AGENDA - PUBLISHED

CONTRA COSTA COUNTY Mental Health Commission

Wednesday, April 3, 2024 **4:30 PM** **1025 Escobar Street, Martinez**

https://zoom.us/j/5437776481
Meeting number: 543 777 6481 | Call in: 1 669 900 6833 | Access code: 543 777 6481

The Committee will provide reasonable accommodations for persons with disabilities planning to attend the Committee meetings. Contact the staff person listed below at least 72 hours before the meeting. Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Committee less than 96 hours prior to that meeting are available for public inspection at 1025 Escobar Street, Martinez, during normal business hours. Staff reports related to items on the agenda are also accessible on line at www.contracosta.ca.gov. Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

I. Call to Order, Roll Call and Introductions

II. Public comments on any item under the jurisdiction of the Commission and not on this agenda (speakers may be limited to two minutes).

In accordance with the Brown Act, if a member of the public addresses an item not on the agenda, no response, discussion, or action on the item will occur, except for the purpose of clarification.

III. Commissioner Comments on any item under the jurisdiction of the Commission and not on this agenda (speakers may be limited to two minutes).

IV. IV. Chair Comments / Announcements **24-0949**
Membership roster 2024

Attachments: Att A_MHC members 2024

Welcome New Commissioner:
*Sani Momoh - District III, Seat 3
"May is Mental Health Awareness Month" Presentation to the Board of Supervisors

V. APPROVE March 6, 2024 Meeting Minutes

VI. VI. RECEIVE Presentation "Navigating an unprecedented reform landscape: Youth mental health systems change in California" by Alex Briscoe, MA, Principal, California Children's Trust (CCT) and Behavioral Health Advocate **24-0950**

Attachments: AttB_Contra Costa Leadership April 2024 PDF

VII. VII. RECEIVE Presentation "How Proposition 1 will improve our loved one's lives" - by Douglas Dunn, NAMI Contra Costa **24-0951**

Attachments: AttC_ Prop. 1 Presentation slides

VIII. RECEIVE Alcohol and Other Drugs (AOD) Advisory Board update – Cmsr. Shires

IX. Question and Answer Session with Behavioral Health Services Director, Dr. Suzanne Tavano
* Children's Crisis Center Stabilization Unit: Is it open?
* Impact of Proposition 1: What to expect moving forward?
* How will Proposition 1 tie into Care Court?

The next meeting is currently scheduled for May 1, 2024 @ 4:30pm

For Additional Information Contact: Angela Beck, EA 925/313-9553

X. Adjourn

File #: 24-0949 **Agenda Date:** 4/3/2024 **Agenda #:** IV.

Advisory Board: Mental Health Commission
Subject: Members list 2024 Updated
Presenter: Commission Chair Laura Griffin

Agenda Item #IV Chair Comments / Announcements:

Welcome New Commissioner
Sani Momoh - District III, Seat 3

MHC Commission Member List 2024 - Updated

MENTAL HEALTH COMMISSION 2024

Name	District	Position	Appointed	Expires
Gina Swirsding	I	Seat #2	8/8/2017	6/30/2026
Geri Stern	I	Seat #3	8/8/2017	6/30/2026
VACANT	I	Seat #1		
Barbara Serwin	II	Seat #2	9/13/2016	6/30/2025
Dr. Rhiannon Shires	II	Seat #3	9/14/2021	6/30/2024
Pamela Perls	II	Seat #1	9/13/2022	6/30/2025
VACANT	III	Seat #2		
Sani Momoh	III	Seat #3	3/19/2024	6/30/2025
Gerthy Loveday Cohen	III	Seat #1	6/7/2022	6/30/2025
Tavane Payne	IV	Seat #2	4/26/2022	6/30/2024
Vanessa Rogers	IV	Seat #3	10/03/2023	6/30/2025
Jenelle M. Towle	IV	Seat #1	2/6/2024	6/30/2024
Laura Griffin	V	Seat #2	2/25/2020	6/30/2025
VACANT	V	Seat #3		
Contesa Tate	V	Seat #1	2/27/2024	6/30/2024
Representatives from the Board of Supervisors:				
Supv. Ken Carlson Representative	IV			
Candace Andersen Alternate Representative	II			

NOTE:
Seat #1 = Member-at-Large
Seat #2 = Consumer
Seat #3 = Family Member

Revised March 2024

File #: 24-0950 **Agenda Date:** 4/3/2024 **Agenda #:** VI.

Advisory Board: Mental Health Commission
Subject: Youth Mental Health Systems Change in California
Presenter: Alex Briscoe, MA, Principal, California Children's Trust (CCT)

VI. Presentation "Navigating an unprecedented reform landscape: Youth mental health systems change in California" by Alex Briscoe, MA, Principal, California Children's Trust (CCT) and Behavioral Health Advocate

California Children's Trust

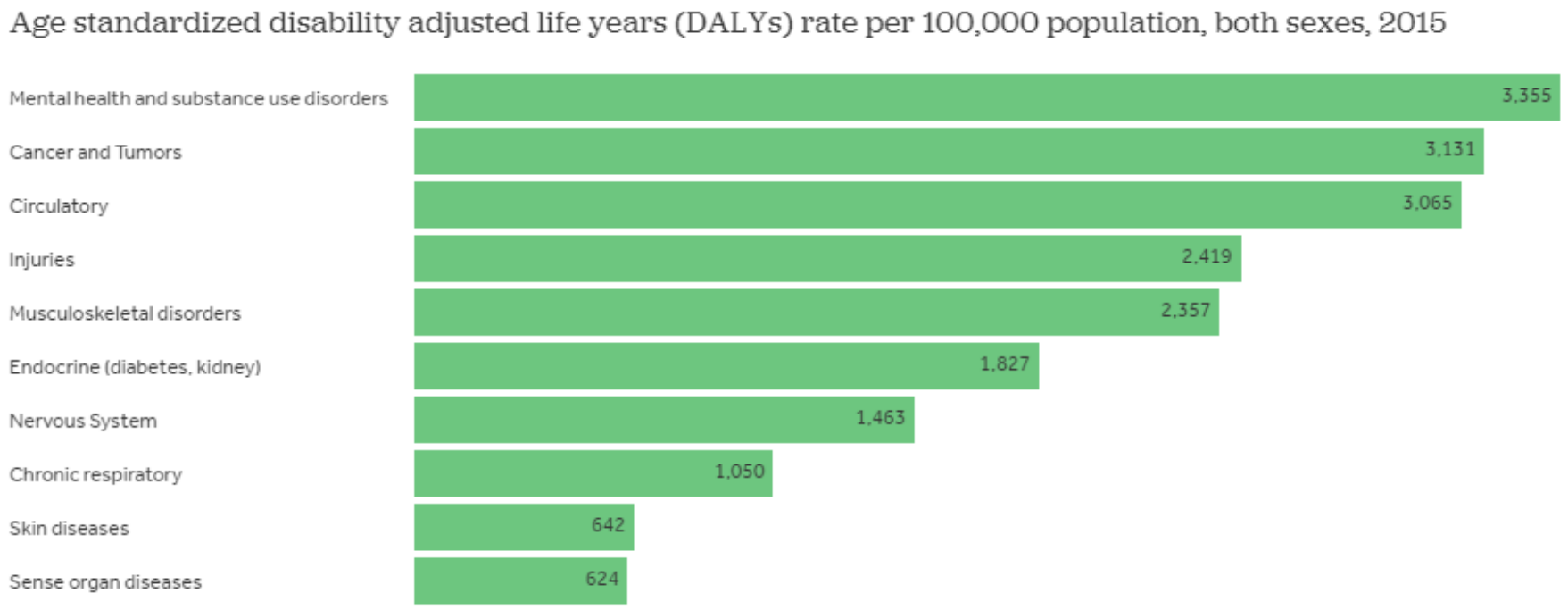
NAVIGATING AN UNPRECEDENTED REFORM LANDSCAPE:

YOUTH MENTAL HEALTH SYSTEMS CHANGE IN CALIFORNIA

CONTRA COSTA COUNTY

APRIL 2024

MENTAL HEALTH AND SUBSTANCE USE DISORDERS ARE THE LEADING CAUSES OF DISEASE BURDEN IN THE US

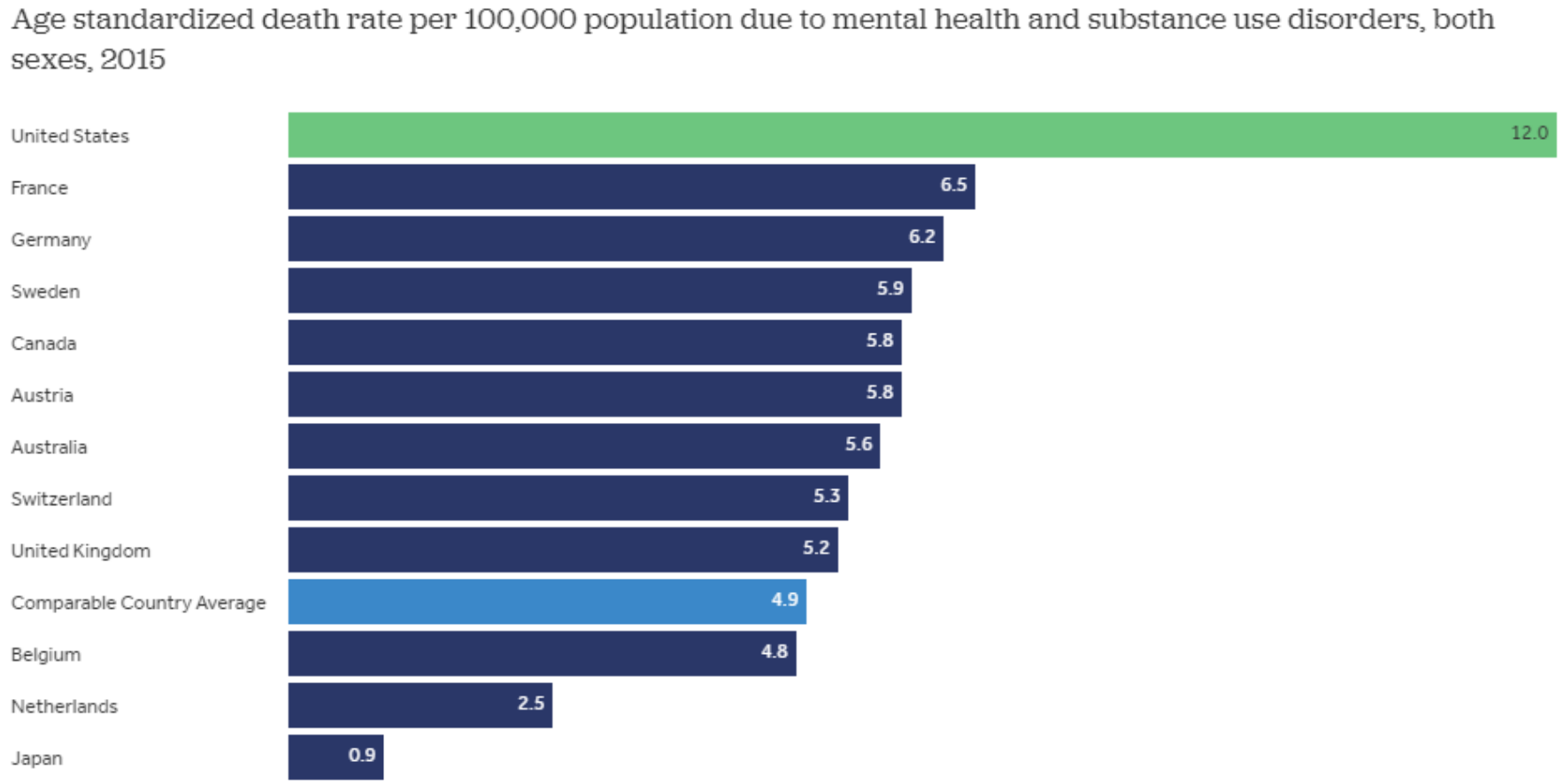


DALY, or the Disability-Adjusted Life-Year, is a metric that combines the burden of mortality and morbidity (non-fatal health problems) into a single number. One DALY can be thought of as one lost year of "healthy" life.

DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences: **DALY = YLL + YLD**

https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-prevalence-mental-illness-among-adults-relatively-stable

AMONG COMPARABLE COUNTRIES, THE U.S. HAS THE HIGHEST RATE OF DEATH FROM MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS



https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-prevalence-mental-illness-among-adults-relatively-stable

THERE IS A CRISIS IN YOUNG PEOPLE'S MENTAL HEALTH

Consider the facts before COVID-19:

Increase in inpatient visits for suicide, suicidal ideation, and self injury
for children ages 1-17 years old, and 151% increase for children ages 10-14

Increase in mental health hospital days
for children between 2006 and 2014

Increase in the rate of self-reported mental health needs
since 2005

California ranks low in the country for
providing access to behavioral, social, and development services and screenings

IMPACT OF COVID: What we feared is coming to pass…

ED VISITS

Beginning in April 2020, the proportion of children's mental health-related ED visits among all pediatric ED visits increased and remained elevated through October

24/31%

Compared with 2019, the proportion of mental health related visits for children aged 5 to 11 and 12 to 17 years increased approximately 24% and 31% respectively

25%

One in for young adults between the ages of 18 and 24 say they've considered suicide because of the pandemic, according to new CDC data that paints a big picture of the nations mental health during the crisis

RADY CHILDREN'S HOSPITAL IN SAN DIEGO:

Between FY2011 and FY2019, annual behavioral health volume has increased

1746%

From 163 visits to 3,009 visits in 8 years

Comparatively, total Emergency Department visits has grown 23% during this same time period

DRAMATIC UNDER-INVESTMENT IN CHILDREN

California is in the bottom 1/3 nationally for health spending at $2,500 per child enrollee.

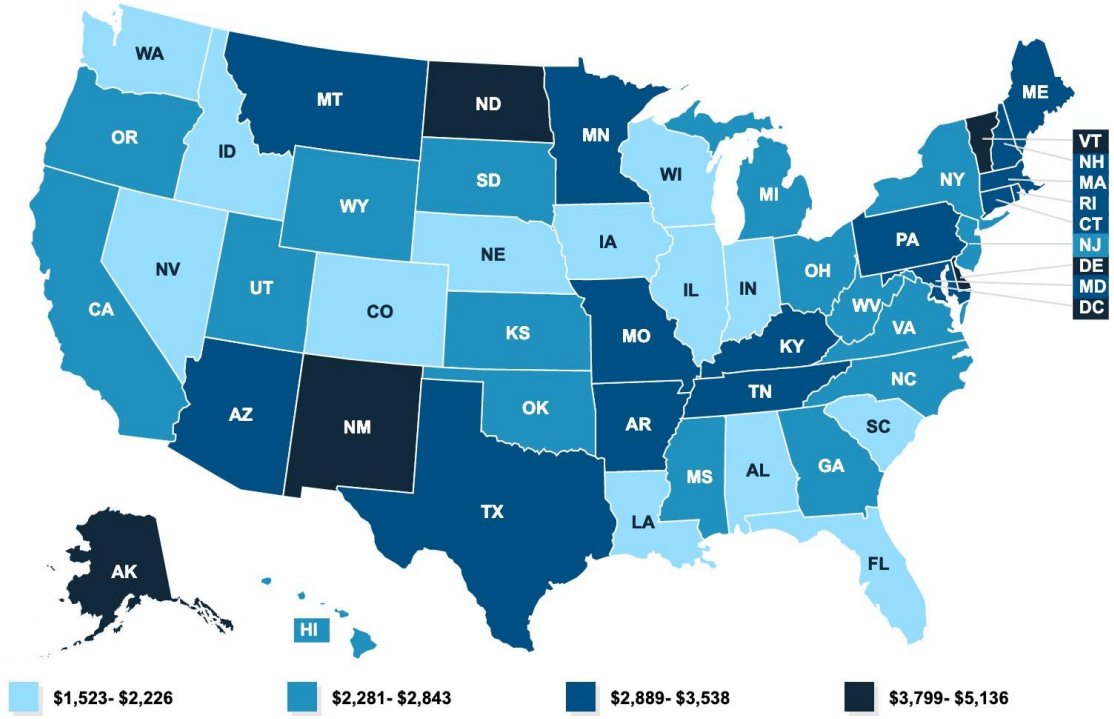
Children represent **42% of enrollees** but only **14% of all expenditures**.

California ranks **44th in the nation of** in access to needed mental health care for children (38th overall).

California operates the largest MediCaid Program in the nation—**April 2019 Audit exposed** significant underperformance under the EPSDT Mandate and Bright Futures Guidelines.

