	☐
9. Commissioner Danovitch	☐	☐	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐	☐	☐
11. Commissioner Mitchell	☒	☐	☐	☐	☐
12. Commissioner Robinson	☐	☐	☐	☒	☐
13. Commissioner Rowlett	☒	☐	☐	☐	☐
14. VACANT					
15. Vice-Chair Alvarez	☒	☐	☐	☐	☐
16. Chair Madrigal-Weiss	☒	☐	☐	☐	☐

AGENDA ITEM 5

Action

July 25, 2024 Commission Meeting

Consent Calendar

Summary:
The Commission will consider approval of the Consent Calendar which contains the following item:

1) Innovation funding request by Sierra County to join the Semi-Statewide Enterprise Health Record (EHR) Multi-County Collaborative
2) Resolution authorizing worker's compensation insurance coverage for persons providing voluntary services to the Commission without compensation within the meaning of Labor Code 3363.5 and California Government Code 3111.

Items are placed on the Consent Calendar with the approval of the Chair and are deemed non-controversial. Consent Calendar items shall be considered after public comment, without presentation or discussion. Any item may be pulled from the Consent Calendar at the request of any Commissioner. Items removed from the Consent Calendar may be held for future consideration at the discretion of the Chair.

(1) Innovation funding request by Sierra County to join the Semi-Statewide Enterprise Health Record (EHR) Multi-County Collaborative

Semi-Statewide Enterprise Health Record Innovation Project – Sierra County
Sierra County requests authorization to use up to $910,906 of Innovation funding to partner with CalMHSA on the Semi-Statewide Enterprise Health Record Innovation Project (EHR Project). If approved, Sierra County will join 23 other counties to affect local level system change by creating a more integrated, holistic approach to county health information technology collection, storage, and reporting. Together, these 24 counties are collectively responsible for more than four million (27%) of the state's Medi-Cal Beneficiaries.

The excessive documentation of health records has been identified as a source of burnout and dissatisfaction among healthcare direct service staff and have not evolved to prioritize the user experience of either the providers or recipients of care, resulting in an estimated 40% of a healthcare staff's workday currently spent on documenting encounters, instead of providing direct client care.

Counties have prioritized this innovation project at this time in response to the severe behavioral workforce challenge they face with the hope that they can preserve the current workforce and improve the quality of services during a time of rising need for mental health treatment services. The goal of the EHR Project is reducing the impact of documentation will improve provider satisfaction, employee retention, and patient care and outcomes.

Sierra County is challenged with current reporting requirements and anticipate that these challenges will grow as they work towards becoming a Mental Health Plan. Sierra is the only county in California that is not currently billing Medi-Cal and reports that their residents are underserved due to the county not being in receipt of needed Medi-Cal funding stream. Sierra County utilizes hand counting, spreadsheets, and other systems that are not efficient and not transferable to the reporting requirements under Medi-Cal. Sierra County has attempted to improve the EHR system through two transitions in recent years, but the current system still does not provide the required level of support, structure, and systems to manage data, medical records and necessary information flow. The burden among providers remains high and contributes to workforce challenges.

By joining the EHR Project, Sierra County will receive additional support through a partnership with CalMHSA and through the learnings of like counties. Joining the EHR Project will assist the county in their transition to Medi-Cal/CalAIM implementation and in addressing issues related to providers having uniform and easy access to records, medication management and data. Additionally, this will allow Sierra County clients, who have little access to medical care within the county, to readily access records for providers outside of the county.

The project identifies three key aims:

1. Reduce documentation burden by 30% to increase the time workforce must provide treatment services to our client population.
2. Facilitate cross county learning by standardizing data collection and outcomes comparisons so best practices can be scaled quickly.
3. Form a greater economy of scale so counties can test and adopt innovative practices with reduced administrative burden.

Behavioral Health Services Act Alignment and Sustainability:

This multi-county innovation project aligns with the Behavioral Health Services Act through a shared focus on (a) meeting behavioral health workforce and technological needs in a rapidly changing and increasingly interoperable environment, and (b) increasing access to meaningful data to evaluate behavioral health service outcomes and equity.

Sierra County will utilize Behavioral Health Services and Supports funding along with Medi-Cal funding to sustain this project. It is expected that the County will be able to leverage

additional sustainable funding using federal financial participation (FFP) by becoming a Mental Health Plan (MHP), which is occurring in tandem and supported by this project.

The Community Program Planning Process:
Sierra County created a stakeholder group comprised of health assistants, clinical staff, and case managers, who determined that joining the EHR Project will support the growing needs within Sierra County and help with the Cal Aim reporting requirements. In addition, Sierra County reports that MHSA community comments have been centered around access, timely prescriptions and Medi-Cal services, all issues that the County hopes to address with this project. Following community input, the County proposed this project plan in their MHSA Three-Year Program and Expenditure Plan. The 30-day public comment period was held January 11, 2024 through February 10, 2024 followed by local Behavioral Health Board hearing on February 8, 2024. A final plan, incorporating community input and MHSOAC technical advice, was submitted to Commission staff on May 30, 2024.

The final version of this project was shared with the Commission's listserv on May 31, 2024. **No comments were received by the Commission in response to the sharing of this project.**

Presenters: None

Enclosures (2): (1) Commission Community Engagement Process; (2) Sierra County Analysis: Semi-Statewide Enterprise Health Record (EHR) Multi-County Collaborative Innovation Project

Handouts: None

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

https://mhsoac.ca.gov/wp-content/uploads/Multi-County-_INN-Plan_EHR-Statewide_Sierra-County.pdf

(2) Resolution authorizing worker's compensation insurance coverage for persons providing voluntary services to the Commission without compensation within the meaning of Labor Code 3363.5 and California Government Code 3111.

As a result of the passage of Proposition 1, on January 1, 2025, the number of Commissioners is expected to grow significantly. Currently, State of California worker's compensation insurance does not apply to Commissioners or to any other individuals serving the

Commission in an unpaid, volunteer capacity, such as serving on Commission committees. With the increased risk presented by the addition of 11 Commissioners, it is recommended that the Commission pass a resolution that would allow unpaid volunteers to the Commission to qualify for State of California worker's compensation insurance for any injuries suffered during the performance of their unpaid, volunteer duties to the Commission.

California Labor Code 3363.5(a)[1] requires a public agency or commission to declare by adoption of a resolution to have State of California worker's compensation insurance apply to its volunteers.

California Labor Code 3363.5(b) defines "voluntary service" as including "services performed by any person, who receives no remuneration other than meals, transportation, lodging, or reimbursement for incidental expenses."

Whereas Commissioners are considered "Administrative Volunteers" to the Commission as defined by Government Code 31111, a Commission Resolution is required to ensure Commissioners are covered by the State of California worker's compensation insurance for any injury suffered or incurred during their official Commission volunteer work.

Additionally, occasionally, the Commission has unpaid volunteers, and it is sound business practice to ensure volunteers are covered by the worker's compensation insurance for any injury sustained while completing their volunteer duties to the Commission.

The Commission is covered by a Master Agreement for Worker's Compensation Claims Administration with the State Compensation Insurance Fund and California Department of Human Resources. The Agreement states the Commission pays service fees and direct medical bills. Any increase is estimated to be minimal, if any.

Presenters: None

Enclosures (1): Resolution

Handouts: None

Additional Materials: None

[1] Specifically, California Labor Code 3363.5(a) provides that

> a person who performs voluntary service without pay for a public agency, as designated and authorized by the governing body of the agency or its designee, shall, upon adoption of a resolution by the governing body of the agency so declaring, be deemed to be an employee of the agency for purposes of this [worker's compensation] division while performing such service.

Proposed Motion:

That the Commission approve the Consent Calendar that includes:

(1) First, funding for Sierra County to join the Semi-Statewide Enterprise Health Record Multi-County Collaborative Innovation Project for up to $910,906; and

(2) Second, that the Commission adopt the Resolution authorizing worker's compensation insurance coverage for persons providing voluntary services to the Commission without compensation within the meaning of Labor Code 3363.5 and California Government Code 3111.

Mental Health Services
Oversight & Accountability Commission

Commission Process for Community Engagement on Innovation Plans

To ensure transparency and that every community member both locally and statewide has an opportunity to review and comment on County submitted innovation projects, Commission staff follow the process below:

Sharing of Innovation Projects with Community Partners

- **Procedure – Initial Sharing of INN Projects**
  i. Innovation project is initially shared while County is in their public comment period
  ii. County will submit a link to their plan to Commission staff
  iii. Commission staff will then share the link for innovation projects with the following recipients:
    - **Listserv recipients**
    - **Commission contracted community partners**
    - **The Client and Family Leadership Committee (CFLC)**
    - **The Cultural and Linguistic Competency Committee (CLCC)**
  iv. Comments received while County is in public comment period will go directly to the County
  v. Any substantive comments must be addressed by the County during public comment period
- **Procedure – Final Sharing of INN Projects**
  i. When a final project has been received and County has met all regulatory requirements and is ready to present finalized project (via either Delegated Authority or Full Commission Presentation), this final project will be shared again with community partners:
    - **Listserv recipients**
    - **Commission contracted community partners**
    - **The Client and Family Leadership Committee (CFLC)**
    - **The Cultural and Linguistic Competency Committee (CLCC)**
  ii. The length of time the final sharing of the plan can vary; however, Commission tries to allow community partner feedback for a minimum of two weeks
- **Incorporating Received Comments**
  i. Comments received during the final sharing of the INN project will be incorporated into the Community Planning Process section of the Staff Analysis.
  ii. Staff will contact community partners to determine if comments received wish to remain anonymous
  iii. Received comments during the final sharing of INN project will be included in Commissioner packets
  iv. Any comments received after final sharing cut-off date will be included as handouts

STAFF ANALYSIS—Sierra County

Innovation (INN) Project Name:	**Semi-Statewide Enterprise Health Record Project**
Total INN Funding Requested:	**Up to $910,906**
Duration of INN Project:	**Four (4) years**
MHSOAC consideration of INN Project:	**July 25, 2024**

Review History:

Approved by the County Board of Supervisors:	March 5, 2024
Mental Health Board Hearing:	February 8, 2024
Public Comment Period:	January 11, 2024 – February 10, 2024
County submitted INN Project:	May 30, 2024
Date Project Shared with Stakeholders:	May 31, 2024

Project Introduction:

Sierra County requests authorization to use up to $910,906 of Innovation funding to partner with CalMHSA on the Semi-Statewide Enterprise Health Record Innovation Project (EHR Project). If approved, Sierra County will join 23 other counties to affect local level system change by creating a more integrated, holistic approach to county health information technology collection, storage, and reporting. Together, these 24 counties are collectively responsible for more than four million (27%) of the state's Medi-Cal Beneficiaries.

Counties have prioritized this innovation project at this time in response to the severe behavioral workforce challenge they face with the hope that they can preserve the current workforce and improve the quality of services during a time of rising need for mental health treatment services. The EHR Project hypothesizes that reducing the impacts of documentation will improve provider satisfaction, employee retention, and improve patient care and outcomes.

Behavioral Health Services Act Alignment and Sustainability (See page 110):

This multi-county innovation project aligns with the Behavioral Health Services Act through a shared focus on (a) meeting behavioral health workforce and technological needs in a rapidly

changing and increasingly interoperable environment, and (b) increasing access to meaningful data to evaluate behavioral health service outcomes and equity.

Sierra County will utilize Behavioral Health Services and Supports funding along with Medi-Cal funding to sustain this project. It is expected that the County will be able to leverage additional sustainable funding using federal financial participation (FFP) by becoming a Mental Health Plan (MHP), which is occurring in tandem and supported by this project.

What is the Problem (pages 2-4):
The excessive documentation of health records has been identified as a source of burnout and dissatisfaction among healthcare direct service staff and have not evolved to prioritize the user experience of either the providers or recipients of care, resulting in an estimated 40% of a healthcare staff's workday currently spent on documenting encounters, instead of providing direct client care.

Sierra County is challenged with current reporting requirements and anticipate that these challenges will grow as they work towards becoming a Mental Health Plan. Sierra is the only county in California that Is not currently billing Medi-Cal and reports that their residents are underserved due to the county not being in receipt of needed funds. Sierra County utilizes hand counting, spreadsheets and other systems that are not efficient and not transferable to the reporting requirements under Medi-Cal. Sierra County has attempted to improve the EHR system through two transitions in recent years, but the current system still does not provide the required level of support, structure, and systems to manage data, medical records and necessary information flow. The burden among providers remains high and contributes to workforce challenges.

By joining the EHR Project, Sierra County will receive additional support through a partnership with CalMHSA and through the learnings of like counties. Joining the EHR Project will assist the county in their transition to Medi-Cal/CalAIM implementation and in addressing issues related to providers having uniform and easy access to records, medication management and data. Additionally, this will allow Sierra County clients, who have little access to medical care within the county, to readily access records for providers outside of the county.

In alignment with challenges reported by participating counties, CalMHSA continues to explain that the majority of EHR vendors develop products to meet the needs of the larger physical health care market, and that the few national vendors who cater to the behavioral health market have been disincentivized from operating in California due to several unique aspects of the California behavioral health landscape.

CalMHSA highlights three ongoing difficulties that result in county behavioral health plans being dissatisfied with their current EHRs with few choices to implement new solutions. The ongoing difficulties are:

- Configuring the existing EHRs to meet the everchanging California requirements,

- Collecting and reporting on meaningful outcomes for all the county behavioral health services (including MHSA-funded activities), and
- Providing direct service staff and the clients they serve with tools that enhance rather than hinder care has been difficult and costly to tackle on an individual county basis.

The California Advancing and Innovating Medi-Cal (CalAIM) changes target documentation redesign, payment reform and data exchange requirements that will bring California Behavioral Health requirements into greater alignment with national physical healthcare standards resulting in a lower-barrier entry for EHR vendors seeking to serve California. CalMHSA proposes to maximize the opportunity presented by the CalAIM changes to support County Behavioral Health Plans to revamp their primary service tool to meet the current challenges by partnering with counties and launching the Semi-Statewide EHR initiative.

Initial MHSA Capital Facilities and Technological Needs (CFTN) funding allowed counties to acquire their first EHRs, catalyzing the transformation from paper charts to electronic documentation. While these electronic tools may have offered the best available solutions at the time, newer software solutions have evolved to meet current health industry standards such as privacy, security, and interoperability. These electronic records are used to document and claim Medi-Cal services that County Behavioral Health Plans (BHPs) provide and, if properly enhanced, can capture vital data and performance metrics across the entire suite of activities and responsibilities shouldered by BHPs.

How this Innovation project addresses this problem (pages 3-7):
California counties have joined together to envision an enterprise solution where the EHR goes far beyond its origins to provide a tool that helps counties manage the diverse needs of their population. The counties participating in the Semi-Statewide EHR have reimagined what is possible from the typical EHR system, hypothesizing that reducing the impacts of documentation will improve provider satisfaction, employee retention, and improve patient care and outcomes.

Through the identification of challenges/shortcomings within existing (legacy) EHRs that contribute to key indicators of provider burnout, this information will be utilized to implement solutions within the new EHR that are compatible with the needs of the County Behavioral Health Plans' workforce as well as the clients they serve.

In addition, the EHR Project is making a considerable investment in ensuring that industry standards for privacy and security are central to the product. CalMHSA is working with healthcare privacy legal experts to create master consenting documents to enhance the opportunity for consenting clients to receive coordinated care.

The project identifies three key aims:

1. Reduce documentation burden by 30% to increase the time our scarce workforce must provide treatment services to our client population.

2. Facilitate cross county learning by standardizing data collection and outcomes comparisons so best practices can be scaled quickly.
3. Form a greater economy of scale so counties can test and adopt innovative practices with reduced administrative burden.

The key principles of the EHR project include (see pages 4-5 for specifics):

• **Enterprise Solution:** Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of County Behavioral Health Plans.

• **Collective Learning and Scalable Solutions:** Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources, and bring forward scaled solutions to current problems.

• **Leveraging CalAIM:** CalAIM implementation represents a transformative moment when primary components within an EHR are being re-designed (clinical documentation and Medi- Cal claiming).

• **Lean and Human Centered:** CalMHSA will engage with experts in human centered design to reimagine the clinical workflow in a way that both reduces "clicks" (the documentation burden), increases client safety, and natively collects outcomes.

• **Interoperable:** Reimagining the clinical workflow so critical information about the people being served is formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like Health Information Exchanges (HIEs).

Through a Request for Proposal competitive process, CalMHSA has selected Streamline Healthcare Solutions, LLC as the vendor for the development, implementation, and maintenance of the Semi-Statewide EHR. CalMHSA stated that their agreement with Streamline Healthcare Solutions includes non-compete terms and provisions for CalMHSA to maintain appropriate intellectual property rights for the customized, California EHR.

RAND is the selected evaluation vendor and will assist in ensuring the Innovation project is congruent with quantitative and qualitative data reporting on key indicators.

To support a more successful multi-county collaboration, CalMHSA has done a deep dive into the Help@Hand Innovation investment to incorporate lessons learned and to work toward implementing a shared decision-making model.

Community Planning Process (See Appendices, pgs. 108-113):
Sierra County created a stakeholder group comprised of health assistants, clinical staff, and case managers, who determined that joining the EHR Project will support the growing needs within Sierra County and help with the Cal Aim reporting requirements. In addition, Sierra County reports that MHSA community comments have been centered around access, timely

prescriptions and Medi-Cal services, all issues that the County hopes to address with this project.

Following community input, the County proposed this project as part of their MHSA Three-Year Program and Expenditure Plan. The corresponding public comment period was held January 11, 2024 through February 10, 2024 followed by local Behavioral Health Board hearing on February 8, 2024.

A final plan, incorporating community input and MHSOAC technical advice, was submitted to Commission staff on May 30, 2024. This project was shared with the Commission's listserv on May 31, 2024. **No comments were received in response to the sharing of this project.**

Learning Objectives and Evaluation (Pages 9-10):
CalMHSA estimates that the project could impact up to 14,000 EHR users throughout the state.

The EHR Innovation project will have three (3) phases:

1) **Formative Evaluation**: Prior to implementation of the new EHR, the project will measure key indicators of time, effort, cognitive burden, and satisfaction while providers utilize their current or "legacy" EHR systems.
2) **Design Phase**: Based on data gathered from the initial phase, HCD experts will assist with identifying solutions to problems identified during the evaluation of the legacy products. This process will help ensure the needs of service providers, inclusive of licensed professionals, paraprofessionals, and peers, and in turn their clients, will be at the forefront of the design and implementation of the new EHR.
3) **Summative Evaluation**: After implementation of the new EHR, the same variables collected during the Formulative Evaluation will be re-measured to assess the impact of the Design Phase interventions.

As a provider of services to CalMHSA through a master agreement and as an expert in California's behavioral health space, CalMHSA selected RAND to complete the EHR Project evaluation. RAND will assist in ensuring the project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the project planning phase. These indicators include, but may not be limited to, impacts of human-centered design principles with emphasis on provider satisfaction, efficiencies, and retention.

To ensure that the project is developed in a manner that is most in line with the needs of the behavioral health workforce and the diverse communities they serve, RAND will subcontract with a subject matter expert in human-centered design.

CalMHSA identified three project objectives with RAND:

Objective I: *Shared decision making and collective impact*. Over the course of the EHR project, RAND will evaluate stakeholder perceptions of and satisfaction with the decision-making process as well as suggestions for improvement.

Objective II: *Formative assessment*. RAND will conduct formative assessments to iteratively improve the new EHR's user experience and usability during design, development, and pilot implementation phases.

Objective III: *Summative assessment*. Conduct a summative evaluation of user experience and satisfaction with the new EHR compared to legacy EHRs, as well as a post-implementation assessment of key indicators.

In addition to the statewide project goals, Sierra County identified that they would focus on obtaining better access to Medi-Cal data through a system designed with improved client access and streamlined provider options for medication management.

The Budget (See pages 109-113):
Sierra County is requesting authorization to spend up to $910,906 in MHSA Innovation funding, over a period of four (4) years, to join the EHR Project.

On January 25, 2023, Imperial, Kings, Mono, Placer, San Benito, San Joaquin, Siskiyou, and Ventura Counties were approved to collectively spend up to $30,003,104.67 in MHSA Innovation funding for this project over a period of five (5) years. On November 17, 2022, Humboldt, Sonoma and Tulare (Phase 1 and Phase 2) Counties were approved to spend up to $12,310,146.54 over five (5) years to launch the project.

Contractor costs in the amount of $715,215 (78.5% of total budget) will be paid to CalMHSA and is allocated for Project Management, Administration and Evaluation.

CalMHSA will serve as the Administrative Entity and Project Manager. CalMHSA will execute Participation Agreements with each respective county, as well as contracts with the selected EHR Vendor and Evaluator:

- Streamline Healthcare Solutions: This vendor will be responsible for the development, implementation, and maintenance of the Semi-Statewide EHR.
- RAND: As the evaluation vendor, RAND will assist in ensuring the INN project is congruent with quantitative and qualitative data reporting on key indicators, as determined by the INN project.

Local Personnel costs total $195,691 (21% of total budget) and include the following administrative position:

EHR Health Assistant, .50 FTE who will:

- Manage the rollout of the HER
- Oversee Data Transmission
- Manual entry of new and existing clients

COUNTY	Total INN Funding Requested	Local Costs for Admin and Personnel	CalMHSA	Evaluation	Sustainability Plan (Y/N)
Sierra	**$910,906**	**$195,691**	**$665,215**	**$50,000 (5.4%)**	**Y**
Previously Approved:					
Imperial	$2,974,849	$718,744	$2,256,105	$150,000 (5%)	Y
Kings	$3,203,101.78	$1,802,706.08	$1,250,395.7	$150,000 (4.7%)	Y
Mono	$986,402.89	$317,350	$669,052.89	$150,000 (15%)	Y
Placer	$4,562,393	$1,199,845	$3,362,548	$250,000 (5%)	Y
San Benito	$4,940,202	$3,785,392	$1,154,810	$150,000 (3%)	Y
San Joaquin	$8,748,140	$744,978	$8,003,162	$500,000 (5.7%)	Y
Siskiyou	$1,073,106	$92,311	$980,795	$150,000 (13.9%)	Y
Ventura	$3,514,910	$917,284	$2,597,626	$500,000 (14%)	Y
Sonoma	$4,420,447.54	In Kind	$4,170,447.54	$250,000 (5.6%)	Y
Humboldt	$608,678	$17,482	$441,196	$150,000 (24%)	Y
Tulare	$7,281,021	$2,508,218	$4,522,803	$250,000 (3.4%)	Y
Innovation Total	**$43,224,157.21**				

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

Mental Health Services
Oversight & Accountability Commission

RESOLUTION

The Mental Health Services Oversight and Accountability Commission (Commission) was formed by the voters of California, through the passage of Proposition 63 (eff. 1/01/2005) as amended by the passage of Proposition 1 (eff. 01/01/2025). The Commission's overall mission remains the same: to increase public awareness of the value of mental and behavioral health, to call for transformational change in California's mental/behavioral health system and to ensure that the lives and perspectives of consumers and families are at the forefront of decision-making.

THIS RESOLUTION AUTHORIZES WORKER'S COMPENSATION INSURANCE COVERAGE FOR PERSONS PROVIDING VOLUNTARY SERVICES TO THE COMMISSION WITHOUT COMPENSATION WITHIN THE MEANING OF LABOR CODE SECTION 3363.5 AND CALIFORNIA GOVERNMENT CODE 3111.

WHEREAS, Except for certain statutory exceptions, persons providing voluntary services to a public agency are not considered employees and therefore are not eligible for worker's compensation insurance coverage by the State of California for job-related illness or injury;

NOW, THEREFORE, the Mental Health Services Accountability and Oversight Commission HEREBY RESOLVES AND DECLARES THAT UPON ADOPTION OF THIS RESOLUTION COMMISSION VOLUNTEERS, AS DEFINED IN CALIFORNIA GOVERNMENT CODE 3111, ARE DEEMED TO BE EMPLOYEES FOR PURPOSES OF WORKERS COMPENSATION INSURANCE COVERAGE BY THE STATE OF CALIFORNIA, WHILE PERFORMING THEIR VOLUNTEER COMMISSION DUTIES AS SET FORTH AT WELFARE AND INSTITUTIONS CODE SECTION 5845, WITHIN THE MEANING OF LABOR CODE SECTION 3365.5.

PASSED AND ADOPTED by Mental Health Services Accountability and Oversight Commission at a regular meeting held on July 25, 2024.

AGENDA ITEM 6

Action

July 25, 2024 Commission Meeting

State Budget and Expenditure Update

Summary:
Each year, the Mental Health Services Oversight and Accountability Commission is presented with a budget update in July at the beginning of the new fiscal year, and again in January which coincides with a presentation on the Governor's proposed budget for the following fiscal year. Staff also provided a budget presentation in May that coincided with the Governor's May Revision. The goal of these presentations are to support fiscal transparency and ensure that Commission expenditures are in line with the Commission's priorities.

Background:
The Commission's budget is organized into three main categories: Operations, Budget Directed, and Local Assistance.

- **Operations:** Includes Personnel and Core Operations. These funds are provided for staff, rent, and other related expenses needed to support the work of the Commission. Funding is usually ongoing with some exceptions such as one-time funding to support Commission-directed initiatives.

- **Budget Directed:** Funding that has been provided in the Governor's Budget Act for technical assistance, implementation, and evaluation of grant programs with one-time and ongoing funding that is allocated over multiple fiscal years.

- **Local Assistance:** Includes the majority of Commission's funding that is provided to counties and other local partners. This funding is provided via grants to counties or organizations on an ongoing and/or one-time basis, spread over multiple fiscal years.

Annual funding in the Commission's budget can be authorized for a single fiscal year, or multiple fiscal years. Fluctuations in annual funding reflect the availability of one-time funding, funding authorizations that are available over multiple years, and periodic on-going budget decisions that result in either growth or reductions in expenditure authority.

The Commission Staff will present the Commission's proposed 2024-25 budget for consideration.

Budget by Fiscal Year and Specific Category

	Fiscal Year 2021-22	Fiscal Year 2022-23	Fiscal Year 2023-24	Fiscal Year 2024-25
Operations				
Personnel	$6,720,000	$8,100,000	$8,968,000	$9,697,000
Core Operations	$3,890,000	$3,168,000	$4,295,000	$4,395,000
Total Operations	**$10,610,000**	**$11,268,000**	**$13,263,000**	**$14,092,000**
Budget Directed				
Anti-Bullying Campaign*	$5,000,000			
MHSSA Admin Augmentation*	$15,000,000			
MHSSA Admin/Evaluation*	$10,000,000	$16,646,000		
Fellowship/Transformational Change*		$5,000,000		
Evaluation of FSP Outcomes		$400,000	$400,000	$400,000
Universal Mental Health Screening Study*			$200,000	
EPI Reappropriation*			$1,675,000	
Total Budget Directed	**$30,000,000**	**$22,046,000**	**$2,275,000**	**$400,000**
Local Assistance				
Children & Youth Behavioral Health Initiative*			$15,000,000	
Community Advocacy Partnership	$5,418,000	$6,700,000	$6,700,000	$6,700,000
Mental Health Student Services Act (MHSSA)**	$188,830,000	$8,830,000	$7,606,000	$7,606,000
Mental Health Wellness Act	$20,000,000	$20,000,000	$20,000,000	$20,000,000
Total Local Assistance Funds	**$214,487,000**	**$78,430,000**	**$49,306,000**	**$34,306,000**
Grand Total	**$255,097,000**	**$111,744,000**	**$64,844,000**	**$48,798,000**

*one-time funds

**one-time funds and ongoing funds

Presenter: Norma Pate, Deputy Director

Enclosures: None

Handouts: PowerPoint slides will be made available at the Commission Meeting

Proposed Motion: That the Commission approves the Fiscal Year 2024-25 expenditure plan, and associated contracts.

AGENDA ITEM 7

Action

July 25, 2024 Commission Meeting

Transformational Change in Behavioral Health: Transparency and Accountability

Summary:
The Mental Health Services Oversight and Accountability Commission will hear from a panel on the opportunities that behavioral health transformation offers for accountability and transparency. The Commission will hear first from thought leaders in the field who will share how data can be used to drive transformational change, followed by a presentation from state and local leaders who will discuss the importance and impact of data to reduce disparities and close equity gaps.

Background:
This section should include any relevant information that Commissioners will need to prepare to hear and respond to the agenda item. This may include information on current and past funding, what the Commission and others have done in this area in the past, and how it relates to the Commission's goals and objectives.

Transformational Change in Behavioral Health: Transparency and Accountability Panel

Presented and facilitated by Melissa Martin-Mollard, Chief of Research and Evaluation, Mental Health Services Oversight & Accountability Commission

- Lishaun Francis, Senior Director of Behavioral Health, Children Now
- Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency
- Ryan Quist, PhD, Behavioral Health Services Director, Sacramento County
- Sergio Aguilar-Gaxiola, MD, PhD, Founding Director, Center for Reducing Disparities, UC Davis
- Debra Oto-Kent, Founder and Executive Director, Health Education Council

The panel of presenters will speak from subject matter expertise and community experience to outline opportunities for strengthening our accountability systems for behavioral health. These presentations will help Commissioners consider what actions can and should be taken to elevate the opportunity and generate strategic solutions for collectively holding ourselves accountable for improving outcomes for individuals and communities.

Enclosures (3): (1) Presenter biographies; (2) Panelist invitation letters; (3) Briefing Memorandum

Handouts(1): Presentation slides from panelists

Proposed Motion: Whereas the Commission recognizes the significant opportunities presented by Behavioral Health Transformation; and whereas Proposition 1 ("Prop 1") outlines an ambitious agenda for improving behavioral health services in California, therefore, the Commission moves to authorize Commission staff to initiate the development of an overarching accountability strategy for Behavioral Health Transformation that shall include an emphasis on data, transparency, and standards, as well as community engagement, in order to provide recommendations and consultation to state agencies and other key partners responsible for the success of Prop 1's agenda.

Transformational Change in Behavioral Health:
Transparency and Accountability
Presenter Biographies
July 25th, 2024

Lishaun Francis, Senior Director of Behavioral Health, Children Now As part of the health team, Lishaun supports Children Now's mental health/trauma efforts. Prior to joining Children Now, Lishaun Francis was an Associate Director at the California Medical Association. She provided policy support and analysis for California physicians on the issues of Medi-Cal, Workers' Compensation, and Health Information Technology. Lishaun spent over two years with the Legislative Analyst Office (LAO where she provided fiscal and policy analyses to the State Legislature on issues of mental health, developmental disabilities, and alcohol and drug programs. In Washington, DC Lishaun Francis worked as a Program Analyst for the U.S Department of Education, providing fiscal support on issues of higher education. Lishaun Francis received her Master's of Public Policy from the University of Michigan, and her Bachelor of Arts in Sociology from Spelman College in Atlanta, GA.

