AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, FEBRUARY 22, 2021

2:30 PM, STATE CAPITOL, ROOM 4202

Due to the ongoing COVID-19 safety considerations, including guidance on physical distancing, seating for this hearing will be very limited for the press and for the public. All are encouraged to watch the hearing from its live stream on the Assembly's website at https://assembly.ca.gov/todayevents.

We encourage the public to provide written testimony before the hearing. Please send your written testimony to: BudgetSub1@asm.ca.gov. Please note that any written testimony submitted to the committee is considered public comment and may be read into the record or reprinted.

A moderated telephone line will be available to assist with public participation. After all witnesses on all panels and issues have concluded, and after the conclusion of member questions, the public may provide comment by calling the toll-free number that will be provided prior to the hearing.

ITEMS TO BE HEARD

NON-PRESENTATION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
4440 DEPARTMENT OF STATE HOSPITALS
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 1: IMPACTS OF THE PANDEMIC ON BEHAVIORAL HEALTH NEEDS AND SERVICES

PANELISTS – PRESENTERS & QUESTIONS FOR EACH DEPARTMENT

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs, State Medicaid Director

Department of State Hospitals
- **Stephanie Clendenin**, Director, Department of State Hospitals

California Department of Public Health
- **Artnecia Ramirez**, Assistant Deputy Director, Office of Health Equity
- **Marina Augusto**, Chief, Office of Health Equity

Mental Health Services Oversight and Accountability Commission
- **Toby Ewing**, Executive Director

County Behavioral Health Directors Association
- **Michelle Doty Cabrera**, Executive Director
- **Dr. Veronica A. Kelley**, DSW, LCSW, Behavioral Health Director, San Bernardino County, CBHDA President

PANELISTS – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director – Behavioral Health
- **Lindy Harrington**, Deputy Director – Health Care Financing

Department of State Hospitals
- **Dr. Katherine Warburton**, Deputy Director, Clinical Operations, Department of State Hospitals (Q&A only)
- **Ellen Bachman**, Deputy Director, Statewide Quality Improvement Division

Mental Health Services Oversight and Accountability Commission

- **Norma Pate**, Deputy Director

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Jack Zwald**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal & Policy Analyst
- **Mark Newton**, Deputy Legislative Analyst

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 2: BEHAVIORAL HEALTH SERVICES FOR YOUTH

PANELISTS – PRESENTERS & QUESTIONS FOR EACH DEPARTMENT

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs, State Medicaid Director

California Department of Public Health
- **Monica Morales**, Deputy Director, Center for Healthy Communities

Mental Health Services Oversight and Accountability Commission
- **Toby Ewing**, Executive Director

County Behavioral Health Directors Association of California
- **Michelle Doty Cabrera**, Executive Director
- **Dr. Veronica A. Kelley**, DSW, LCSW, Behavioral Health Director, San Bernardino County, CBHDA President

California Association of Health Plans
- **Jedd Hampton**, Legislative Advocate

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

PANELISTS – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director – Behavioral Health
- **Lindy Harrington**, Deputy Director – Health Care Financing

California Department of Public Health
- **Stacy Alamo**, Chief, Injury and Violence Prevention Branch

Mental Health Services Oversight and Accountability Commission
- **Norma Pate**, Deputy Director

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Jack Zwald**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal & Policy Analyst
- **Mark Newton**, Deputy Legislative Analyst

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 3: SUICIDE AND DRUG OVERDOSE PREVENTION

PANELISTS – PRESENTERS & QUESTIONS FOR EACH DEPARTMENT

Mental Health Services Oversight and Accountability Commission
- **Toby Ewing**, Executive Director

California Department of Public Health
- **Monica Morales**, Deputy Director, Center for Healthy Communities

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs, State Medicaid Director

County Behavioral Health Directors Association of California
- **Michelle Doty Cabrera**, Executive Director
- **Dr. Veronica A. Kelley**, DSW, LCSW, Behavioral Health Director, San Bernardino County, CBHDA President

PANELISTS – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director – Behavioral Health
- **Lindy Harrington**, Deputy Director – Health Care Financing

California Department of Public Health
- **Stacy Alamo**, Chief, Injury and Violence Prevention Branch

Mental Health Services Oversight and Accountability Commission
- **Norma Pate**, Deputy Director

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Jack Zwald**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal & Policy Analyst
- **Mark Newton**, Deputy Legislative Analyst

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4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 4: BEHAVIORAL HEALTH SERVICES FOR THE HOMELESS AND OTHER HIGH-NEED POPULATIONS

PANELISTS – PRESENTERS & QUESTIONS FOR EACH DEPARTMENT

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs, State Medicaid Director

Department of State Hospitals
- **Stephanie Clendenin**, Director
- **Chris Edens**, Deputy Director, Forensics Division

Mental Health Services Oversight and Accountability Commission
Toby Ewing, Executive Director

County Behavioral Health Directors Association of California
- **Michelle Doty Cabrera**, Executive Director
- **Dr. Veronica A. Kelley**, DSW, LCSW, Behavioral Health Director, San Bernardino County, CBHDA President

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

PANELISTS – Q&A ONLY

Department of Health Care Services (Q&A only)
- **Kelly Pfeifer**, Deputy Director – Behavioral Health
- **Lindy Harrington**, Deputy Director – Health Care Financing

Mental Health Services Oversight and Accountability Commission
- **Norma Pate**, Deputy Director

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Sonal Patel**, Finance Budget Analyst

Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: MEDI-CAL BEHAVIORAL HEALTH

PANELISTS – PRESENTERS & QUESTIONS FOR EACH DEPARTMENT

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs, State Medicaid Director

County Behavioral Health Directors Association of California
- **Michelle Doty Cabrera**, Executive Director
- **Dr. Veronica A. Kelley**, DSW, LCSW, Behavioral Health Director, San Bernardino County, CBHDA President (Presenter)

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

PANELISTS – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director – Behavioral Health
- **Lindy Harrington**, Deputy Director – Health Care Financing

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Sonal Patel**, Finance Budget Analyst

Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst

AGENDA OVERVIEW

This agenda covers behavioral health issues and proposals across several departments. Specifically:

Department of Health Care Services (DHCS)

The Governor's budget includes ten Budget Change Proposals (BCPs), of which 4.5 are related to behavioral health and therefore are included in this agenda. The half refers to the behavioral health components of the California Advancing and Innovating Medi-Cal ("CalAIM") BCP. The remaining 5.5 BCPs, and Medi-Cal issues that are not specific to behavioral health, likely will be included on the agenda for the Subcommittee's hearing on March 8, 2021. Of the BCPs included here, the following two are included in the discussion/presentation section of this agenda:

- Increased Access to student Behavioral Health Services – see Issue 2.
- CalAIM Initiative BCP – see Issue 5.

The other three DHCS behavioral health BCPs included in this agenda are in the Non-Presentation section of the agenda in Issues 6 – 8. The Governor's budget also includes several proposed trailer bills, three of which relate to behavioral health and can be found in Issues 9 – 11 of this Agenda. Other trailer bill proposals will be included on the March 8th agenda.

California Department of Public Health (CDPH)

The majority of the proposed CDPH budget, including all CDPH BCPs, was included in the Subcommittee's agenda on February 8, 2021. Included here are a few select behavioral health programs and issues that CDPH oversees, including: the California Reducing Disparities Project and Mental Health Equity Fund (Issue 1), the All Children Thrive Program (Issue 2), and suicide prevention work (Issue 3).

Department of State Hospitals (DSH)

The proposed budget for DSH includes various program updates and caseload estimates, and 11 BCPs, all of which are contained in this agenda. The following three are included in the discussion/presentation section of this agenda:

- Covid-19 Direct Response Expenditures – see Issue 1.
- Skilled Nursing Facility Infection Preventionists (AB 2644) – see Issue 1.
- Community Care Demonstration Project for Felony ISTs – see Issue 4.

The other eight DSH BCPs are in the Non-Presentation section of the agenda in Issues 12 - 19.