Medicaid Spending per Child

FY 2014



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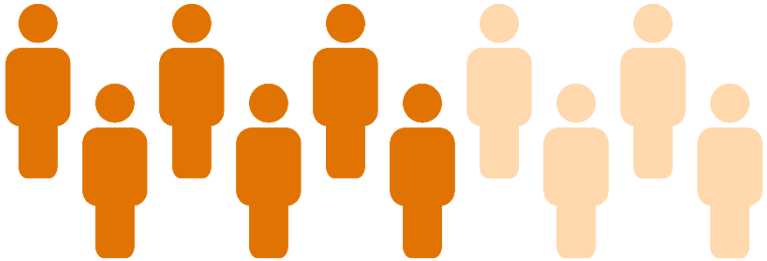
AND ALTHOUGH ELIGIBILITY FOR HEALTH SERVICES HAS INCREASED….



Almost 60% of California's Children are now covered by Medi-Cal and the EPSDT entitlement (a 30% increase over last seven years)

Everyone under 21 living in a family that makes less than 266%FPL qualifies for MediCal (138% for Adults)

Everyone under 25 and over 50 regadless of immigration status are now eligible (26-50's coming in 2023)

Mental Health Access Remains Low:

Less than 6% of all children access any care at all. Less than 3% are in ongoing care.

THE “PRICE” IS HIGHER FOR BLACK AND BROWN CHILDREN

Many receive the wrong services at the wrong time…in restrictive or punitive settings.

81%

81% of children on medicaid are **children of color.**

2X

The **suicide rate for black children**, ages 5-12, is 2x that of their white peers.

80%

80% **of youth in California's juvenile justice system have unmet behavioral health needs**, and youth of color are dramatically over-represented.

Making Healing Centered Systems…

Requires acknowledgment of how racism and poverty impact the social and emotional health of children and families—and how limited traditional medical model services are to addressing them

THERE IS REAL OPPORTUNITY TO ADDRESS A CRISIS IN THE LIVES AND EXPERIENCE OF CHILDREN AND FAMILIES:

Public opinion and policymaker agendas are aligned…

Political Will: State and Federal administration have established a focus on child and family well-being driven by covid, the youth mental health crisis that preceded it, and decades of evidence from the SDOH movement

Community Support: Half (52%) of all Californians addressing mental health needs as "extremely important" and list it among the most important issues for the state to address

Emerging Consensus and Consciousness… …of the impact of adversity, structural racism, and the pandemic on the social and emotional health of children and families

$

A Reform Landscape with **Unprecedented Level of Investment** ($10+ Billion) and a **shifting payor landscape**

TO TAKE ADVANTAGE OF THIS MOMENT, WE NEED TO…

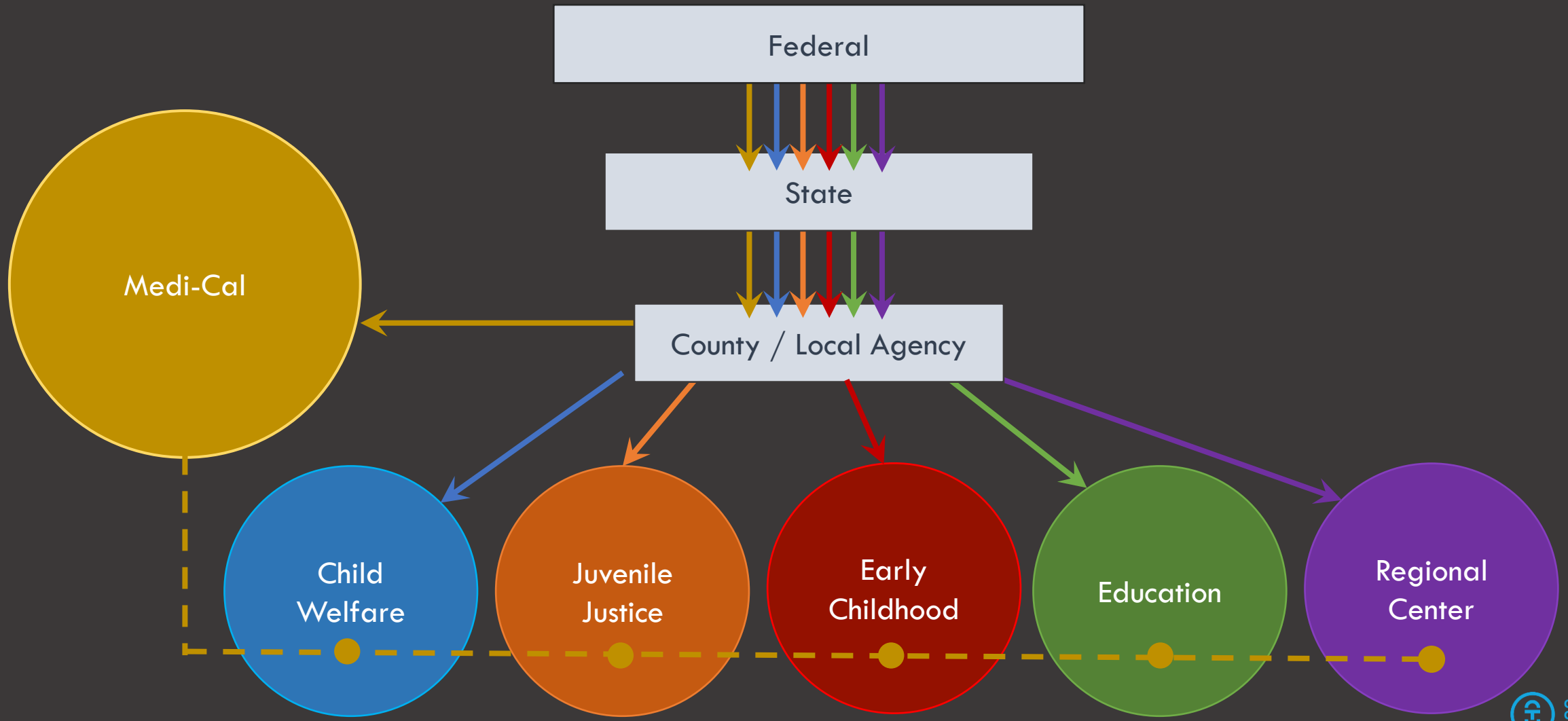
1. Develop new and expanded **partnerships with Managed Care Plans** (Commercial and MediCal)

2. Embrace the critical need to **reform our financing and delivery models** so that they are team based, healing, and relationship centered.

3. Focus on **building a health care system for people by people** through new provider types and community networks

4. Adopt a **paradigm shift that reimagines mental health as a support for healthy development**, not a response to pathology.

MEDICAID AS THE TIE THAT BINDS FRAGMENTED SYSTEMS



Medicaid & Child Welfare Impact Areas

Upstream prevention

Provide children, youth, and families in the community with access to services and supports to meet emerging needs.

Intensive evidence-based services

Provide children, youth, and families in the community with access to services and supports to meet emerging needs living in the community.

Tailored services for children in foster care

Proactively address trauma and mental & behavioral health challenges for children and youth in foster care.

Primary/Secondary — Secondary/Tertiary — Tertiary

SDOH:
A MEDICAID & CHILD WELFARE INTERSECTION

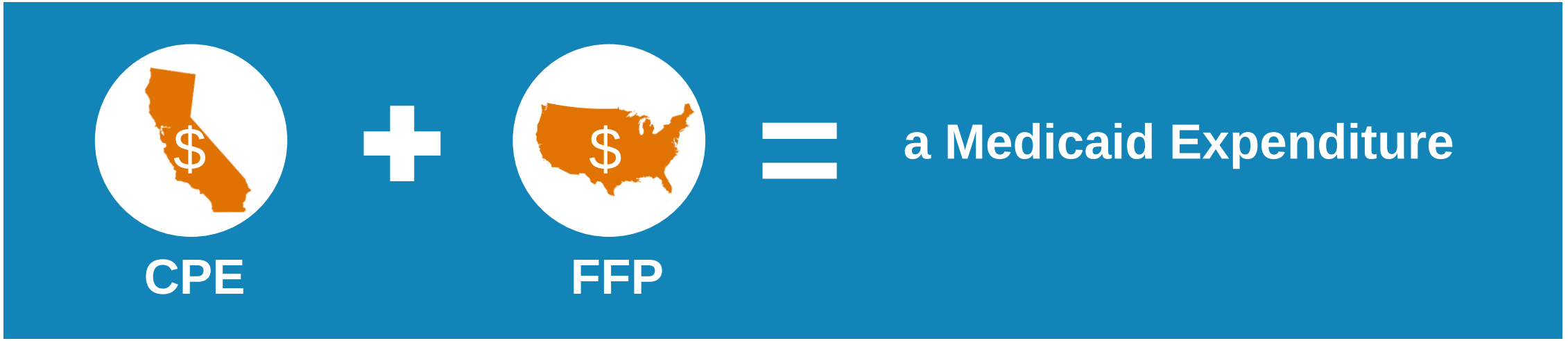
Child Welfare seeks upstream prevention strategies & funds

Medicaid increasingly addresses SDOH.