Stephanie Welch, Deputy Secretary of Behavioral Health, California Health and Human Services Agency Stephanie N. Welch was appointed Deputy Secretary of Behavioral Health at the California Health & Human Services Agency in 2020. Stephanie previously served as Executive Officer for the Council on Criminal Justice and Behavioral Health since 2015. She was the Senior Program Manager for the California Mental Health Services Authority from 2011 to 2015, an Associate Policy Director at the County Behavioral Health Directors Association from 2007 to 2011, and the Associate Director of Public Policy at the Council of Community Behavioral Health Agencies from 2000 to 2005. Welch earned a BA in Social Work from University of California at Davis and a Master's Degree in Social Work from the University of Southern California.

Ryan Quist, Ph.D., is the Behavioral Health Director in Sacramento County. His focus is on mental health and substance abuse services for the homeless population, criminal justice population, and bolstering the crisis continuum of care to prevent psychiatric hospitalizations. For children's services, he is dedicated to promoting field-based and school-based services and collaborating to support the foster youth and probation populations. He currently holds the position of President for the County Behavioral Health Directors Association (CBHDA).

Sergio Aguilar-Gaxiola, MD, PhD, Founding Director, Center for Reducing Disparities, UC Davis. Dr. Aguilar-Gaxiola is an internationally renowned expert on mental health in ethnic populations. As on-site principal investigator of the Mexican American Prevalence and Services Survey – the largest mental health study conducted in the United States on Mexican Americans – he identified the most prevalent mental health disorders in the Mexican-origin population in California's central valley; showed that the rate of disorders increases the longer the individual resides in the United States; and demonstrated that children of immigrants have even greater rates of mental disorders. From this study, he developed a model of service delivery that increased access to mental health services among the Central Valley's low-income, underserved, rural populations.

Dr. Aguilar-Gaxiola conducts cross-national epidemiologic studies on the patterns and correlates of psychiatric disorders in general population samples. He is the coordinator for Latin America and the Caribbean of the World Health Organization's Mental Health Survey, and coordinates the work of the National Mental Health Institute surveys in Mexico, Columbia, Brazil, Peru, Costa Rica and Portugal. He also develops culturally and linguistically sensitive diagnostic mental health measures and translates mental health research into practical information for consumers and their families, health professionals, service administrators and policy makers.

Debra Oto-Kent, Founding Executive Director, Health Education Council, a nonprofit organization committed to cultivating health and well-being in under-served communities by leveraging the power of collaboration. For three decades, HEC has created innovative programs promoting community well-being and reducing health disparities. HEC received a 2016 Department of Public Health Innovation Award and was named a Nonprofit of the Year for engaging residents to reduce health disparities.

Ms. Oto-Kent has served on a variety of boards of local and statewide health and research organizations, with current board of director service on the West Sacramento Housing Development Corporation, Cien Amigos, and the UC Davis Comprehensive Cancer Center and UC Davis Center for Reducing Health Disparities Research and Education Community Advisory Boards. She is an American Leadership Forum fellow and has been recognized by the Sacramento Metropolitan Chamber of Commerce (2020) and by Senator Richard Pan. She is a recipient of many honors and awards including the Al Geiger Memorial Award for Community Service, the Exceptional Women of Color (EWOC) Excellence Award (2019), and Unsung Hero Award.

Ms. Oto-Kent has a Health Science B.S. degree from San Diego State University, and Master's of Public Health from UCLA's School of Public Health. Her two primary areas of expertise – cross-sector coalition building and reducing health disparities in diverse low-income communities.

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

July 9th, 2024

Sergio Aguilar-Gaxiola, MD, PhD
Founding Director, Center for Reducing Disparities, UC Davis

Letter sent via email

Dear Dr. Aguilar-Gaxiola:

Thank you for agreeing to present at the public hearing on Transformational Change in Behavioral Health: Transparency and Accountability during the Commission's July 25th, 2024 meeting.

Behavioral Health Transformation (BHT) is California's collective effort to implement the Proposition 1 ballot initiative. One of the mandates outlined in the initiative is stronger mechanisms for accountability for our behavioral health system, including: 1) establishing metrics to measure and evaluate the quality and efficacy of programs and services, with an emphasis on identifying demographic and geographic disparities; 2) establishing standards of care for FSPs; 3) creating a list of evidence-based practices and community-defined evidence-based practices for county implementation; and, 4) making recommendations for improving and standardizing promising practices. We seek your input on setting a bold and expansive agenda for accountability. This agenda should include monitoring whether BHT is moving the dial on the seven negative outcomes of untreated mental illness; suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes, but also whether we are being innovative, efficient, and good stewards of public dollars.

The meeting begins at 9:00 a.m. PST, and this panel is scheduled to begin at approximately 10:20am PST following announcements, public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by 9:50am PST if possible, or by 10am PST at the latest. We request that your presentation be approximately 10 minutes. Please share your insights on and experience with:

• The importance of data and accountability systems for identifying and reducing disparities.

• Describing how community voice can and should be central to the development of accountability strategies.

• Any relevant examples of how data and accountability strategies have improved system-level outcomes, particularly for vulnerable and marginalized populations.

Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

July 9th, 2024

Lishaun Francis
Senior Director, Behavioral Health, Children Now

Letter sent via email

Dear Ms. Francis:

Thank you for agreeing to present at the public hearing on Transformational Change in Behavioral Health: Transparency and Accountability during the Commission's July 25th, 2024 meeting.

Behavioral Health Transformation (BHT) is California's collective effort to implement the Proposition 1 ballot initiative. One of the mandates outlined in the initiative is stronger mechanisms for accountability for our behavioral health system, including: 1) establishing metrics to measure and evaluate the quality and efficacy of programs and services, with an emphasis on identifying demographic and geographic disparities; 2) establishing standards of care for FSPs; 3) creating a list of evidence-based practices and community-defined evidence-based practices for county implementation; and, 4) making recommendations for improving and standardizing promising practices. We seek your input on setting a bold and expansive agenda for accountability. This agenda should include monitoring whether BHT is moving the dial on the seven negative outcomes of untreated mental illness; suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes, but also whether we are being innovative, efficient, and good stewards of public dollars.

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• Identifying metrics for children's behavioral health.

• The challenges presented by limitations of existing data and the gap between what we do collect versus what we should collect.

• Any relevant examples of how data and accountability strategies have improved system-level outcomes

Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

July 9th, 2024

Debra Oto-Kent
Founding Director, Health Education Council

Letter sent via email

Dear Ms. Oto-Kent:

Thank you for agreeing to present at the public hearing on Transformational Change in Behavioral Health: Transparency and Accountability during the Commission's July 25th, 2024 meeting.

Behavioral Health Transformation (BHT) is California's collective effort to implement the Proposition 1 ballot initiative. One of the mandates outlined in the initiative is stronger mechanisms for accountability for our behavioral health system, including: 1) establishing metrics to measure and evaluate the quality and efficacy of programs and services, with an emphasis on identifying demographic and geographic disparities; 2) establishing standards of care for FSPs; 3) creating a list of evidence-based practices and community-defined evidence-based practices for county implementation; and, 4) making recommendations for improving and standardizing promising practices. We seek your input on setting a bold and expansive agenda for accountability. This agenda should include monitoring whether BHT is moving the dial on the seven negative outcomes of untreated mental illness; suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes, but also whether we are being innovative, efficient, and good stewards of public dollars.

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• The importance of data and accountability systems for identifying and reducing disparities.

• Describing how community voice can and should be central to the development of accountability strategies.

• Any relevant examples of how data and accountability strategies have improved system-level outcomes, particularly for vulnerable and marginalized populations.

Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

July 9th, 2024

Ryan Quist
Behavioral Health Director, Sacramento County

Letter sent via email

Dear Mr. Quist:

Thank you for agreeing to present at the public hearing on Transformational Change in Behavioral Health: Transparency and Accountability during the Commission's July 25th, 2024 meeting.

Behavioral Health Transformation (BHT) is California's collective effort to implement the Proposition 1 ballot initiative. One of the mandates outlined in the initiative is stronger mechanisms for accountability for our behavioral health system, including: 1) establishing metrics to measure and evaluate the quality and efficacy of programs and services, with an emphasis on identifying demographic and geographic disparities; 2) establishing standards of care for FSPs; 3) creating a list of evidence-based practices and community-defined evidence-based practices for county implementation; and, 4) making recommendations for improving and standardizing promising practices. We seek your input on setting a bold and expansive agenda for accountability. This agenda should include monitoring whether BHT is moving the dial on the seven negative outcomes of untreated mental illness; suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes, but also whether we are being innovative, efficient, and good stewards of public dollars.

The meeting begins at 9:00 a.m. PST, and this panel is scheduled to begin at approximately 10:20am PST following announcements, public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by 9:50am PST if possible, or by 10am PST at the latest. We request that your presentation be approximately 10 minutes. Please share your insights on and experience with:

• The county perspective on the importance of data and accountability for system-level decision-making.

• The challenges presented by current legacy data collection systems and local solutions for quality monitoring, clinical decision-making, and system performance management.

• The need for standardization of metrics and outcomes.

Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Mental Health Services
Oversight & Accountability Commission

STATE OF CALIFORNIA
GAVIN NEWSOM, Governor

July 9th, 2024

Stephanie Welch
Deputy Secretary of Behavioral Health, California Health and Human Services Agency

Letter sent via email

Dear Ms. Welch:

Thank you for agreeing to present at the public hearing on Transformational Change in Behavioral Health: Transparency and Accountability during the Commission's July 25th, 2024 meeting.

Behavioral Health Transformation (BHT) is California's collective effort to implement the Proposition 1 ballot initiative. One of the mandates outlined in the initiative is stronger mechanisms for accountability for our behavioral health system, including: 1) establishing metrics to measure and evaluate the quality and efficacy of programs and services, with an emphasis on identifying demographic and geographic disparities; 2) establishing standards of care for FSPs; 3) creating a list of evidence-based practices and community-defined evidence-based practices for county implementation; and, 4) making recommendations for improving and standardizing promising practices. As you may recall, the Commission engaged community members to explore how to best support accountability for California's behavioral health system. Based on community input and consistent with the statutory requirements for counties to support community engagement to guide expenditure decisions, the Commission outlined an accountability framework focused on continuous reporting on behavioral health funding, expenditures and balances, the services supported with limited public funds, and the outcomes achieved through those services. That framework focused on the seven negative outcomes - now eight, recognizing the addition of substance use disorder services and outcomes.

The meeting begins at 9:00 a.m. PST, and this panel is scheduled to begin at approximately 10:20am PST following announcements, public comment, and any other agenda items. If you are attending via Zoom, please log into the meeting by

9:50am PST if possible, or by 10am PST at the latest. We request that your presentation be approximately 10 minutes. Please share with the Commission the Administration's current thoughts on the following:

1. What it will take to improve the efficacy and efficiency of our behavioral health system through a data-driven, results-based accountability framework

2. Provide guidance to the Commission on how we can best support Behavioral Health Transformation

3. Share emerging strategies and efforts by the Administration that focus on accountability and metrics.

Please note that written responses and biographies will be shared as public documents. As a speaker, you will receive Zoom log-in information from Commission staff.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.

Executive Director

Transformational Change in Behavioral Health: Transparency and Accountability Briefing Memo

July 25, 2024

Summary

In this memo, you will see a proposed accountability framework that supports California's multiple efforts to transform its behavioral health system, focusing on **resources**, **services**, and **outcomes**.

Purpose

The Commission identified data as a priority during the January 2023 strategic plan report out. Staff have worked since then to shape a research and evaluation agenda for the Commission that supports its initiatives and broad portfolio. With the passage of Prop 1, there are additional opportunities to support the Governor and legislature on its bold agenda to transform the behavioral health system. The Commission has allocated two hours to focus on accountability during the July 25, 2024 Commission meeting.

During this time, we will hear from speakers representing community voice, a perspective from county behavioral health, and a representative from California's Health and Human Services Agency. After the panel presentation, Commissioners will have the opportunity to ask questions and generate discussion, and public comment will follow.

Background

There is shared agreement on the importance of data and accountability for our behavioral health system. Based on community input and consistent with the statutory requirements for counties to support community engagement to guide expenditure decisions, the Commission outlined an accountability framework focused on continuous reporting on behavioral health funding, expenditures and balances, the services supported with limited public funds, and the outcomes achieved through those services. That framework focused on the seven negative outcomes – now eight, recognizing the addition of substance use disorder services and outcomes. This framework led to the development of the Commission's Fiscal Transparency Suite, spurred the effort to create a Data Center with linked administrative datasets from HCAI, Department of Education, CDPH, DHCS, and others, and has guided efforts across initiatives to establish standards and metrics for discrete subgroups and focus areas (e.g. criminal justice, school mental health). Last August, 2023, the Commission held a panel discussion on Data and heard from thought leaders and researchers on how data can and should be used to drive decision-making and quality in public systems of care. Between that discussion and the panel discussion for the July 2024 meeting, staff have been facilitating engagement with multiple community partners and groups to understand their perspective on what should be measured within various domains of the behavioral health system.

California has made tremendous investments in behavioral health the last several years. CalAIM, a multiyear reform led by the California Department of Health Care Services, seeks to transform Medi-Cal to be more coordinated and equitable. The California Youth Behavioral Health Initiative (CYBHI) is a one-time investment of $4 billion to improve children's behavioral health. The Mental Health Student Services Act (MHSSA) also invested over $200 million toward improving partnerships between schools and county behavioral health. Through the Mental Health Wellness Act (MHWA), the Commission has invested in older adults, and pending Commission approval, children ages 0-5 and Full Service Partnerships (FSPs).

Given these ambitious reforms and a statewide agenda focused on transforming the behavioral health system, what is needed now is an overarching accountability framework that support these aims.

An accountability framework that supports Behavioral Health Transformation broadly, should focus on resources, services, and outcomes.

- *Resources*: With limited public dollars, how can we promote efficiency and measure our return on investment for dollars spent?
    - Opportunities: Fiscal transparency models; outcomes-based contracting; Fiscal Transparency Suite; innovation dollars; statistical models that quantify the cost savings for addressing mental illnesses
- *Services:* As a system, we have struggled to understand what is being purchased and whether those services or program models are effective.
    - Opportunities: National and global examples of Return on Investment (ROI) models; Prop 1 mandate to establish standards of care, including step-down protocols, for FSPs; Prop 1 mandate to create a list of evidence-based practices and community-defined evidence-based practices; quality monitoring; Centers of Excellence for key levels of care/program models (e.g. FSPs, school mental health)
- *Outcomes:* The Commission's community engagement on data and accountability has illuminated that we measure and track a tremendous amount of information; however, there are gaps in what we currently measure and what we should be measuring (e.g. wellbeing measures). In their report, How to Transform the U.S. Mental Health System: Evidence-based Recommendations, the Rand Corporation highlights the importance of "patient-important outcomes" for treatment planning

Accountability Framework

Resources: Promote efficiency and measure return on investment of limited public funds

Systems: Understand what is purchased and whether those services or program models are effective

Outcomes: Align provider and patient goals and correct gaps in what is currently measured and what should be measured

and assessments of care quality. The authors stress the importance of aligning provider-based and patient-based goals, including "patient outcomes, such as social functioning and occupational goals."[i] Additionally, there are legacy data systems that need updating. The California Health Care Foundation described the importance of data sharing and aggregation between different parts of the system. "The success of both local and state data sharing initiatives are critical in enabling whole-person care."[ii] Another concern is that there are currently no clear standards for monitoring the behavioral health system, making it difficult to benchmark and track progress.

    - Opportunities: Innovation dollars; new technologies that facilitate streamlining of data collection and interoperability; an invitation to participate in a global forum on measuring well-being for societies. Prop 1 reinforces this concept by calling for recommendations on improving and standardizing promising practices and establishing metrics to measure and evaluate the quality and efficacy of programs and services, with an emphasis on identifying demographic and geographic disparities.

Data alone will not solve the persistent and entrenched issues of mental illness, substance use, and homelessness. Behavioral Health Transformation signals that it is time to work collectively to do better. To accomplish the goals set forth, California needs to set a bold accountability agenda around *resources, services, and outcomes* that includes the following elements:

- Research agenda for behavioral health
- Creation of standards for behavioral health
- Identification of corresponding metrics across dimensions of quality utilizing the Institute of Medicine's framework of 1) Effectiveness; 2) Client-centeredness; 3) Timeliness; 4) Safety; 5) Efficiency; and 6) Equity.
- Plans to implement data collection systems and data sharing to measure, monitor, and drive quality improvement.

[i] https://www.rand.org/pubs/research_briefs/RBA889-1.html
[ii] https://www.chcf.org/resource/calaim-in-focus/data-exchange/

AGENDA ITEM 9

Action

July 25, 2024 Commission Meeting

Proposition 1 Implementation: Exploring Commission Opportunities

Summary:
The passage of Proposition 1 in March of 2024 presents numerous opportunities to improve the Commission's processes and strengthen its commitment to the goals of the Behavioral Health Services Act. Proposition 1 also broadens the Commission's scope, duties, and roles, offering a unique opportunity to support the implementation of these reforms over the next few years. Navigating this transformative period will require strategic planning, innovation, and a steadfast commitment to improving behavioral health outcomes for all Californians.

At the July Commission meeting, Commissioners will have the opportunity to discuss their priorities, goals, and vision for implementing Proposition 1 beginning with changes effective January 1, 2025, focusing on the shift to behavioral health, integration of eleven new Commissioners, and the evolving functions and roles of the Commission. This discussion will also cover preliminary planning for additional changes effective July 1, 2026, including the launch of the Innovation Partnership Fund, establishment of consulting roles with behavioral health partners, and introduction of new reporting requirements.

Presenter: Kendra Zoller, Deputy Director of Legislation

Enclosures: None

Handouts (2): (1) PowerPoint; (2) Reference Guide

Proposed Motion: None

AGENDA ITEM 10

Action

July 25, 2024 Commission Meeting

Early Psychosis Strategic Plan Draft

Summary:
The Commission will hear an update on the work underway to develop a strategic plan to expand access to early psychosis care across California.

Background:
During its January 2024 meeting, the Commission directed staff to enter into a contract with a consultant to draft a strategic plan for early psychosis intervention. The Commission released a Request for Proposals to pursue three opportunities: 1) document the extent that Californians who develop psychoses have access to early psychosis care consistent with best practices, 2) estimate the cost of expanding access to cover 90 percent of the need based on best available research, and 3) develop a strategic plan to achieve that 90 percent coverage.

The Commission received three proposals to partner with the Commission to pursue those goals and awarded a contract to McKinsey and Company. Commission staff and the McKinsey team have engaged state and national experts in early psychosis care, economic analyses of the cost of care, the impacts of barriers to care and related themes.

Commission staff will provide an overview of the draft report and a proposal to widely disseminate the draft for public engagement, comment and refinement.

Presenters: Toby Ewing, Commission Executive Director; Kana Enomoto, Partner, McKinsey and Company; and Sameer Chowdhary, Partner, McKinsey and Company.

Enclosures (1): A Draft Early Psychosis Strategic Plan will be distributed prior to the meeting.

Handouts: None

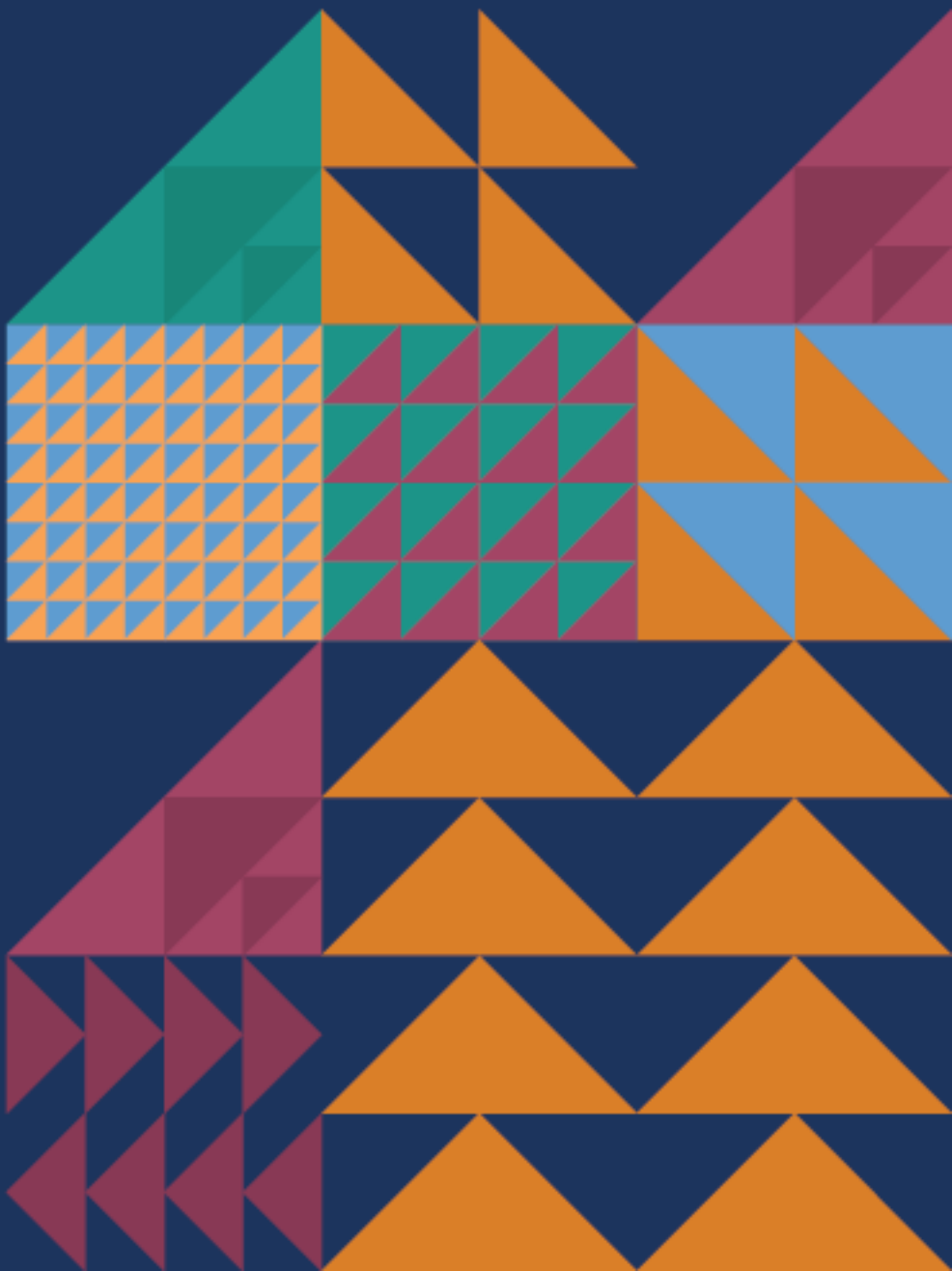
Proposed Motion: The Commission reserves the right to propose a motion, but no action is proposed at this time.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

STATEGIC PLAN

EARLY PSYCHOSIS CARE IN CALIFORNIA

DRAFT
JULY 2024



PURPOSE

Draft as of 20th July 2024

This document provides initial preliminary content for the MHSOAC's Early Psychosis Intervention (EPI) Strategic Plan. It guides a discussion with MHSOAC about the structure and initial content to be included in the Strategic Plan.

This document has been created at the request of MHSOAC. All information is based on inputs from MHSOAC.

The approaches and considerations included in this document are preliminary and may be further developed based on additional inputs from MHSOAC.

Table of Contents

Key terms glossary

Term	Definition
Coordinated Specialty Care	A multicomponent, evidence-based, early intervention service for individuals experiencing a first episode of psychosis (FEP)[1]
Clinical High Risk/ Prodrome	The early symptoms of an illness which may indicate that an individual may be at a higher risk of developing a psychotic disorder[2]
Early Psychosis/ First - Episode Psychosis	The initial period of up to five years following the emergence of psychotic symptoms[3]
Early Psychosis Intervention	An evidenced-based specialized approach to providing services to individuals affected by first episode psychosis. It is aimed at early recognition of psychosis, the provision of timely comprehensive treatments that are stage and age-appropriate, family/caregiver inclusive and with a client-centered strengths-based approach[4]
Duration of Untreated Psychosis (DUP)	The time from manifestation of the first psychotic symptom to initiation of adequate antipsychotic drug treatment[5]
Psychosis	A collection of symptoms that affect the mind, where there has been some loss of contact with reality. During an episode of psychosis, a person's thoughts and perceptions are disrupted and they may have difficulty recognizing what is real and what is not[6]
Serious Mental Illness (SMI)	Mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities[7]

[1] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care
[2] Yale PRIME Clinic
[3] Lundin et al, Identification of Psychosis Risk and Diagnosis of First-Episode Psychosis: Advice for Clinicians, March 2021
[4] BC Early Psychosis Intervention Program: Early Psychosis Intervention
[5] JAMA: Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients A Systematic Review
[6] NIMH: Understanding Psychosis
[7] NIMH

1. Executive Summary

Reasons to Scale Early Psychosis Intervention (EPI)

Approximately **1 in 33 people** will experience a psychotic episode in their lifetimes.[8] Psychosis touches many lives deeply, shaking the foundations of reality for those experiencing symptoms and reshaping their lives and that of their loved ones. In California alone, 21,000 people experience their first episodes of psychosis every year.

According to the National Institute of Mental Health, psychosis represents a collection of symptoms that suggest a loss of contact with reality—reflecting a profound disruption in a person's ability to perceive the world accurately. Every experience with psychosis is unique and the effects vary, with research only able to capture some impacts, including:

- **Unemployment:** Approximately one-quarter of people with serious mental illness are unemployed, according to a study by Guhne et al.[9]
- **Criminal and legal system:** A 2017 study found that 37% of patients experiencing first-episode psychosis were incarcerated at some point during their pathway to clinical care[10], often delaying access to treatment[11.] The costs of incarceration in California (~$70,000 per year) far exceed the cost of treatment for mental health treatment (~$22,000).[12]
- **Homelessness:** Research shows that approximately ~20% of people who are experiencing homelessness are affected by psychosis13, as compared to 4% of the general population[14]
- **Chronic disease burden**: individuals with psychotic disorders are 3.5x more likely to die due to cardio-vascular disease, tobacco use, and substance use[15]
- **Hospitalization**: people with psychotic disorders often have higher utilization of the healthcare system, including higher rates of emergency department visits. These additional healthcare cost costs amounted to $62.3B in 2019 for those affected by schizophrenia.[16]

[8] NIMH Recovery After an Initial Schizophrenia Episode (RAISE)
[9] Guhne et al, Employment status and desire for work in severe mental illness: results from an observational, cross-sectional study, *Apr 2021*
[10] Wasser et al, First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities, *Sep 2017*
[11] Wasser et al, First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities, *Sep 2017*
[12] Stanford Justice Advocacy Project: The Prevalence And Severity Of Mental Illness Among California Prisoners On The Rise
[13] Ayano et al, The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis, *Nov 2019*
[14] Calabrese: Psychosis
[15] Simons et al. Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults
[16] Kadakia et. al. The Economic Burden of Schizophrenia in the United States, 2019

- **Death:** individuals with psychotic disorders have shorter life expectancy by an average of 10-15 years[2] and exhibit a 15x-30x increase in mortality due to suicide[17]

Family, friends, and communities also experience the impact of psychosis in their roles as caregivers. Beyond the physical and emotional tension, caregivers experience an economic impact due to missed work days and lost income.

The initial phase of psychosis, known as early psychosis or first episode psychosis (FEP), marks a critical time in the lives of those experiencing these symptoms as early identification and access to evidence-based care is critical; receiving timely and effective treatment can significantly change both short- and long-term outcomes, offering hope for a healthy, fulfilling life.

Early Psychosis Intervention (EPI) programs like Coordinated Specialty Care (CSC) provide evidence-based care for individuals experiencing psychosis and their families. CSC not only provides symptom relief but also includes supports that help individuals reclaim their lives and pursue their goals without being defined by their condition. CSC improves symptoms of schizophrenia and psychosis over 24 months[5] and fosters stronger, more supportive communities that are informed, compassionate, and proactive. Through individual, group, and family treatment; medication management; supported education & employment; case management; community outreach; and peer & family partners, CSC cultivates environments to uplift those experiencing psychosis and equip their families, friends, and community members to support long-term recovery and resilience. CSC also provides positive impacts on the community and social systems:

- **Reduced hospitalization**: Reduces average inpatient days by 33% and average number of ED visits per year by 36%[18]
- **Reduced Unemployment:** Reduces the likelihood of being unemployed by ~42%[19]
- **Stable housing:** Reduces the need for homelessness services amongst the FEP population by 48%[20]
- **Reduced criminal justice system involvement:** Reduces risk of committing first crime by 76%[21]
- **Reduced caregiver burden:** Reduces average cost of lost productivity due to caregiving duties by 28% and lowers average incremental healthcare costs through improved health outcomes for caregivers by 29%[22]

[17] Simons et al. Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults
[18] Rosenheck et al
[19] Dickerson et al,
[20] Tsiachristas et al
[21] Pollard et al.
[22] McDonell et al.

Currently, MHSOAC estimates that only 10% of Californians in need have access to Coordinated Specialty Care, with many facing barriers to timely, equitable and affordable care. The State's mission is to expand access to 90% of Californians over the next three years.[23] The State has a pivotal opportunity to guarantee that individuals experiencing psychosis, along with their families, receive equitable, high-quality, and targeted early psychosis care that is appropriately and fully funded. This is vital in addressing mental health needs comprehensively and compassionately across the state.

Impact of Scaling EPI

Expanding access to EPI from an estimated 10% to 90% of Californians in need—an expansion from 2,100 to 19,000 individuals receiving care annually—**could transform lives and livelihoods.** Outside of individual impacts on clinical and non-clinical outcomes, there would also be positive benefits on friends, families, and communities.

In California, scaling CSC may generate $858M in annual system cost savings and productivity gains in year five.[24] These savings arise from shifting costs and reduced expenses related to unemployment, homelessness, and incarceration associated with untreated psychosis:

- ~$900M increase in healthcare costs driven by realigning care from inpatient settings to CSC and ongoing outpatient care for 9x the number of clients
- ~$865M in caregiver savings from recovered earnings and healthcare costs for caregivers
- ~$457M in employment savings from recovered earnings and Supplemental Security Income (SSI) / Social Security Disability Insurance (SSDI) payments
- ~$355M in criminal justice savings from reduced criminal justice interactions
- ~$15M in housing savings from reduced homelessness and the need for supportive housing

Key Solutions to Scale EPI

MHSOAC, in collaboration with advisors, has developed a plan for scaling EPI to ensure that 90% of individuals in need have access to care within their first year of symptoms. The plan includes both strategic objectives required to realize the vision and foundational levers that are critical enablers necessary to expand access to EPI successfully:

[23] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics) Total programs in CA = 43; Clients per program – average 50-75 (assume 60)
[24] See Chapter 4 Opportunity for additional details and model assumptions

Our vision is to ensure Californians experiencing psychosis and their families have equitable access to high-quality, appropriate, holistic early psychosis care.