Mental Health Services Oversight and Accountability Commission (OAC)

The proposed budget for the OAC includes one BCP, the Mental Health Student Services Act Partnership Grant Program Augmentation, which is included in Issue 2 of this agenda, as well as a proposal related to a new tax return check-off for suicide prevention, which can be found in Issue 20 of this agenda. The OAC will provide updates on work they are doing on Youth Drop-In Centers and Early Psychosis, as a part of Issue 2. The OAC is engaged in suicide prevention work, including completion of a State Suicide Prevention Strategic Plan, which is described in Issue 3.

ITEMS TO BE HEARD

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
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4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 1: IMPACTS OF THE PANDEMIC ON BEHAVIORAL HEALTH NEEDS AND SERVICES

OVERVIEW

This issue (Issue 1) covers:

A. Data on the impacts of the pandemic on behavioral health needs and services.
B. COVID-19 morbidity and mortality rates within State Hospitals.
C. Actions taken to respond to the pandemic by DSH and DHCS (specific to behavioral health).
D. DSH BCP on Skilled Nursing Facilities Infection Preventionists (AB 2644).
E. DSH portion of the multi-agency BCP on COVID-19 expenditures.
F. Updates on CDPH programs, including: the California Reducing Disparities Project (CRDP) and the Mental Health Equity (MHE) Fund.

PANELISTS – PRESENTERS & QUESTIONS FOR EACH DEPARTMENT

Department of Health Care Services

- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs, State Medicaid Director

1. Please share any data that you have which shows the impact of the pandemic on behavioral health needs and on the demand for behavioral health services.
2. Please provide a high-level overview of how the Medi-Cal program has responded to the pandemic specific to behavioral health.

Department of State Hospitals

- **Stephanie Clendenin**, Director, Department of State Hospitals

1. Please share the data on COVID-19 in State Hospitals and DSH's response to the pandemic.
2. Please present the the SNF IP BCP and the DSH portions of the multi-agency COVID-19 expenses BCP.
3. Please share lessons learned about State Hospitals being prepared to respond to a pandemic (or major infectious disease outbreak).

4. Please provide any available data specific to the 52 deaths, such as age or other demographic data, percent who were SNF patients, percent with underlying medical conditions, etc.
5. Please provide a response to the allegations made by Coalinga-SH patients that the hospital has been negligent in protecting patients.

California Department of Public Health
- **Artnecia Ramirez**, Assistant Deputy Director, Office of Health Equity
- **Marina Augusto**, Chief, Office of Health Equity

1. Please provide a high-level overview of the California Reducing Disparities Project and the Mental Health Equity Program, both at CDPH and DHCS.
2. What is the timeline for the CRDP funding, and what do you expect to happen to the currently-funded projects when this funding ends?
3. What evaluation or other data shows the value or effectiveness of these programs? What is the status and timeline for the statewide evaluation of CRDP?

Mental Health Services Oversight and Accountability Commission
- **Toby Ewing**, Executive Director

1. Please share any information you have on the impacts of the pandemic on behavioral health needs in California.

County Behavioral Health Directors Association
- **Michelle Doty Cabrera**, Executive Director
- **Dr. Veronica A. Kelley**, DSW, LCSW, Behavioral Health Director, San Bernardino County, CBHDA President

1. Please describe what is known about the impacts of the pandemic on behavioral health needs and services in California.
2. What have been the most significant challenges facing counties in responding to behavioral health needs during the pandemic?
3. What are the lessons learned that will help counties improve behavioral health services in the future, both during and outside of crises?

PANELISTS – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director – Behavioral Health
- **Lindy Harrington**, Deputy Director – Health Care Financing

Department of State Hospitals
- **Dr. Katherine Warburton**, Deputy Director, Clinical Operations, Department of State Hospitals (Q&A only)
- **Ellen Bachman**, Deputy Director, Statewide Quality Improvement Division

Mental Health Services Oversight and Accountability Commission
- **Norma Pate**, Deputy Director

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Jack Zwald**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal & Policy Analyst
- **Mark Newton**, Deputy Legislative Analyst

A. DATA ON IMPACTS OF PANDEMIC ON BEHAVIORAL HEALTH

It is widely believed that the COVID-19 pandemic is having very significant impacts on behavioral health, which may even worsen before getting better. A recent Kaiser Family Foundation (KFF) survey found that 4 in 10 adults in the U.S. have reported symptoms of anxiety or depressive disorder, up from 1 in 10 prior to the pandemic. See the figure below from the KFF study:

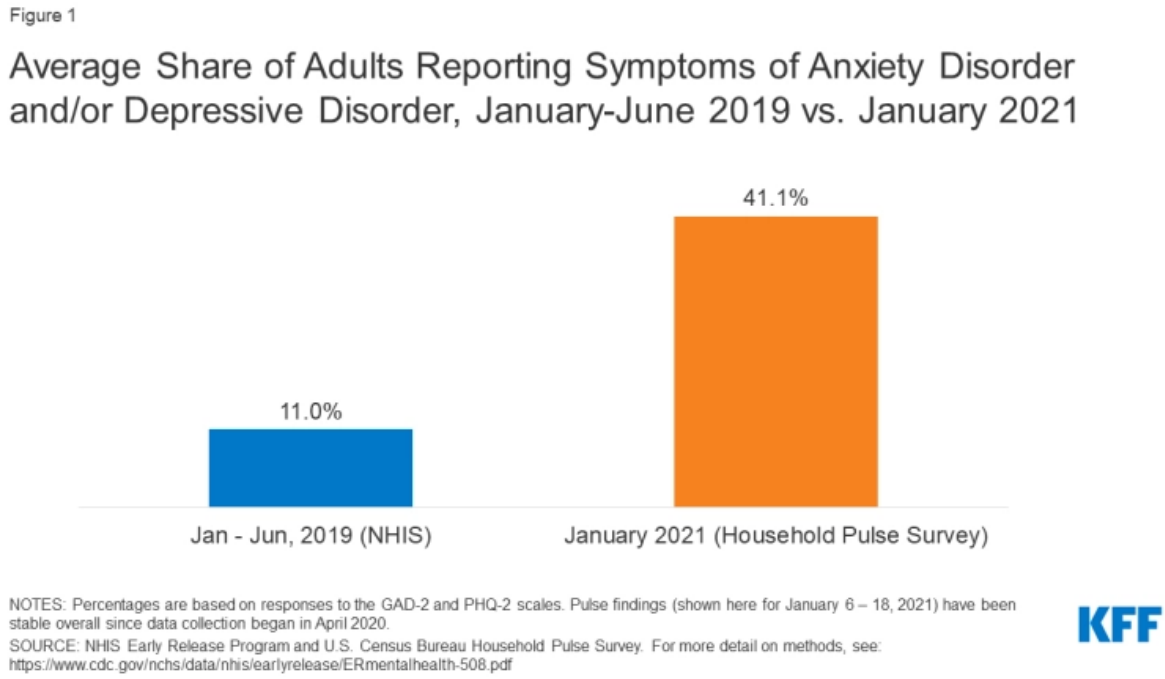


Figure 1: Average Share of Adults Reporting Symptoms of Anxiety Disorder and/or Depressive Disorder, January-June 2019 vs. January 2021

"A KFF Health Tracking Poll from July 2020 also found that many adults are reporting specific negative impacts on their mental health and well-being, such as difficulty sleeping (36%) or eating (32%), increases in alcohol consumption or substance use (12%), and worsening chronic conditions (12%), due to worry and stress over the coronavirus." (Panchal, Kalmal, Cox, Garfield, *The Implications of COVID-19 for Mental Health and Substance Use*, February 10, 2021)

The KFF study authors offer the following key takeaways:

- "Young adults have experienced a number of pandemic-related consequences, such as closures of universities and loss of income that may contribute to poor mental health. During the pandemic, a larger than average share of young adults (ages 18-24) report symptoms of anxiety and/or depressive disorder (56%). Compared to all adults, young adults are more likely to report substance use (25% vs. 13%) and suicidal thoughts (26% vs. 11%). Prior to the pandemic, young adults were already at high risk of poor mental health and substance use disorder, though many did not receive treatment.