DO WE?

Have the will and skill to build new community and team based models of care that that integrate payors across fragmented safety net systems?

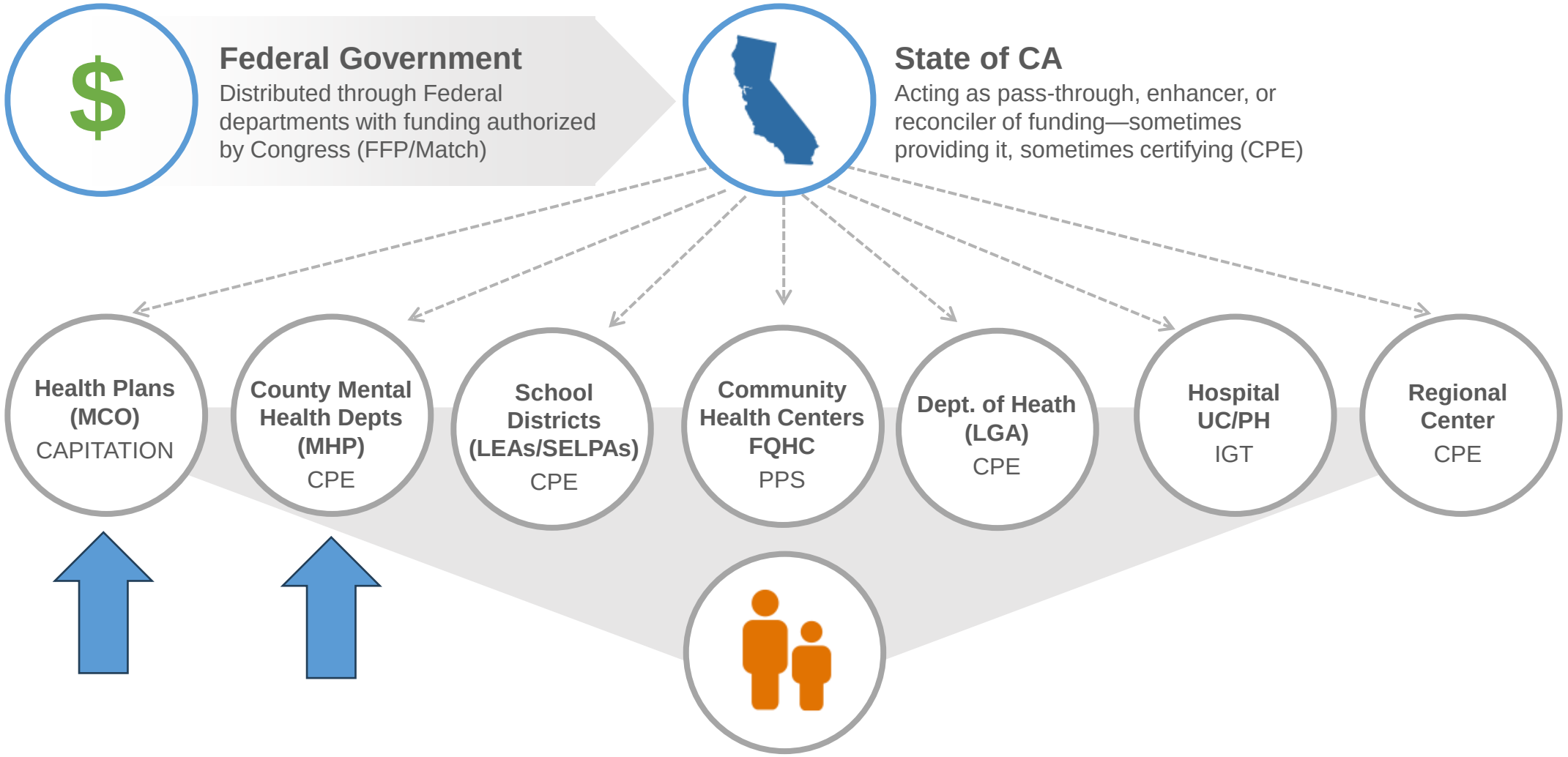
THE FEDERAL MATCH IS GUARANTEED:



Certified Public Expenditure (CPE) = A governmental entity, including a governmental provider (e.g., county hospital, local education agency) incurs an expenditure eligible for FFP under the state's approved Medicaid state plan (DHCS definition).

Federal Financial Participation (FFP) = The federal share of Medicaid dollars when all state and federal requirements are met.

THE MEDICAID MAP: WHO PAYS FOR FEDERALLY ENTITLED SERVICES TO CHILDREN AND FAMILIES



MEDI-CAL MANAGED CARE and BEHAVIORAL HEALTH: What is the difference?

- **Delivery of Medi-Cal Behavioral health services is bifurcated between counties and Medi-Cal managed care plans (MCPs):**

Specialty Mental Health Services (SMHS)

- **County Health Departments** are responsible for *specialty mental health* and substance use disorder services

Non Specialty Mental Health Services (NSMHS)

- **Managed Care plans** (MCPs) are responsible for lower-acuity mental health services (i.e., “mild-to-moderate” services); this is also known as *non-specialty mental health*

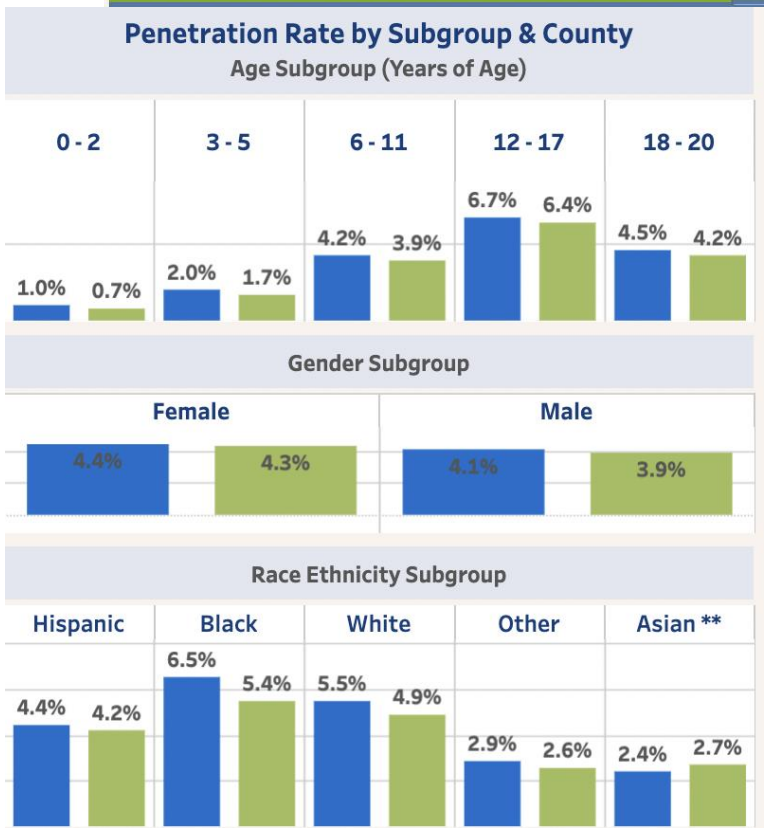
- **This fragmented delivery system leads to frustration for patients, providers, health plans & counties – and as a result many students are NOT being served!!**

CALIFORNIA CHILDREN & SERVICES DASHBOARD & INTERACTIVE MAP

Access interactive data, https://cachildrenstrust.org/our-work/data-backgrounders/

Specialty Mental Health Plans and Non-Specialty Managed Care Plans for CA Children & Youth Mental Health Medi-Cal Beneficiaries
Access, Penetration, & Engagement, Reporting Year, 2021

	Total Beneficiaries	Visits 1+	Visits 5+	Penetration Rate	Engagement Rate
Specialty Mental Health Services	5,663,276	241,182	183,043	4.3%	3.2%
Non-Specialty Mental Health Services	5,123,267	206,883	156,816	4.0%	3.1%



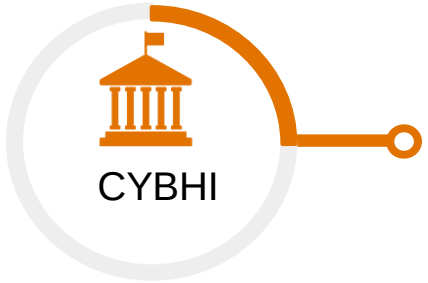
Key Facts

- Medi-Cal enrollment is up by 30% due to both state and federal policy.
- Non-Specialty Mental Health Services grew significantly over the same period.
- Children's utilization and acuity have risen sharply across the state.
- Correspondingly, non-federal based revenues have increased.
- However, for children in foster care, penetration and access rates are flat or declining.