Strategic Objectives

- **Awareness:** Enhance statewide awareness and understanding of early psychosis symptoms and resources to reduce stigma and elevate expectations for quality EPI. Educate community influencers like teachers and physicians about psychosis, destigmatize related conditions, and highlight the effectiveness of EPI through comprehensive resource centers, integration of psychosis education into wider health campaigns, and development of communication strategies to boost engagement in psychosis care across healthcare, housing, criminal justice, and social service systems.
- **Access:** Address key challenges to access, including varying levels of service convenience, coverage disparities between public and private insurance, and inconsistent eligibility and intake processes. Define access standards for different community types, establish community-led working groups, address capacity and infrastructure barriers, and refine diagnostic and referral guidelines.
- **Quality:** Ensure services adhere to a stringent level of care, with the CSC model promoted as the standard, to improve the fidelity of intervention models. Provide continuous enhancement of care quality, including leading ongoing trainings for providers, standardizing treatment protocols, and conducting rigorous program evaluation.
- **Equity:** Ensure full and equitable access to high-quality treatment, focusing on vulnerable communities accessing EPI less frequently. The focus of work is cultural and language competency of care through improving workforce diversity, co-designing EPI programs with communities, and establishing and tracking measurable goals around equity metrics.

Foundational Levers

- **Sustainable funding:** Secure sustainable funding and optimize resource allocation to support the expansion and maintenance of EPI programs statewide, to provide timely access to individuals in need regardless of a patient's insurance type. Develop consensus among funding partners, secure programmatic funding to ensure 100% coverage for all CSC components, and advocate for policy changes to increase financial support for EPI programs.
- **Workforce & capabilities:** Address California’s significant workforce shortages in trained clinicians and prescribers by recruiting new members, optimizing the use of existing staff, and enhancing capabilities through state-wide CSC-specific training

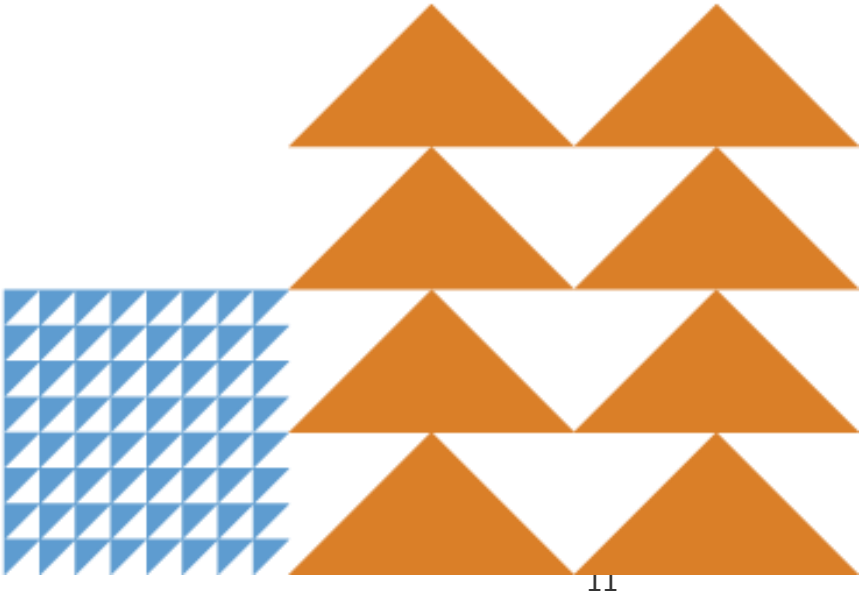
programs. Conduct a comprehensive assessment of workforce supply and demand, develop and implement recruitment and retention strategies, and expand training opportunities to build a capable, diverse workforce prepared to meet the needs of those with early psychosis, regardless of where they live.

- **Accountability:** Establish governance structures to ensure responsibility, measure progress, and facilitate continuous improvement in access, cost, quality, and outcomes of EPI. Refine and implement strategic goals, align efforts across partners, and develop incentives and structures to ensure consistent and accountable care delivery across California.
- **Infrastructure:** Improve the availability and distribution of EPI programs throughout California—including closing the gap for counties without an EPI program—through cutting-edge physical and digital infrastructures and revised public policy. Scale care models, particularly in underserved areas, by identifying infrastructure needs, developing strategic partnerships, and leveraging technology to optimize care delivery and access for individuals experiencing early psychosis.
- **Ecosystem engagement:** Establish an integrated care delivery model for individuals experiencing psychosis and their families, involving a wide range of partners from healthcare, education, housing, and criminal justice systems. Increase awareness and coordination among partners by improving training, sharing information for better care coordination, and strengthening partnerships to ensure seamless and timely care delivery.

Next Steps

If this strategic plan is supported by the public, the governor and legislature, execution will involve forming workstreams to support implementation, such as integrated coordination, performance management, communication strategies, and change management to foster ecosystem-wide transformation. Implementation involves a phased approach over three years. The first phase includes forming workgroups and conducting analysis to further understand current state, align on innovative solutions and design initiatives to execute these solutions. During this phase, working groups will also establish necessary partnerships with public, private and social sector organizations to implement solutions. Subsequently, the focus will be on developing partnerships before piloting initiatives and refining efforts based on data analytics. The work will be dynamic and regularly incorporate feedback from stakeholders with the aim of widespread access to high-quality early psychosis care in California by the end of the third year of implementation.

2. The need to scale Early Psychosis Intervention in California



It is estimated that each year, over 130,000 individuals in the United States, including nearly 21,000 Californians, experience their first episodes of psychosis.[25]

Early psychosis, also known as first-episode psychosis (FEP), is defined[26] as the initial period of up to five years following the emergence of psychotic symptoms. Early identification and access to evidence-based care is critical, as treatment within this period can improve short- and long-term health outcomes for people with schizophrenia and other psychotic disorders.[27] Studies estimate that approximately **1 in 33 people** will experience a psychotic episode in their lifetimes.[28]

According to the National Institute of Mental Health, psychosis represents a collection of symptoms that suggest a loss of contact with reality. When experiencing a psychotic episode, individuals may struggle to recognize what is real and what is not. Psychosis may also result in reduced levels of self-care, educational and professional challenges, disruptions in family and community connections, and an increased risk of harming oneself or others. Psychosis often signals the onset of psychotic disorders like schizophrenia.[29]

Psychosis may be a symptom of a mental illness, such as schizophrenia, bipolar disorder, or severe depression. However, a person can experience psychosis and never be diagnosed with schizophrenia or any other disorder. Individuals affected by schizophrenia have additional symptoms beyond psychosis.
Source: NIMH

Individuals with psychotic disorders face significant **health challenges and higher mortality rates.** Research indicates that the life expectancy of people with psychosis is shorter by an average of 10-15 years, driven largely by accidental injury, self-harm, suicide or unintentional overdose.[30] The lifetime suicide rate for individuals with psychotic disorders is 5.6%, with highest risk following initial contact with mental health services.[31] Comparatively, the age-adjusted suicide risk in the US is 14.1 per 100,000 population.[32]

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[25] Estimated by applying the observed rate in the Medicaid population (Radigan et al) to the Medicaid and uninsured populations and the observed rate in a sample size with 85% commercially insured population to the commercially insured populations. Methodology based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics)
[26] Lundin et al, Identification of Psychosis Risk and Diagnosis of First-Episode Psychosis: Advice for Clinicians, March 2021
[27] Yale School of Medicine- What is Psychosis
[28] NIMH Recovery After an Initial Schizophrenia Episode (RAISE)
[29] NIMH: Understanding Psychosis
[30] Simon: Mortality Rates After the First Diagnosis of Psychotic Disorder in Adolescents and Young Adults
[31] Nordentoft: Suicidal behavior and mortality in first-episode psychosis
[32] U.S. Centers for Disease Control and Prevention

There are also significant economic and healthcare costs associated with psychosis. The estimated excess economic burden of schizophrenia in the US in 2019 was $343.2 billion, of which, only $62.3 billion was in direct health care costs (18.2%). Caregiving ($112.3 billion), premature mortality ($77.9 billion), and unemployment ($54.2 billion) are other significant drivers of economic costs.[33]

The impact of psychosis extends to **employment and education.** People with a serious mental illness (SMI) (defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment that substantially interferes with or limits one or more major life activities[34]) are often excluded from employment even though studies show that such individuals with SMI can succeed in mainstream employment with effective supports.[35] A study in 2021 estimated that ~25% of people with serious mental illness are unemployed,[36] compared to a 4 - 6% unemployment rate in the general population.[37]

Psychosis also can affect **housing security.** A 2019 study found that approximately 20% of individuals experiencing **homelessness** are affected by psychosis,[38] as compared to less than 4% in the general population.[39] Similarly, research published in 2022, found the risk of homelessness is ~5 times higher among veterans with schizophrenia compared to those without.[40]

In the **criminal justice and legal system,** the figures are similarly concerning. A study in 2017 found that 37% of individuals experiencing first-episode psychosis (FEP) were incarcerated at some point along their pathway to clinical care. These individuals experienced longer delays to treatment and more severe positive symptoms, and they averaged having more than two episodes of incarceration, mostly for nonviolent, petty crimes.[41] A 2016 study by the Department of Correctional Health Care Services found that approximately 30% of California Prisoners received treatment for a serious mental disorder. Mental health treatment is more effective and less expensive than incarceration, with the average annual cost of incarcerating a state prisoner in California at over $70,000, not including mental healthcare costs, while the cost of treating a person with mental illness in the community is approximately $22,000.[42]

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[33] Kadakia et. al. The Economic Burden of Schizophrenia in the United States, 2019

[34] NIMH

[35] Prior: An enhanced individual placement and support (IPS) intervention based on the Model of Human Occupation (MOHO); a prospective cohort study, 2020

[36] Guhne et al, Employment status and desire for work in severe mental illness: results from an observational, cross-sectional study, *Apr 2021*

[37] U.S. Bureau of Labor Statistics range for unemployment in 2021

[38] Ayano et al, The prevalence of schizophrenia and other psychotic disorders among homeless people: a systematic review and meta-analysis, *Nov 2019*

[39] Calabrese: Psychosis

[40] Lin et al, Unemployment, homelessness, and other societal outcomes in patients with schizophrenia: a real-world retrospective cohort study of the United States Veterans Health Administration database, *July 2022*

[41] Wasser et al, First-Episode Psychosis and the Criminal Justice System: Using a Sequential Intercept Framework to Highlight Risks and Opportunities, *Sep 2017*

[42] Stanford Justice Advocacy Project: The Prevalence And Severity Of Mental Illness Among California Prisoners On The Rise

The impact of psychosis extends beyond individuals and systems to **caregivers.** Family members and other caregivers for people with psychosis report higher levels of emotional or physical tension relative to caregivers for individuals without psychotic disorders. The time needed to care for an individual experiencing psychosis may also impinge on workplace attendance, income, professional aspirations, and personal health.[43]

These challenges underscore the need to make effective evidence-based interventions that can improve outcomes in early psychosis care widely available at the individual, community, and societal levels.[44]

There are treatment models that have been demonstrated to be effective in alleviating symptoms and mitigating the impacts of early psychosis. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies **Coordinated Specialty Care (CSC)** as the standard of care for early psychosis.[46] CSC. CSC is a multi-modal, team- and community-based, collaborative treatment methodology. It comprises six primary components: psychotherapy, medication management, service coordination (e.g., case management), family education and support, supported education and employment, and peer support services.[47]

Coordinated Specialty Care (CSC) has been associated with positive outcomes for participants, including mitigation of symptoms and improvements in occupational and social functioning.[48] Select impacts are highlighted in Exhibit 1 (featured below).

The American Psychiatric Association (APA) in its 2020 updated practice guidelines for the treatment of schizophrenia, recommends Coordinated Specialty Care program for patients experiencing a first episode of psychosis. [45]
Source: American Psychiatric Association

[43] Cham et al, Caregiver Burden among Caregivers of Patients with Mental Illness: A Systematic Review and Meta-Analysis, Dec 2022
[44] Hirschtritt et al, Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis, Mar 2024
[45] APA: New Practice Guidelines on Treatment of Patients with Schizophrenia
[46] SAMHSA: Coordinated Specialty Care for First Episode Psychosis
[47] SAMHSA: Coordinated Specialty Care for First Episode Psychosis
[48] SAMSHA: Evidence-Based Resource Guide Series Overview

Potential impact of CSC on program participants

Sector	Select examples of observed impact (based on empirical studies) on participants
Healthcare	On average, reduces **inpatient days** by 33% and average number of **ED visits** per year by 36%[1] Improves **symptoms of schizophrenia and psychosis** (based on measures of both PANSS[2]/CDI[3])[4] observed over 24 months[5]
Employment and education	Reduces likelihood of being **unemployed** by ~42% (represents reduction from 50% to 29%)[6]. Increases appropriate access to **social security support** where needed by 37%[1] Improves **education and employment rates** increased by 2x (from 40% to 80% in six months)[7]
Housing	Reduces **need for homelessness services** amongst the FEP population by 48%[8] Reduces average per person cost of providing supportive housing to program participants[8]
Criminal justice	Participants **experience a 76% reduction in the risk of committing a first crime** and are significantly less likely to be convicted of any crime when enrolled in CSC[9]
Caregiving	Reduces average cost of **lost productivity** due to caregiving duties by 28%[10] Reduces average **incremental healthcare costs** through improved health outcomes for caregivers by 29%[10]

Exhibit 1: Overview of select patient outcomes from CSC as identified in the literature

Sources 1. Rosenheck et al ; 2. Positive and Negative Syndrome Scale ;3. Clinical Global Impressions; 4. Kane et al.; 5. Dixon LB et al.; 6. Dickerson et al, 7. Nossel et. al. .; 8. Tsiachristas et al; 9. Pollard et al.; 10. McDonell et al.

Despite the impact of Coordinated Specialty Care, it is estimated that in California, only 10% of individuals in need have access to Coordinated Specialty Care[49]

[49] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics) Total programs in CA = ~43; Client per program – average 50-75

Access to high-quality, timely CSC can transform the care journey for individuals experiencing early psychosis.

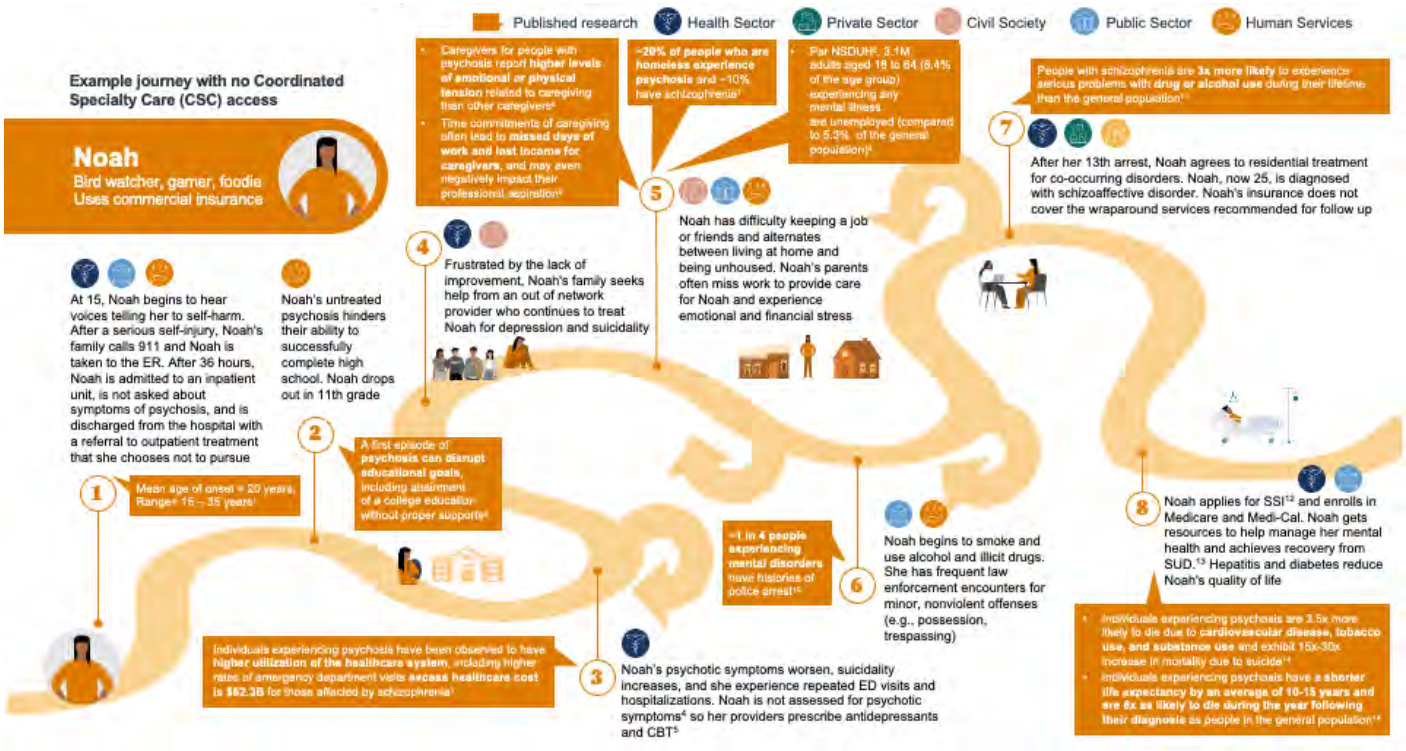


Exhibit 2: Illustrative care journey of an individual experiencing psychosis without access to Coordinated Specialty Care

Sources

1. Heinssen ; 2. Shinn et. al. ; 3. Kadakia et. al. ; 4. MHSOAC ; 5. CBT= Cognitive Behavioral Therapy; 6. Cham et. al. ; Gupta et. Al.; 7. Ayano et .al.; 8. NSDUH= National Survey on Drug Use and Health; 9. NSDUH; Guhne et al; BLS; 10. Livingston; 11. Khokar et. al. ; 12.SSI =Supplemental Security Income; 13. SUD= Substance Use Disorder; 14. Simon et. al.

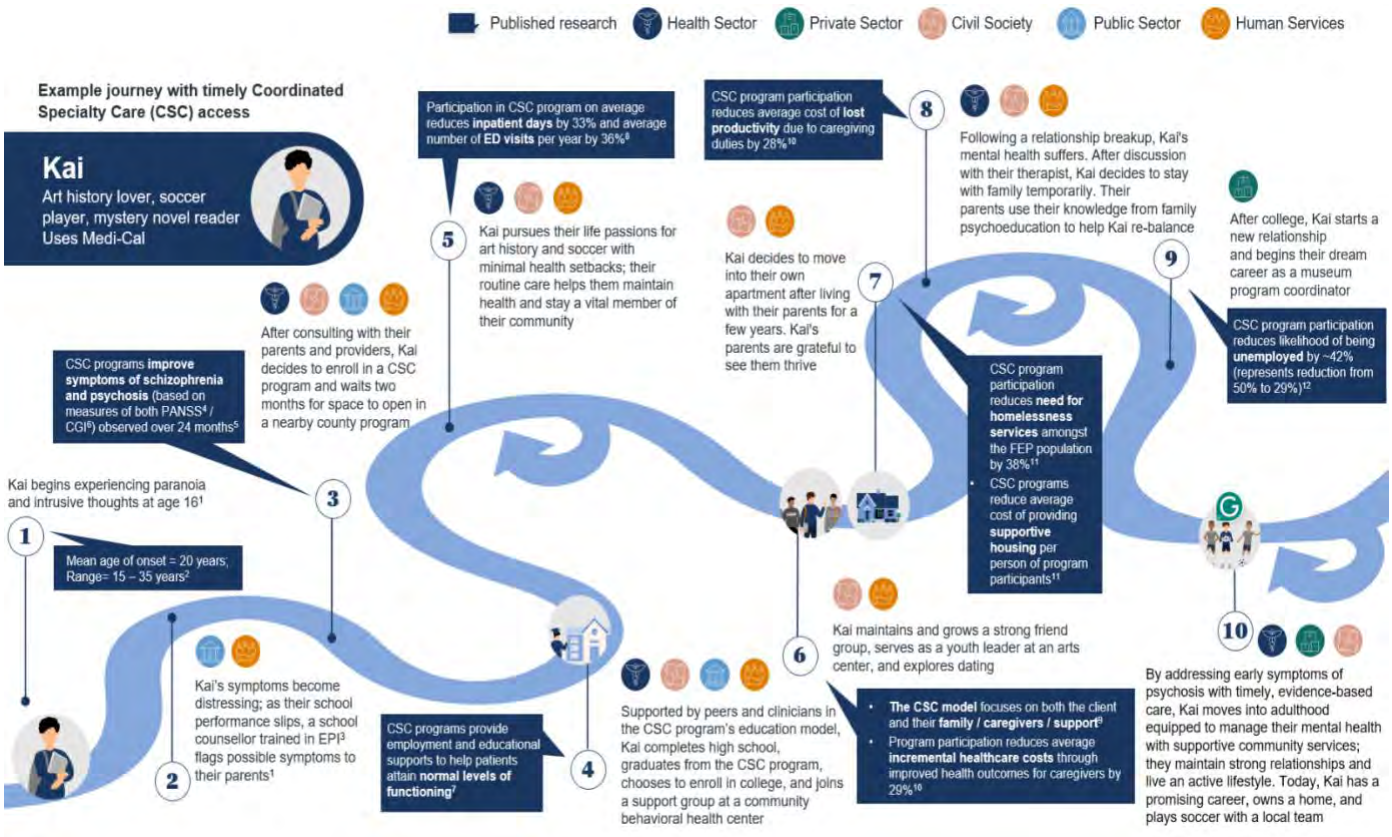


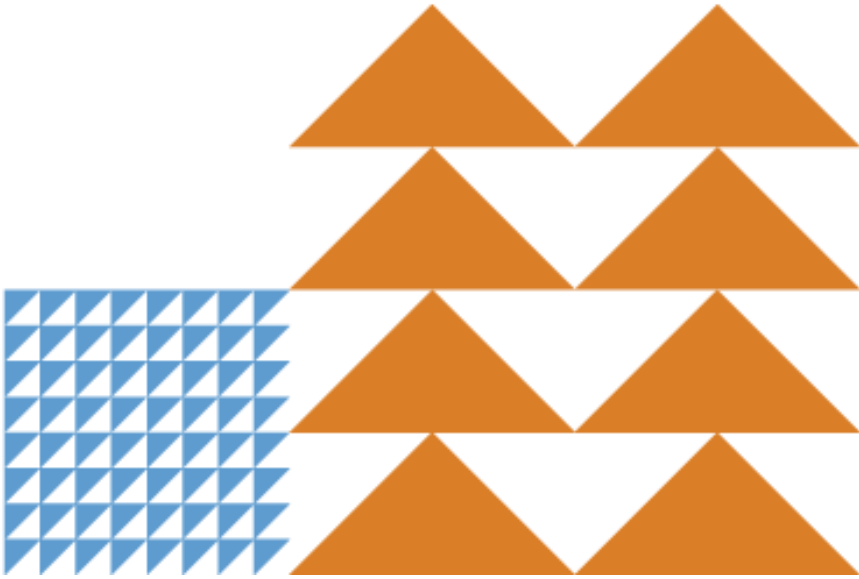
Exhibit 3: Illustrative care journey of an individual experiencing psychosis with access to Coordinated Specialty Care

Sources

1. MHSOAC; 2. Heinssen ; 3. EPI= Psychosis Intervention; 4. PANSS= Positive and Negative Syndrome Scale; 5. CGI= Clinical Global Impressions; 6. Positive and Negative Syndrome Scale; Clinical Global Impressions; Kane et. al. Dixon LB et. al. ; 7. Global assessment of functioning; 8. Rosenheck et. al.; 9. NAMI ; 10. McDonnell et. al. ; 11. Tsiachristas et. al; 12. Dickerson et. al.

There is an opportunity for California to ensure equitable access to high-quality and appropriate early psychosis care for individuals experiencing psychosis and their families.

3. Overview of the current state of early psychosis care in California



California has been a pioneer in expanding access to evidence-based care for early psychosis.[50]

3.1 Efforts in expanding early psychosis care

The Mental Health Services Oversight and Accountability Commission, an independent state agency, was created in 2004 by the Mental Health Services Act. The first of its kind in the U.S., the MHSOAC oversees and allocates funds to 59 local mental health departments across California's 58 counties. For each county, approximately 20% of MHSA annual revenues is earmarked to support prevention and early intervention programs and services,[52] which has helped to facilitate the rapid development of early psychosis programs across California.

Proposition 1, an effort to rebuild California's behavioral health system, expands access to funding for BH reforms through a two-bill package – The Behavioral Health Services Act (BHSA) provides funds through a stream of income tax revenue of ~$3.4B, and the Behavioral Health Infrastructure Bond Act (BHIBA) draws from a $6.4B general obligation bond to provide resources for supportive housing and behavioral health treatment.51 This reform provides a critical opportunity to make high-quality and appropriate Early Psychosis Intervention available statewide.

[50] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[51] Based on FY23-24 projected expenditures from Mental Health Services Act Expenditure Report – Governor's Budget
[52] MHSOAC, Well and Thriving Prevention and Early Intervention in California, *Jan 2023*

Select milestones are shown in the figure below:

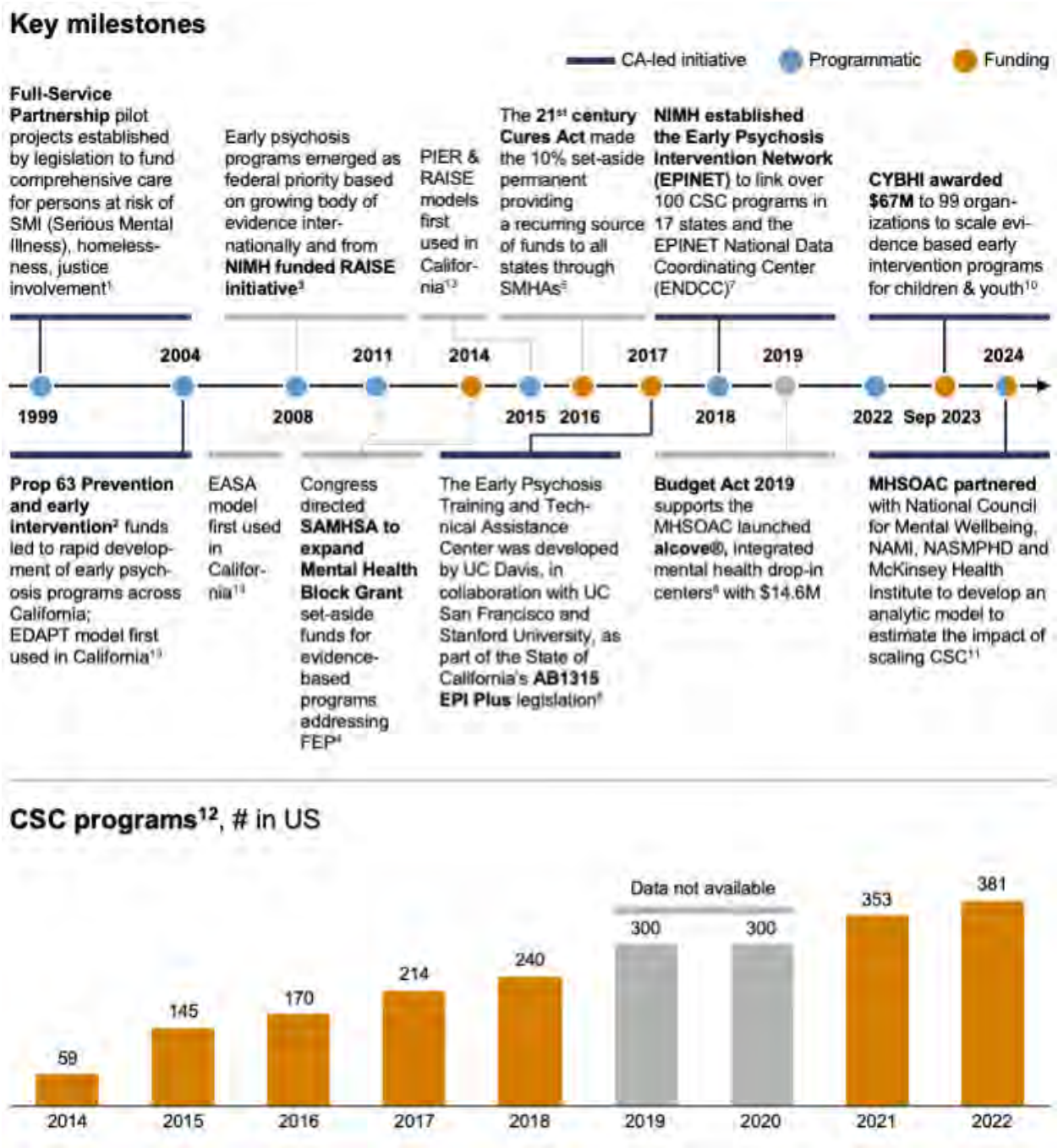


Exhibit 4: Timeline of select investment milestones in Early Psychosis Intervention (EPI) care within California

Sources

1. MHSOAC Report to the legislature on FSP, 2. MHSOAC, 3. NIMH RAISE, 4. SAMHSA, "Coordinated Specialty Care for FEP: Costs and Financing Strategies," Aug. 2023, 5. NIH Cures ACT , 6. MHSOAC EPI Plus 7. EPINET 8. MHSOAC allcove 9. Psychiatry Online, Psychiatric News. Mark Moran, 10. CYBHI 11. MHSOAC. 12. # of active CSC programs in 2022 as per SAMHSA 13. Niendam et al.