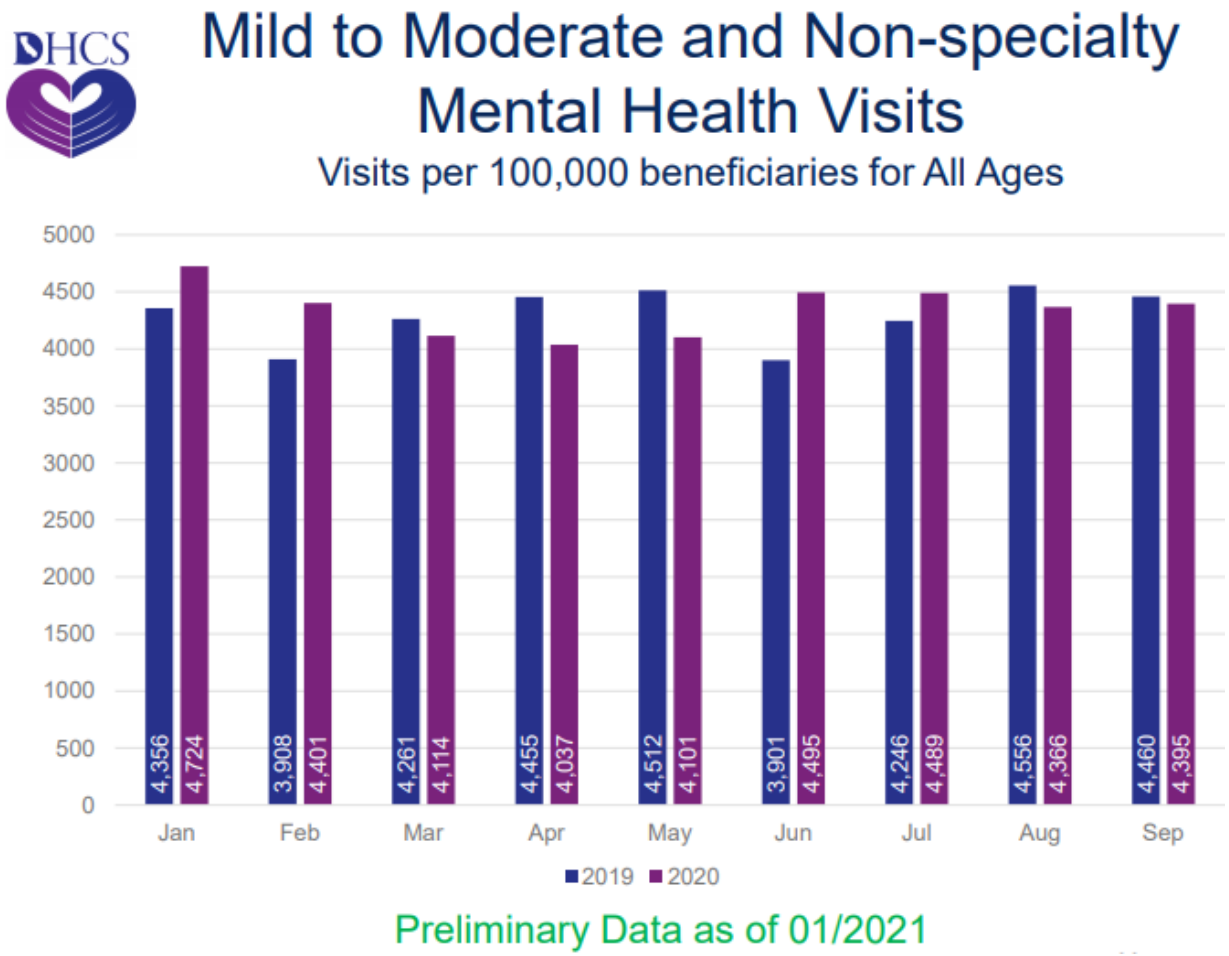
- Research from prior economic downturns shows that job loss is associated with increased depression, anxiety, distress, and low self-esteem and may lead to higher rates of substance use disorder and suicide. During the pandemic, adults in households with job loss or lower incomes report higher rates of symptoms of mental illness than those without job or income loss (53% vs. 32%).

- Research during the pandemic points to concerns around poor mental health and well-being for children and their parents, particularly mothers, as many are experiencing challenges with school closures and lack of childcare. Women with children are more likely to report symptoms of anxiety and/or depressive disorder than men with children (49% vs. 40%). In general, both prior to, and during, the pandemic, women have reported higher rates of anxiety and depression compared to men.

- The pandemic has disproportionately affected the health of communities of color. Non-Hispanic Black adults (48%) and Hispanic or Latino adults (46%) are more likely to report symptoms of anxiety and/or depressive disorder than Non-Hispanic White adults (41%). Historically, these communities of color have faced challenges accessing mental health care.

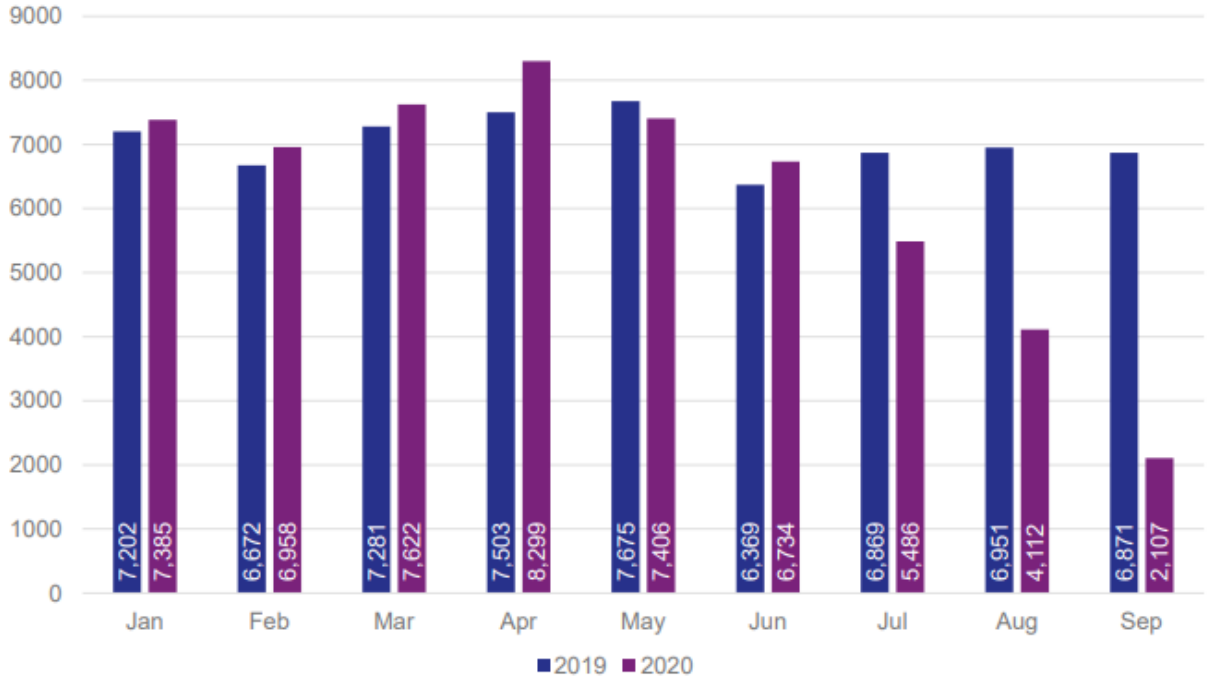
- Many essential workers continue to face a number of challenges, including greater risk of contracting the coronavirus than other workers. Compared to nonessential workers, essential workers are more likely to report symptoms of anxiety or depressive disorder (42% vs. 30%), starting or increasing substance use (25% vs. 11%), and suicidal thoughts (22% vs. 8%) during the pandemic."