MEDI-CAL AND CALIFORNIA'S UNPRECDENTED REFORM LANDSCAPE

AN UNPRECEDENTED INVESTMENT:

FUNDING OPPORTUNITIES: FOR NEW NETWORKS OF CARE



- Managed Care Plans and Schools/SBHIP ($400 million)
- School Competitive Grants Program ($550 million)
- MHSA SSA funding ($250 million)
- Workforce including BH Coaches ($800 million)
- BH Virtual Platform: ($750 million)
- Expanding Evidence Based Programs ($429 million)
- DYADIC Benefit ($800 Million)
- Universal Feel Schedule: (TBD)

CalAIM: $4.5 billion ($3.1 billion in 22-23 year)

- Population Health Management
- Universal Eligibility for System Involved Children to SMHS
- Enhanced Care Management (ECM)
- Community Supports (CS)
- PATH
  - IPP (incentive payment program)
  - CITED (capacity building for providers)
  - Regional Collaboratives and TA (upcoming)

- Community School Partnership Grant Program ($4 billion+)
- Expanded Learning Opportunity Grant Program ($4 billion)
- Mindfulness ($75 Million); Peer to Peer Demonstration ($10 million)
- Investments in Counselor/Social Worker pipeline
- Educator Effectiveness Grant ($1.5 billion)
- HCSB/Special Ed/Other....($1.5 billion)
- Universal TK ($176 million)
- ESSER 1, II, III ($23.4 billion)

CYBHI: $4.4 Billion Dollar Initiative Centering Schools, Workforce, and Pediatric Primary Care

01 **Behavioral Health Service Virtual Platform: DHCS, $749.7 M**

02 **School-Linked Behavioral Health Services: DHCS/DMHC, $950M**

03 Develop and Expand Age-Appropriate, Evidence-Based Behavioral Health Programs: Agency/DHCS, $429M

04 Building Continuum of Care Infrastructure: DHCS, $310M

05 **Plan Offered Behavioral Health Services:** DHCS, $800M

06 **School Behavioral Health Counselor + Behavioral Health Coach Workforce:** OSHPD, $352M

07 **Broad Behavioral Health Workforce Capacity:** OSHPD, $448M

08 **Pediatric, Primary Care And Other Healthcare Providers:** DHCS, $50M

09 **Comprehensive And Culturally And Linguistically Proficient Public Education And Change Campaign:** CDPH + OSG, $100M

10 **Oversight, Coordination, Convening, And Evaluation:** DHCS, $70M

CYBHI: $4.4 Billion Dollar Initiative Centering Schools, Workforce, Technology and Pediatric Primary Care

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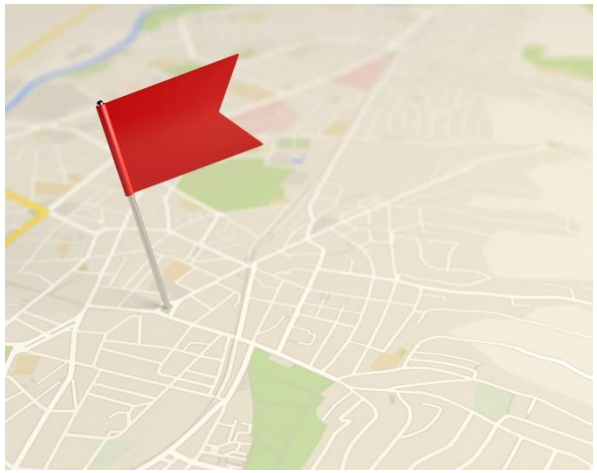
MediCal Managed Care Opportunity Map….

1. INTEGRATING NEW NON-CLINICAL BENEFITS:

Enhanced Care Management and Community Supports

2. ACCESSING NEW MENTAL HEALTH BENEFITS:

Dyadic and Family Therapy Benefits



3. INTEGRATING NEW PROVIDER CLASSES:

CHW, Doula, Peers, Wellness Coaches

4. PARTNERING WITH SCHOOLS ON THE Fee Schedule

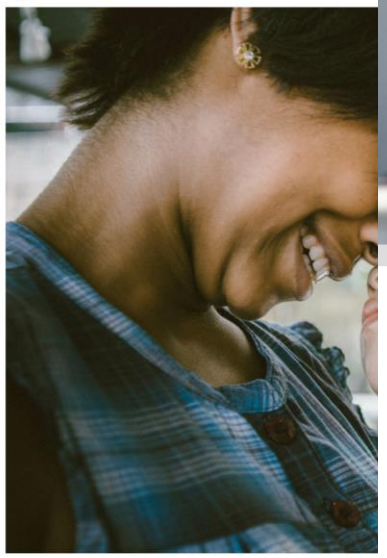
Becoming designated providers and billing case management and psycho education codes.

REFORMING MEDICAL NECESSITY AND EXPANDING ACCESS TO INTEGRATED BEHAVIORAL HEALTH

THE REMOVAL OF DIAGNOSIS AS A PRE-REQUISITE FOR CARE AND THE NEW FAMILY THERAPY AND DYADIC BENEFITS:

New California pr
health coverage p
front and center

LAURIE UDESKY (PACES CONNECTION STAFF)



CLASP
The Center for Law and Social Policy

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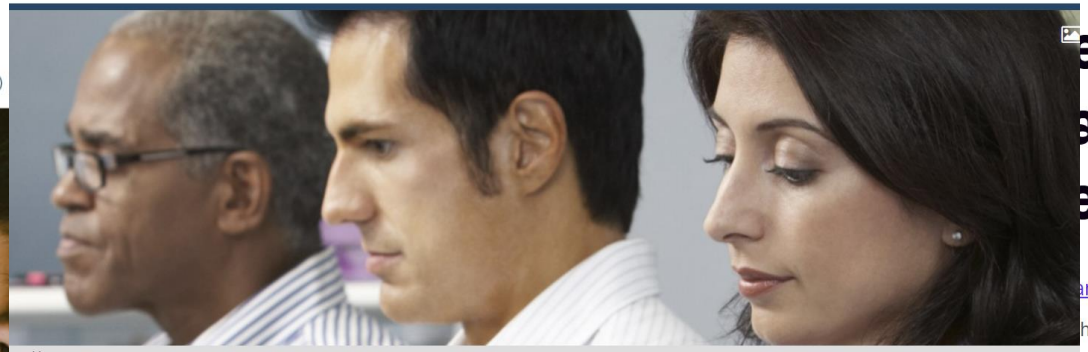


Home

SHARE

California's Medicaid Family Therapy Benefit Reimagines Medical Necessity

Innovations in Youth Mental Health

By Nia West-Bey

HEALTH AND MENTAL HEALTH

Children, Youth & Families
Young Adult Behavioral Health
Youth and Young Adults

Blog Post
May 31, 2022

In 2022, we have seen growing attention on the youth mental health crisis in this country. The U.S. Surgeon General's office issued an unprecedented advisory about the critical state of youth mental health. In response, the Biden Administration released a comprehensive plan and budget proposal. Young people—particularly young people of color and those living in poverty—were

Babies Don't Go to the Doctor By Themselves:

Innovating a Dyadic Behavioral Health Payment Model to Serve the Youngest Primary Care Patients and Their Families

AUTHORS

Kate Margolis, PhD Assistant Professor, UCSF
kathryn.margolis@ucsf.edu

Alex Briscoe Principal, California Children's Trust
alex@cachildrenstrust.org

Jennifer Tracey Senior Director of Growth and Sustainability for HealthySteps, Zero to Three
jtracey@zerotothree.org

- A statewide demonstration project to align reimbursement with clinical best practices in early childhood mental health
- Essential support for proven dyadic models
- Improving health outcomes for young children and their caregivers
- Pioneering clinical best practices to inform state-level guidance
- Demonstrating partnership with safety-net clinical leadership