The MHSOAC (also known as the Commission) supports numerous initiatives to improve access to care for prevention and early intervention, including programs and partnerships intended to strengthen psychosis care delivery and improve public understanding of psychosis.[53] Example Commission activities and efforts include:

- Assembly Bill 1315 established the **EPI+ program** through which the Commission has made investments to support components of existing CSC programming, including care delivery, technical assistance, and data collection/evaluation strategy, and the formation of a multi-site learning collaborative.[54] Many CSC programs are operated at the county level using a variety of funds, including Medi-Cal and MHSA. [55]
- The commission supports **Full-Service Partnerships** (FSPs) that are county-level programs established under the Mental Health Services Act (MHSA). These programs support prevention and early intervention services delivered at the community level, with many services covered by Medi-Cal. FSPs are supported by the Commission through occasional funding for evaluation. Since the MHSA was passed in 2004, numerous statewide evaluations have provided quantified evidence demonstrating the success of FSPs, as indicated by fewer emergency department visits, a reduction in emergency mental health services, and decreased involvement with the criminal justice system.[56] The Commission recently approved a study to evaluate the effectiveness of a "whatever it takes" approach to recovery and management of psychosis and other mental or behavioral health needs through FSPs.[57]

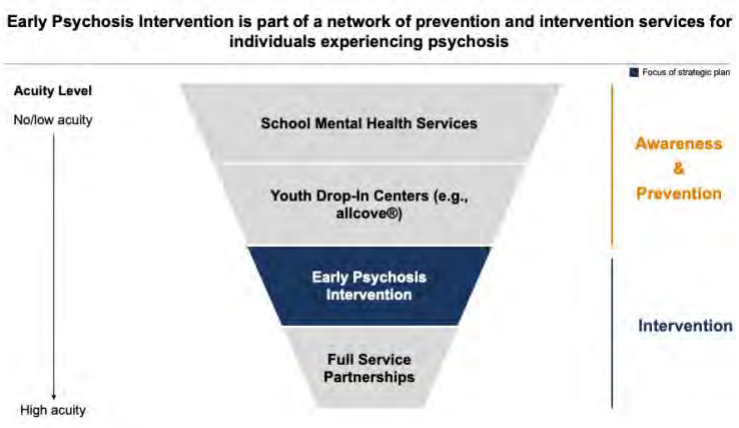


Exhibit 5: Intervention and prevention services for early psychosis

Source: Early Psychosis Intervention (EPI) Advisory Group

- The Commission has invested in strategies to support **school mental health services** for children and youth. **In 2024, DHCS partnered with MHSOAC and** awarded $67M to 99 organizations across 30 counties to expand early intervention programs for children, youth, and young adults, including coordinated specialty care.[58]

[53] MHSOAC publicly listed initiatives
[54] EPI Plus program
[55] Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[56] Report to the Legislature on Full-Service Partnerships, MHSOAC, January 2023
[57] MHSOAC Report to the Legislature on Full Service Partnerships
[58] DHCS news release

- The introduction of BH-CONNECT is expected to expand coverage for evidenced practices including Coordinated Specialty Care for First-Episode Psychosis[59]

3.2 Expanded CSC model

CSC is a team-based, collaborative, multidimensional approach to treatment that emphasizes the use of evidence-based interventions, shared decision-making, voluntary participation, and program fidelity.

There are six core elements of care that are part of CSC[60]:

1. **Psychotherapy** can be individual- or group-based and is typically based on cognitive-behavioral treatment (CBT) principles and emphasizes resilience training, symptom management, and coping skills
2. **Medication management** involves catering dosage and drug type to a client's specific needs and monitoring for psychopathology, side effects, and attitudes towards medication
3. **Supported education and employment (SEE)** typically involves sessions with an SEE specialist who acts as a coach to help clients plan life goals and return to education or the workforce to achieve those goals
4. **Family support and education** involves educating family about psychosis, alongside coping and communications skills to best engage with loved ones
5. **Service coordination** includes collaborative communication between providers (e.g., using phone, videoconference, electronic health records; between team leads, physicians, nurses, SEE specialists) to discuss topics such as progression of care, medication needs, and the client's treatment/life goals; individual case management is also used to coordinate catered support and services
6. **Peer support** provides CSC-FEP program participants with a sponsor with shared lived experiences related to FEP or other factors (e.g., demographics, substance use), who provides mentorship and healthy coping skill

[59] The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BHCONNECT) Section 1115 Demonstration

[60] Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care

In addition to these core elements, the California CSC model focuses on the client and their family, caregivers, and/or other supporters at the center of the care team, incorporating an assertive case management approach. This approach includes peers and family partners, community outreach and education, and weekly team meetings to improve client outcomes.

Exhibit 6: Expanded CSC model followed in California

Sources
EPICAL TTA CSC Model presented in collaboration with UC Davis, Stanford University and UCSF, MHSOAC

3.3 Funding for EPI programs

Financing for existing early psychosis programs in California comes from program-based sources at the national, state, and county levels (e.g., SAMHSA Mental Health Block Grant, CA Mental Health Services Act funding), and claims-based reimbursements. According to the California Early Psychosis Assessment Survey (CEPAS) of 28 CSC programs, state funding appears to be the most common source of nonclaims-based program funding, with 54% of programs reporting receipt of programmatic state funding. Around twice as many early psychosis programs receive reimbursement from Medicaid (Medi-Cal in California) compared

to programs receiving reimbursement from commercial insurance plans (43% and 21%, respectively).[61]

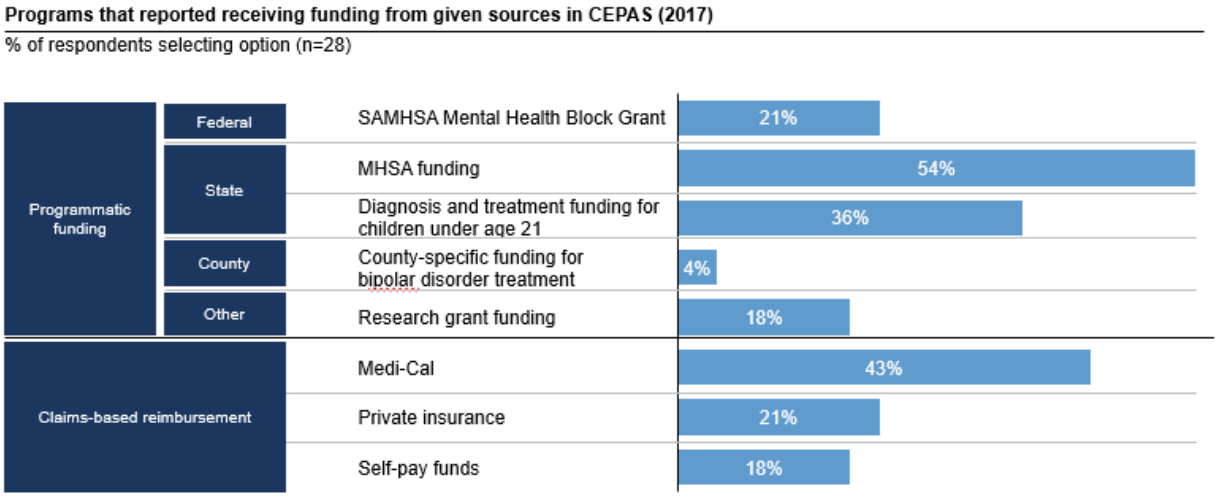


Exhibit 7: Programmatic funding and claim-based reimbursement sources for CSC programs

Sources
Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017, discussions with experts

3.4 Access to programs across geographies

California counties have developed a range of locally designed behavioral health programs to serve California's diverse population[62],[63]. The realignment of health and social services programs in 1991 restructured California's public behavioral health system, allowing counties to become responsible for program design and delivery within statewide standards for eligibility and services.

There is a need for additional Early Psychosis Intervention (EPI) Programs. In order to serve all residents experiencing early psychosis in California each year, EPICAL estimates the state will

[61] Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[62] The California County Platform Chapter 6 Health Services, *March 2023*
[63] County Behavioral Health Director Association

need 277 facilities providing EPI services that have the capacity to support 75 clients each.[64] Currently, there are 43 EPI programs in California.[65]

In order to serve all residents experiencing early psychosis in California each year, EPICAL estimates the state will need 277 facilities providing EPI services that have the capacity to support 75 clients each.[66] Currently, there are 43 EPI programs in California.[67]

As a result, the implementation of early psychosis intervention programs in California varies across counties. This variation is observed in performance against access metrics, with 13% of state residents living in counties without an Early Psychosis Intervention (EPI) program.[68] There are also differences between counties in treatment models and fidelity to CSC program components. In 2017, across the 58 California counties, 24 counties representing 76% of the states population and 41% of counties reported having at least one active program for treatment of early psychosis. Only five counties reported having multiple programs active. Another 21% counties had programs in development, while the remaining 38% reported no programs for early psychosis. [69]

Exhibit 8: Map of California Countries by EPI Program

Sources
Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

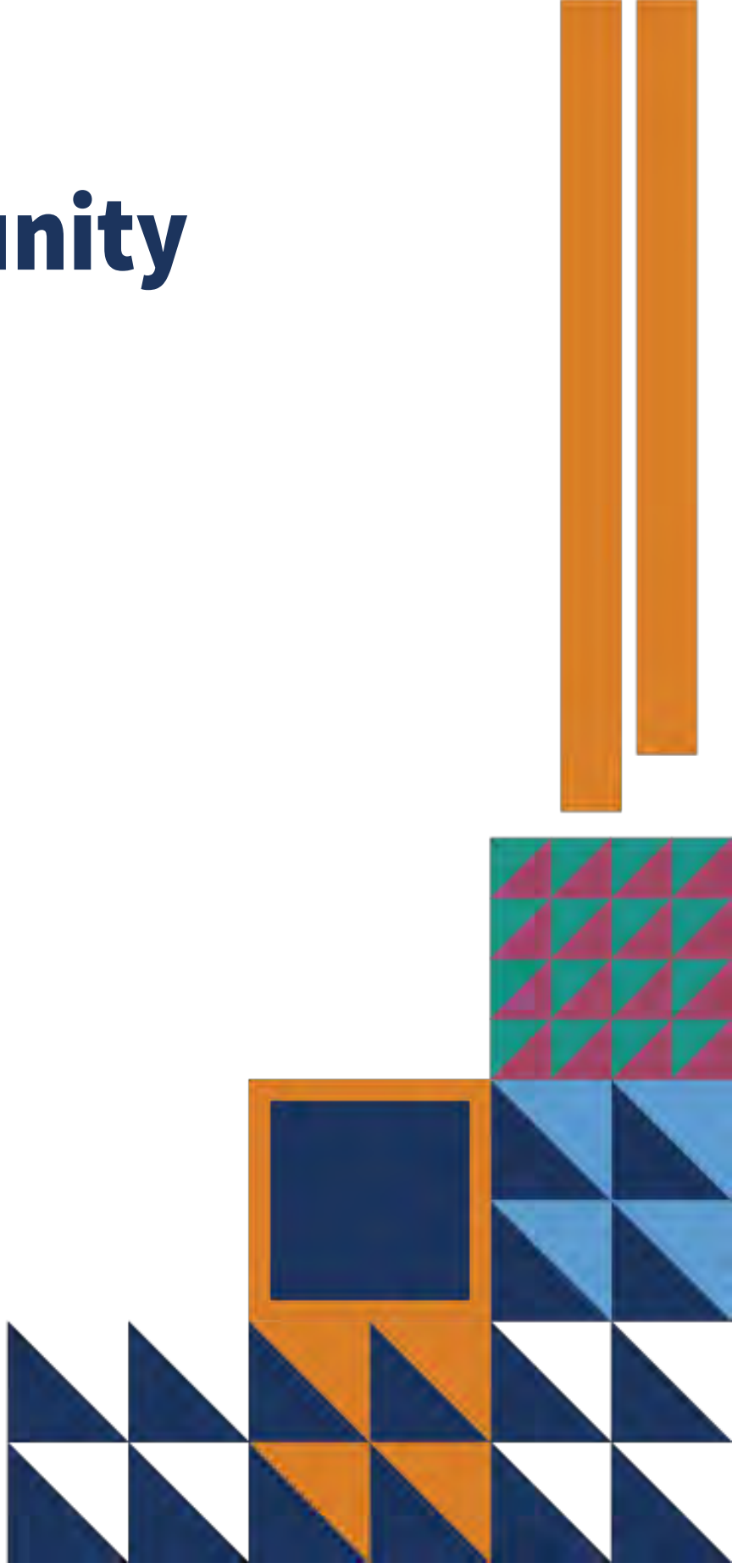
Many counties are working to address workforce gaps to expand access. While all U.S. states are working towards building a sufficient CSC-trained workforce to meet population needs, California faces a critical lack of CSC-trained staff. The state would need an estimated 5000

[64] EPI-CAL calculator estimating the number of EPI programs needed; the Incidence of early psychosis in California is 21,000 individuals. Assuming the average # of clients served by each EPI program is 75, the number of programs needed to serve 100% of annual incidence is 277
[65] Interview with Executive Director of EPI-CAL, 17th April 2024
[66] EPI-CAL calculator estimating the number of EPI programs needed; the Incidence of early psychosis in California is 21,000 individuals. Assuming the average # of clients served by each EPI program is 75, the number of programs needed to serve 100% of annual incidence is 277
[67] Interview with Executive Director of EPI-CAL, 17th April 2024
[68] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[69] Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017.

more CSC personnel to meet its needs[70]. Further, only 50% of CSC programs in California have staff training specifically in CSC, compared to 85% across the US.[71]

[70] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[71] California 2022 Uniform Reporting System Mental Health Data report SAMHSA

4. Opportunity



In early 2024, the MHSOAC partnered with the National Alliance on Mental Illness (NAMI), the National Association of State Mental Health Program Directors (NASMHPD), the National Council for Mental Wellbeing, and the McKinsey Health Institute (MHI) to develop a National Early Psychosis Intervention Impact Model to estimate the effect of expanding access to Coordinated Specialty Care (CSC). Through interviews with 19 psychosis and CSC subject matter experts[72], and review of dozens of academic research papers, articles and policy briefs, the collaboration produced an analytic model. This model estimates the direct system cost savings and indirect productivity gains of expanding CSC access across several impact categories (i.e., healthcare, housing, employment and education, criminal and legal system involvement) and to caregiving family members, based on published research on the outcome evaluations of CSC[73]. The analyses have been further refined to detail the impact of expanded access to CSC in California.

Scaling access to EPI programs from the estimated 10% today to 90% would provide access to CSC for an additional 135,000 individuals in California experiencing psychosis. Further, 11,500 caregivers will be able to continue to pursue their careers and to spend time with their loved ones and friends in a non-caregiving capacity

Moreover, preliminary estimates suggest that expanding access to CSC from addressing 10%[74] of estimated need (i.e., the current estimated level of access in California) to 90%[75] of estimated need will generate measurable cost savings for the system.

If a plan to expand access from 10% to 90% for individuals with needs is implemented in a strategic manner, the state is likely to generate $12B of overall value for the entire ecosystem, compared to a system addressing only 10% of the need over a 10-year period

Increasing CSC access from 10% to 90% provides services to an additional ~17,000 individuals a year (from approximately 2,100 to 19,000). It also generates an estimated $858 million in annual system cost savings and productivity gains by year 5.[76]

[72] Subject matter interviews conducted between January – February 2024. Additional information included in Chapter 6.1 Approach
[73] Detailed list of references can be found throughout this document and specifically in this chapter
[74] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics) Total programs in CA = ~43; Client per program – average 50-75
[75] The Kennedy Forum
[76] California Early Psychosis Intervention Impact Model

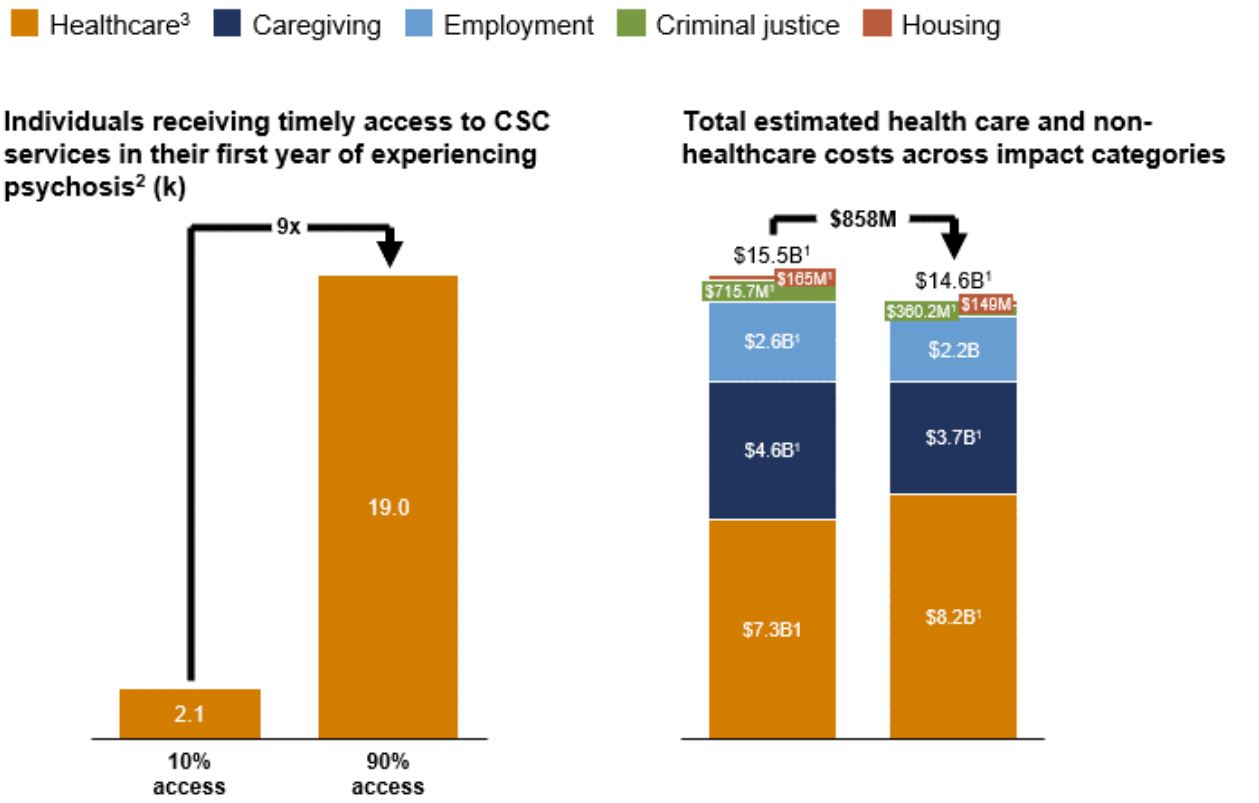


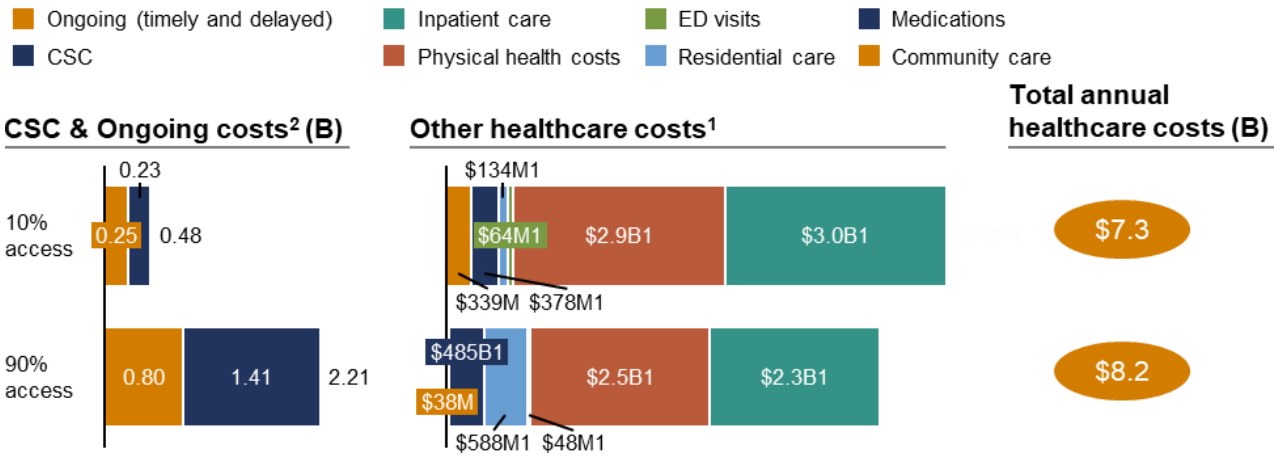
Exhibit 9: Preliminary high-level estimates of the impact of increasing access to CSC from 10% to 90% in California

Sources

1. Annual impact is based on an estimated CA incidence of approximately 21K per year for first-episode psychosis based on Radigan et al. (2019) for Medi-Cal and uninsured populations, and Simon et al. (2017) for the 19-34 aged population with commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care for 5 years compared to receiving CSC for 2 years and ongoing care for 3 years.
2. Number of individuals receiving timely access in their first year and delayed access in their second year (6.7%) of experiencing psychosis per the 10% and 90% access rate. Incidence is calculated based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics). Age range from the Radigan paper has been expanded to assume the same incidence rate for individuals between 19-34 years with Medi-Cal and for the uninsured population.
3. Healthcare is inclusive of inpatient and residential care, outpatient visits, ED visits, medications, and physical health. Individuals not receiving CSC are assumed to receive community care, estimated at 37 visits per year and $102 per visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study. For individuals receiving CSC, outpatient care is estimated at the cost of a team to deliver CSC or ongoing care.

In year 5, healthcare costs increase from $7.3B to $8.2B as a result of expanding access to CSC from 10% to 90%. Approximately $0.9B in healthcare costs would shift from inpatient settings to CSC and ongoing outpatient care

Difference in healthcare costs[1] at 90% vs 10% of CSC access[2] ($B), by healthcare category[5]



Overall, annual **healthcare costs** increase from ~**$7.3B to ~$8.2B** with:

- Annual costs of providing CSC ongoing care increasing by ~**$1.7B**
- Annual costs of other healthcare services (e.g., inpatient, residential care, ED, physical) decreasing by ~**$0.9B**

The average per person healthcare costs for those receiving access to CSC decreased by **~10% from ~$61k to ~$55k**[7]

Exhibit 10: Preliminary estimates of impact on healthcare costs from expanding CSC access from 10% to 90% of estimated need

Sources

1. Healthcare is inclusive of inpatient and residential care, outpatient visits, ED visits, medications, and physical health. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits per year and $102 per visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study. For individuals receiving CSC, outpatient care is estimated at the cost of a team to deliver CSC or ongoing care.
2. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis
3. Costs are based on the salaries (adjusted to 2024 USD) of a team to deliver CSC or ongoing care as estimated in Humensky et. al. (2013). Interactive tool to estimate costs and resources for FEP initiative in NY.
4. Annual impact is based on an estimated CA incidence of approximately 21K per year for first-episode psychosis based on Radigan et. al. for Medi-Cal and uninsured populations, and Simon et. al. for the 19-34 aged population with commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care or in CSC and ongoing care for 2 and 3 years, respectively
5. Medication and residential care costs are indirect cost increases – annual cost increases as a result of increasing access.
6. Calculated by dividing the total healthcare cost of providing CSC by total people receiving CSC care for 10% and 90% access respectively. Does not account for community care.

Increasing access to CSC is estimated to generate $1.7B in non-healthcare cost savings[31] in year 5 (Exhibit 10). The net savings are estimated to be around $858M a, with $2.4B in direct annual costs and $3.3B in direct and indirect savings across the full ecosystem.

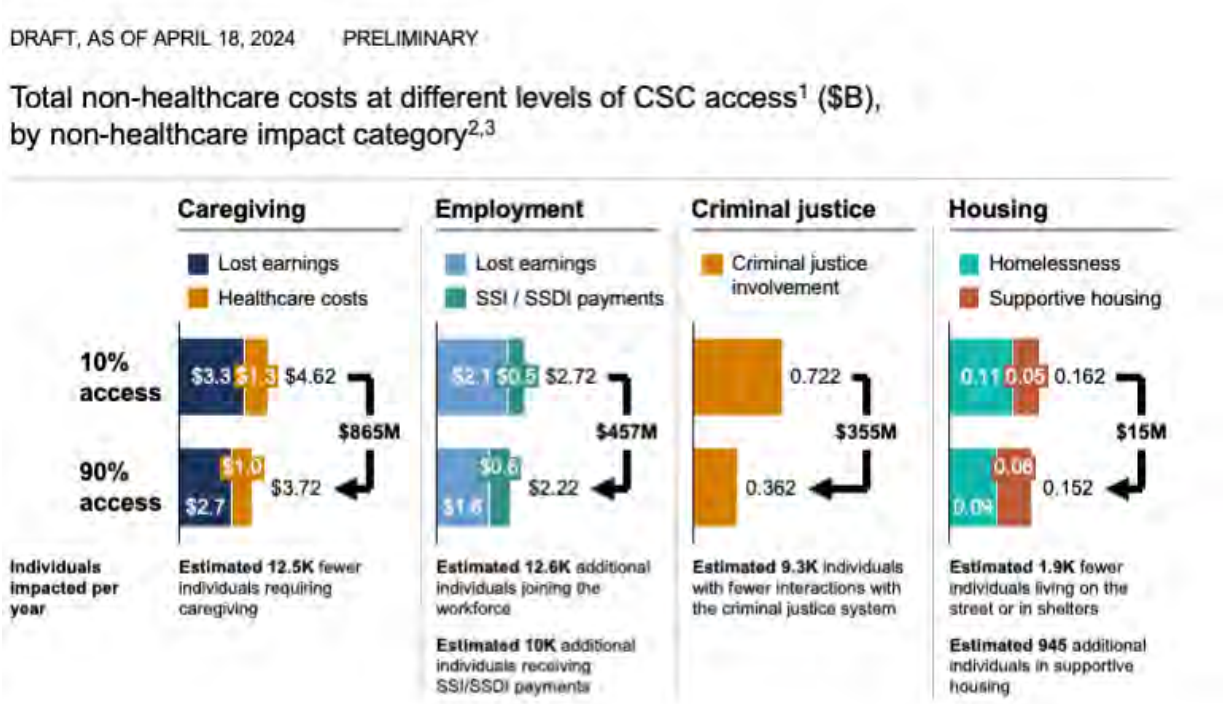


Exhibit 11: Increasing timely access from 10% to 90% is estimated to generate $1.7B in potential non-healthcare cost savings per year

Sources

1. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits per year and $102 per visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study.
2. Annual impact is based on an estimated CA incidence of approximately 21K per year for first-episode psychosis based on Radigan et al. for Medi-Cal and uninsured populations, and Simon et. al. for the 19-34 aged population with commercial insurance. First presentation with psychotic symptoms in a population-based sample and accounts for a 5-year period in which individuals are either in community care or in CSC and ongoing care for 2 and 3 years, respectively

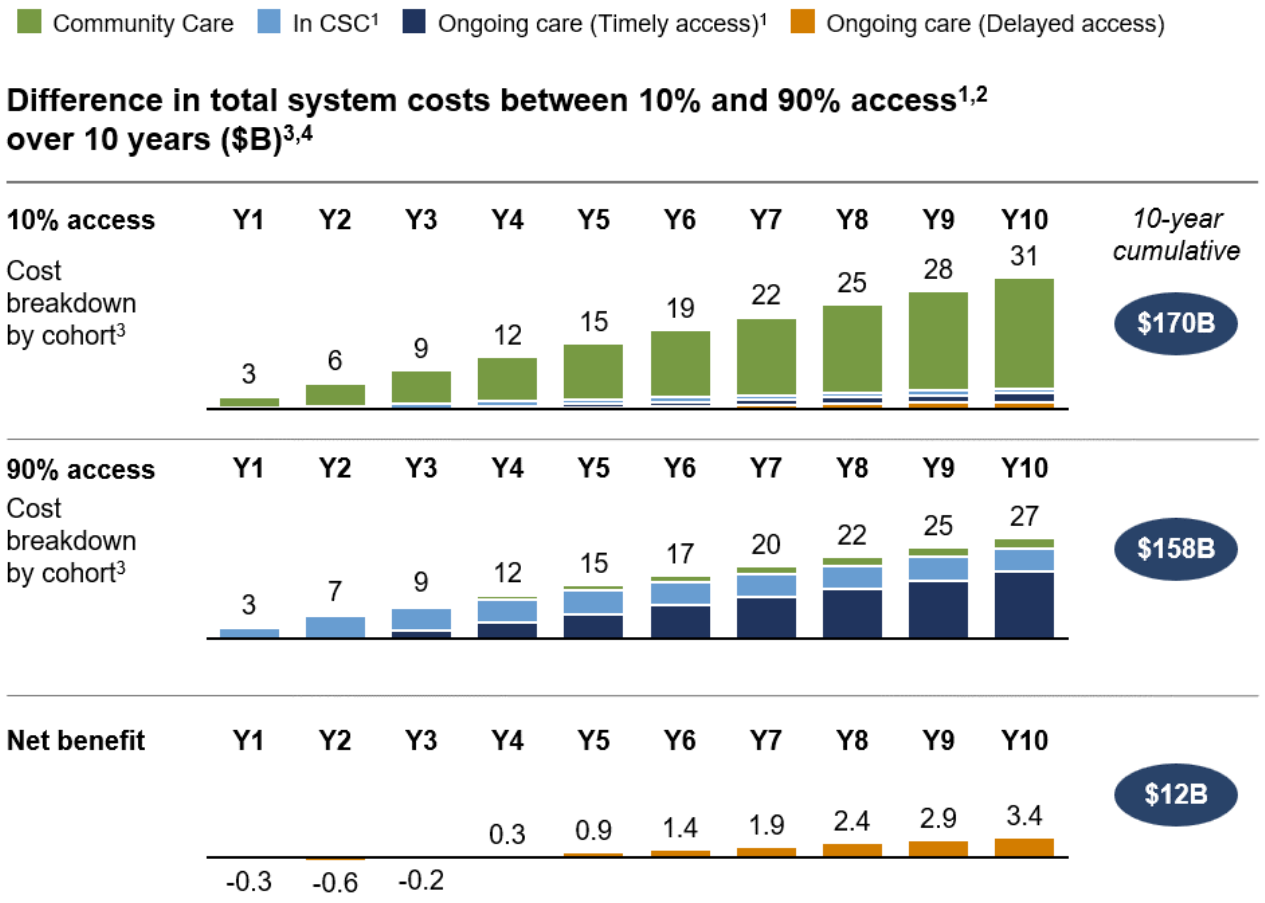


Exhibit 12: Over a 10-year span, a system that addresses 90% of need may generate an estimated $12B in savings for California compared to a system addressing only 10% of need

Sources

1. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis
2. Individuals not receiving CSC are considered to receive community care, estimated at 37 visits / year and $102 / visit (adjusted to 2024 USD) based on data from the NIMH RAISE-ETP study.
3. Costs are based on the salaries (adjusted to 2024 USD) of a team to deliver CSC or ongoing care as estimated in Humensky et. al. (2013). Interactive tool to estimate costs and resources for FEP initiative in NY.
4. Annual impact is based on an estimated CA incidence of approximately 21K / year for first-episode psychosis based on Radigan et. al. for Medi-Cal and uninsured population and Simon et. al. for 19-34 aged population that has commercial insurance. First presentation with psychotic symptoms in a population - based sample and accounts for a 5-year period in which individuals are either in community care or in CSC and ongoing care for 2 and 3 years, respectively

This expansion would positively impact over 135,000 individuals experiencing psychosis and their families, demonstrating the substantial long-term benefits of investing in early psychosis care (Exhibit 13).