As depicted in the following charts, DHCS reports that utilization of non-specialty (mild-to-moderate) as well as for specialty (serious/severe) mental health services in Medi-Cal, has fluctuated during the pandemic with some months higher and some lower in 2020 as compared to 2019:



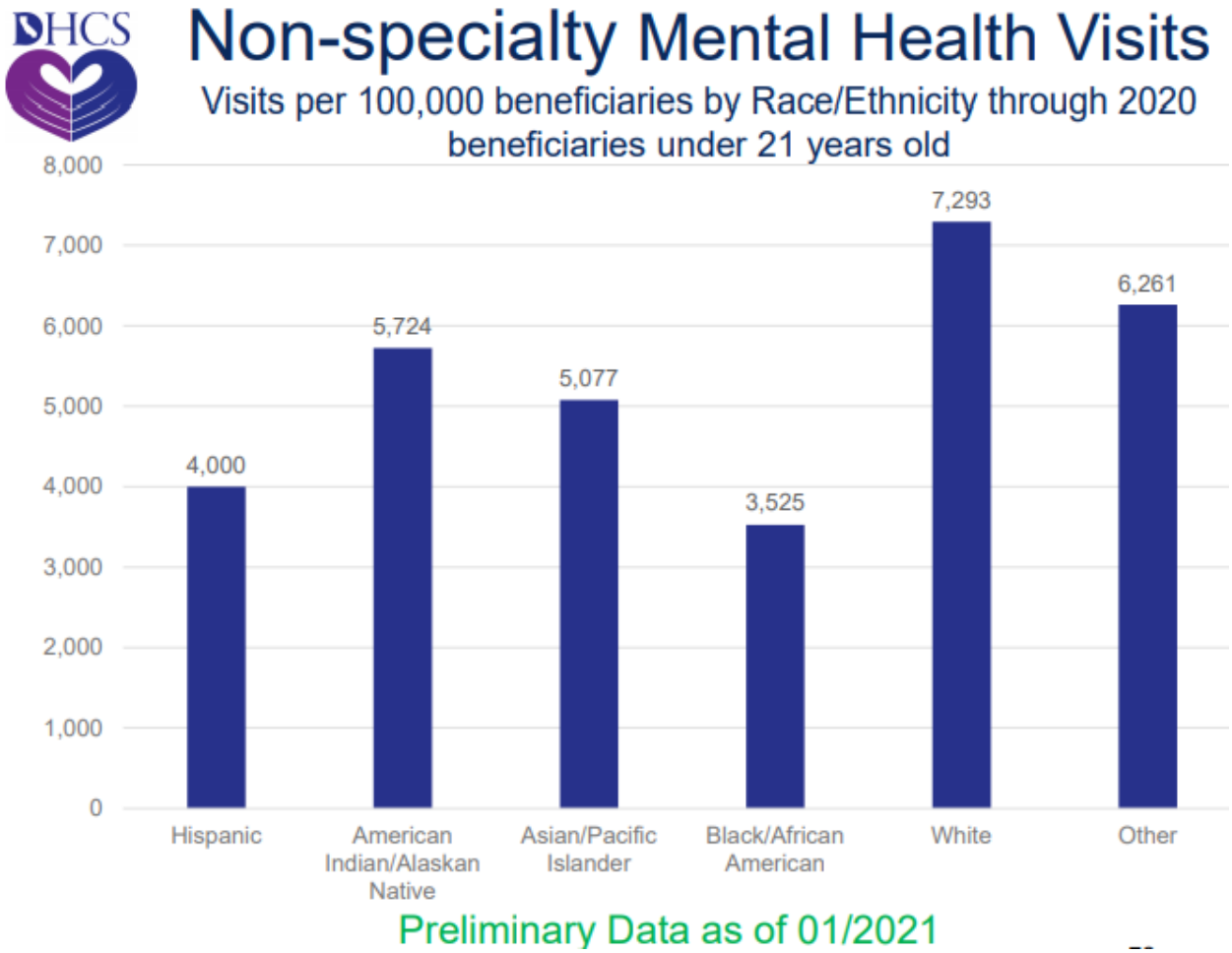
Specialty Mental Health Visits

Visits per 100,000 beneficiaries for All Ages



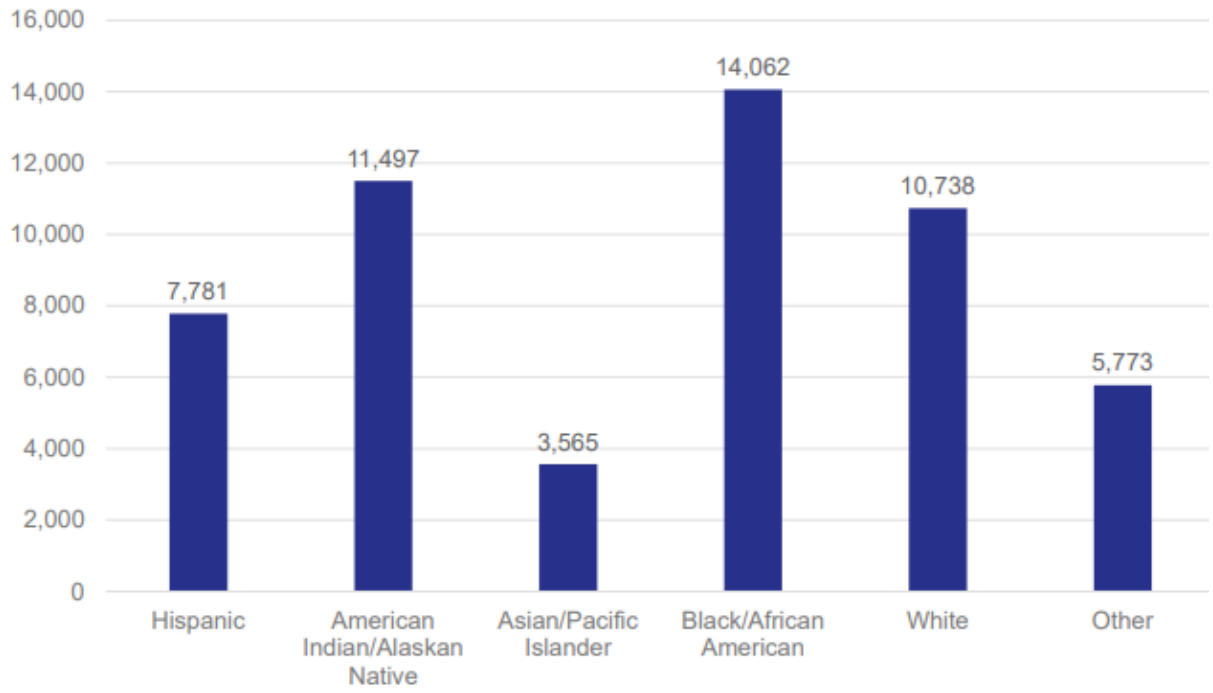
Preliminary Data as of 01/2021

The following charts from DHCS show the racial/ethnic disparities in the youth population in terms of who accessed mental health services through Medi-Cal in 2020:



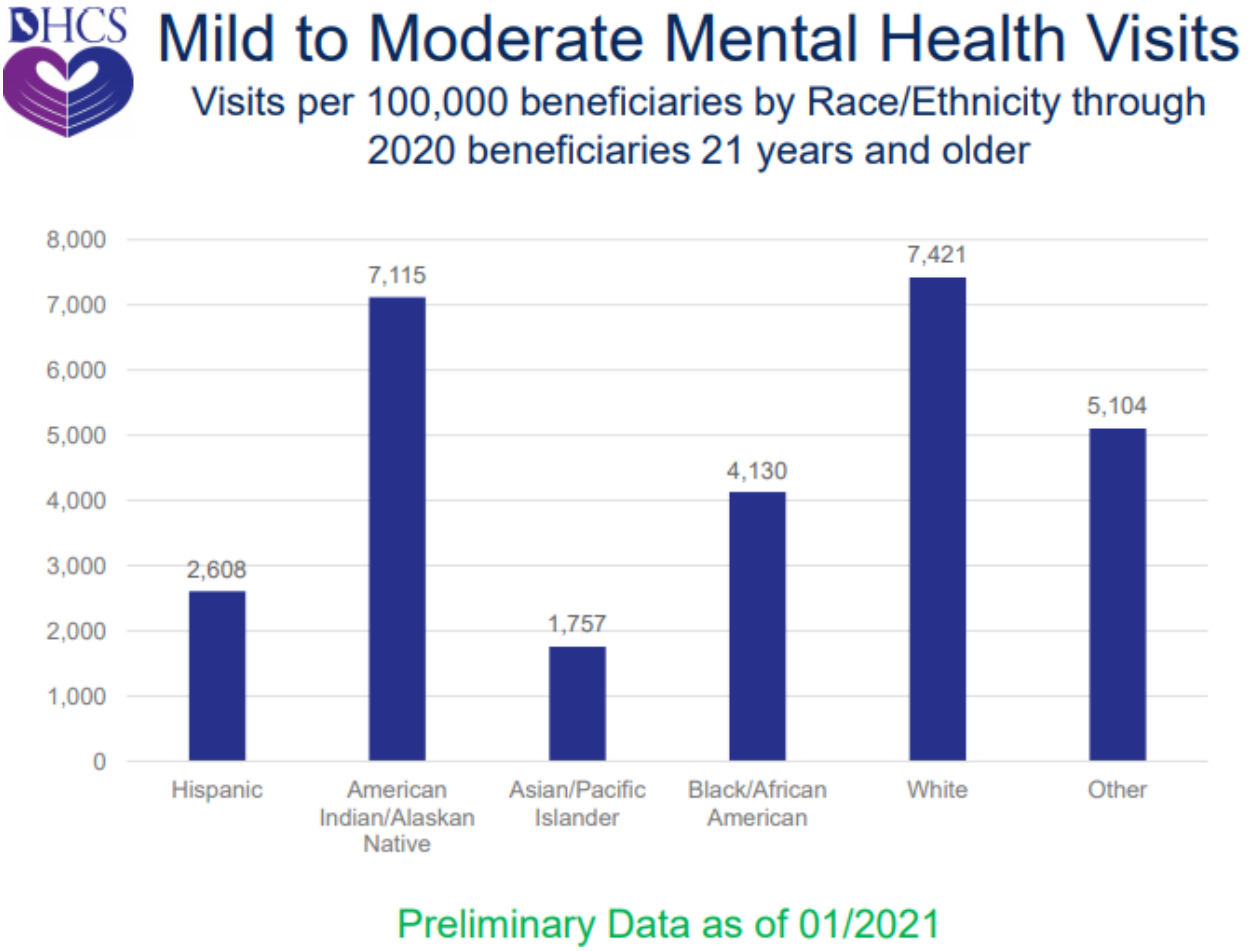
Specialty Mental Health Visits

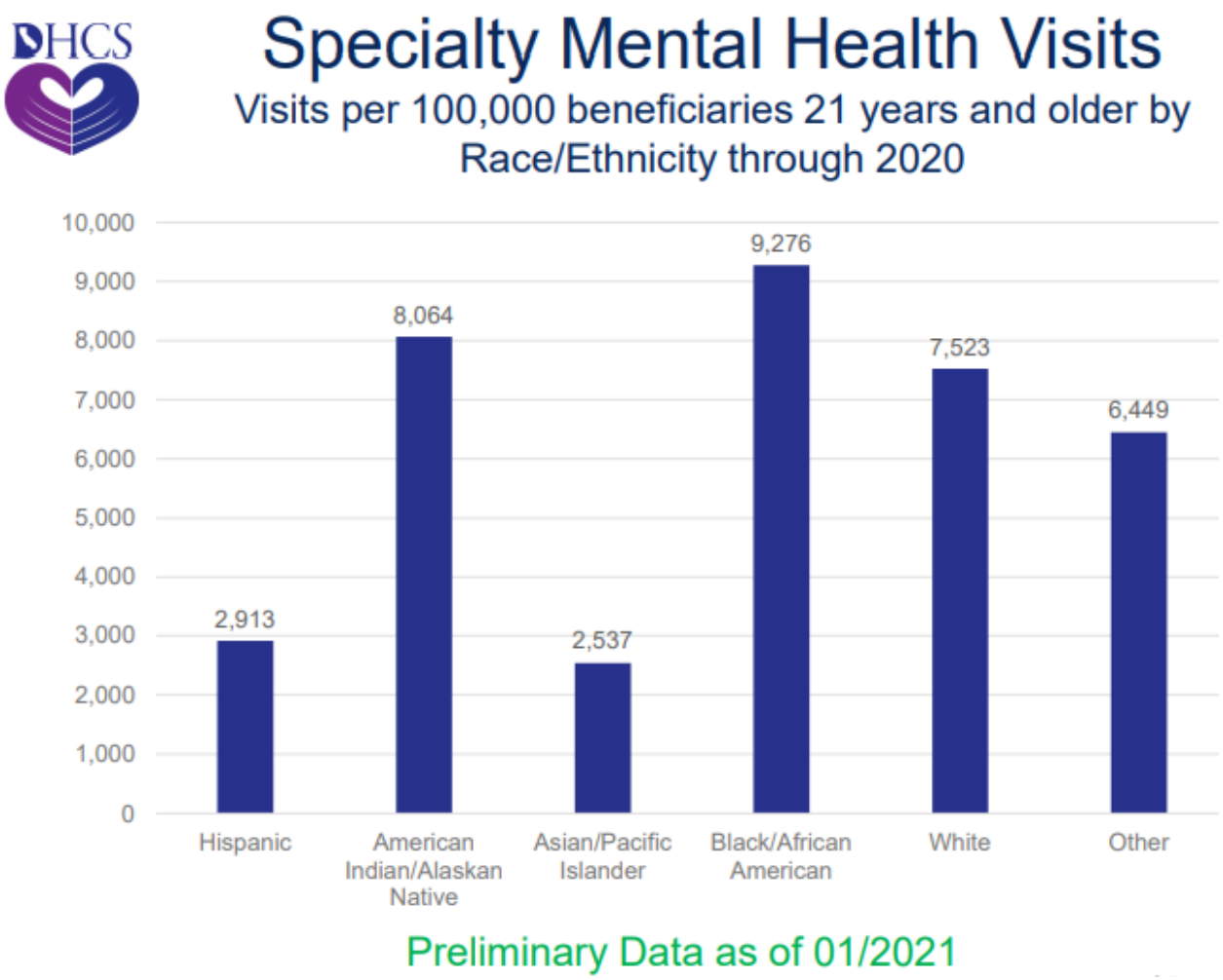
Visits per 100,000 beneficiaries by Race/Ethnicity through 2020 beneficiaries under 21 years old