Proposal Summary

eed Parenting Help? Therapy? Food? alifornia Pediatrician Offices May Soon e Able to Help

ariana Dale

hed Nov 16, 2021 1:19 PM

EXPANDING PROVIDER CLASS :

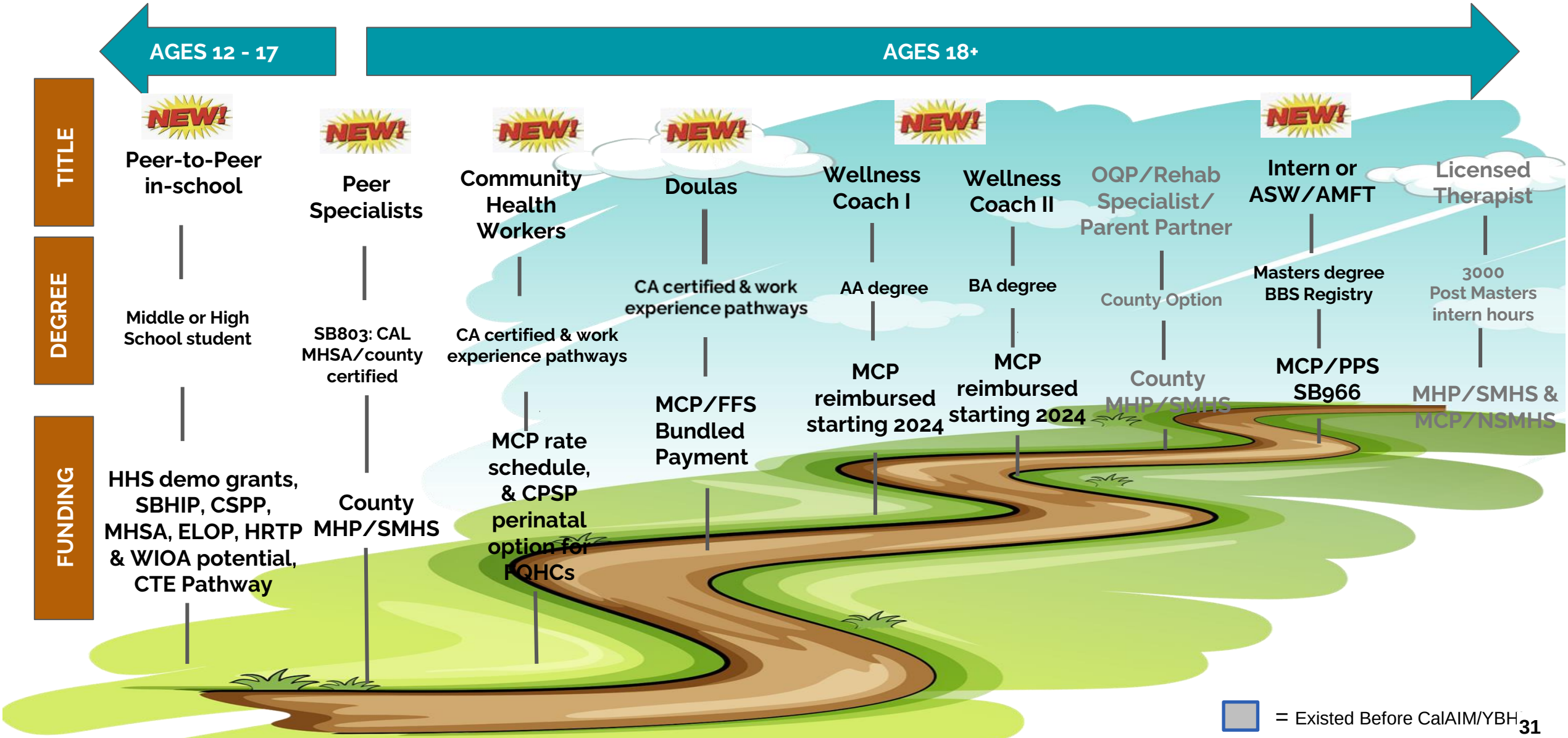
DOULAS, CHWS, PEERS, AND BH COACHES

Provider Expansion Guidelines

Scope	What can the provider do, in what setting, under what supervision and articulation, and what codes will they bill? Are community defined and culturally concordant practices specifically named and included?
Credentialing	Who is responsible for curriculum development, certifying the content and quality of the training, defining the core competencies, and certifying attainment?
Paneling	How does the new class sign-up with the payor? What is the required process and documentation?
Payor	Who pays claims—the Managed Care Organization or Mental Health Plan? Under what authority and what process?
Rates	What is the time, frequency, duration, and reimbursement level of all eligible services? Does it reflect a living wage?

NEW Medi-Cal Reimbursable Career Pathways to Support ACEs Networks of Care

Leveraging and Integrating The Wisdom and Experience of Culturally Concordant Providers



CARE COORDINATION AND COMMUNITY NETWORKS:

Enhanced Care Management:

Provision of care management for certain "Populations of Focus" (POF) focused on addressing clinical and non clinical needs in non clinical settings.

Community Supports:

14 Cost effective alternative to meet health related needs by addressing the SDOH. 67% of MCO's intend to offer all 14.

Mobile Crisis Benefit:

Develop non law enforcement response to BH crisis (988/Compassionate Response Models).

The Children and Youth ECM Populations of Focus going live statewide on July 1, 2023, which include:

1. Children and Youth Experiencing Homelessness
2. Children and Youth At Risk for Avoidable Hospital or Emergency Department (ED) Utilization (Formerly "High Utilizers")
3. Children and Youth with Serious Mental Health and/or Substance Use Disorder (SUD) Needs
4. Children and Youth Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Condition
5. Children and Youth Involved in Child Welfare
6. Children and Youth with Intellectual or Developmental Disabilities
7. Children and Youth who are Pregnant and Postpartum At Risk for Adverse Perinatal Outcomes

Percentage of MCPs Operating in Each County Planning to Offer Each Community Support by 2024

Pre-Approved Services	% of MCPs
1. Housing Transition/Navigation	98%
2. Housing Deposits	92%
3. Housing Tenancy & Sustaining Services	98%
4. Short-Term Post-Hospitalization Housing	90%
5. Recuperative Care (Medical Respite)	94%
6. Respite Services	86%
7. Day Habilitation Programs	69%
8. Nursing Facility Transition/Diversion	71%
9. Community Transition Services/Nursing Facility Transition to a Home	71%
10. Personal Care and Homemaker Services	86%
11. Environmental Accessibility Adaptations	75%
12. Medically-Supportive Food/Meals/Medically Tailored Meals	95%
13. Sobering Centers	74%
14. Asthma Remediation	73%

1A. Defining the Statewide All-Payer School-Linked Fee Schedule

NON-EXHAUSTIVE AS OF 05/22/23

Authorizing Statute, *California Welfare & Institutions Code section 5961.4*

"The State Department of Health Care Services shall develop and maintain a **school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment** provided to a student 25 years of age or younger at a schoolsite[1]"

Scope of services[2]

Services included in the fee schedule at launch on January 1, 2024, will include:

- Psychoeducation
- Screening & Assessment
- Therapy
- Peer counseling
- Care coordination

Providers included[1]

A LEA or public institution of higher education enrolling in the network will enable **their "designated providers" to provide services** (including employed, contracted, or affiliated provider who an individual school deems part of their provider network and who has the credentials required by DMHC/DHCS

8

Who is eligible to participate?

Entities eligible to enroll in the provider network[1]

1. Local Education Agencies (LEA), i.e.,

- School district
- County office of education
- Charter school
- California Schools for the Deaf and Schools for the Blind

2. Public institutions of higher education, i.e.,

- California Community Colleges
- California State Universities
- University of California campuses

1. CYBHI Fee Schedule – Outstanding Policy and Operational Questions meeting (April 18, 2023)

Source: California Welfare & Institutions Code 5961.4 (link); Section 1374.722 of the Health and Safety Code (link)

A CALL TO ACTION

1. **Remove diagnosis** as a requirement for treatment (expand Medical Necessity Criteria in context of EPSDT and ACES)
2. **Reform Medicaid** by claiming against exisiting expenditures in child serving systems and expanding the role of MCO's
3. **Center schools and Primary Care** as healing and anti-racist centers of support
4. **Expand Eligible Provider Classes** to address workforce shortages, build culturally concordant workforce, and honor the widsom and intelligence of lived experience
5. **Focus on Benefit Design in Managed Care Organizations to develop scaleable reimbursement for Dyadic Models** in Pediatric Primary Care.
6. **Focus on Care Coordination models** to bring culturally concordant non clinical CBO's into health system networks.
7. **Develop social model, cascading mentorship, and mutual aid** strategies as essential social capital building strategies in Medicaid.