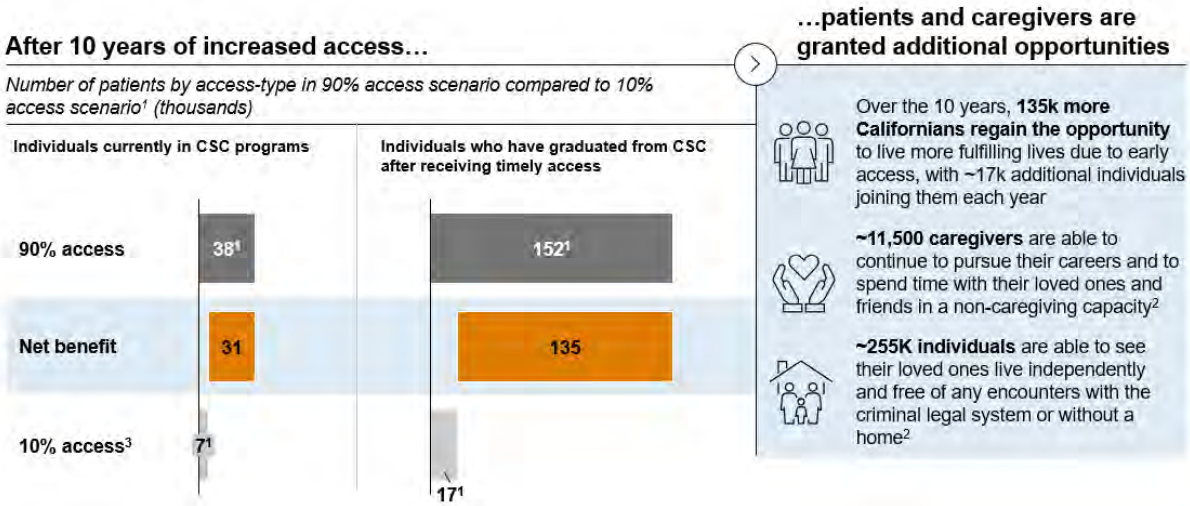


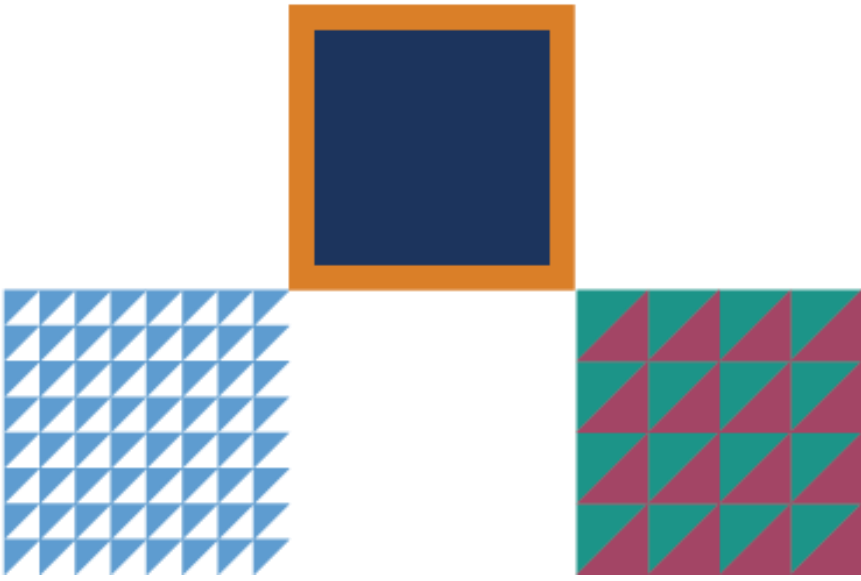
Exhibit 13: Expanded access in California reaches over 135k individuals experiencing psychosis and their families over a 10-year span

Sources

1. Representing percent of individuals receiving timely access in their first year and delayed access in their second year of experiencing psychosis
2. Based on a fixed assumption of 10% of individuals experiencing psychosis require caregivers
3. Based on the 2022 US Census estimate that the average persons per California household is 2.89; Assumes 1.89 persons per household are granted additional years with loved ones in a non-caregiving capacity Note that timely and delayed access is based on when an individual is identified as having early psychosis. Individuals may have wide variability in duration of untreated psychosis (DUP) at the time of identification. However, based on available data in empirical research, a conservative approach to mapping outcomes was taken. Where DUP is provided, shorter DUP outcomes were mapped to the timely access group and long DUP outcomes were mapped to the delayed access group. For referenced studies that did not provide DUP, outcomes were assumed to align with the timely access group

All estimates are based on published research on CSC and its impact on early psychosis, using research published between 2013-2024. Estimates of the potential system impact of expanding access to CSC may not include the impact of more recent care delivery innovations that may be deployed but were not captured in our research due to the availability of published research and data. There are components of the system impacted by the expansion of early intervention that are not included in the model due to a lack of published research, such as the impact on state hospitals, for which we might expect CSC to have downstream impacts. The real-world impact of scaling CSC in California will depend on model design and investment decisions, including those laid out in this strategic plan.

5. Potential path forward to scale early intervention



This Early Psychosis Intervention (EPI) strategic plan was formulated through an iterative process, seeking input from a broad range of experts to build consensus, encourage alignment across key partners, and engage California residents. MHSOAC sought technical inputs from subject matter experts, including people with lived experience, to inform key components of the strategic plan. These components will be shared with a broad range of ecosystem partners including individuals with lived experience, national leaders, state, and county administrations focused on health, education, housing, and criminal and legal systems, private sector health care providers and payors, CSC programs, researchers, community-based organizations, non-profits and philanthropic organizations for input. We will ensure that all Californians have the opportunity to engage in and refine the strategic plan through a public hearing prior to the Commission's review and adoption of the plan.

Exhibit 14: Distribution process for the draft EPI strategic plan

This draft describes the **overall vision** for the early psychosis intervention and the **strategic objectives** required to realize this vision. These cover awareness, access, quality, and equity. The plan also discusses **foundational levers** that are critical enablers necessary to expand access to EPI successfully. These levers include sustainable funding, workforce and capabilities, accountability mechanisms, infrastructure, and ecosystem engagement.

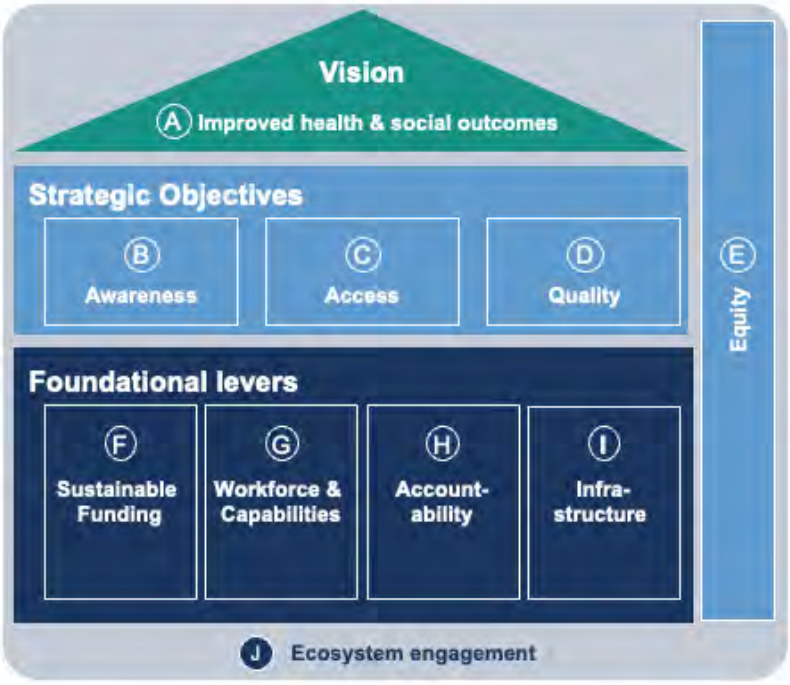


Exhibit 15: Overview of the strategic plan for early psychosis intervention in California

5.1 EPI Vision[77]

The primary goal is to ensure Californians experiencing early psychosis and their families have equitable access to high-quality, appropriate, holistic care.

To this end, the State may consider:

- Building on its pioneering focus on behavioral health.[78]
- Creating alignment across public and private sectors to expand access.
- Promoting fidelity across formats of care using a comprehensive learning health agenda and training for providers.
- Bolstering a population-based approach for indicated adults and adolescents with needs.
- Using widespread public education to destigmatize, identify, and address psychosis early on.

[77] Discussions with MHSOAC
[78] MHSOAC

- Engaging diverse perspectives and center community voices in learning, design, and implementation.

The plan targets measurable and specific goals over a three-year time horizon that could include elements such as:

- Increase access to timely, affordable, high-quality EPI services and reduce time to treatment
- Right-size the need for high acuity and high-cost downstream resources (e.g., state hospital inpatient psychiatric beds)
- Address some drivers of social needs (e.g., housing, education, and employment);
- Enhance the State's capacity and capabilities to provide high-quality EPI services by expanding the behavioral health workforce.

Progress against the targeted goals should be evaluated through outcome measures such as access to coordinated specialty care, client experience and outcomes, improvements in stable housing, career attainment and retention, reduced involvement with criminal and legal systems.

DRAFT, AS OF APRIL 23, 2024

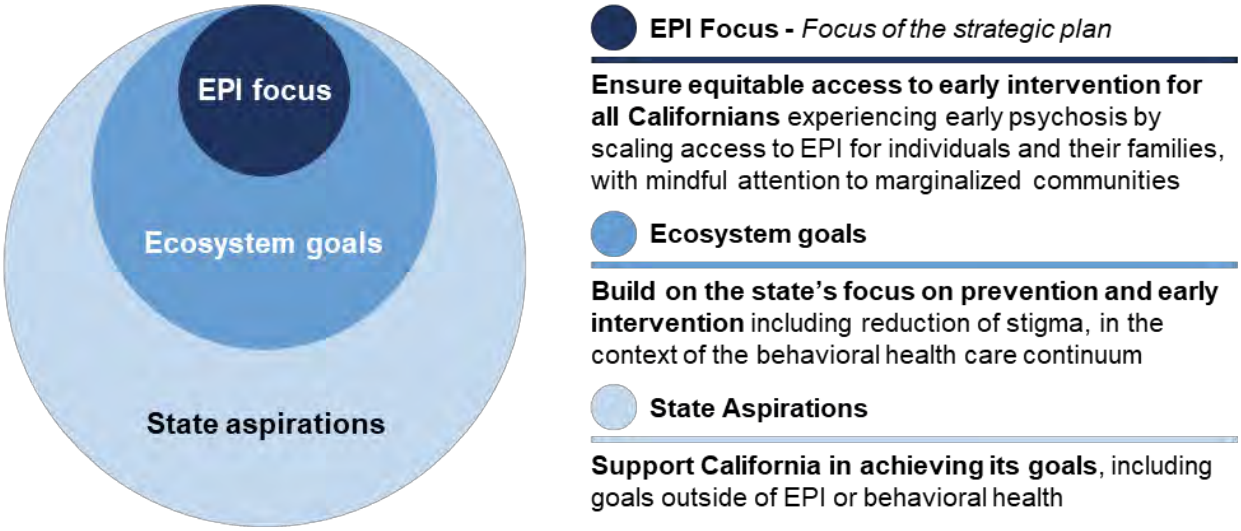


Exhibit 16: The focus of the strategic plan for EPI is situated within broader ecosystem goals and state aspirations

Sources
Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

5.2 Strategic Objectives

In order to achieve the vision and scale impact, the State will need to elevate awareness and education about early symptoms of psychosis and available resources, tackle barriers to psychosis treatment access, and improve the quality of evidence-based care, all while maintaining a focus on equity.

In the following sections, the Plan will examine how California is performing against the strategic objectives in the current state, potential goals that the State may aspire towards, key milestones for achieving progress, and possible next steps to inform the solutions that California considers. In order to achieve the State's goal of 90% access and minimize the duration of untreated psychosis (DUP), each component will be essential.

5.2.1 Awareness

This plan defines awareness as statewide **understanding and familiarity** with the symptoms and available resources and care for early onset of psychosis. Awareness may be built through educational approaches that **minimize stigma around psychosis and psychosis treatment** and **strengthen public expectation** of access to high-quality EPI services Awareness also includes ensuring that individuals experiencing psychosis have information on treatment effectiveness and potential impacts on their lives and well-being.[79]

Key objectives/goals[34]

The key goals of the plan regarding awareness are:

- **Improving awareness** of symptoms of early psychosis, particularly among individuals who may play a role in identifying these signs and connecting individuals to care (e.g., teachers and primary care physicians) through intentional and educational approaches informed by research and best practices including integrating screenings where appropriate.

[79] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

  - **Enhance familiarity** with psychosis assessments and care resources for individuals and their loved ones.
  - **Destigmatize psychosis** and related conditions among the general population through education
  - **Destigmatize care-seeking behavior** with a particular focus on vulnerable population segments.
  - **Educate Californians on the effectiveness of EPI** for short- and long-term recovery.
- Establish and strengthen expectations of access to high-quality EPI services through publicized targets (e.g., 90-90-90 treatment targets set by UNAIDS5)

Current state of awareness

Lack of awareness may result in high levels of stigmatization; studies have found that 55% of individuals on the schizophrenia spectrum experience stigma.[80] In California specifically, experts report that stigma and lack of awareness continues to be a challenge to providing the needed care.[81]

California has invested in improving awareness and reducing stigma associated with seeking mental health care through multiple initiatives spearheaded by MHSOAC, CDPH, DHCS, CYBHI, and other agencies; a few key initiatives include:

- **allcove®, an integrated mental health youth drop-in center**,[82] seeks to offer destigmatizing and accessible services for youth ages 12 to 25. Beyond treatment for moderate mental health challenges, allcove® provides linkages to services. Originally launched in 2018 by Santa Clara County, allcove® became a state-wide effort through the Budget Act of 2019**.**
- **The Workplace mental health project**,[83] launched in 2018 through Senate Bill 1113, enabled the development of five voluntary standards that employers may adopt to support mental health awareness. These include leadership and organizational commitment; positive workplace culture and climate; access to services; crisis preparation, response and recovery; and measurement, evaluation and continuous quality improvement.

[80] C. Simonsen et al, Perceived and experienced stigma in first-episode psychosis: A 1-year follow-up study, Comprehensive Psychiatry (2019)
[81] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[82] allcove®
[83] Workplace mental health

- **CYBHI Public Education & Change Campaigns**[84] is a youth-co-designed statewide campaign to reduce mental health stigma and boost help-seeking behavior. Launched in 2022, the 100M effort will span 4 years and work towards culturally appropriate solutions that are grounded in community empowerment strategies. **The CYBHI ACEs & Toxic Stress Public Awareness and Healing-Centered Campaign,**[85] spearheaded by CA-OSG with $24 million funding, is a dynamic statewide initiative spanning 2023-2024. By convening diverse partners, the campaign aims to enhance public understanding of Adverse Childhood Experiences (ACEs) and toxic stress, including how toxic stress is a treatable health condition.

Next steps

MHSOAC proposes the following next steps for consideration:

- Improve public awareness:
  - **Creating one-stop resource centers** for psychosis care-seekers and families to access content on early psychosis symptoms and pathways to access care[86]
  - **Create educational materials** that feature **scientists and doctors** who can speak with authority on the effectiveness and impact of EPI
  - Build an EPI **champion/ambassador program** where individuals who have gone through EPI programs themselves share their lived experiences and knowledge with the community

Tailor communications to **specific population groups including channel usage and culturally relevant messaging,** leaning on community partners to help inform and implement population-specific communication approaches that address stigmatization and other barriers that limit care seeking.

  - **Build partnerships with existing behavioral health awareness campaigns** to create or enhance psychosis-specific programming (e.g., integrating psychosis education into other awareness programs such as ACE)[87]
  - Ensure individuals working within crisis responses systems (e.g., 988 mobile crisis units, emergency room clinicians) are aware of early psychosis symptoms and treatment avenues

- Establish and strengthen public expectations:

[84] CDPH Public education and change campaigns
[85] CYBHI ACEs and toxic stress public awareness campaigns
[86] Interview with Lead Investigator of social and cultural determinants of psychosis risk, City College of New York, 28 Mar 2024
[87] Interview with Director, Stanford Center for Youth Mental Health and Wellbeing, 20 March 2024

- **Enhance transparency and strengthen public engagement** by making current access, coverage, and equity measures for EPI publicly accessible; implement regular reporting and tracking of KPIs to strengthen and foster accountability.
- Develop **a public communications strategy with awareness campaigns that facilitate a call to action by Californians** to catalyze engagement from key ecosystem partners in pursuit of the goal of achieving access to CSC for 90% of individuals within the 1st year of onset of psychosis.
- **Enhance school mental health curriculum and public awareness campaigns** to explain the benefits of CSC and showcase its comparative advantage in terms of prevention and control outputs

Potential Milestones/Progress Measures

Prospective milestones towards achieving awareness objectives include the following:[88]

- Align with advisory group and partners on the timeline and sequencing for awareness building based on EPI system readiness
- Review landscape of behavioral health awareness programs in California and identify potential partnerships and/or learnings to support awareness building for early psychosis intervention.
- Convene a workgroup with a charter to design a public engagement strategy including target metrics for awareness (e.g., awareness and stigma as measured through annual surveys, average duration of untreated psychosis) and approaches to build awareness among vulnerable populations.
- Determine community organizations to potentially partner with on tailoring messaging for specific populations or engaging in awareness efforts directly within the community.
- Engage a team of critical ecosystem partners to implement and refresh awareness strategies.

[88] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

5.2.2 Access

Access is defined as the adequate supply of affordable, timely, and evidence-based care across geographies and sub-populations.[89] The implications of providing access may vary based on geography (e.g., urban vs. rural vs. suburban settings) and population-based factors (e.g., children and youth vs. adults).

Current state of access

An estimated 10% of Californians experiencing psychosis are currently able to access effective early intervention services.[90] This Plan evaluates the current state through four lenses of access: timeliness, convenience, coverage, and eligibility. Workforce and infrastructure, which are key access enablers, are discussed in later sections of the strategic plan (4.3.2 and 4.3.4, respectively).

Timeliness

The California Department of Managed Health Care (DMHC) requires health plans to provide timely access to care. In the context of non-urgent mental health appointments, including for early psychosis, health plan members have the right to appointments within 10-15 business days and within 48-96 hours for urgent care.[91] However, experts report that many clients do not receive an appointment within the target time frame, especially in cases where the initial point of care is for stabilizing services (e.g., emergency departments and crisis care centers).[92] Per the 2022 DMHC Timely Access Report, the mean wait time for urgent appointments with a psychiatrist was 109 hours, exceeding the 48-96 our threshold. [93]

Convenience of access

In California, convenient access to EPI programs varies across counties; as on 2017, 59% of counties did not have an active EPI program, and less than half of the counties without active programs are in the process of developing a program. [94] Lack of convenient access may be particularly pronounced in vulnerable places within California.[95] Additionally, even in counties with EPI programs, there may be insufficient capacity and/or infrastructure to meet community needs.[96]

[89] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[90] EPI-CAL estimates; Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group)
[91] DMHC
[92] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[93] DMHC 2022 Timely Access Report
[94] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[95] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[96] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

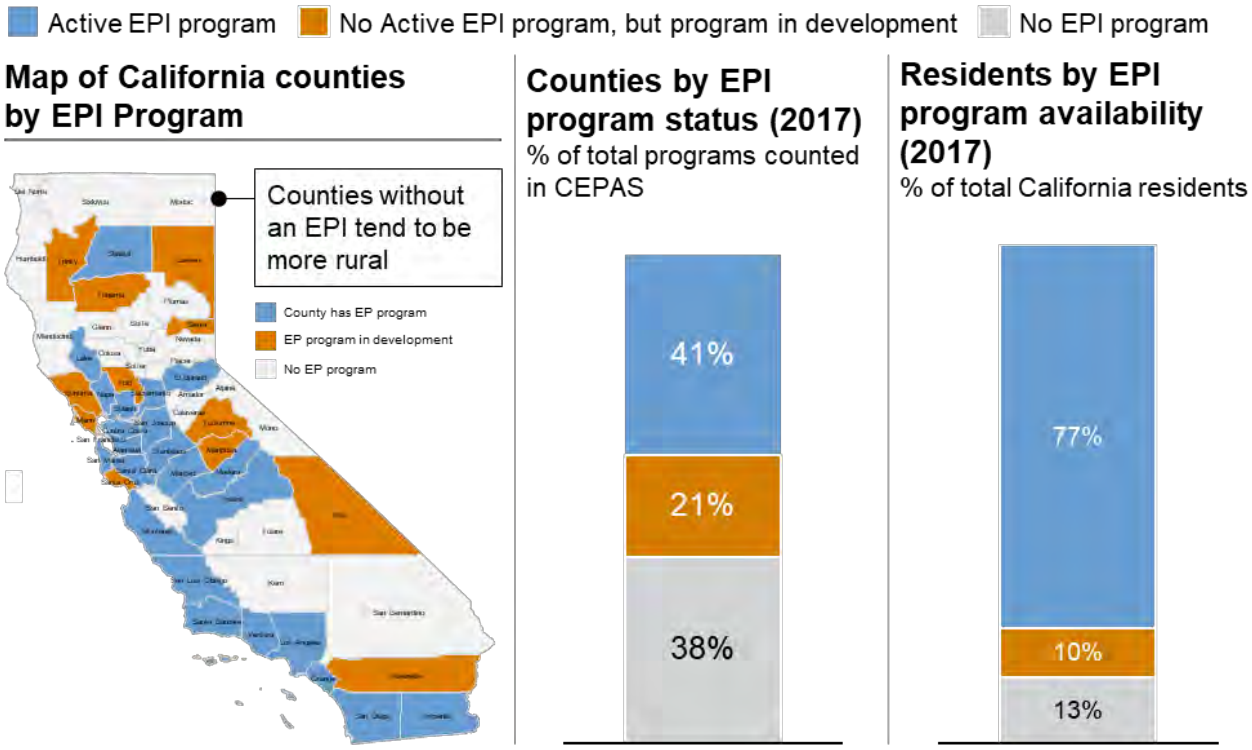


Exhibit 17: Landscape of active and developing EPI programs within California

Sources

California Early Psychosis Assessment Survey (CEPAS); U.S. Census Bureau Data: Annual estimates of Resident Population: April 1, 2010 to July, 2019

Note – This visual is not meant to assess sufficiency of EPI treatment offerings by county as needs vary based on population density and the CSC standard of care.

Coverage

In the current state, there are differences **between counties' CSC reimbursement model (Medi-Cal) and that of private health plans**. Medi-Cal often covers the suite of CSC services.[98] In contrast, private insurance usually only reimburses specific clinical services such as psychotherapy and medication management.[99] Private health plans rarely reimburse non-clinical components of CSC care (e.g., peer-support programs, supportive education and employment) despite the robust evidence base demonstrating the effectiveness of these interventions in improving health and social outcomes for people with early psychosis.[100] In California, 53.9% of the population is covered by private insurance, 26.8% by Medi-Cal, 12.0% by Medicare, and 0.8% by the military; 6.5% of Californians are uninsured.[101]

"A robust international body of literature demonstrates the effectiveness of a multimodal, recovery-oriented, and team-based treatment model—referred to as coordinated specialty care (CSC) in the United States—for addressing the complex needs of individuals with early psychosis. However, CSC remains out of reach for many individuals who would benefit from it. One major barrier to access in the United States is financial restrictions: CSC programs often struggle to receive compensation for nonbillable but essential patient-specific services (such as occupational and educational guidance, peer support, and community outreach), and patients with commercial insurance may need to pay for some or all CSC services out of pocket." Hirschtritt et. al (2024) [97]

On the federal level, there have been efforts to ensure coverage for mental health services. In 2008, the Mental Health Parity and Addiction Act called for mental health benefits covered by insurance to be provided at the same level as physical health care benefits. Mental Health Parity has been strengthened by executive and legislative actions, most recently through an executive rule in 2023; however, many still struggle to afford the care they need.[102]

California is advancing mental health legislation that encourages more participation in the delivery of mental health services for plans and providers. The State enacted the Senate Bill (SB) 855[103] in 2020. SB 855 requires health insurance to cover medically necessary

[97] Hirschtritt et. al. Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis
[98] CMS approves payment for Coordinated Specialty Care of First-Episode Psychosis
[99] NAMI – Coverage of Coordinated Specialty Care for early of First-Episode Psychosis, SAMHSA, Coordinated Specialty Care for First Episode Psychosis: Cost and Financing Strategies
[100] Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis by Hirschtritt et. al. 2024
[101] KFF
[102] The White House: FACT SHEET: Biden-Harris Administration Takes Action to Make it Easier to Access In-Network Mental Health Care (July 25.2023)
[103] Senate Bill 855

mental health and substance-use disorder care. All benefits that are medically necessary to prevent, diagnose, or treat mental health conditions and substance use disorders must be covered, including visits to a mental health care provider, **intensive outpatient treatment, residential treatment, hospital stays,** and prescription drugs if covered by policy.[104] An additional requirement is that networks include coverage for sufficient providers and facilities within a reasonable distance to provide timely care or arrange care from out-of-network providers or facilities.[105]

While Medi-Cal (California's Medicaid program) has historically covered many CSC components, it has not defined CSC as a distinct benefit or provided bundled reimbursement. California's Department of Healthcare Services (DHCS) proposed **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH- CONNECT)** may change this. One of the goals of BH-Connect is "improved availability in Medi-Cal of high-quality community-based behavioral health services, evidenced-based practices (EBPs_, and community-defined evidence practices, including CSC for first-episode psychosis". By defining CSC as a county-optional Medi-Cal benefit and offering bundled payments to county BH plans, California aims to support delivery of the comprehensive Early Psychosis Intervention.[106]

Eligibility and Intake

California currently does not have a consistent standard for CSC eligibility and intake, in part reflecting the complexity of consistently and accurately diagnosing early psychosis. Studies have shown that the diagnostic stability (the degree to which a diagnosis remains the same during subsequent assessments) of psychotic disorders is 47.7%.[107] This is indicative of both the complexity of accurate psychosis assessment and potential opportunities to improve consistency in screening and diagnosis for psychosis. Experts also suggest expansion of eligibility criteria for accessing EPI programs like CSC.[108] In California, eligibility criteria vary across EPI programs. Most EPI programs under the stewardship of EPI-Cal extend treatment to a broader continuum of psychotic disorders, including individuals at Clinically High Risk (CHR) for psychosis and individuals affected by mood disorders.[109] However, as of 2017, 17%

[104] California Department of Insurance
[105] California Department of Insurance
[106] The California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BHCONNECT) Section 1115 Demonstration
[107] Peralta et al, Long-term diagnostic stability, predictors of diagnostic change, and time until diagnostic change of first-episode psychosis: a 21-year follow-up study, Nov 2021
[108] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[109] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

of EPI programs in California do not serve individuals at CHR and 7% of programs do not treat people whose primary diagnosis is a mood disorder.[110]

Key objectives/goals

The goal for access is to ensure that 90% of individuals within the 1st year of onset of psychosis have **timely, affordable, appropriate,** and **convenient** access to CSC programs that are designed to inspire trust. [111] In the long term, the State may seek to ensure access within a shorter timeframe, recognizing that the World Health Organization recommends specialized treatment no more than 90 days after the start of psychosis symptoms.[112]

Next steps[113]

MHSOAC proposes the following next steps for consideration:

- **Timeliness:** To improve the timeliness of access, California could establish a workgroup to collect data to identify root causes for access barriers and establish incremental and long-term targets related to the average duration of untreated psychosis (DUP), average wait times for enrollment into CSC programs, and other metrics of timely access
- **Coverage:** To work towards ensuring all individuals experiencing early psychosis have access to CSC, regardless of their insurance coverage, California could consider exploring strategic optimization of service-based reimbursements and programmatic funding sources, explored in some more detail in Chapter 4.3.1.
- **Convenience:** California could explore the following steps to improve convenience:
  - Survey care seekers, their families, and community members to understand care experiences, timelines, and convenience challenges and identify solution to address access barriers outside of the health system (e.g., transportation for treatment)
  - Establish county-level archetypes and corresponding care models for convenient access based on factors such as population density, existing infrastructure, and the presence of vulnerable places and communities.[114] Develop criteria for determining when to deploy a given model (e.g., hub and spoke, regional models, virtual care elaborated in chapter 4.3.4)

[110] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[111] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[112] J Bertolote et al, Early intervention and recovery for young people with early psychosis: consensus statement
[113] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[114] CDPH definitions of vulnerable communities and vulnerable places

  - Explore and build out telehealth offerings related to EPI.
  - Build partnerships with trusted community-based organizations to enable more culturally competent programs that create an environment of safety and accessibility (described further in chapter 4.2.4. Equity.)

- **Eligibility and intake:**
  - Standardize psychosis diagnosis and intake processes (e.g., refining clinical guidelines, providing enhanced clinician and provider training for individuals who may screen or identify psychosis, such as primary care providers, school mental health providers, and healthcare providers in correctional settings).
  - Improve access to screening for individuals in child welfare homes and youth involved with the criminal/ legal systems due to the strong linkage between trauma exposure and psychosis.[115]
  - Strengthen care referral networks through partnerships with health systems, health plans, criminal/legal system facilities, housing services providers, and community- and faith-based organizations to connect patients with EPI screening and treatment services.
  - Explore universal screening for select settings (e.g., within the criminal justice and behavioral health systems)
  - Develop protocols and training for individuals without a healthcare background who may play a role in the identification of psychosis symptoms.
  - Strenthen linkages between EPI and the crisis care continuum system (e.g., 988) to ensure individuals in crisis experiencing pyschosis receive the proper care and referrals include mobile supports when needed
  - Establish Centers of Excellence to offer training and technical assistance EPI program to ensure model fidelity, improve outcomes for clients, dissiminate community-defined care practices and strengthen culturally- sensitive care[116].