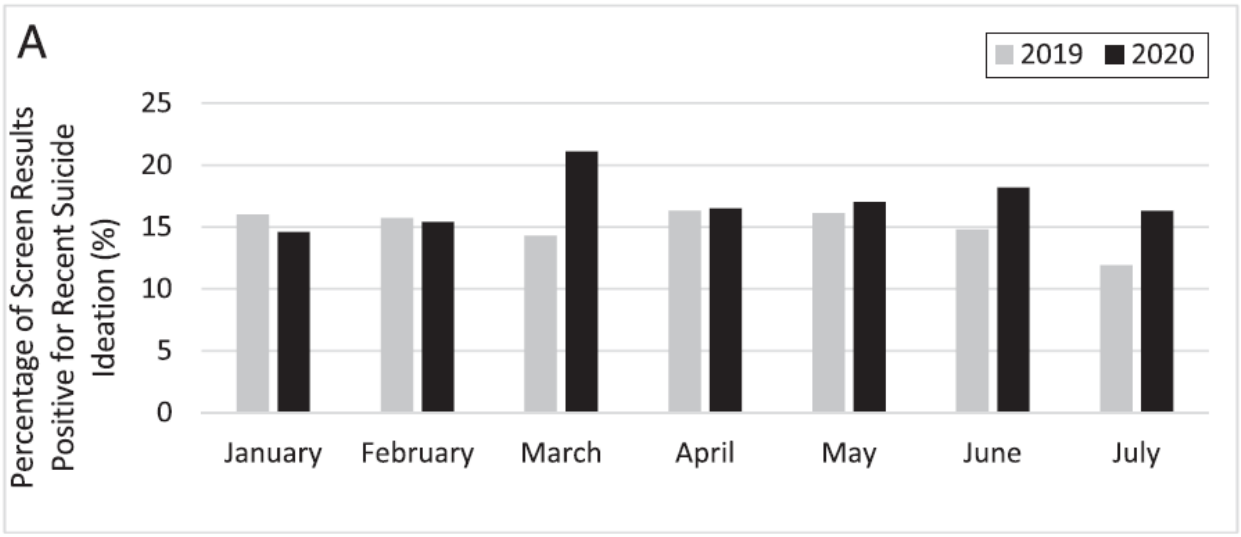
Preliminary Data as of 01/2021

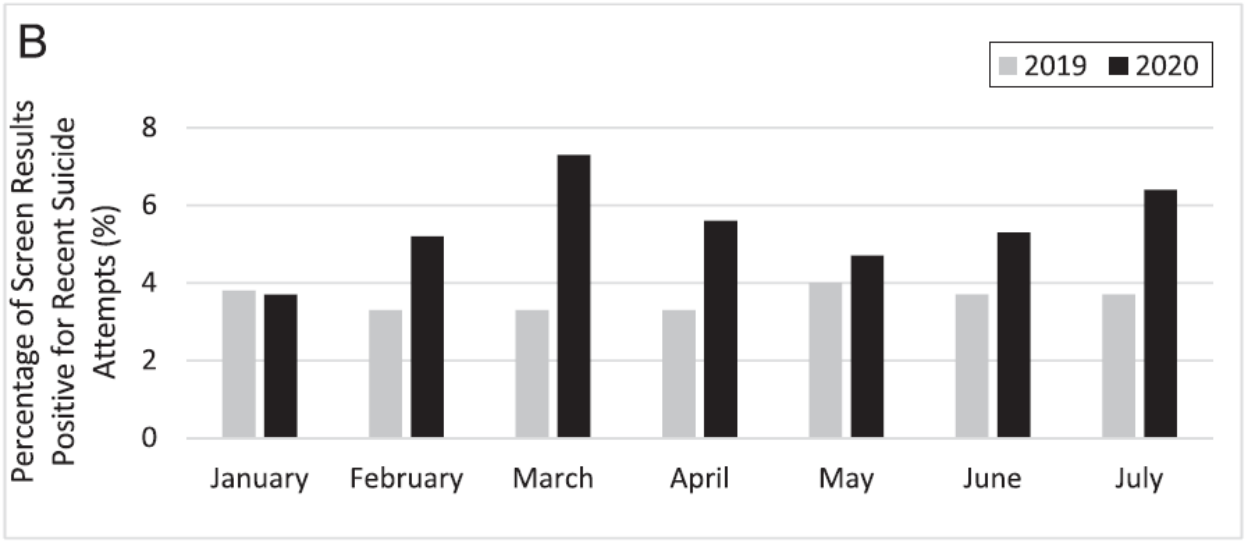
And for adults accessing and utilizing specialty mental health care:





Finally, a study published in *Pediatrics* comparing suicide attempts and ideation in youth (aged 11 – 21) between the first six months of 2019 with the same six months in 2020 found higher rates of both in 2020, particularly in certain months that corresponded with increased COVID-19-related stressors and heightened community response. Specifically, the study found significantly higher rates of suicide ideation in March and July 2020, and higher rates of suicide attempts in February, March, April and July 2020, as compared with the same months in 2019. (Hill, *Pediatrics*, Volume 147, number 3, March 2021). See figures A and B on the following page:





B. COVID-19 MORBIDITY AND MORTALITY RATES IN STATE HOSPITALS

The following chart shows that the rates of COVID-19 morbidity and mortality in State Hospitals, for both staff and patients, has followed the COVID-19 rates in the community with a spike in the patient mortality rate in January 2021:

Department of State Hospitals			
MONTH	**STAFF POSITIVE CASES**	**PATIENT POSITIVE CASES**	**PATIENT DEATHS**
March 2020	<11	0	0
April 2020	<11	0	0
May 2020	<11	<11	0
June 2020	70	103	0
July 2020	154	98	<11
August 2020	108	109	<11
September 2020	63	<11	<11
October 2020	39	18	0
November 2020	203	236	<11
December 2020	714	652	<11
January 2021	491	568	23
TOTAL TO DATE	**1,854**	**1,792**	**52**

A recent *Fresno Bee* article highlighted Coalinga State Hospital patient allegations that sufficient protections for patients have not been put in place at Coalinga-SH. For comparison, the following table shows the numbers of positive cases and deaths (in total numbers and by percent of the hospital population) in each of the five State Hospitals. These rates likely reflect the variance in community spread, as compared to any variation in the hospitals' responses to the pandemic. Nevertheless, patients allege that hospital staff did not follow standard COVID-19 safety protocols.

Month	Atascadero	Coalinga	Metropolitan	Napa	Patton	Total
Positive COVID Cases & % of Population	212 20.6%	468 34.3%	393 49.3%	158 14.5%	561 38.8%	1,792 31.3%
COVID Deaths & % of Population	<11 0.9%	20 1.5%	12 1.5%	<11 0.9%	16 1.1%	52 0.9%
Population on July 1, 2020	1,027	1,365	797	1,090	1,445	5,724

C. RESPONSES TO THE PANDEMIC BY DSH AND DHCS-BH

Department of State Hospitals Pandemic Response

General Response:

DSH executed a COVID-19 response plan across its system that followed guidance from CDPH and the CDC, including the following actions:

- In mid-March, DSH activated its Emergency Operation Center. DSH hospitals activated their Incident Command Centers and Developed incident action plans to better communicate and coordinate DSH's pandemic response efforts, including infection control and respiratory protection.
- Implemented policies and procedures for infection control, respiratory protection, COVID-19 testing and personal protective equipment at its hospitals.
- Pursuant to Executive Order N-35-20, DSH issued directives temporarily suspending admissions and discharges of its patients to provide DSH time to implement significant infection control measures across its system.
- Resumed admissions for specified patient types in April 2020 and for all remaining patient types in May 2020.
- Implemented policies to reduce the risk of patients with COVID-19 entering DSH facilities by requiring updated health information related to COVID-19 from sending facilities; not accepting individuals currently positive for COVID-19, under investigation for COVID-19 or currently quarantined due to an exposure; and admitting patients in cohorts each week to screen, observe and isolate cohorts as needed.

Quarantine/Isolation/Surge Capacity:
Each hospital developed quarantine and isolation plans, including emergency plans and supplemental procedures on management of isolation units and infection control methods. Hospital isolation units are activated as needed as patients become symptomatic and test positive for COVID-19. Additional areas of the hospitals have also been identified to provide some surge capacity, as needed. DSH also entered into an Interagency Agreement with California Department of Corrections and Rehabilitation (CDCR) to utilize a portion of the Southern Youth Correctional Reception Center and Clinic in Norwalk, CA through September 30, 2021 as an Alternate Care Site (ACS).

Due to the increase in patient cases that began to rise significantly in November, the first ACS unit was activated, and 43 patients who tested negative for COVID-19 were transferred to the ACS the week of December 2nd to provide for additional isolation space at DSH-Patton.

Isolation and Testing:
When a positive employee or patient is identified, the hospitals perform widespread PCR testing on-site for both patients and employees. DSH also performs regular ongoing surveillance testing for employees working in specified units. Beginning in December 2020, due to the widespread community transmission of COVID-19 throughout California, DSH increased surveillance testing for its hospital employees to daily antigen testing for all employees working on patient units or in-patient care areas and to weekly PCR testing of employees working in non-patient care areas. Patient testing is still performed via PCR; however, antigen testing is being used for those patients who are symptomatic. DSH now receives test results in 48 hours or less, which significantly assists in reducing

transmission and the likelihood of outbreaks, according to DSH. DSH explains that although PCR testing is more sensitive (accurate), studies show that using antigen testing more frequently prevents outbreaks more effectively. Moreover, the cases that get missed tend to have lower viral loads. A person must be well-trained to administer the antigen test and therefore the tests are performed on site at the hospital.

When a patient is actively displaying symptoms of COVID-19, nursing staff immediately isolate the patient in a private room and instruct the patient to wear a surgical face mask when in the presence of others. Nursing staff utilize additional PPE, perform nursing assessments in a private room, and contact the physician for further evaluation and instruction. Any area the patient accessed as well as the assessment location must be cleaned and disinfected if the patient is ordered to be isolated by the physician. Laboratory samples are taken in the isolation room where the patient is housed, and the patient remains in isolation until the results are received.