Read and share our policy briefs

cachildrenstrust.org

Join our Coalition

@CAChildrenTrust

Sign up for the CCT Newsletter

MediCal Managed Care Opportunity Map….

1. INTEGRATING NEW NON-CLINICAL BENEFITS:

Enhanced Care Management and Community Supports

2. ACCESSING NEW MENTAL HEALTH BENEFITS

Dyadic and Family Therapy Benefits

3. INTEGRATING NEW PROVIDER CLASSES:

CHW, Doula, Peers, Wellness Coaches

4. PARTNERING WITH SCHOOLS ON THE FEE Schedule

Becoming designated providers and billing case management and psycho education codes.

TAKE AWAYS:

- BIG CHANGES ARE HERE… AND MORE ARE COMING SOON.
- KNOW THE MANY FACES OF MEDICAL AND HOW THEY CAN BE INTEGRATED TO SUSTAIN YOUR WORK—UNDERSTAND THE CENTRICITY OF THE PLANS
- TRACK NEW AND EMERGING BENEFIT DESIGN AND CONSTRUCTION
- MINE THE NEW PROVIDER TYPE OPPORTUNITIES
- THERE IS A LOTS OF ONE-TIME MONEY—SUSTAINABILITY REMAINS MURKY

SUSTAINABILITY DISTILLED:

HEALTH PLANS ARE THE CENTER

BEHAVIORAL HEALTH IS CHANGING

MEDI-CAL WILL PAY FOR THINGS IT DIDN'T PAY FOR BEFORE

MEDI-CAL WILL PAY FOR NEW TYPES OF PROVIDERS

APPENDIX:

INCREMENTAL AND TRANSFORMATIONAL APPLICATIONS

Paths Forward: Driving System Improvement

Incrementalism

Identify high yield levers for improvement in current structures and implement

Transformational

Reimagine service delivery design and reprocure or certify networks of services through intentional collaboration with other key agencies: BHCS, Managed Care Plans, and DCFS

Incrementalism

Incremental Opportunities for better data and connections to MH/SUD services

- **Better data, tracking & navigation:**
  - ➔ Electronic Referral Management System, including data collection

- **Leveraging Medi-Cal services:**
  - ➔ Ensuring eligibility checks is standard, easy process
  - ➔ Developing dedicated referral paths to DMH, SAPC and MCPs for parents. Hold other systems accountable.
  - ➔ Examine if new CHW benefit can be used to support navigation (TIPS, Multidisciplinary Assessment Teams)
  - ➔ Look at new benefits: Enhanced care management, community supports, CHW

Transformational

Reimagine system design through a coordinated re-procurement

1. **Build on P&A SPA Boundaries to create Regional Networks** that have lead agencies responsible for convening and maintaining the network of CBOs, provide cross-referrals, share best practices, manage communication, and oversee important administrative functions including data collection and reporting.

2. **Clarify referral pathways to expand evidence-based practices** and help families navigate complex and siloed service systems,

3. **Build CBO capacity to engage families and help them navigate local systems of care** by engaging families, assessing their strengths and needs, and providing warm handoffs to existing evidence-based practices and other local community resources.

4. **Fund Regional Networks to provide all mandated services at no cos**t for family maintenance and family reunification

5. Require Regional Networks **providers to enroll in all Medi-Cal payer network**s. Do **joint procurement and oversight** with all payers:

    - L.A. Managed Care Plans , DMH SAPC

6. **Implement Performance-Based Contracts** & require Regional Networks to publish online dashboards quarterly with metrics, such as:

    - Number of service referrals
    - Percent of completed referrals
    - Timeliness of referral completion
    - % of parents required to pay for FM/FR service by category
    - % of appropriate services to serve individualized needs of parents measured by service class (parenting, MH, SUD, anger management, DV, etc)
    - Appropriate language availability

Children's Data Network. Los Angeles County Family Centered Services: Using Administrative Data to Understand the Landscape of Community Based Child Welfare Supports. https://www.datanetwork.org/wp-content/uploads/FCS-final-report-12-11-2020.pdf

Transformational

Reimagine system design through a certification process

- ✓ **Certified providers must offer all court mandated services either on their own or through partnerships at no cost to families**
- ✓ **To be certified, provider must have contracts for Medi-Cal reimbursable services:**
  - Managed Care Contracts for: non-specialty MH services, community health workers, enhanced care management, community supports
  - Specialty MH contracts with DMH
  - Drug Medi-Cal service contract with SAPC
- ✓ **Implement Performance-Based Contracts** with incentive payments & required reporting that gets published in online dashboards quarterly. Example standards:
  - #% of service referrals accepted and connected
  - % of referrals connected within # days
  - % of referrals initiating treatment within # days
  - Completion rates by service
  - Client satisfaction rates

Children's Data Network. Los Angeles County Family Centered Services: Using Administrative Data to Understand the Landscape of Community Based Child Welfare Supports. https://www.datanetwork.org/wp-content/uploads/FCS-final-report-12-11-2020.pdf

File #: 24-0951 **Agenda Date:** 4/3/2024 **Agenda #:** VII.

Advisory Board: Mental Health Commission
Subject: Proposition 1 - Affects in real lives
Presenter: Douglas Dunn, NAMI CC

RECEIVE Presentation "How Proposition 1 will improve our loved one's lives" - by Douglas Dunn, NAMI Contra Costa

Proposition 1: A Bed and Care Instead of Tents, the Street or Death for our Most Mentally Vulnerable

Improving Community Care, Sub-Acute and Acute Behavioral Health Care

By Douglas Dunn

Former Commissioner & Chair, MHC Finance Committee

E-mail: douglas.wm.dunn@gmail.com

Slide 1— Introduction

Slide 2—Agenda

Slide 3—Acronyms and Phrases

Slide 4—Proposition 1—High Level Summary

Slides 5 & 6—Proposition 1 Key Points

Slide 7—Contra Costa Behavioral Health Services Budget

Slide 8—CC County MHSA/BHSA Budget Categories

Slide 9—Housing Needs: Contra Costa County

Slide 10—Proposition 1 CC Housing & Treatment Needs

Slide 11—Bond Measure Dollars for Prop. 1 Bond Measure Statewide Housing Categories

Slide 12—Prop. 1 Statewide Housing Bond Beds & Outpatient Treatment Slots

Slide 13—Possible Prop. 1 Housing Effects on CC County

Slide 14—Background Prop. 1 Contra Costa Issues

Slide 15—Prop. 1 Ongoing Issues, since passed by Voters

Acronyms and Phrases

Acute Level of Care—Refers to the locked Psychiatric Ward level of care for children (ages 0-11), adolescents (ages 12-17), and adults (ages 18 and above)

AOD—Alcohol and Other Drugs: Behavioral Health portion of Mental Health dept.

BHSA—if approved by voters at the March 5, 2024 Primary election, would rename the Mental Health Services Act (MHSA) the Behavioral Health Services Act (BHSA).

Community Assistance, Recovery & Empowerment (CARE) Court

CCBHS—Contra Costa Behavioral Health Services

IMD—Institute of Mental Diseases (civil locked facility)
MHRC—Mental Health Rehabilitation Center (civil locked care facility)

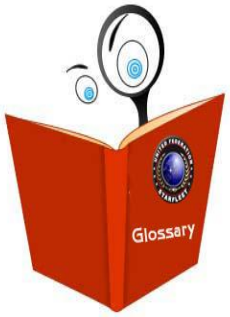
IST—Incompetent to Stand Trial connected to the Dept. of State Hospitals (DSH)

Sub-acute level of care—civil law locked services and care facility for persons on an LPS (Mental Health) Conservatorship. They are placed in an IMD MHRC.

Community based care—unlocked state licensed and unlicensed care housing, services and treatment for mentally ill persons needing it.

TAY—Transition Age Youth (State: Ages 16-25)

WIC—Welfare & Institutions Code



High Level Prop. 1 Summary

- Per very narrow passage by the voters at the March 5, 2024 Primary, Proposition 1 will do several things:
  - Rename the Mental Health Services Act (MHSA) the Behavioral Health Services Act (BHSA).
  - Collapse the current 5 MHSA Categories into 3 BHSA categories without increasing state funding.
  - Authorize a $6.38B housing Bond to cover either building new or refurbishing existing housing for up to 13,000 full spectrum of care (including civil locked acute and sub-acute level facility) beds.
  - Through the Housing Bond, also create 27,000 Outpatient Treatment slots primarily for Substance Use Disorder treatment.
- Focus County Behavioral Health Depts. & Svc. Providers to fully serve their Severely Mentally Ill population.