Potential milestones/progress Measures[117]

- Establish access standards in the context of urban, suburban, and rural communities.
- Establish community-led working groups to
  - Evaluate EPI access barriers across counties and population groups within California (e.g., capacity, coverage, infrastructure)

[115] Morrison et al, Relationships between trauma and psychosis: an exploration of cognitive and dissociative factors, September 2005
[116] BH-CONNECT 2023
[117] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

  - Build out an iterative timeline for addressing access barriers and meeting goals.
  - Identify and implement solutions with relevant partners in private, public and social sectors.
- Refine and reinforce guidelines for psychosis diagnosis and referral.
- Track and report on impact. Potential metrics could include:
  - **Timeliness:** average duration of untreated psychosis (DUP), average wait time for the first appointment, % of individuals within the first year of onset of psychosis receiving CSC
  - **Coverage:** the # of individuals with private insurance with fully covered CSC treatment, out-of-pocket expense for clients using self-pay funding
  - **Convenience:** # of community partners engaged in EPI program design, self-reported ease of access for EPI programs for clients through surveys
  - **Eligibility and intake:** % of diagnosed individuals referred to EPI, % of clinicians reporting using the same clinical guidelines for early psychosis diagnosis.

5.2.3 Quality[118]

Quality is defined as the approach for ensuring that Early Psychosis Intervention (EPI) services increase the likelihood of desired outcomes, foster a positive client experience, and are consistent with learnings and individual community needs.[119]

Current state of quality

The American Psychiatric Association (APA) proposes Coordinated Specialty Care (CSC) as the **established standard of care** for early psychosis intervention.[120]

However, nationally and within California, the interpretation of Coordinated Specialty Care varies with multiple treatment models deployed.[121] Within California, **different treatment models are in use for EPI** including the Portland Identification and Early Referral (PIER)

[118] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[119] Institute of Medicine definition cited in Dimensions of Quality in Mental Health Care
[120] Keepers et al, The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia, Sep 2020
[121] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

model, the Felton Institute Prevention and Recovery in Early Psychosis (Felton) model, the Early Diagnosis and Preventative Treatment (EDAPT) model, the Early Assessment and Support Alliance (EASA) model, and the Recovery After an Initial Schizophrenia Episode (RAISE) model. The California Early Psychosis Assessment identified the PIER model as the most commonly used approach for CSC (20% of programs that responded to the survey cited using this model), followed by Felton and EDAPT models (17% of programs). Approximately 27% of programs reported utilizing other models that incorporated different components of CSC with modifications. [122]

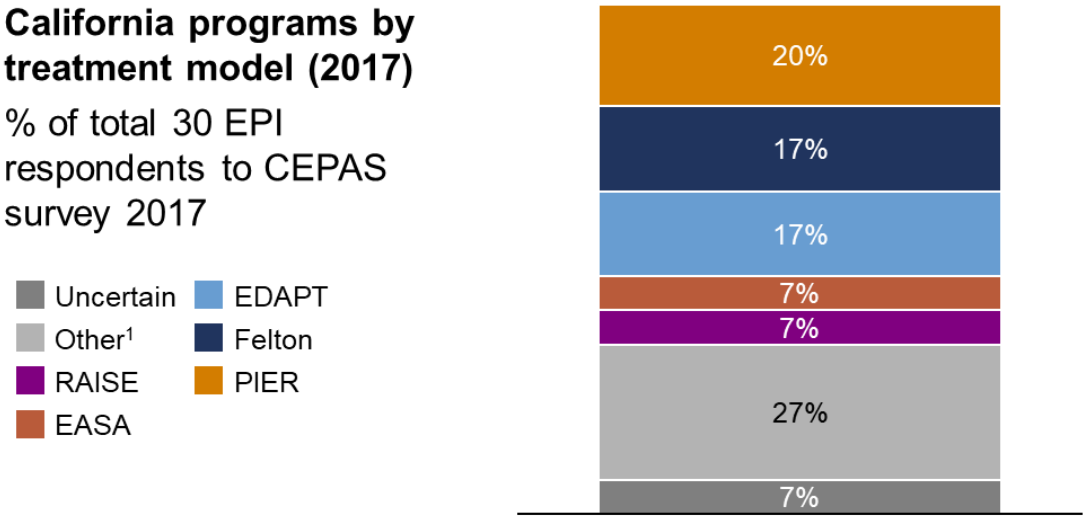


Exhibit 18: California CSC programs vary in the specific type of CSC they offer

Sources
The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services, Tara Niendam et al,
1 Other models that include various CSC components. For example, Los Angeles reported using the University of California, Los Angeles, Center for the Assessment and Prevention of Prodromal States model; Contra Costa County reported using the PIER model with adaptations; and Madera County reported using a "peer supportive service" within a full-service partnership to support linkage to medications and therapy.

Across CSC models, fidelity is a critical component of quality. The First Episode Psychosis Services Fidelity Scale (FEPS-FS) is based on a list of 35 essential components identified by systematic reviews and an international consensus process. It has been used in California as part of EPI-CAL fidelity assessments. In California, CSC **programs have varied in fidelity** to the 35-point FEPS-FS scale across models, indicating differences in adherence to evidence-based practices.[123]

[122] The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services, Tara Niendam et al,
[123] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017

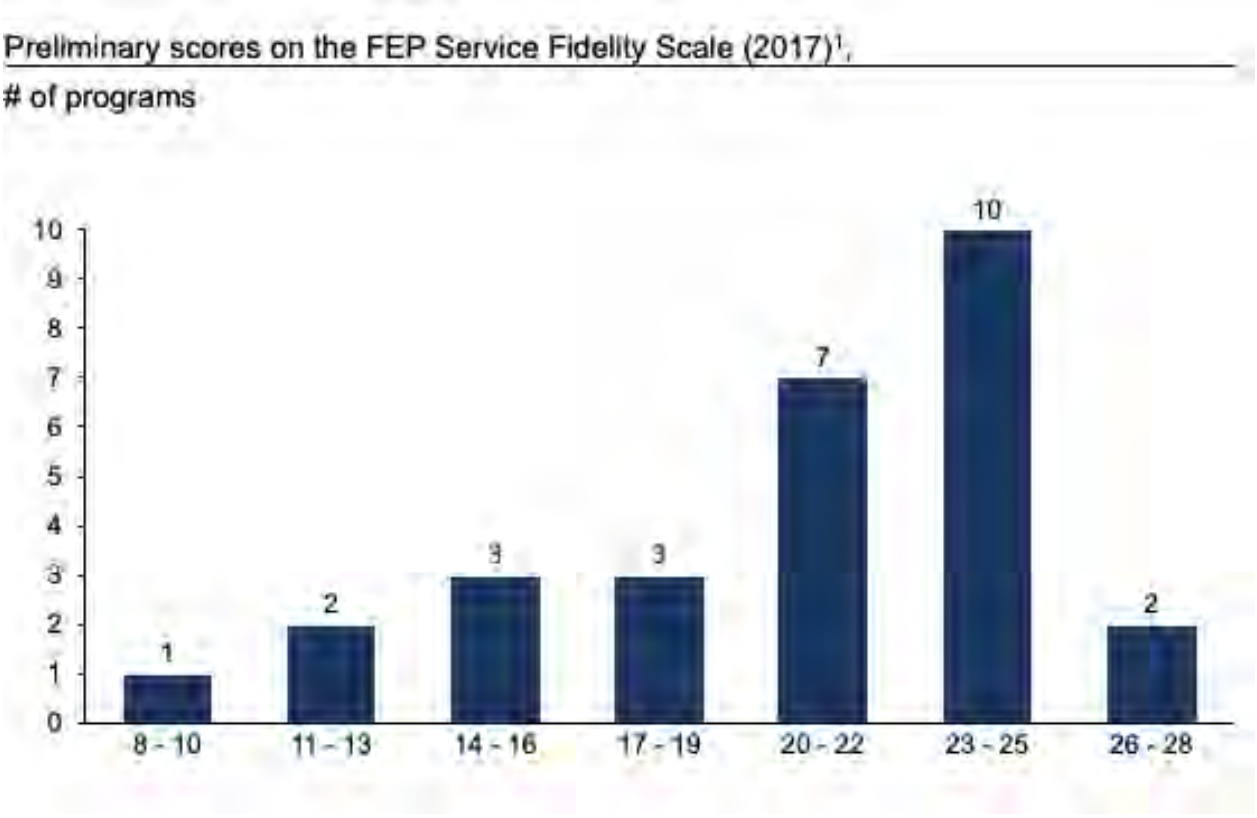


Exhibit 19: California CSC programs vary in fidelity

Sources
The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services, Tara Niendam et al., 2017

Furthermore, **programs also have varied design dimensions,** such as the duration of the care plan, eligibility criteria for care seeking, and data collection and maintenance practices.[124]

Despite variations in care delivery, **a slightly higher percentage of participants in California CSC programs reported general satisfaction** regarding the quality and appropriateness of their programs compared to the national average. According to a SAMHSA survey, 90.9% of participants in California CSC programs reported general satisfaction with care, while the national average was 89.2%.[125]

However, most Californians do not have access to CSC care currently, and other treatment programs may not be meeting the same level of care. Moreover, as CSC programs scale, there will be questions on how to maintain program quality and ensure fidelity.[126]

[124] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[125] SAMHSA, 2022 Unified reporting summary
[126] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

To monitor and improve quality, the National Institute of Mental Health (NIMH) established the EPINET National Data Coordinating Center (ENDCC), with **EPI-CAL serving as California's regional hub for EPINET.**[127] EPI-CAL aims to improve the quality of services and measure the impact of treatment through initiatives such as the Learning Healthcare Network (LHCN), which supports the standardization of practices and knowledge sharing between programs.[128] Additionally, EPI-CAL Training and Technical Assistance (TTA) provides training to support the implementation and sustainability of county-led EPI programs.[129]

Key objectives/goals[130]

The key goals of the plan with regard to quality are to:

- Promote a clearly defined CSC model as the **standard of care for treatment of early psychosis.**
- **Improve fidelity to the CSC model** for EPI programs in California. Set clear standards with tailored approaches integrated, that evolves overtime to address culture, age and geographic needs.
- Continuously improve the CSC model and care delivery to **enhance experience and outcomes** for individuals with early psychosis.

Next steps[131]

MHSOAC proposes the following next steps for consideration:

- Promote a **standard of care for treatment of early psychosis**.
  - **Consider aligning on a single CSC program model** for California and promote **the implementation of all CSC components for EPI,** including non-clinical components (e.g., Supportive Education and Employment)
- Research and pilot standards of care for **step-down services** (e.g., community-based services) to be provided after receiving care from CSC as well as **coordination between CSC programs, primary care providers and other parts of the care continuum for psychosis** (e.g., Full Service Partnerships) to ensure integrated mental health and physical health care for clients to ensure integrated mental health and physical health care for clients
- **Improve fidelity to the CSC model**

[127] EPINET National data coordinating center
[128] EPI-CAL
[129] EPI-CAL TTA Orientation
[130] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[131] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

  - **Align on approach and tools for measuring fidelity**: Identify metrics to measure both fidelity and establish defined targets.
  - **Review EPI programs against fidelity scores**: Review EPI programs against fidelity scores to facilitate targeted interventions for improving adherence to modalities such as Early Diagnosis and Preventative Treatment (EDAPT), PIER, and FELTON; tailor assessments to promote and ensure cultural and contextual appropriateness.

- Continuously improve the CSC model and care delivery to **enhance experience and outcomes** for individuals with early psychosis.
  - **Identify service-user-driven quality metrics** that can assess outcomes (e.g., patient experience, clinical outcomes, and broader ecosystem impact) and establish goals for each metric in collaboration with clients and ecosystem partners. These goals may need to account for various deployment models (e.g., peer-led or virtual) of EPI while promoting shared ownership and accountability.
  - **Consider incentive mechanisms for EPI linked** to fidelity goals, outcome goals, and client experience goals (e.g., align reimbursements to quality outcomes or establish shared savings program to incentivize quality outcomes).
  - **Ensure technical assistance and training programs** to consider the needs of vulnerable places (e.g., hyper-rural, hyper-urban settings) and provide additional resourcing where needed to meet quality standards. Training programs could be connected or established through a **Center of Excellence.**
  - **Examine models of data infrastructure management implemented** in other states (e.g., Massachusetts, Georgia, Nebraska, Tennessee, Oklahoma) to inform metrics and mechanisms that may form the basis of a robust data system for EPI programs in California.

Potential milestones/ progress measures[132]

A few prospective milestones in the process of working toward the quality goals are:

- Establish an evidence-based standard of care and continuous quality improvement strategy through a workgroup of relevant ecosystem partners.
- Collect and review evidence on quality outcomes.
- Identify metrics across dimensions of quality. The Institute of Medicine outlines six dimensions of quality[133] that may be used to inform metrics:

[132] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[133] Institute of Medicine definition cited in Dimensions of Quality in Mental Health Care

  - Effectiveness: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit
  - Client-centeredness: providing care that is respectful of and responsive to individual client preferences and needs. Ensuring that client values guide all clinical decisions.
  - Timeliness: reducing waits and sometimes harmful delays for both those who receive and those who give care
  - Safety: avoiding injuries to patients from the care that is intended to help them
  - Efficiency: avoiding waste, including waste of equipment, supplies, ideas, energy and human resources
  - Equity: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status
- Build a mechanism to manage, measure, monitor, and improve quality, including:
  - EPI program reporting requirements.
  - Data validation mechanisms.
  - Centralized monitoring capacity (establish quality metric working group).
  - Launch impact tracking with potential metrics such as:
    - Improvements in quality outcomes.
    - Increases in fidelity scores for EPI programs.

5.2.4 Equity

The plan defines equity as ensuring full and equitable access to high-quality early psychosis care resources focusing on vulnerable communities.[134]

Current state of equity for EPI in California

California has established **key definitions and operating bodies** within the health equity space that can serve as the foundation for this plan's equity approach. The California Department of Public Health (CDPH) defines **health equity** as efforts to ensure that all people

[134] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

have full and equal access to opportunities that enable them to lead healthy lives.[135] CDPH established the Office of Health Equity (OHE) to lead efforts focused on reducing health and mental health disparities experienced by **vulnerable communities** in California. According to CDPH, vulnerable communities include but are not limited to racial or ethnic groups; low-income individuals and families; individuals who are incarcerated or have been incarcerated; individuals with disabilities; children, youth, and young adults; seniors; women; immigrants and refugees; individuals who are limited English proficient; and LGBTQ+ communities; or combinations of these populations.[136]

Workforce diversity is also critical for ensuring culturally competent and equitable care. According to the 2021 California Behavioral Health Workforce Assessment, there is cultural and racial diversity in the California behavioral health workforce on aggregate: ~60% of behavioral health workers are people of color, which reflects the diversity of California's population. However, the highest-paid professions in behavioral health—counselors, psychologists, physicians, and psychiatrists—are disproportionately white. Additionally, while approximately one-third of physicians in the state speak Spanish, that statistic does not necessarily indicate that client language needs are being met.[137]

Within behavioral health care, California has driven efforts aimed at **identifying and addressing health disparities.** In 2015, CDPH published the "California Statewide Plan to Promote Health and Mental Health Equity" which included demographic analyses of mental health disparities and a discussion on the root causes and consequences of state health inequities.[138] In 2017, Assembly Bill 470 led the Department of Health Care Services (DHCS) to improve reporting for specialty mental health services at the county and statewide levels.[139] As a result, DHCS now provides publicly available data on disparities in mental health utilization, access, and outcomes.[140]

Several **initiatives are underway to advance equity** in mental health care access and delivery. The Community Mental Health Equity Project (CMHEP) is a cross-departmental effort focused on reducing disparities in behavioral health care through allocating grants to community organizations.[141] Another effort is the California Reducing Disparities Project, which CDPH founded in 2009 to address mental health equity for key population groups.[142]

From a **regulatory and oversight standpoint,** AB 133 authorized the Department of Managed Health Care (DMHC) to establish health equity and quality measures for behavioral

[135] California Department of Public Health Office of Health Equity
[136] California Department of Public Health Office of Health Equity
[137] CDPH Demographic Report on Health and Mental Health Equity in California
[138] CDPH Portrait of Promise: the California Statewide Plan to Promote Health and Mental Health Equity
[139] CPEHN, Existing Disparities in California's system of specialty mental health care, May 2019
[140] DHCS Adults Age 21 and Over Mental Health Services Demographic Dashboards (AB470)
[141] DHCS, Community mental health equity project
[142] The California Reducing Disparities Project

health plans to address long-standing health inequities and ensure the equitable delivery of high-quality health care services.[143] On the county level, DHCS has oversight and monitoring responsibilities of county Mental Health Plans' cultural competence and quality improvement programs.[144]

There is limited historical data on equity in EPI programs, however, experts report similar equity trends to what is seen in California's Behavioral Health system more broadly. In terms of access, experts note specific populations that are accessing EPI services less frequently, potentially due to cultural or language barriers. Additionally, many California leaders have stressed the importance of improving cultural competency and workforce diversity to better meet the needs of vulnerable populations.[145]

Key objectives/goals[146]

In order to fulfill the vision of this plan with regard to equity, key goals of the plan are:

- **Reduce barriers** to receiving appropriate and timely care for vulnerable populations by **co-designing EPI programs with communities** to ensure culturally competent, contextually appropriate, and holistic solutions for individuals with early psychosis and their families.
- **Improve tracking and establish measurable goals around equity metrics.**
- Address the needs of California's diverse population by **developing a more diverse healthcare** workforce.

Next steps[147]

MHSOAC proposes the following next steps for consideration:

- **Reduce barriers to access:**
  - Assess key barriers to access for vulnerable communities (e.g., trust in institutions, concerns of confidentiality) through direct engagement and partnership.
  - Identify trusted community partners to co-create solutions to access barriers (e.g., churches, schools, community colleges)[148]

[143] 2022 Health equity and quality committee recommendations report
[144] CDPH Community Mental Health Project
[145] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[146] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[147] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[148] Program for residency, community engagement and peer support training (PRECEPT) Connecting Psychiatrists to Community Resources in Harlem, NYC

  - Invest additional funding for awareness efforts designed for vulnerable populations in partnership with community organizations.
  - Build out specialized care options for individual population groups as needed (e.g., children and youth)
  - Address realized or perceived gaps in funding for EPI services, particularly among those who are low-income and/or uninsured
  - Partner with community organizations to ensure cultural competency is central to CSC model design and delivery.
  - Explore public-private partnerships that facilitate equitable access
- **Track and set measurable goals around equity metrics:**
  - Collaborate with communities to set measurable equity goals (e.g., parity in access and outcome metrics, increases in the percentage of vulnerable communities with access)
  - Establish data collection and analysis approaches that can inform decision-making in partnerships with community coalitions.

Potential milestones/ progress measures[149]

Prospective milestones in the State's process of working towards EPI equity goals could include:

- Align on a definition for equity in the context of scaling early psychosis care in California.
- Create a working group to identify priority populations and asses the key barriers (e.g., linguistic barriers, lack of trust).
- Review and evaluate community partnership models.
- Determine community organizations for potential partnerships.
- Establish platforms and processes to strategically partner with diverse and traditionally underserved population groups.
- Set up structures to continuously assess and iterate on equity strategies.

[149] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

5.3 Foundational Levers

To achieve the strategic objectives of improved awareness and access to high-quality early psychosis care with a focus on equity the following building blocks need to be in place.

5.3.1 Sustainable Funding

The plan defines sustainable funding as the 'scaling strategy' and fiscal model to ensure high-quality, timely access to early psychosis care regardless of insurance type[150].

Current state of funding

Government funds are the most common source of CSC-FEP funding, with each source typically funding specific components of care. Some of the key funding sources in California are listed below:

	Funding sources	Current State
Programmatic funding	Federal	• **MHBG** Grant and 10% set aside funding for FEP[1]
	State and county	• Assembly Bill 1315 established the EPI Plus program[3] • The Budget Act of 2019 provided MHSOAC with $19.5M in one time MHSA funds to support expansion of programs[4] • Prop 1 authorized $6.38 billion in bonds to build mental health treatment facilities for those with mental health and substance use challenges and for providing housing for the homeless[5] • In Feb 2020 MHSOAC approved allocation of $15.6M to support existing programs and $3.9M to contract UC Davis to provide training and technical assistance to grantees; awarded 5 EPI Plus program grants totaling $10M, $1M for public awareness and increasing workforce development and retention, $600K for research on early barriers to accessing care[4] • **DHCS** in partnership with MHSOAC awarded $67M to 99 organizations across 30 counties to expand EPI programs funded through CYBHI in March 2024[6]
	Other sources (e.g., foundations)	18% programs receive philanthropic funding[7]
Service-based reimbursement	Medicaid	• Centers for Medicare and Medicaid Services approved new billing codes enabling Medicaid to cover previously non-reimbursable CSC components such as peer support • 43% of programs accepts Medi-Cal[7] • Experts estimate receiving only 30-40% compensation for CSC service costs[8]
	Private insurance	• Only 21% program accept private insurance coverage[8] • Pilot program with small cohorts of commercially insured populations are underway with Kaiser Permanente Northern California patients[8]

Exhibit 20: Programmatic funding and service-based reimbursement sources for CSC

Sources

1. SAMHSA, "Coordinated Specialty Care for FEP: Costs and Financing Strategies," Aug. 2023, 2. EPINET 3. EPI Plus, 4. MHSOAC 5. Prop 1 6. DHCS, 7 CEPAS 8. Hirschtritt et al mention commercially insured population is excluded from coverage through Medical and eligibility criteria could have more room for evolution.

[150] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

A few barriers regarding funding for early psychosis care are:

- Design challenges across the healthcare system billing processes that may be focused on covering services by clinical providers and not the other components of EPI interventions such as education and housing supports[151]
- Most **commercial health plans do not provide coverage for several CSC components,** for example Supported Education and Employment or case management and peer support, only reimbursing direct clinical care[152]
- **Perceived lack of incentives** for commercial plans to invest in early intervention as individuals may not remain on the same plan for several years[153].
- **Opportunity for improving the authorization process** to EPI programs to increase claims approval rates: Since the Coordinated Specialty Care programs are often out of network for commercial health plans, there may be instances where patients with commercial insurance seek care from programs not contracted with plans without authorization from plans, leading to claims denials.[154]
- **County-led CSC programs** face challenges in navigating the funding system.
  - Many county-led EPI programs may have challenges navigating complex **billing processes** to receive appropriate payment for reimbursable services from Medi-Cal with insufficient technical assistance to address these challenges[155]
  - **Competing priorities and budget constraints among counties** that are trying to navigate budget challenges, build residential facilities, and plan for upcoming changes related to SB43[156].

These funding challenges have an impact on care delivery:

- **Discontinuity of care** for individuals on commercial plans – in addition to challenges getting authorization for the CSC programs, when individuals change or lose insurance coverage, there is a disruption in care delivery that may impact patient outcomes[157.]

[151] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[152] Powell et. al. Implementing Coordinated Specialty Care for First Episode Psychosis: A Review of Barriers and Solutions (2020)
[153] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[154] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[155] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[156] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[157] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Inability to access all components of CSC:** Reportedly, seven county-run programs in California have not adopted the peer-support service component in their treatment. Experts believe that challenges in achieving coverage for providing these services from health plans are potentially one reason why the adoption and provision of this CSC component are not uniform for all counties.[159]

To address financial barriers in accessing CSC care, the Centers for Medicare and Medicaid Services (CMS) introduced two billing codes specifically for CSC in 2023. These codes aim to streamline billing processes and ensure reimbursement for a broader range of CSC services. By allowing programs to bill for team-based care rather than individual services, the new codes will enhance financial viability, improve service coverage, and encourage innovation within CSC programs.
However, while the introduction of team-based billing codes represents a significant step forward for CSC funding, further actions are needed to address remaining barriers and ensure equitable access to high-quality early psychosis care. [158]

Key objectives/goals[160]

This plan lays out the following goals with regard to sustainable funding:

- Coverage for EPI services: Refine reimbursement models and rates to fully cover the cost of EPI for Californians with early psychosis regardless of insurance coverage.
- Funding for scaling to 90% access: Quantify and secure funding required to scale high-quality and equitable access to EPI.
- Innovative funding models to address future demand: Incentivize public and private investments in setting up and delivering EPI to meet future demand.

Next steps[161]

MHSOAC proposes the following next steps for consideration:

- **Establish approaches for covering the cost of care:**
  - Examine the barriers to accepting Med-Cal reimbursement by EPI service providers[162]

[158] Reimbursement for a broader array of services in CSC for early Psychosis (Matthew et. Al.)
[159] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[160] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[161] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[162] DHCS

- Identify the key billing challenges like the multiplicity of HCPCS billing codes and draft the steps needed to transition from a fee-for-service payment model[163]
- Develop an approach for providing information to commercial plans about individuals seeking treatment for early psychosis to validate insurance status sooner and fast-tracking authorization, where appropriate.
- Design and deploy additional training to support EPI program administrators in navigating billing and reimbursements.

- **Secure funding for scaling to 90% access:**
  - Conduct landscape analysis of reliable funding streams in partnerships with departments/agencies with an interest in expanded access to EPI.
  - Explore using a regional fund allocation while piloting the hub and spoke and regional care models (described in Chapter 4.3.4) to better resource areas with low population density.
  - Consider allocating EPI funding at the state level instead of the county level, similar to the California Children's Services Program[164] to explore the impact of improved participation in CSC model of care.
  - Explore learnings from other states, including Illinois, which required coverage of some components of CSC by all insurers[165].
  - Collaborate with other programs with aligned objectives (e.g., CalAIM[166] Care Court[167], BH-CONNECT[168], BHSA[169]) to design and fund key initiatives to enhance coordination and optimize funding allocated to each program.
- **Identify innovative funding models:**
  - Investigate incentive models to encourage private investment in programmatic funding for EPI programs such as bundled rates for team-based care and collaboration with private insurance providers to improve the commercial viability of private investment in CSC care.
  - Explore enhancing network adequacy standards for EPI to better address network needs to deliver high-quality EPI services and incentivize improved coverage from commercial health plans.

[163] Hirschitritt et al, Reimbursement for a Broader Array of Services in Coordinated Specialty Care for Early Psychosis, March 2024
[164] California's Children Services Program
[165] SAMHSA Coordinated Specialty Care for First Episode Psychosis: Cost and Financing Strategies
[166] California Health Care Foundation: CalAIM in Focus
[167] Fact Sheet: CARE Court
[168] BH-CONNECT
[169] BHSA

- Identify and evaluate the impact of initiatives (e.g., patient assistance programs/ drug costs, co-pay assistance to reduce out-of-pocket expenses) on the total affordability of EPI service.

Potential milestones/ progress measures[170]

To achieve 100% coverage for all components of CSC through service-based reimbursement and improve the proportion of programmatic funds used for enhancing infrastructure, therefore reducing the proportion used for subsidizing service delivery, California may need to **develop workgroups** to identify critical barriers and develop consensus amongst key funding partners on potential next steps in addressing them to achieve the following milestones:

- **Align on needs and sources:**
  - Estimate funding needs for programmatic and service-based reimbursement.
  - Identify funding sources across federal, state, county, and philanthropic entities.
  - Convene key funding partners to align on funding allocations for EPI.
- **Identify challenges in service-based reimbursements:**
  - Identify key challenges to the reimbursement model.
  - Establish workgroups to refine the reimbursement model and address challenges.
- **Implement solutions:**
  - Secure and disperse programmatic funding.
  - Design and implement initiatives to improve the reimbursement model.
- **Track impact:** Potential metrics include:
  - % of programs that accept Medi-Cal and commercial insurance
  - % of CSC care delivery cost covered by claims-based reimbursement

[170] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

5.3.2 Workforce Supply & Capabilities

Achieving the objectives outlined in the EPI strategic plan requires sufficient capacity of staff trained in evidence-based care for individuals experiencing early psychosis. MHSOAC believes it is critical to approach workforce considerations through the lens of reducing disparities in access across populations and regions.[171]

Current state of Workforce Supply & Capabilities in California

Throughout California, there are workforce shortages across behavioral health roles (e.g., case managers, physicians, psychiatrists, psychologists, nurses, community workers, and peer & family support members). For EPI specifically, experts report significant gaps in the availability of trained clinicians and prescribers, particularly child psychiatrists.[172] Workforce deficits vary by region. For example, while the California-wide average is 11.0 psychiatrists, the Greater Bay area has 16.7 psychiatrists per 100k population compared to San Joaquin Valley, which has 5.2 per 100k population. There are also workforce disparities based on race: Black and Latino Californians are underrepresented among psychiatrists and psychologists relative to the general population, and Latinos are also underrepresented among counselors and clinical social workers (discussed in more detail in section 4.2.4 on Equity).[173]

Workforce deficits in behavioral health are projected to continue. According to research from UCSF, if current trends persist, in 2028, California will have **50% fewer psychiatrists and 28% fewer psychologists, LMFTs, LPCCs, and LCSWs combined** than will be needed to meet population needs.[174]

Growing workforce constraints and disparities within EPI and behavioral healthcare more broadly may be attributed to several potential drivers.