When a patient is designated as under investigation (PUI) or is awaiting COVID-19 test results, the unit where the patient is/was housed is placed under quarantine until released by a physician. The room assignment is single occupancy for the affected patient and contact with unaffected patients is not permitted. Each PUI is placed in a separate isolation room. Once the test confirms that the patient has tested positive for COVID-19, the patient is transferred to the COVID-19 isolation unit for disease care and will be isolated for a minimum of 14 days. The unit where the patient was housed when they tested positive remains in quarantine and all patients undergo response testing serially at Baseline (Day 1), Day 7 and Day 14. If all three tests are negative for all patients and patients are asymptomatic, the unit is released from quarantine.

Vaccinations:
DSH has offered COVID vaccines to all staff and patients and has administered over 15,000. Over 70% of patients have received 1st doses. Over 60% of staff have been vaccinated. DSH hopes to get close to 100% coverage over next few weeks. DSH receives weekly allocations of vaccine from CDPH and states that the vaccine distribution has been very well managed by CDPH for state departments.

Employee Support:
DSH has made a number of support resources available for employees that may be struggling during the pandemic, including establishing an Employee Support Line, making the California Chaplain Corps available, and collaborating with the state's Employee Assistance Program to allow employees access to massage therapy, tele-health, and tele-EAP coaching platforms.

Patient Support:
DSH "continues to educate and provide updates on COVID-19, PPE and safety practices, sanitizing equipment and the importance of testing to patients. DSH also implemented

changes to treatment protocols to allow hospitals to continue treating patients, including providing tele-visits for specialty medical providers; reducing group sizes and establishing social-distancing practices; and offering tele-video visits with loved ones."

Department of Health Care Services (BH) Pandemic Response

DHCS's BH pandemic response has included a variety of actions, including:

- Agreed to Mental Health Services Act (MHSA) funding flexibilities for counties via a 2020 budget trailer bill (also see Issue 11 for related proposed trailer bill to extend these flexibilities for another year).
- Provided interim payments to counties to assist with cash flow.
- Applied for and implementing CalHOPE (see more detail in Issue 3).
- Agreed to temporary BH licensing flexibilities.
- In response to surge in demand for services in late 2020, set up communications between hospitals, county BH departments, and BH facilities. Identified facilities that would accept out-of-county placements. Worked to expand capacity in facilities.
- Provide All Facility calls to provide updated information.
- Worked to include BH professionals in the first tier for vaccinations, specifically prioritizing staff in residential/congregate living facilities.

D. DSH BCP ON SNF INFECTION PREVENTIONISTS (AB 2644)

DSH requests $350,000 General Fund in Fiscal Year (FY) 2021-22 and ongoing for 2.0 permanent positions to establish Infection Preventionists at DSH- Metropolitan and DSH-Napa in accordance with requirements set forth in Assembly Bill 2644 (Wood, Chapter 287, Statutes of 2020).

Two of the hospitals, DSH-Metropolitan and DSH-Napa, operate licensed Skilled Nursing Facility (SNF) programs. DSH-Metropolitan has 102 SNF beds. DSH-Napa has 36 SNF beds. These programs meet CDPH SNF licensing requirements and Federal Centers for Medicare and Medicaid Services (CMS) certification. These programs provide continuous nursing treatment and care for both Penal Code and civilly-committed state hospital patients whose primary need is availability of skilled nursing care on an extended basis.

In response to COVID-19 in 2020, CDPH issued numerous All Facilities Letters (AFL), providing specific guidance and regulatory updates to health care facilities to address infection control and mitigation expectations. Due to the higher risk of severe illness and death from COVID-19 among elderly persons and those with chronic medical conditions, CDPH issued specific requirements for SNFs to expand their existing infection control policies. AFL 20-52, issued May 11, 2020, advised SNFs of the requirement to submit a facility specific COVID-19 mitigation plan with specific elements to the CDPH within 21 calendar days and provided updated infection control guidance for healthcare providers. The mitigation plan required that the SNF have a full-time, dedicated Infection Preventionist (IP). The IP role could be shared by more than one staff member, but a plan had to be in place for infection prevention quality control.

Assembly Bill 2644 made permanent the IP requirement that was established under AFL 20-52 and was signed by the Governor on September 29, 2020. This bill states:

HSC Section 1255.9:
(a) (1) A skilled nursing facility shall have a full-time, dedicated Infection Preventionist (IP).

(2)The IP role may be filled either by one full-time IP staff member or by two staff members sharing the IP responsibilities, as long as the total time dedicated to the IP role equals at least the time of one full-time staff member.

(3) The IP shall be a registered nurse or licensed vocational nurse and shall not be included in the calculation of three and one-half hours of direct patient care per day provided to skilled nursing facility residents.

(b) A skilled nursing facility shall have a plan in place for infection prevention quality control.

(c) A skilled nursing facility shall ensure all health care personnel receive infection prevention and control training on an annual basis.

E. COVID-19 DIRECT RESPONSE EXPENDITURES BUDGET CHANGE PROPOSAL

This BCP covers estimated COVID-19 expenditures across many departments throughout state government. The components that are specific to DSH are described here.

The Administration proposes a total of $1.8 billion one-time General Fund in fiscal year 2021-22 for various departments related to estimated direct response expenditure costs to continue responding to and mitigating the impacts of the COVID-19 Pandemic. In

addition, it is requested that budget bill language be added to address the remaining uncertainties as the state continues its response to the COVID-19 Pandemic.

The BCP states that, "although these cost estimates are the best available information at this time, it is anticipated this request will be updated as part of May Revision as additional information continues to be gathered and evaluated as the pandemic unfolds."

Current estimates of total direct COVID-19 Pandemic emergency response costs are approximately $13 billion, with an estimated net General Fund impact of approximately $2.5 billion. This represents costs incurred in the prior fiscal year as well as projected costs in fiscal years 2020-21 and 2021-22.

Department of State Hospitals

The Budget proposes $52 million to continue the DSH response efforts. Proposed funding will be used for three main areas of response: personal services, operating expense and equipment (OE&E), and testing. The table below reflects projected expenditures primarily between July 1, 2021 through December 31, 2021. A brief description of each of the response areas follows.

BY 2021-22 (Whole Dollars)	
Personal Services: Regular Time	$2,517,000
Personal Services: Overtime	$7,666,000
OE&E: Commodity Purchase	$12,525,000
OE&E: Service Contracts	$300,000
OE&E: Other Operating Costs	$22,349,000
Testing: Employees	$5,201,000
Testing: Patients	$1,424,000
Total	**$51,982,000**

Personal Services—Personal services captures costs for staff whose straight time is directly related to COVID-19 and overtime hours for additional cleaning/sanitization, staffing coverages, environmental projects, performing custody tasks, screening staff, and isolation staff. Projections in this category are based on 2020-21 data and reduced by half to align with the assumed end of the PHE.

Operating Expense and Equipment—OE&E captures commodity purchases of both consumable and non-consumable items. Consumable items include PPE, sanitation supplies, and food and food supplies that exceed normal expenditures because of necessary changes in food service. Non-consumables items are related to modifying

existing space and setting-up temporary space to support COVID-19 response activities. This also includes equipment, heating/air, filters, and IT solutions. Projections in this category are based on 2020-21 totals and reduced by half to align with the assumed end of the PHE. Additionally, any one-time contract costs are also included in the projections for 2021-22.

Testing—Although DSH assumptions assume testing shifting to the Valencia Branch Laboratory, some costs will continue to be incurred for testing employees and patients. DSH hired a contractor to work onsite at all state hospitals to collect, process, and report staff testing results. Patient testing is conducted by DSH staff and currently processed at a number of contracted laboratories. Projections in this category utilize weekly average testing data from 2020-21, and multiply the weekly average by 26 weeks to align with the assumed end of the PHE.

F. UPDATES ON THE CRDP AND MHE FUND

California Reducing Disparities Project

California Reducing Disparities Project (CRDP), under Prop 63-MHSA (Mental Health Services Act), funds 35 culturally responsive, innovative Implementation Pilot Projects (IPPs) across the state of California working in five population groups: African American/ Black identified; Latino/x; Asian and Pacific Islander; Native American; and LGBTQ+. The goal of the CRDP is to simultaneously demonstrate that community derived mental health practices reduce mental health disparities across the five unserved, underserved, and inappropriately served population groups as compared to traditional mental health services based on Western clinical models.