Key Points: Proposition 1

Financial Changes:

- The state will take some functions from the counties and thus, decrease each county's BHSA allocation from the present 95% to 90% ($140M annually statewide) for the following purposes:
  - 4%--Behavioral Health workforce expansion (previously Workforce Education & Training [WET])
  - 3%--State run Prevention program (previously county run
  - 3%--State BHSA Administration (down from 5 %)
- **The current MHSA Categories are:**
  - Community Services and Supports (CSS)—50% minimum
  - Prevention & Early Intervention (PEI)—5% minimum
  - Innovation (INN)—5% minimum
  - Workforce Education & Training (WET)—1% minimum
  - Capital Facilities/Info. Technology (CF/TN)—1% min

Key Points: Proposition 1 (cont'd)

- Will be "folded" into:
  - Housing Intervention—30%
  - Full Services Partnerships (FSPs + AOT)—35%
  - Behavioral Health Services & Supports (BHSS)—35%
    1. 51% of BHSS must be used for Early Intervention (EI)
    2. 51% of Early Intervention (EI) must serve persons under 25 years of age.
  - As I understand it, these changes will take effect July 1, 2026
- Housing bond of $6.38B critical to help prevent further homelessness, jail, or death for persons who, at times, need:
  1. Acute psychiatric bed care, Respite Care, and/or
  2. Civil locked facility care help to keep them out of the criminal justice system and off the streets or death.
  3. Proper step-up and step down community care to avoid, as much as possible, justice involved locked facility care.
  4. Especially important for the Black Indigenous Persons of Color (BIPOC) communities in Contra Costa County.

Contra Costa Behavioral Health Services (CCBHS) Budget (2022-2023)

- Fed. Fin. Participat.(Medi-Cal): $101,109,300--33%
- 1991 & 2011 Realignment: $ 87,025,700—29%
- Mental Health Services Act: $ 63,520,000—21%
- Alcohol and Other Drugs: $ 33,136,000—11%
- County portion: $ 17,305,000— 6%
- TOTAL: $ 302,096,000

- Public Guardian (LPS Conservat.): $4,500,000
- MHSA (FSP+AOT--Community): $33,647,090
- 1991 & 2011 Realignment: $87,025,700
- TOT. High Need Care Costs: **$125,172,790—41%**

- Persons involved: 900-1,000/year

CC County MHSA/BHSA Budget Categories

Current MHSA Categories

- Com. Support Services (CSS): $ 48,149.000—75.8%
- Prevent. & Early Interv. (PEI): $ 9,849,000—15.5%
- Innovation (INN): $ 2,329,000— 3.7%
- Workforce Educ./Train. (WET): $ 2,943,000— 4.6%
- Cap. Fac./Tech Needs (CF/TN): $ 250,000— 0.4%
- TOTAL: $ 63,520,000

Proposed BHSA Categories

- Housing Interventions—30%: $19,056,000
- Full Service Partnerships (FSP)—35%: $22,232,000
- Behav. Health Svcs.&Sup. (BHSS)—35%: $22,232,000
- TOTAL: $63,520,000

Source: 2022-2023 Actual CCBHS Published budget and then "recast" into the new proposed BHSA Categories.

Housing Needs: CC County

- **Current Budget Provided (High Need persons):**
- MHSA (FSP+AOT & Housing): $33,640,090
- 1991and 2011 Realignment: $87,025,700
  - $20M/yr. of state Realignment funding used for State Hospital and Institute of Mental Diseases (IMD) care
- County Jail--$50M/yr. per Prison Law Office settlement
- State Prison: Unknown
- **Persons involved (Ages 18 & above): 1,200-1,250 (incl. jail & State Hosp.)**
- MHSA (Community Unlocked): 650 (FSP & AOT)
- 1991 Realign. LPS Conserv. MHRC Care: 139-180+
- State Hosp.+ Condit. Release (CONREP): 75+
- County Jail: 300 (out of 700 persons—40% have a severe mental illness and co-occurring Substance Use Disorder)
- State Prison: Unknown
- **Unhoused in CC County: 2,000-2,500/year, 50%+ of whom have co-occurring severe mental illness and substance use disorder issues. This is especially the population Prop. 1 seeks to reach and serve.**

General Prop. 1 CC Housing & Treat. Needs

- **Community Based Care:**

1. Peer Respite:
2. Substance Use Disorder Treatment slots:

- **Mental Health Rehab. Center Care & SUD Care:**

1. Forensic (IST and LPS Murphy):
2. LPS Conservatorship (incl. CARE Court, if nec.):
3. Additional Discovery House type Care:

- **Possible Ratio of Community Beds to MHRC Beds:**
  - 2 "step down" beds for every 1 "step up" MHRC bed to 4 step down" beds for every 1 "step up" MHRC bed.
  - "Sweet spot" could be 3 "step down" beds for every 1 "step up" MHRC bed.
- **KEY: Unclog the "Human log jam" at both ends of the housing continuum.**
- Slide 14 further touches on these concerns.

Prop.1 Bond Measure Dollars for Statewide Housing Categories

- Chap. 4: Behav. Health Infrastructure Bond Act of 2024—pp. 102-105

1. Homeless or "At risk of" veterans: $1.065B
2. Gen. pop.—Homeless or at risk of: $ 922M
3. Short Term Crisis, Acute, Sub-Acute, Com.: $1.500B
4. Gen. pop.—Crisis, Acute, Sub-Acute, Com: $2.893B

- TOTAL: $6.380B

NOTE; I understand all rounds of funding will be via the Behavioral Health Care Continuum Infrastructure Program (BHCIP) competitive bid process.

Prop. 1 Housing Bond Beds & Outpatient Treatment Slots Involved Statewide

1. Veterans (In Community):	2,350
2. General Population (incl. SUD):	2,000
3A. Crisis (incl. Acute Care & Peer Respite):	2,050
3B. Sub-Acute:	2,700
3C. Community (incl. SUD):	2,050
4. Gen. Pop., including 3A, 3B, 3C:	1,850
TOTAL:	13,000

Outpatient Treatment slots (prim. SUD): 27,600

Source: CA Public & Policy Center website—
Understanding Proposition 1

Pos. Prop. 1Housing Bond Effects on CC County

Dollars—Approx., CCC 2.4% of state pop. & Medi-Cal recipients

1. Veterans (Community—Incl. AOD): $28,755,000
2. General Pop. (Community): $24,894,000
3. Crisis, Sub-Acute, & Community: $40,500,000
4. Gen. Population (Com., incl. 3): $78,111,000

TOTAL Approx. Prop. 1 Dollars for CCC: $172,260,000

Beds—Approx. , CCC 2.4% of state pop&M-Cal recipients

1. Veterans (Community): 64
2. General Population (Community): 54

3A. Crisis & Stabilization: 56
3B. Sub-Acute (LPS Conserv.): 73
3C. Community: 56

4. Gen. Pop., incl. 3A, 3B & 3C: 43

TOT. Approx. Prop. 1 Beds for Contra Costa County: 346

VERY PRELIM: **Only** based on county pop. & M-Cal recip.

Background Prop. 1Contra Costa Issues

- CARE Court coming Dec. 1, 2024
  - LPS Conservatorship “the default” if person “fails” CARE Court.
  - How many persons could be involved?
- Felony Incompetent to Stand Trial (FIST) 18 month county housing and treatment services
  - $9M+ in state funding provided thru the DSH.
  - To be provided for up to 100 persons-6/30/28.
  - LPS Conservatorship housing part of the the “continuum of care” as needed.
  - How many persons could be involved?

Ongoing issues

- **BHSA**
  - With funding not increased, stress on current funding for Core Services, such as treatment and housing, esp. for historically underserved communities (BIPOC & LGBTQUI). **Focus: "Braided" Medi-Cal funding.**
  - CCBHS has attempted to get around this by putting as much money as possible in the 2023-2026 3 Yr. Plan for Housing (approx. $66M in this plan time period).
- **Housing Bond**
  - $310M/yearly in bond payments over 30 years means a cost of $9.38B over 30 years for this $6.3B Bond.
  - Will slightly strain the General Fund for other programs.
  - **Overall, a very worthwhile "trade-off" for persons who really need this care. The tragic alternative is often the criminal justice system, homelessness, or death, especially for families of loved ones in Black Indigenous Persons of Color (BIPOC) communities in this county.**