One such driver within the behavioral health field is the age distribution of providers: ~40% of psychiatrists and psychologists in the state are **over 60 years old and are likely to retire or reduce working hours in the next decade**.[175]

Additionally, California may not be realizing the full potential of **peer specialists and team leads within the state.**[176] Centers for Medicare & Medicaid Services (CMS) instructs that "peer support providers must complete training and certification as defined by the State" without dictating any further guidance or stipulations regarding peer certification.[177] SAMHSA's National Model Standards for Peer Support Certification recommend that "in lieu of any

[171] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[172] Based on input from Tara Niendam, Executive Director, UC Davis Early Psychosis Programs (EDAPT and SacEDAPT Clinics)
[173] Healthcare Center at UCSF: An Overview of California's Behavioral Health Workforce Presentation (2022)
[174] Coffman et al, Research Report on California's Current and Future Behavioral Health Workforce (2018)
[175] Healthcare Center at UCSF: California's Current and Future Behavioral Health Workforce (2018)
[176] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[177] CMS Center for Medicaid and State Operations SMDL#07-011, August 15, 2007

formal educational requirements, prospective certified peer workers should be able to demonstrate literacy and fluency in the language in which they will be providing services, either through required examinations or other application requirements."[178] However, in California, Medi-Cal Peer Support Specialists must have a high school diploma, GED, or equivalent degree for certification.[179] This may limit the pool of individuals who are eligible to apply for peer support provider certifications and may impose additional recruitment barriers for some individuals, including those from marginalized communities.[180]

An additional recruitment challenge for expanding the peer workforce is **funding constraints** from both public and private insurance to reimburse peer-led support services (discussed in detail in 4.3.1).[181]

Outside of recruiting difficulties, there are also challenges with workforce retention. Behavioral health professionals may experience burnout and high turnover rates due to the demanding nature of the work and limited resources.[182] In the case of CSC, experts report that challenges retaining the workforce are exacerbated by few clinicians trained to deliver CSC care, which results in high case volumes for those trained. These workforce constraints may have an impact on care delivery. Many EPI programs utilize **telehealth or rely more heavily on nurses or physician assistants** for elements of care delivery. Additionally, to serve diverse communities in their preferred languages, some providers may rely on **interpreting services** to enable care for individuals in languages other than English.[183]

CSC programs are largely funded and run by the public sector and face further challenges in addition to those impacting the broader behavioral health landscape:

- Funding models have historically not reimbursed for some components of the CSC model (e.g., community outreach and education) or only partially reimbursed.[184] This may lead to limitations for CSC providers in reliably retaining their workforce.[185]
- In the **public sector for behavioral health services**, wages may not be competitive with private sector alternatives, which can impact the number of available workers at all skill levels including **master's and PhD level practitioners**.[186]

Another aspect of the workforce is **training & skill development.** The number of EPI programs in California with staff trained specifically in CSC components is 35% lower than the

[178] SAMHSA's National Model Standards for Peer Support Certification, 2023
[179] California Department of Health Services "Medi-Cal Peer Support Services Specialist Program - Frequently Asked Questions"
[180] SAMHSA's National Model Standards for Peer Support Certification, 2023
[181] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[182] SAMSHA: Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies
[183] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[184] Powell et. al. Implementing Coordinated Specialty Care for First Episode Psychosis: A Review of Barriers and Solutions (2020);
[185] Meadows Mental Health Policy Institute, 2020; Powell et al., 2021
[186] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

national average (CA: 50%, US: 85%).[187] Additionally, there are an insufficient number of mental health providers that have the combined specialized competencies needed for CSC, creating a significant training burden on CSC program leaders.[188] Moreover, specialized education in EPI is often less accessible within counseling and social work disciplines.[189]

California is making significant investments to bridge behavioral health workforce supply gaps and build capabilities.[190] In 2019, the Office of Statewide Health Planning and Development launched a five-year plan for growing and training the behavioral health workforce.[191] Building on its progress, in 2023, California announced it is investing $5.1B and proposing an additional $2.4B investment through reforms to the Mental Health Services Act to train and support 65,000 health care workers over the next five years.[192] **Specifically for EPI programs**, MHSOAC invested $1M in 2020-21 in workforce development and retention efforts. In 2020, MHSOAC also awarded $3.9M to the University of California, Davis, the leaders of EPI-CAL, to provide training and technical assistance to CSC programs across four years.[193]

Key objectives/goals

The workforce objectives of the EPI strategic plan are:[194]

- **Increase interest in and prestige of early psychosis intervention careers** to expand workforce timeline
- **Increase supply:** Recruit new individuals into the EPI workforce to achieve 90% access to CSC services for all Californians and align incentives to reduce attrition of clinicians (for all specialists and non-specialists) in CSC programs.
- **Enable more efficient use of existing workforce:** Efficiently deploy existing workforce to ensure optimized use of their capacity to ensure deployment of all components of CSC.
- **Improve capabilities across the workforce:** Ensure availability of CSC-specific state-wide training programs to meet or exceed the national average level of 85% of staff trained specifically in CSC components (as compared to the current 50% for California)

[187] California 2022 Uniform Reporting System Mental Health Data Report SAMHSA
[188] Pollard, J. M., & Hoge, M. A. (2017). Workforce development in coordinated specialty care programs. National Association of State Mental Health Program Directors, Confronting the Dialectic Between Quality and Access in Early Psychosis Care in the United States: Finding the Synthesis by Leveraging Psychological Expertise, Wood et. al., 2023
[189] Kourgiantakis, T., Sewell, K. M., McNeil, S., Lee, E., Logan, J., Kuehl, D., McCormick, M., Adamson, K., & Kirvan, A. (2022). Social work education and training in mental health, addictions, and suicide: A scoping review; Confronting the Dialectic Between Quality and Access in Early Psychosis Care in the United States: Finding the Synthesis by Leveraging Psychological Expertise, Wood et. al., 2023
[190] Workforce for a Healthy California
[191] OSHPD 2020-2025 Mental Health Services Act Workforce Education and Training Five-Year Plan
[192] CA MH Movement
[193] MHSOAC Investments
[194] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Optimize use of available funding sources** (e.g., Prop 1) for workforce education and recruitment
- **Measure and monitor workforce supply and demand** to identify and address critical capacity constraints

Next steps[195]

MHSOAC proposes the following next steps for consideration:

Supply of diverse workforce:

- **Conduct landscape assessment** of demand for EPI workforce capacity and potential supply sources from educational institutions; identify where additional support to expand supply is needed. Identify programs and schools for expanding recruitment efforts and roles to extend the capacity of the current workforce.
- **Increase recruitment efforts to attract** the needed workforce based on capacity and capability requirements (e.g., explore new recruitment channels, revamp compensation and benefits, set up job fairs and other career events to promote EPI program opportunities, establish deeper partnerships with training programs and academic institutions, recruit from non-traditional sources, provide incentives for working in EPI).
- **Identify solutions to optimize the efficiency of the current workforce** and enhance their capacity to provide CSC (e.g., implement flexible staffing models to allow for redistribution of resources based on fluctuating demand; expand the use of mobile outreach teams to provide EPI services to different locations; implement task-shifting models to help with detection, referral, and providing basic services).
- Develop incentives for graduate programs and other learning institutions to **partner with CSC programs** to pair students with job opportunities.
- **Expand peer-led workforce:**
  - **Consider** broadening **eligibility criteria for peer support specialist certifications** to expand the pipeline of potential providers.
  - **Recruit CSC graduates** to train as peer support specialists.
  - **Consider** broadening **eligibility criteria for peer support specialist certifications** to expand the pipeline of potential providers.
  - **Provide additional training on CSC model delivery** for individuals with lived experience and their communities.

[195] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- **Grow pipeline of diverse future workforce:**
  - Increase funding for stipends and scholarships for students in behavioral health professions, social services, education or other related fields.
  - Increase funding for stipends and scholarships for students in behavioral health professions, social services, education or other related fields.
  - Increase funding for postbaccalaureate programs that focus on medical school reapplicants from underserved communities.
  - Increase psychiatry resident positions.
  - Recruit and train students from underserved areas to practice in community health centers in their home regions.
  - Expand rotations for social work, education degrees in organizations engaged in EPI services
- **Develop a more diverse workforce:**
  - Launch workforce training and development efforts within vulnerable communities (e.g., in collaboration with community colleges)
  - Identify programming for EPI workforce development, retention, and promotion to increase diversity.
  - Develop strategies to engage peers in the EPI workforce (e.g., engaging CSC graduates as peer specialists)[196]

Explore options to improve total compensation to address pay parity gaps and retain providers (e.g., funding to support EPI workforce costs, loan repayment benefits, improved healthcare coverage for employees and their families, programs to support burnout prevention, continuing education stipends).

Launch workforce training and development efforts within vulnerable communities (e.g., in collaboration with community colleges)

Capabilities/training & development:

- **Explore options to improve total compensation to address pay parity gaps** and retain providers (e.g., funding to support EPI workforce costs, loan repayment benefits, improved healthcare coverage for employees and their families, programs to support burnout prevention, continuing education stipends).

[196] Oluwoye et al, Study protocol for a multi-level cross-sectional study on the equitable reach and implementation of coordinated specialty care for early psychosis, Aug 2023

- **Partner with professional schools** to enhance curriculums for specialist and non-specialist providers in recognizing early psychosis and referring individuals to appropriate care.
- **Create a central repository for CSC curricula**, including on-the-job training and essential competencies for health professionals as well as other service provides such as social-workers, employment specialists.[197]
- **Increase and promote opportunities for future clinicians to engage in behavioral health, specifically CSC programs** (e.g., psychiatric rotations, clinical psychology internships, externships to enhance training (e.g., through grant funding, scholarships).
    - Launch workforce training and development efforts within vulnerable communities (e.g., in collaboration with community colleges)

Highlight career pathways within EPI for non-clinical roles (e.g., education specialists, social workers, peer counsellors) during education and trainings for these professions

Potential milestones/progress measures[198]

- Establish a workforce and capabilities workgroup to conduct analysis, develop and roll out a recruitment strategy based on the findings.
- Conduct a current state demand and supply assessment of EPI workforce, including analysis by region and expertise/role.
- Identify key drivers of attrition and develop a plan to address prioritized drivers.
- Identify workforce diversity needs and integrate findings into a recruiting strategy.
- Design and implement the recruitment strategy and roll-out plan.
- Develop training programs for upskilling the existing workforce and training new professionals.
- Establish KPIs to measure progress on workforce supply and capabilities and the efficiency of training programs (e.g., workforce supply and demand by region, by role, and through the lens of workforce diversity; number of appointments via telehealth vs. in person; number of family and peer partners for each region/community; performance, morale, and satisfaction before and after training programs; performance against benchmarks of standard of care).

[197] Confronting the Dialectic Between Quality and Access in Early Psychosis Care in the United States: Finding the Synthesis by Leveraging Psychological Expertise, Wood et. al., 2023

[198] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

- Implement continuous monitoring mechanisms to improve workforce supply and capabilities.

5.3.3 Accountability

This plan defines accountability as the approach to establishing or utilizing governance structures to enable responsibility and ownership, measure progress for access, cost, quality, and other related outcomes, and establish ongoing improvement processes through research initiatives.[199]

Current state of Accountability for EPI in California

Accountability structures for CSC programs are closely tied to funding sources for the various county and commercial EPI programs. County-run EPI programs are established using funds received from both state, federal and grant sources and commercial EPI programs are primarily supported through research grants, as described in Chapter 4.3.1 Sustainable Funding.

Counties generally have some discretion in the allocation of funds for mental health services[200]. Counties do not have to establish an EPI program with funding received but may utilize it for other needs[201]. As of 2017, 38% of counties do not have an EPI program.[202] Additionally, there are **challenges in coordination among different counties in delivering and funding EPI care.** County EPI Programs are able to serve individuals within their county utilizing funding dispersed via County Departments of Behavioral Health (DBH). While some counties may have reciprocity systems in place to serve individuals across counties, many individuals who seek care in counties that differ from that for which they enroll in Medi-Cal have challenges accessing EPI. This could potentially add a barrier to access to care for some individuals who are moving across counties (e.g., for education), are housed in a state child welfare system, or are in a juvenile system in a different county[203].

The counties that have EPI programs **may have different contractual obligations that may impact their approach to deploying EP**I. There are variations in contractual requirements for EPI providers contracted with DBH. For example, some programs are required to measure

[199] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[200] Example sources: Funding for Medi-Cal Mental Health Services, Mental Health Block Grant
[201] Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group
[202] Tara Niendam et al, The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[203] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

and track the fidelity of the program, while others may not be.[204] There are limited mandatory contract components which may pose challenges to ensuring EPI programs are accountable to delivering care aligned to set standards.[205]

Both county and commercial EPI programs lack robust data-gathering mechanisms, limiting the ability to identify opportunities for improvement.[206] This is further elaborated in Infrastructure, Chapter 4.3.4.

MHSOAC's strategic plan (2024-2027)[207] includes a goal to develop a behavioral health index that will track and promote key indicators of behavioral health by county, with benchmarks from peer counties, peer states, and nations to compare with California and its counties. Additionally, California launched the **Learning Healthcare Network initiative,** for which one of the goals is to utilize a collaborative statewide evaluation to examine the impact of LHCN[208] on EPI care network and evaluate the effect of EPI programs on the consumer- and program-level outcomes.

The **Behavioral Health Services Act (BHSA),** which replaced the 2004 Mental Health Services Act, enhances oversight, transparency, and accountability at both state and local levels. The Act also creates pathways to ensure equitable access to care, advancing equity and reducing disparities for those with behavioral health needs.[209] BHSA requires that counties "establish and administer an early intervention program that is designed to prevent mental illnesses and substance use disorders from becoming severe and disabling and to reduce disparities in behavioral health." The early intervention programs should include, among other criteria, "access and linkage to care includes the scaling of, and referral to, the Early Psychosis Intervention (EPI) Plus Program […] Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs[210]

Key objectives/goals[211]

- **Establish governance structure & mechanism** to define roles and responsibilities in expanding access to EPI and develop accountability mechanism for all ecosystem partners.
- **Develop a monitoring & evaluation framework** to track progress against goals with KPIs that provide insight into client experience and impact across various ecosystem

[204] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[205] Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group
[206] Discussions between MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group
[207] MHSOAC Strategic Plan
[208]
\hLearning Healthcare Network
[209] Behavioral Health Services Act - DHCS
[210] Cal. Welf. and Inst. Code § 5840
[211] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

partners and develop reporting mechanisms to communicate progress to all ecosystem partners.

- **Establish an ongoing improvement process** that utilizes learnings to identify development opportunities in EPI program design and delivery.

Next steps[212]

MHSOAC proposes the following next steps for consideration:

Governance structure & mechanism

- Align on which organization(s) will be responsible for refining and implementing the EPI strategic plan.
- Establish the purview of the leadership team(s) and their authority to design and implement the strategic plan with key partners.
- Identify existing efforts in California aligned with the strategic plan and align on partnership approaches where feasible.
- Convene ecosystem partners to determine which groups will lead each of the initiatives.
- Design incentive models and accountability structures for each implementation partner and implement infrastructure or legislative changes to ensure accountability.
- Develop mechanisms to incentivize all counties to establish or partner with existing EPI programs.
- Identify and develop mechanisms to ensure care across counties for those who need care (e.g., additional reciprocity relationships between counties)

Monitoring & evaluation framework

- Develop a process for gathering and reporting on metrics to assess implementation progress, building on the learning healthcare network [213]
- Establish KPIs to measure the impact of expanded EPI access for clients and ecosystem partners.

[212] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[213] Learning Healthcare Network

Ongoing improvement

- Develop a process to gather learnings (including insights from people with lived experience, academic research, and data) and refine program design and implementation.

Potential milestones/ progress measures[214]

To ensure accountability goals are met, the potential milestones may include:

- Identify existing accountability, monitoring & evaluation, and process improvement initiatives for early psychosis intervention.
- Identify the leadership team to implement the EPI strategic plan.
- Implement accountability initiatives.
- Establish monitoring, evaluation, and reporting framework to assess implementation progress.
- Develop and implement a process for gathering and reporting on progress metrics.

5.3.4 Infrastructure

Infrastructure is defined as the availability of facilities and technology to provide care that is accessible, equitable, and effective, including the use of telehealth where appropriate.[215]

Current state of infrastructure

California has invested in both physical and digital infrastructure for EPI.

The **physical infrastructure** includes the facilities and resources necessary for the provision of EPI services (e.g., physical clinics for providing CSC components and screening services). Currently, the availability of EPI **programs per capita** in California is trailing the national average (1 program for every **907K** Californians compared to 1 program for every **879K** residents in the US).[216] The availability of EPI facilities **varies across the counties:** 41% of counties having an active EPI program, 21% of counties are in the process of developing an

[214] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[215] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[216] Programs per capita is derived by dividing the CA population as per census, by number of programs as per EPICAL. CA has ~43 programs for a population of 38.9M; US has 381 programs for a population of 334.9M

EPI program, and 38% have no EPI programs (described further in Chapter 4.2.2).[217] Some of the rural and low-density counties cite challenges relating to low incidence rates and challenges in finding sufficiently qualified local service providers as barriers to setting up their own EPI programs.[218]

There are also physical infrastructure considerations beyond EPI programs across different levels of care. California has invested in infrastructure to support **care across the continuum of psychosis**, ranging from drop-in facilities for youth (e.g., allcove®)[219] to a buildout of crisis infrastructure through the Behavioral Health Continuum Infrastructure Program.[220]

Digital infrastructure is the technical foundation and systems that support the delivery of services. Digital infrastructure also involves the management of data, including the hardware, software, networks, and protocols, to enable the secure and efficient exchange of information between care providers, clients, payors, and other ecosystem partners. Examples of digital infrastructure include technology that enables the delivery of CSC service components like case management, technology that enhances access using telehealth, electronic health records (EHR) platforms, and centralized data systems and tools for measuring key metrics for scaling EPI programs.[221]

One key aspect of digital infrastructure is the health information and billing system. There is currently no unified approach across counties to managing **medical records and billing.** Additionally, there is limited interoperability between county programs and health plans that limits the ability of some programs to bill for CSC services and consequently limits reimbursement,[222] as discussed in Chapter 4.3.1.

Digital infrastructure may also be used to inform individual and provider-level decision making. Currently, EPI-CAL uses an EPI-focused **technology platform (mHealth)** to collect core client outcomes and metrics of data use. Data insights from this platform are available to clients and their physicians across 30 programs to support care decisions; the platform is also available in 13 languages.[223] EPI-CAL also utilizes **Beehive**, which is a data collection and visualization software platform that incorporates information about a client's recovery and wellness into their mental health care.[224]

On a systems level, there are opportunities to strengthen **data infrastructure in support of scaling EPI.** There is currently no centralized method for tracking system capacity (e.g., open

[217] Tara Niendam et al., The Rise of Early Psychosis Care in California: An Overview of Community and University-Based Services CEPAS, 2017
[218] Interview with Executive Director of EPICAL, 2nd May 2024
[219] MHSOAC: allcove® Youth Drop-In Centers
[220] DCHS: Behavioral Health Continuum Infrastructure Program
[221] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[222] Interview with Executive Director of EPI-CAL, 17th April 2024
[223] EPI-CAL
[224] EPI-CAL Beehive

workforce positions, number of programs, number of clients) or metrics to assess network strength and integrity (e.g., wait times for clinic availability, the average duration of untreated psychosis). Related systems are currently managed through individual record-keeping such as excel spreadsheets.[225]

There are also opportunities to improve the digital infrastructure to facilitate **care coordination**. While there is a national database for locating care for serious mental illness,[226] the state may consider creating a publicly available state-wide EPI coordination system for accessing CSC programs and other resources.[227]

Experts point out that select vulnerable places and communities may require improved digital ecosystem readiness as a foundation for specialized EPI digital infrastructure. This includes reliable broadband, population-level digital literacy, access to suitable devices for engaging with telehealth, and digital support accessing information management systems. There may also be challenges in building capabilities for new technology adoption.[228]

Draft key objectives/goals[229]

Design and build the infrastructure needed for **delivering affordable, appropriate care to 90%** of individuals who need it with a focus on ensuring equity and a high standard of care.

Next steps[230]

MHSOAC proposes the following next steps for consideration:

- **Explore and scale multiple archetypes of care deployment models** to improve access to care in alignment with workforce improvement strategies (Chapter 4.3.3):
  - **Increase the number of EPI programs:** EPICAL estimates the need for 277 EPI care centers to cater to the annual incidence of early psychosis in California each year. A few potential steps towards achieving this target may be:
    - Identifying areas with the greatest gaps in the supply of EPI services based on community demand and prioritizing a list of locations for standing up EPI programs.
    - Designing a phased plan to develop facilities and provide resourcing in the form of equipment and service providers.

[225] Interview with Executive Director of EPI-CAL, 17th April 2024
[226] SAMHSA SMI care program locator
[227] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[228] Interview with Director Mental Health Strategic Impact Initiative, 30th April 2024
[229] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[230] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

  - **Explore new formats of extending EPI:** Collaborate with partners to understand local strengths and needs to meet demand in the context of the CSC approach; explore innovative partnerships for CSC (e.g., Hub and spoke model, multi-county collaborative or regional mobile care delivery models).
  - Identify **digital capabilities** required for expanding telehealth, omnichannel care delivery, tailored mobile applications and remote monitoring.
  - Estimate resource needs at the program and provider level relating to digital and physical infrastructure.
- **Identify resources for infrastructure development:**
  - **Establish partnerships** with other healthcare providers, supportive housing providers, community organizations, or academic institutions to accelerate infrastructure development & deployment.
  - **Explore solutions for improving interoperability of medical records and billing modules** for EPI programs specifically and mental health services broadly; this could involve building on national efforts such as the SAMSHA Behavioral Health Information Technology Initiative that is investing more than $20M over the next three years to advance interoperable exchange of behavioral health data across the care continuum.[231]
  - **Identify technical support** and funding to transition EPI programs to the same medical records and billing systems.
- **Improve care coordination and access:**
  - Develop a publicly available resource that identifies EPI programming across the state to help individuals select potential programs in their area.
- **Training for effective use of technology and digital infrastructure:**
  - Conduct needs assessments to identify training gaps in technology and digital infrastructure.
  - Collaborate with technology experts to design tailored training programs.
  - Ensure accessibility of training programs for all ecosystem partners
  - Provide digital literacy training in underserved communities.
  - Establish monitoring and evaluation mechanisms for progress tracking and refinement.

[231] SAMHSA Behavioral Health Information Technology Initiative, Feb 2024

- Draft milestones/ progress measures[232]
- Establish working groups to design and implement infrastructure initiatives.
- Identify digital and physical infrastructure gaps for the state and each county.
- Complete an infrastructure development plan and identify resource requirements.
- Identify and contact infrastructure partners.
- Deploy infrastructure development plan.
- Complete need assessment of technical training
- Establish cadence and mechanism to refresh and re-estimate infrastructure needs.

5.3.5 Ecosystem Engagement

Ecosystem engagement focuses on establishing a more integrated care delivery model for people experiencing early psychosis and their families by encouraging incentive alignment and coordination among key partners. The key ecosystem partners considered in this chapter include people with lived experience, families, community-based organizations, public and private payors and providers, state and county agencies focused on housing, education actors, and the criminal and legal systems.[233]

[232] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[233] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

Exhibit 21: Overview of sectors and ecosystem partners

Sources
The Kennedy Forum System Mapping Tool

Current state of ecosystem engagement in California

Ecosystem partners play a crucial part in Early Psychosis Intervention (EPI). Roles include developing human capital, funding system elements, collecting and sharing relevant information, providing products / services, and developing policy.

For example, ecosystem partners may play a crucial role in identifying symptoms for individuals experiencing psychosis. However, there are key challenges across the ecosystem **in symptom identification, referral, and diagnosis.** These include **limited education on the symptoms of psychosis for workers in education, criminal and legal, and housing systems** and limited knowledge of referral pathways for individuals experiencing a psychotic episode.[234] This may lead to delays in referral to appropriate screening and care. **Even within healthcare, there may be a need for additional training on psychosis** diagnoses and

[234] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

treatment for early psychosis, as individuals may be incorrectly diagnosed and treated for other conditions.[235] This occurrence is not unique to California. A retroactive chart review of 78 patients referred to a specialty early psychosis consultation clinic found that of the 43 cases that had a primary diagnosis at referral of a schizophrenia spectrum disorder, the primary diagnosis in the consultation clinic was different in 22 (51%) of these 43 cases.[236]

Ecosystem partners' **contributions extend beyond the identification of symptoms; they are also often engaged in care delivery.** Both county and commercial EPI programs collaborate with state and local programs, national organizations, and community partners to coordinate services such as supportive education and employment.[237] These services are typically coordinated by individual EPI programs through relationships with county and community organizations. Such relationships are **often not established as formal partnerships and vary by program.**[238]

[235] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[236] Specialized Consultation for Suspected Recent-onset Schizophrenia: Diagnostic Clarity and the Distorting Impact of Anxiety and Reported Auditory Hallucinations, Coulter et. al
[237] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[238] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

NON-EXHAUSTIVE

✓ Partner plays a primary role ✓ Partner plays a secondary role

Roles of select ecosystem partners		People Developing the human capital needed to support progress	Funding Funding or enabling funding specific system elements	Data & information Collecting and sharing data and/or information	Products & services Developing and/or deploying products and services	Policy Developing and shifting policies
Health Sector	Insurance		✓	✓	✓	✓
	Providers	✓		✓	✓	✓
	Research			✓	✓	✓
Human Services	Education	✓		✓	✓	
	Community supports	✓		✓	✓	
	Criminal legal system			✓	✓	✓
	Housing and social services			✓	✓	
Civil Society	People with lived experience	✓	✓	✓	✓	✓
	Non-govt. organizations	✓			✓	✓
Public Sector	Local Govt.	✓	✓	✓	✓	✓
	State & tribal Govt.	✓	✓	✓	✓	✓
Private Sector	Employers	✓	✓		✓	
	Technology			✓	✓	
	Private sector funders		✓			

Exhibit 22: Illustrative roles of ecosystem partners along the care journey

There is an opportunity to enhance coordination among key ecosystem partners to achieve the goal of expanding EPI access. While there is collaboration across ecosystem partners, limitations in processes and data sharing restrict the ability to gather important information about treatment history and coordinate care delivery across provider types (i.e., crisis care, inpatient care, and CSC programs) and between systems (e.g., housing and criminal and legal systems). Effective coordination and collaboration could help ensure individuals are referred to appropriate sites of care.[239]

In California, programs such as the Mental Health Court Linkage Program (CLP) provide examples of ecosystem collaboration to support individuals with mental illnesses, including psychosis. The CLP is a joint effort between the Los Angeles County Department of

[239] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

Mental Health (LACDMH) and the Los Angeles County Superior Court. It is run by a team of 15 mental health clinicians who are stationed at 22 courts throughout the county. This program is designed to assist adults who have a mental illness or a co-occurring mental health and substance abuse disorder and are involved with the criminal and legal system. It is part of LACDMH's system of support and services that are available throughout the criminal justice process, from arrest to release. The program follows the "no wrong door" philosophy by using the courtroom as a point of entry for services. The program's goals are to improve coordination and collaboration between the criminal and legal systems and mental health systems, increase access to mental health services and support, and improve continuity of care.[240] Services provided include individual needs assessments; information to individuals and the Court on available treatment options; development of diversion, alternative sentencing, and post-release plans that take into account best-fit treatment alternatives and Court stipulations; linkage of individuals to treatment programs; and expedition of mental health referrals. [241]

Expanded access to CSC will have an impact on partners in healthcare, education, criminal and legal systems, child welfare, and housing systems. In healthcare, CSC reduces average inpatient days by 33% and the average number of ED visits per year by 36%.[242] Outside of direct health impacts, CSC reduces the likelihood of being unemployed by approximately 42%[243]. The CSC model also reduces the need for homelessness services amongst the FEP population by 48% and reduces the average cost per person of providing supportive housing to program participants.[244]

In the criminal and legal system, participation in CSC programs for Early Psychosis Intervention reduces involvement in the criminal justice system. Participants experience a 76% reduction in the risk of committing a first crime and are significantly less likely to be convicted of any crime when enrolled in CSC.[245]

Key objectives/goals[246]

Potential objectives/goals to be considered for ecosystem engagement are as follows:

[240] Los Angeles Department of Mental Health – Metal Health Court Linkage Program
[241] Los Angeles Department of Mental Health – Metal Health Court Linkage Program
[183] Cost-Effectiveness of Comprehensive, Integrated Care for First Episode Psychosis in the NIMH RAISE Early Treatment Program, Rosenheck et al. Cost-Effectiveness of Comprehensive, Integrated Care for First Episode Psychosis in the NIMH RAISE Early Treatment Program, Rosenheck et al.
[243] Predictors of occupational status six months after hospitalization in persons with a recent onset of psychosis, Dickerson et. al.
[244] Tsiachristas et al. "Economic impact of early intervention in psychosis services: results from a longitudinal retrospective controlled study in England"
[245] Pollard, Jessica M et al. "Analysis of Early Intervention Services on Adult Judicial Outcomes." JAMA psychiatry vol. 77,8 (2020). Based on the difference between % of individuals with convictions for any offense after enrolling in the STEP program (5%) and the % of individuals with convictions for any offense receiving usual treatment (19%)
[246] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

Enhanced integrated care delivery network: ensure coordination among ecosystem partners to enable timely and seamless access to all components of the Coordinated Specialty Care model for clients and their families.

Next steps[247]

MHSOAC proposes the following next steps for consideration:

- Improve **awareness, education, and training for early psychosis**
  - Communicate the impact of early identification and treatment of early psychosis for ecosystem partners to align incentives.
  - Provide training on symptom identification and referral pathways for state, county, and community ecosystem partners (e.g., law enforcement, K-12 educators, supportive housing workforce)
  - Provide additional training for medical students and residents on psychosis diagnosis and treatment.
- Enable **improved information sharing for care coordination**
  - Expand the use of psychiatric advanced directives to provide information on the care needs and preferences of individuals with psychosis and coordinate care delivery across partners (i.e., crisis care, Full-Service Partnerships, CSC programs, and inpatient care)
  - Explore resources for enabling interoperability of EHR systems and other data-sharing platforms across health systems, health plans, criminal and legal systems, and other partners to enable data-sharing.
  - Establish coordination mechanisms to refer patients for diagnosis and treatment (e.g., centralized referral portals)
- **Establish stronger alliances among ecosystem partners for CSC care delivery**
  - Expand the use of programs deploying the "no wrong door" philosophy[248] to screen and refer individuals for psychosis in partnership with criminal and legal, housing, and other supportive services.
  - Consider establishing state-wide or county-wide partnerships for housing, education, employment, and other client needs where appropriate.

[247] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group
[248] No Wrong Door

Potential milestones/ progress measures[249]

- To drive alignment among ecosystem partners and ensure the development of a more integrated care delivery network, the following milestones could help guide execution:
- Convene key ecosystem partners to highlight shared benefits of expanded access to EPI.
- Identify initiatives to deploy better care delivery and size additional resourcing needs.
- Identify and deploy digital resources and operating model changes.
- Initiate impact tracking.

[249] Discussions between MHSOAC and Early Psychosis Intervention (EPI) Advisory Group

6. Implementation plan

MHSOAC has prepared an initial draft of a high-level implementation approach for the rollout of the strategic plan. The implementation plan **will undergo further enhancement as the strategic plan is refined through input from ecosystem partners, public engagement and additional guidance from the Governor, Legislature and other stakeholders. The approach will also need to be tailored based on the entity responsible for spearheading implementation** if the plan is adopted.

To support the successful executions of milestones across our Strategic Objectives and Foundational Levers, **four Implementation Support workstreams have been identified.** These workstreams will focus on coordinating across key partners to implement initiatives, identifying and tracking key metrics to monitor the performance of the overall plan, developing and implementing a robust communications plan, and overseeing change management efforts to drive transformational change in the ecosystem.

- **Integrated coordination:** This workstream will establish a dedicated central team to coordinate among ecosystem partners and across initiatives to ensure successful and timely implementation of the plan.
- **Performance management:** To promote accountability during the implementation of the strategic plan, this workstream will identify metrics and track progress. The dedicated central team will be responsible for developing an integrated process for collecting and reporting on implementation progress across initiatives and partners and measuring impact.
- **Communication plan:** This workstream will develop and roll out coordinated communication and engagement strategies to ensure clarity, consistency, and alignment in messaging with California agencies, ecosystem partners, and other interested parties. Additionally, it will provide regular updates on progress.
- **Change management:** This workstream will support identifying change champions and sponsors across ecosystem partners to promote adoption and implementation of the strategic plan.

This chapter outlines key themes and milestones over a 3-year time horizon, with an initial perspective on where additional funding may be required to ensure the timely execution of our key goals across each element of the strategic plan as outlined in Chapters 4.2 and 4.3[250]. The multi-year time horizon allows for appropriate sequencing of milestones to account for interdependencies across teams and milestones. It also ensures sustainable impact over time, with each milestone achieved serving as a building block for subsequent successful milestones. By the end of year 3, the expectation is that 90% of Californians with needs will have access to equitable, high-quality, and appropriate early psychosis care in California.[251]

[250] Objectives and milestones developed based on input from the Early Psychosis Intervention (EPI) Advisory Group
[251] Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

Over the course of **Year 1**, implementation begins with forming workgroups, conducting landscape analyses and opportunity identification, and developing initial strategies and partnerships:

- **Workgroups:** Convene workgroup(s) to define goals and design innovative strategies across Strategic Objectives and Foundational Levers, as well as align on roles and responsibilities.
- **Landscape analyses:** Review behavioral health landscape, including identifying gaps, estimating infrastructure, funding, and other requirements to fill those gaps, and outlining barriers to impact.
- **Strategies and partnerships:** Develop strategies for working with populations MHSOAC has identified as areas of focus and source partnerships across public, private, and social sector organizations.

Within **Year 2**, work progresses to establishing and rolling out pilots, prioritized by estimated level of impact, followed by aligning on performance indicators to ultimately begin tracking success:

- **Pilots:** Act on planned initiatives and pilot approaches, from engagement to funding, based on prioritization. Appropriately utilize embedded community partnerships and facilitate necessary training.
- **Performance indicators:** Define and implement measurements of success while simultaneously gathering pilot participant and partnership feedback to determine adjustments needed to pilots.

By **Year 3**, as pilots are well underway, the emphasis of work is on continued data analytics and consequent effort refinement for maximum impact:

- **Data analytics:** Continuously collect performance data in service of improving awareness, access, quality, and equity of care.
- **Effort refinements:** Based on analytics, redirect resourcing and refine goals to ensure adherence to the priority needs of target populations.

For specific milestones by year, see exhibits.

Exhibit 23: Milestones related to improving Awareness and Access

Sources
Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

Exhibit 24: Milestones for enhancing Quality and Equity

Sources
Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

Exhibit 25: Milestones related to Sustainable Funding and Workforce & Capabilities

Sources Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

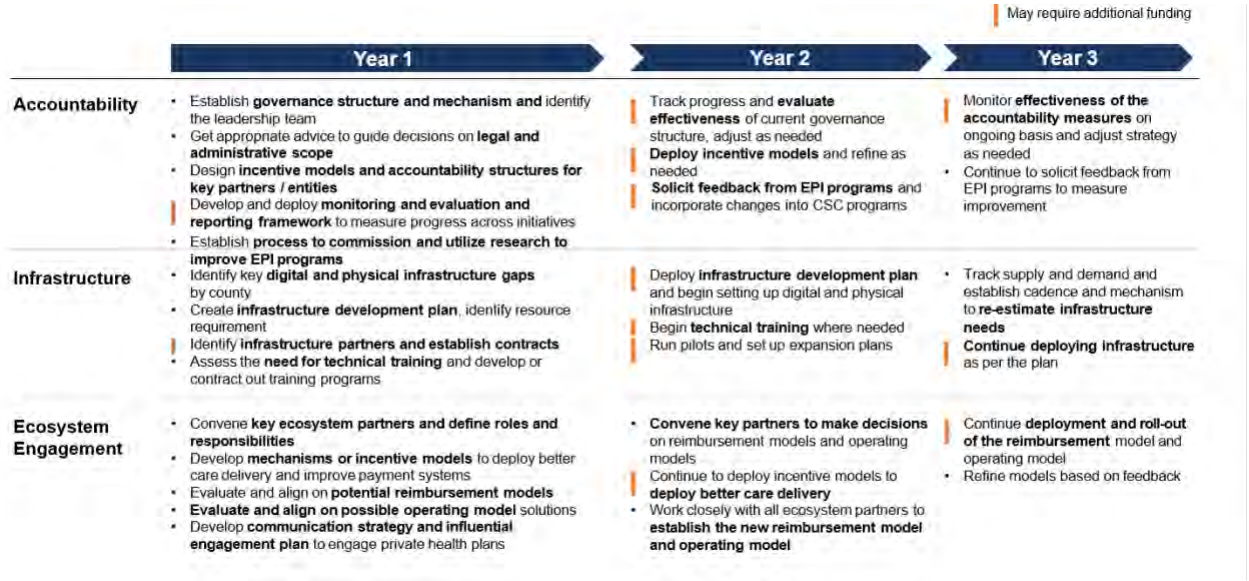
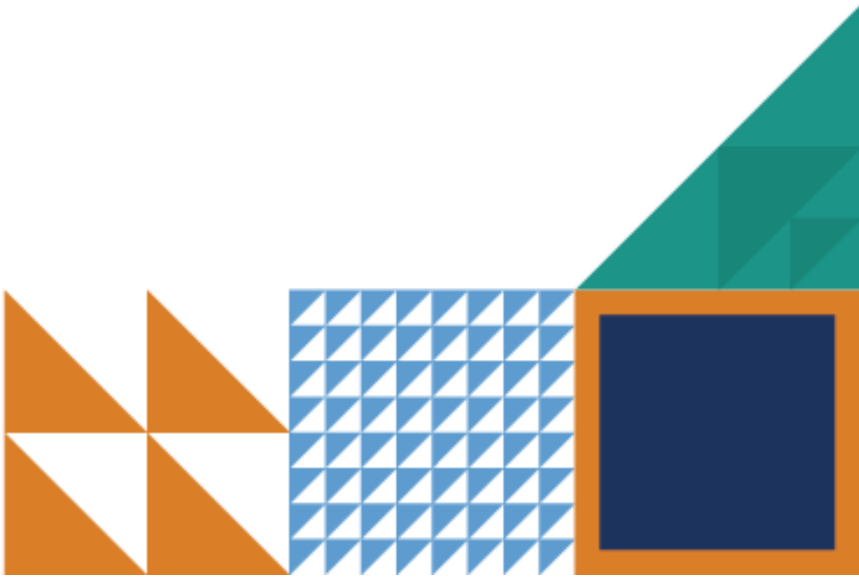


Exhibit 26: Milestones related to Accountability, Infrastructure and Ecosystem Engagement

Sources Discussions with MHSOAC and the Early Psychosis Intervention (EPI) Advisory Group

7. Appendix



7.1 Approach

The approach to drafting this strategic plan for expanding early psychosis care in California involved the following:

7.1.1 Syndicating quantitative estimates based on perspectives from national leaders and experts.

Through interviews and synthesis of existing research, a model was developed to demonstrate the potential impact of scaling CSC, looking at both the potential economic savings as well as the impact on quality of life. The impact was estimated across two-time horizons: a near -term view and a lifespan view.

A National Impact Model on Early Psychosis was developed, incorporating expert opinions, partnerships with leading organizations, and a thorough review of academic literature. The process involved interviews of over 19 subject matter experts from various organizations, including national, state government agencies and universities. Partnerships were established with leaders of the National Council of Mental Wellbeing, the National Association of State Mental Health Program Directors (NAMHPD), the National Alliance on Mental Illness (NAMI), and the McKinsey Health Institute (MHI). Additionally, dozens of academic research papers and articles, as well as more than ten policy briefs, were reviewed to gather relevant information.

Expert	Organization and roles	Interview date
Richard Frank	*Director, Center on Health Policy,* Brookings Institution	Jan 21
Steve Adelsheim	*Director,* Stanford Center for Youth Mental Health and Wellbeing	Jan 22
Lisa Dixon	*Director, Division Behavioral Health Services and Policy Research*, Columbia University	Jan 23
Robert Heinssen	*Senior Advisor*, NIMH, RAISE, EPINET	Jan 23
Tamara Sale	*Director EASA Center for Excellence,* OHSU	Jan 26
Vinod Srihari	*Director of STEP Program,* STEP program Yale University	Jan 29
David Shern	*Senior Public Health Advisor,* NASMHPD; *Moderator* PEPPNET Financing Workgroup	Jan 31
Patrick McGorry	*Director Orygen Youth Health, Chair Youth Mental Health,* University of Melbourne	Feb 1
Robert Rosenheck	*Director Division of Mental Health Services and Outcomes Research,* Yale, NIMH RAISE	Feb 1
Tara Niendam	*Executive Director* UC Davis, SacEDAPT Clinics; *Principal Investigator,* EPI-CAL	Feb 8
Keris Myrick	*Co-Director Mental Health Strategic Impact Initiative,* Mental Health America; Inseparable	Feb 8
Carolyn Dewa	*Director Behavioural Health Center of Excellence,* UC Davis	Feb 14
Brandon Staglin	*President, One* Mind	Feb 14
Debra Pinals	*Medical Director Behaviorial Health and Forensic Programs,* University of Michigan	Feb 16
Oladunni Oluwoye	*Co-director Washington State Center for Excellence in Early Psychosis*, Washington State University	Feb 22
Iruma Bello	*Director of OnTrackNY*, Behavioral Health Services and Policy Research, Columbia University	Feb 22
Ken Duckworth	*Chief Medical Officer*, NAMI	Mar 4
Jessica Banthin	*Senior Fellow & CBO expert*, Urban Institute	Mar 8
Deidre Anglin	*Lead Investigator of social and cultural determinants of psychosis risk*, City College of New York	Mar 28

Exhibit 27: Interviews with subject matter experts

In building the model, the first step involved estimating the early psychosis incidence rate among the population by age and insurance type (e.g., Medicaid, commercial, uninsured). The second step was to determine the level of access and estimate the proportion of individuals experiencing psychosis who receive access to Coordinated Specialty Care (CSC) either in a timely manner, in a delayed manner, or do not receive CSC and rely on community care for support. The third step was to estimate the costs of scaling CSC and the benefits of receiving CSC across various dimensions of an individual's life, such as healthcare, education and employment, housing, criminal justice, and caregivers and family members.

It's important to note that the initial model accounts for impact areas and estimates that have been empirically studied and reported in published literature. However, there are other known areas of CSC's impact that are not included in the model, such as productivity loss due to premature mortality. This comprehensive approach to building the economic model provides a robust business case for investing in upstream care for psychosis, demonstrating its potential cost-effectiveness compared to more expensive downstream care like the need for more psychiatric beds.

Preliminary insights from the national impact model

Increasing the availability of CSC has the potential to improve the lives and livelihoods of individuals experiencing first-episode psychosis and to generate system impact. As access to CSC increases, more individuals receive services early in their psychosis journey, and overall

system costs decrease. For example, increasing access across the nation to CSC from 25% to 90% of individuals in need could generate $21K per year in healthcare and social impact per individual who receives CSC early in their psychosis journey, translating to $5.7B per year in national system impact.

The California specific impact model was built using the same methodology but with California specific estimates to help articulate the economic case for investment in upstream care for psychosis.

7.1.2 Series of consultative meetings and discussions with subject matter experts

An Advisory Group of Subject Matter Experts (SMEs) was formed to facilitate the discussion and development of the Early Psychosis Incidence (EPI) Strategic Plan. This group comprised a diverse range of stakeholders, such as state leaders, MHSOAC commissioners, healthcare partners, DHCS, DMH, DSH, local implementers, county leaders, public safety, EPI programs, ecosystem partners, commercial healthcare payors, healthcare providers, employers, communities and individuals, individuals with lived experience, family members, justice-involved individuals, tribal communities, children and youth, and national leaders. The group worked together to review the findings of the impact model, develop a landscape analysis of California, and share inputs for a strategic roadmap for the expansion of early psychosis care outlined in this plan.

Advisory group members

NOT EXHAUSTIVE

Category	Group	Name
Communities and Individuals	Individuals with lived experience	Brandon Staglin
	Individuals with lived experience	Claire Conway
	Individuals with lived experience	Keris Myrick
	Family members	Gladys Mitchell
	Children and Youth	Radha
	Tribal communities	Virgil Moorehead
Ecosystem Stakeholders	Payors - CalPERs	Julia Logan
	CHA	Paul Rains
Local Implementors	County Leaders	Supervisor Ellenberg
	Rural	Phebe Bell
	Public Safety	Sheriff Bill Brown
	EPI Programs	Ann Boynton
	EPI Programs	Steve Adelsheim
	EPI Programs	Kerry Ahern
	EPI Programs	Tara Niendam

Category	Group	Name
National Leaders	National Council for Wellbeing	Chuck Ingoglia
	NAMI	Daniel H. Gillison, Jr.
	NAMI	Darcy Gruttadaro
	NASMHPD	Brian Hepburn
	NIMH	Robert Heinssen
	Brookings Institute	Richard Frank
State Leaders	Healthcare - Dept Managed Care	Amanda Levy
	Healthcare - DSH	Ambarin Faizi
	Healthcare- Cal HSS	Stephanie Welch
	MHSOAC Commissioners	Jay Robinson
	MHSOAC Commissioners	Mark Bontrager
	Healthcare - CBHA	La Ondra Clark Harvey
	Healthcare - DHCS	Paula Wilhelm
	Healthcare - Cal HSS	Sohil Sud

Exhibit 28: Early Psychosis Intervention Advisory Group members

MISCELLANEOUS ENCLOSURES

July 25th, 2024 Commission Meeting

Enclosures (4):

(1) Evaluation Dashboard
(2) Innovation Dashboard
(3) Department of Health Care Services Revenue and Expenditure Reports Status Update
(4) Rolling Calendar

Summary of Updates

Contracts

New Contracts: 0

Total Contracts: 4

Funds Spent Since the May 2024 Commission Meeting

Contract Number	Amount
21MHSOAC023	$ 353,695.84
22MHSOAC025	$ 150,000.00
22MHSOAC050	$ 0.00
23MHSOAC018	$ 0.00
TOTAL	**$ 150,000.00**

The Regents of the University of California, San Francisco: Partnering to Build Success in Mental Health Research and Policy (21MHSOAC023)

MHSOAC Staff: Melissa Martin-Mallard
Active Dates: 07/01/21 - 06/30/27
Total Contract Amount: $7,544,350.00
Total Spent: $4,244,350

UCSF is providing onsite staff and technical assistance to the MHSOAC to support project planning, data linkages, and policy analysis.

Deliverable	Status	Due Date	Change
Quarterly Progress Reports	Complete	09/30/21	No
Quarterly Progress Reports	Complete	12/31/21	No
Quarterly Progress Reports	Complete	03/31/2022	No
Quarterly Progress Reports	Complete	06/30/2022	No
Quarterly Progress Reports	Complete	09/30/2022	No
Quarterly Progress Reports	Complete	12/31/2022	No
Quarterly Progress Reports	Complete	03/31/2023	No
Quarterly Progress Reports	Complete	06/30/2023	No
Quarterly Progress Reports	Complete	09/30/2023	No
Quarterly Progress Reports	Complete	12/31/2023	No
Quarterly Progress Reports	Complete	03/31/2024	No
Quarterly Progress Reports	Complete	06/1/2024	Yes
Quarterly Progress Reports	Not Started	9/30/2024	Yes
Quarterly Progress Reports	Not Started	12/31/2024	Yes
Quarterly Progress Reports	Not Started	3/21/2025	Yes
Quarterly Progress Reports	Not Started	6/30/2025	Yes
Quarterly Progress Reports	Not Started	9/30/205	Yes

Quarterly Progress Reports	Not Started	12/31/2025	Yes
Quarterly Progress Reports	Not Started	3/31/2026	Yes
Quarterly Progress Reports	Not Started	6/30/2026	Yes
Quarterly Progress Reports	Not Started	9/20/2026	Yes
Quarterly Progress Reports	Not Started	12/31/2026	Yes
Quarterly Progress Reports	Not Started	3/31/2027	Yes
Quarterly Progress Reports	Not Started	6/1/2027	Yes

WestEd: MHSSA Evaluation Planning (22MHSOAC025)

MHSOAC Staff: Kai LeMasson
Active Dates: 06/26/23 - 12/31/24
Total Contract Amount: $1,500,000.00
Total Spent: $650,000.00

This project will result in a plan for evaluating the Mental Health Student Services Act (MHSSA) partnerships, activities and services, and student outcomes. The MHSSA Evaluation Plan will be informed by community engagement and include an evaluation framework, research questions, viable school mental health metrics, and an analytic and methodological approach to evaluating the MHSSA.

Deliverable	Status	Due Date	Change
Project Management Plan	Complete	August 1, 2023	No
Community Engagement Plan	Complete	September 1, 2023	No
Community Engagement Plan Implementation (a, b and c)	Complete Complete In Progress	December 15, 2023 January 15, 2024 October 30, 2024	No
Evaluation Framework and Research Questions	Complete	December 15, 2023	No
School Mental Health Metrics	In Progress	June 15, 2024	No
Evaluation Plan (draft and final)	Not Started	September 1, 2024 October 30, 2024	No
Consultation on Report to the California Legislature	In Progress	March 1, 2024	No
Progress Reports (a, b, and c)	Complete Complete In Progress	September 15, 2023 January 15, 2024 June 15, 2024	No

Mental Health Services
Oversight & Accountability Commission

Third Sector: FSP Evaluation (22MHSOAC050)

MHSOAC Staff: Melissa Martin Mollard
Active Dates: 06/28/23 – 6/30/24
Total Contract Amount: $450,000.00
Total Spent: $285,000.00

This project will evaluate the effectiveness of FSPs through community engagement, outreach and survey activities culminating in a final report to the Commission with specific recommendations for strengthening the implementation and outcomes of FSP programs throughout the State.

Deliverable	Status	Due Date	Change
Community Engagement Plan (draft and final)	Complete	August 31, 2023 September 30, 2023	No
Statewide Survey (draft and final)	Complete	October 31, 2023 December 31, 2023	Yes
Progress Reports (#1 and #2)	#1 Complete #2 Complete	October 31, 2023 March 31, 2024	Yes
Final Report (draft and final)	In Progress	March 31, 2024 June 28, 2024	Yes

The Regents of the University of California, San Francisco:: Universal Screening Project (23MHSOAC018)

MHSOAC Staff: Kali Patterson

Active Dates: 12/12/23 -12/31/24

Total Contract Amount: $160,000

Total Spent: $10,000

The project will support the Commission in conducting research on the subject of universal mental health screening for children and youth and conduct a landscape analysis to understand universal mental health screening policies and practices for children and youth in California. Doing so will allow the Commission, as part of its required legislative Report, to develop recommendations to improve universal screening of students in California schools.

Deliverable	Status	Due Date	Change
Survey Tool	Complete	02/01/2024	No
Literature Review Report	Complete	02/01/2024	No
Project Support and Consult a. Workplan b. Meetings and Interviews c. Analysis and Summary	 a. In Progress b. Complete c. In Progress	 1/15/2024 1/15/2024 4/30/2024	No
Landscape Analysis Report a. Draft Report b. Final Report	In Progress	6/30/2024 7/31/2024	No

Mental Health Services
Oversight & Accountability Commission

INNOVATION DASHBOARD

July 2024

UNDER REVIEW	Final Proposals Received	Draft Proposals Received	TOTALS
Number of Projects	1	0	**1**
Participating Counties (unduplicated)	1	0	**1**
Dollars Requested	$910,906	$0	**$910,906**

PREVIOUS PROJECTS	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
FY 2018-2019	54	54	$303,143,420	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%)
FY 2022-2023	31	31	$354,562,909	26 (44%)
FY 2023-2024	15	15	$197,481,034	13 (22%)

TO DATE	Reviewed	Approved	Total INN Dollars Approved	Participating Counties
2024-2025				

INNOVATION PROJECT DETAILS

FINAL PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
Under Final Review	Sierra	Semi-Statewide Enterprise Health Record Multi County Collaborative	$910,906	4 Years	5/30/2024	6/10/2024

DRAFT PROPOSALS						
Status	County	Project Name	Funding Amount Requested	Project Duration	Draft Proposal Submitted to OAC	Final Project Submitted to OAC
NONE	---	---	---	---		

APPROVED PROJECTS (FY 23-24)			
County		Funding Amount	Approval Date
Ventura	Early Psychosis Learning Health Care Network – Multi-County Collaborative	$10,137,474.63	5/23/2024
Fresno	California Reducing Disparities Project - Extension	$2,953,244	5/23/2024
Mendocino	Native Crisis Line – A Partnership between Pinoleville Pomo Nation and Mendocino County BHRS	$1,001,395	5/23/2024
Fresno	PADs: Phase 2 – Multi-County Collaborative	$5,915,000	5/23/2024
Shasta	PADs: Phase 2 – Multi-County Collaborative	$1,000,000	5/23/2024
Riverside	Eating Disorder Intensive Outpatient and Training Program	$29,139,565	2/22/2024
Sacramento	Community Defined Mental Wellness Practices for the African American/Black/African Descent Unhoused	$15,500,231	1/25/2024
Sutter-Yuba	Multi County FSP Project	$1,226,250	1/25/2024
Sacramento	allcove Multi-County Collaborative	$10,000,000	11/16/2023
Los Angeles	Kedren Children and Family Restorative Care Village	$100,594,450	11/16/2023
Tri-City	Community Planning Process	$675,000	10/26/2023
Amador	Workforce Retention Strategies	$1,995,129	9/28/2023
Santa Cruz	Crisis Now Multi-County Innovation Plan	$4,544,656	9/28/2023
San Luis Obispo	Embracing Mental & Behavioral Health for Residential Adult Care & Education (EMBRACE)	$860,000	9/28/2023
Santa Clara	TGE Center	$11,938,639	7/27/2023

DHCS Status Chart of County RERs Received
July 25, 2024, Commission Meeting

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 July 12, 2024. This Status Report covers FY 2021 -2022 through FY 2022-2023, all RERs prior to these fiscal years have been submitted by all counties.

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these for Reporting Years FY 2012-13 through FY 2022-2023 on the data reporting page at: https://mhsoac.ca.gov/county-plans/.

The Department also publishes County RERs on its website. Individual County RERs for reporting years FY 2006-07 through FY 2015-16 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 years FY 2016-17 through FY 2021-22 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.

DHCS also publishes yearly reports detailing funds subject to reversion to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). These reports can be found at: https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx.

DCHS MHSA Annual Revenue and Expenditure Report Status Update

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Alameda	1/31/2023	2/6/2023	2/7/2023	1/30/2024	1/31/2024	2/14/2024
Alpine	4/14/2023		4/17/2023			
Amador	1/31/2023	2/7/2023	2/17/2023	2/8/2024	2/8/2024; 2/14/24	2/16/2024
Berkeley City	1/31/2023	2/2/2023	2/7/2023	1/31/2024	2/2/2023	2/6/2024
Butte						
Calaveras	1/27/2023		2/7/2023	1/31/2024	2/2/2024	2/5/2024
Colusa	4/3/2023	4/4/2023	5/11/2023	3/15/2024	3/20/2024	4/2/2024
Contra Costa	1/30/2023		2/1/2023	2/13/2024	2/14/2024	2/15/2024
Del Norte	1/30/2023		2/7/2023	1/30/2024	1/31/2024; 2/1/24	2/5/2024
El Dorado	2/24/2023		2/28/2023	1/30/2024	1/30/2024	1/30/2024
Fresno	1/31/2023	2/2/2023	2/10/2023	1/29/2024	1/30/2024	2/1/2024
Glenn	12/14/2023	12/21/2023	2/16/2024			
Humboldt	1/31/2023		2/2/2023	1/30/2024	1/31/2024	2/2/2024
Imperial	1/20/2023	1/23/2023	2/1/2023	1/19/2024	1/24/2024; 1/30/24	2/7/2024
Inyo	5/19/2023		8/16/2023	5/28/2024	5/29/2024	
Kern	1/31/2023	2/1/2023	2/15/2023	2/2/2024	2/9/2024	2/23/2024
Kings	1/10/2023	1/19/2023	2/14/2023	2/8/2024	2/14/2024	2/16/2024
Lake	1/31/2023		2/1/2023	5/8/2024	5/8/2024	5/9/2024
Lassen	2/8/2023	2/9/2023	2/14/2023	2/29/2024	2/29/2024	3/5/2024
Los Angeles	1/31/2023	2/2/2023	2/17/2023	2/5/2024	2/6/2024	2/16/2024
Madera	2/8/2023	2/9/2023	2/14/2023	3/22/2024		3/29/2024

DHCS Status Chart of County RERs Received
July 25, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Marin	1/30/2023	1/31/2023	2/3/2023	1/31/2024	2/2/2024	2/5/2024
Mariposa	4/19/2023	4/20/2023	4/21/2023	2/7/2024	2/15/2024	2/15/2024
Mendocino	1/31/2023		2/2/2023	1/31/2024	2/5/2024	2/15/2024
Merced	1/19/2023		1/23/2023	1/18/2024	1/19/2024	1/23/2024
Modoc	3/23/23	4/4/2023	4/5/2023	5/6/2024	5/8/2024	5/13/2024
Mono	1/31/2023		2/2/2023	1/31/2024	2/5/2024	
Monterey	1/31/2023	2/2/2023	2/2/2023	1/31/2024	2/1/2024	2/6/2024
Napa	1/31/2023	2/1/2023	2/13/2023	2/6/2024	2/9/2024	3/11/2024
Nevada	1/31/2023	2/1/2023	2/2/2023	1/31/2024	2/9/2024	2/14/2024
Orange	1/31/2023		2/1/2023	1/31/2024	2/7/2024	2/15/2024
Placer	1/31/2023	2/1/2023	2/14/2023	1/31/2024	n/a	2/7/2024
Plumas	2/14/2023	2/15/2023	2/21/2023	2/9/2024	2/9/2024	2/15/2024
Riverside	1/31/2023	2/1/2023	2/15/2023	2/1/2024	2/8/2024	2/21/2024
Sacramento	1/25/2023	1/26/2023	1/27/2023	1/31/2024	2/14/2024	2/23/2024
San Benito	5/10/2023	5/11/2023	5/25/2023	3/18/2024	3/18/2024	3/22/2024
San Bernardino	1/31/2023		2/6/2023	1/31/2024	2/12/2024	2/21/2024
San Diego	1/31/2023	1/31/2023	2/14/2023	1/30/2024	2/5/2024	2/14/2024
San Francisco	1/31/2023	2/1/2023	2/16/2023	1/31/2024	2/8/2024	
San Joaquin	1/31/2023		2/1/2023	2/22/2024	3/7/2024	3/27/2024
San Luis Obispo	12/30/2023	1/6/2023	1/19/2023	1/25/2024	2/8/2024	2/14/2024
San Mateo	3/6/2023	3/24/2023	4/3/2023	2/16/2024	2/22/2024	4/9/2024
Santa Barbara	12/23/2023	2/7/2023	2/15/2023	1/30/2024	2/9/2024	2/12/2024
Santa Clara	1/31/2023	1/31/2023	2/16/2023	2/1/2024	2/15/2024	2/22/2024
Santa Cruz	4/6/2023	4/14/2023				
Shasta	1/31/2023	2/2/2023	2/16/2023	1/30/2023	2/15/2024	2/21/2024

DHCS Status Chart of County RERs Received
July 25, 2024, Commission Meeting

County	FY 21-22 Electronic Copy Submission	FY 21-22 Return to County	FY 21-22 Final Review Completion	FY 22-23 Electronic Copy Submission	FY 22-23 Return to County	FY 22-23 Final Review Completion
Sierra	1/27/2023	1/30/2023	2/16/2023	12/18/2023	12/27/2023	1/15/2024
Siskiyou	2/6/2023	2/7/2023	2/9/2023	2/2/2024	2/15/2024	2/15/2024
Solano	1/31/2023	1/31/2023	2/15/2023	1/31/2024	2/15/2024	2/20/2024
Sonoma	1/31/2023	2/2/2023	3/6/2023	1/31/2024	2/7/2024	2/14/2024
Stanislaus	1/31/2023	2/2/2023	2/3/2023	1/31/2024	2/6/2024	2/9/2024
Sutter-Yuba	1/31/2023	2/2/2023	3/6/2023	3/29/2024		4/2/2024
Tehama						
Tri-City	1/25/2023	1/25/2023	2/16/2023	1/31/2024	2/6/2024	2/9/2024
Trinity	7/18/2023	7/24/2023	8/24/2023	5/21/2024	5/29/2024	6/10/2024
Tulare	1/31/2023	1/31/2023	2/15/2023	1/30/2024	2/20/2024	5/1/2024
Tuolumne	3/29/2023	3/30/2023	4/5/2023	3/1/2024	3/4/2024	3/7/2024
Ventura	1/30/2023	1/30/2023	1/31/2023	1/31/2024	2/15/2024	2/15/2024
Yolo	1/31/2023	2/2/203	3/15/2023	4/4/2024	4/5/2024	4/19/2024
Total	**57**	**42**	**57**	**54**	**51**	**53**

Mental Health Services
Oversight & Accountability Commission

Commission Meeting Calendar (Tentative)

Focus areas are identified through the Commission's Strategic Plan goals and objectives. The 2024-2027 goals include: Champion Vision into Action, Catalyze Best Practice Networks, Inspire Innovation and Learning, and Relentlessly Drive Expectations.

The Commission's 2024-27 North Star priority is to accelerate system-level improvements to achieve early, effective, and universally available services. This priority will guide the evolution and design of the Commission's initiatives and projects, further informed by three more clearly defined operational priorities: (1) Build foundational knowledge, (2) Close the gap between what is being done and what can be done, and (3) Close the gap between what can be done and what must be done.

Meeting locations are considered based on agenda items, ease of access for Commissioners, and site visit considerations.

In 2024 the Commission held meetings in the following locations:

January- Santa Barbara
February- Napa
March- No Meeting
April, May- Sacramento
June- No meeting
July- Sacramento

The draft calendar below reflects efforts to align the Commission meeting focus areas with priorities outlined in the 2024-2027 Strategic Plan. **All topics and locations subject to change**.

Dates	Locations	Focus Areas*
August 22	San Diego	Innovation Consent: Orange County: Community Planning Process Extension Orange County: Psychiatric Advanced Directives (PADs) Phase Two Population Based Prevention/Suicide Prevention Full-Service Partnership Funding Allocation Mental Health Student Services Act Legislative Report
September 26	Los Angeles	Behavioral Health Workforce Strategies Substance Use Disorder and Mental Health Integration Universal Screenings Draft Report Quarterly Strategic Plan Report Out 0-5 Mental Health Wellness Funding Allocation

Mental Health Services
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October 24	Sacramento	Impact of Proposition 1 on Rural Counties Chair and Vice Chair Election Executive Director Performance Evaluation Impact of Firearm Violence Report Community Engagement Planning
November 21	Riverside	Research Agenda Behavioral Health Reform Progress Report Behavioral Health Innovation Priorities Legislative Priorities Quarterly Strategic Plan Report Housing
January 23, 24	Sacramento	Commissioner on-boarding Early Intervention Priorities for Mental Health Wellness Act Funding K-12 Advocacy Funding Governor's Proposed 2024 Budget, Expenditure Update, and Legislative Priorities for 2024

*NOTE: The priorities listed are not the only agenda items under consideration for each month.