CRDP is in Phase 2, which is required to demonstrate the extent to which the $60 million investment, administered by CDPH-Office of Health Equity (CDPH-OHE), contributed to:

- Reductions in the severity of mental illness for five priority populations;
- Systems changes in county PEI level operations;
- A return on investment (the business case); and
- Changes in state and county mental health policies and practices.

The MHSA includes an accountability mandate that must be addressed by all recipients of this $60 million investment. The Implementation Pilot Projects (IPPs) design, implement, and evaluate their local community defined evidence practices (CDEPs). The Technical Assistance Providers (TAPs) provide technical support to the IPPs and coordinate efforts with CDPH-OHE and the Statewide Evaluator (SWE). The SWE evaluates the overall initiative and its various components and provides evaluation guidelines and technical support to the IPPs and TAPs. While the Psychology Applied

Research Center (PARC) implements the statewide evaluation, CDPH-OHE owns the CRDP Phase 2 data collected by PARC.

The CDPH-OHE guidelines delineate 15 deliverables, 2 program objectives, and 7 evaluation questions which informed the development of the statewide evaluation:

Objective 1: To evaluate overall CRDP Phase 2 effectiveness in identifying and implementing strategies to reduce mental health disparities.

1. How effective are CRDP strategies and operations at preventing and/or reducing the severity of mental illness in California's historically unserved, underserved and/or inappropriately served communities?
2. How can CRDP strategies and operations be strengthened?
3. What are vulnerabilities or weaknesses in CRDP's overarching strategies and operations?
4. To what extent do CRDP strategies show an effective Return on Investment, including developing a business case and evaluating the potential to reduce mental health disparities by expanding effective strategies to a statewide scale?

Objective 2: To determine effectiveness of Community Defined Evidence Practices.

1. To what extent were IPPs effective in preventing and/or reducing the severity of targeted mental health conditions in their participants and within specific or sub-populations?
2. To what extent did CRDP Phase 2 Implementation Pilot Projects effectively validate Community-Defined Evidence Practices?
3. What evaluation frameworks were developed and used by the Pilot Projects?

The following are a few examples of IPPs within the LGBTQ+ Hub:

API Wellness Center/SF LGBT Center—San Francisco

Let's Connect

API Wellness Center in partnership with SF LGBT Center will deliver the "Touchpoints" intervention, a prevention and early intervention program that aims to prevent and/or reduce a number of mental health disparities facing transgender people and LGBTQ+ youth. The intervention impacts specific mental health-related problems by improving community resilience by developing social support, empowering participants, and reducing stigma, isolation and barriers to care, through:

- Culturally and linguistically appropriate community outreach and engagement efforts;
- Early identification and accurate assessment of mental health needs; and
- Addressing the social and environmental determinants of health such as education, employment, and income through the provision of wraparound services.

Gender Health Center—Sacramento

Mental Health, Health Advocacy, Community-Building Social and Recreational Programming

Gender Health Center's CDEP is a PEI (Prevention Early Intervention) program that aims to prevent and/or reduce risk of mental illness consequences resulting from systemic violence, such as suicide, depression, isolation, anxiety, unemployment, homelessness, school failure and dropout, for LGBTQ+ populations by decreasing stigma and social isolation, and increasing access to affirming relationships, including cultural and community connections and mental health care. It is designed to address lack of Access to Mental Health Services, Improve Quality of Mental Health Services, and Build on Community Strengths to Increase Capacity and Empowerment.

Gender Spectrum—Statewide

Gender Inclusive Schools

Gender Spectrum's CDEP is a prevention and intervention program that is designed to prevent and reduce the mental health needs of transgender and gender expansive youth by providing and evaluating comprehensive services to transform schools from what are often experienced as hostile settings into inclusive centers of wellness that celebrate gender diversity.

The following are a few examples of IPPs within the Latino/Latinx Hub:

La Clínica de la Raza —Alameda County

Cultura y Bienestar

Cultura y Bienestar (CyB) addresses two areas of community need. First, Latinos are four times less likely than African Americans and more than two times less likely than Caucasians to be served in the mental health system (Alameda County MHSA Community Services and Supports (CSS) Plan, 2006). Second, Latinos living in the United States have poorer mental health status than their counterparts in their country of origin (CRDP Latino Report; Alderete, 2000). CyB is a prevention and early intervention program targeting Latinos at high risk for experiencing mental health problems in Alameda County whose purpose is to reach the following goals: 1) successfully engage unserved & underserved Latinos, 2) improve Latinos' knowledge about mental health issues and decrease mental health stigma, 3) decrease acculturation stress & early mental health symptoms, and 4) increase mental health service use. CyB's desired outcomes are to: decrease mental health problems & reduce disparities in mental health care among low income Latinos in Alameda County. CyB uses five of the six core strategies from the CRDP Latino Population report including: 1) peer-to-peer approaches, 2) family psychoeducational curricula to increase family & extended family involved & promote health & wellness, 3) promotes culturally relevant wellness & illness management, 4) increases community capacity by building on community strengths to improve Latino behavioral health outcomes, and 5) reduces stigma through media & education.

Integral Community Solutions Institute—Fresno County

Atención Plena and Pláticas

Integral Community Solutions Institute (ICSI) was founded to ensure community health through advocacy and systems change that promotes wellness of body, mind, spirit and soul. ICSI provides clinical mental health and wellness services in partnership with other Central Valley agencies through practices reflecting cultural competence, responsiveness, humility, and development using traditional approaches as well as the latest innovations in integral psychotherapy to address the needs of victims of human trafficking, domestic violence, sexual abuse, those with critical life span concerns, and families in conflict due to intergenerational conflict, acculturation issues, and cultural adaptation. ICSI therapists use a variety of innovative techniques such as Hip Hop therapy and partner with other agencies to provide mentoring and counseling with mindfulness and "pláticas" interventions in each of the programs. ICSI works with mostly the Latino population, women and children, victims of domestic violence, human trafficking and victims of crime. The Latino populations are predominantly Mexican in origin, recent immigrants who are dealing with acculturative stress, intergenerational conflict as well as distancing and loss, and adaptation to a "world of confusion."

Latino Service Providers—Sonoma County

Testimonios

Latino Service Providers (LSP) was founded in 1989 by Latino leaders in education, government, and social service sectors. It is currently comprised of over 1300 members from multiple sectors such as, neighborhood groups, schools, public and private health, behavioral health organizations, social service, immigration and naturalization agencies, etc. The LSP mission is to serve and strengthen Latino families and children by building healthy communities and addressing stigma and disparities in mental health within Sonoma County. Testimonios is based on the community health outreach and education model, recruiting and training up to 20 youth "Promotores" per year from the local schools that have health pathway programs with the anticipation of retaining at least 12 of them. These bilingual and bi-cultural students who express an interest in healthcare will be introduced to an opportunity to gain real-life training and experience in raising mental health awareness with messages that reduce stigma and promote information and resources about early identification and intervention in a manner that is appropriate and acceptable to the Latino community.

The following are a few examples of IPPs within the African American Hub:

California Black Women's Health Project—Los Angeles County

Sisters Mentally Mobilized

Sisters Mentally Mobilized (SMM) is a community defined practice and intervention of the California Black Women's Health Project (CABWHP) that is designed to prevent and reduce mental illness severity in Black women. Sisters Mentally Mobilized incorporates the foundational advocacy and empowerment principles of CABWHP's signature

Advocate Training Program (ATP) while also building the ongoing capacity of Black women to address mental health conditions and barriers in their lives and communities. An additional component of Sisters Mentally Mobilized is the formation of mental-health focused "Sister Circles" that will be mobilized to employ culturally responsive community defined interventions that address mental health issues in the following areas: 1) identification of risk factors and symptoms, 2) stigma awareness and reduction, 3) prevention of early onset and deterioration, and 4) increased awareness, solicitation and access of care. This comprehensive and combined approach is a culturally responsive prevention and early intervention (PEI) strategy to mitigate multiple risk factors and limitations in interventions that contribute to and exacerbate mental health disparities in Black women, their families and communities.

Catholic Charities of the East Bay—Alameda County

Experience Hope for Teens

Catholic Charities of the East Bay (CCEB) will expand and evaluate its school-based Experience Hope for Teens program to develop a better understanding of how to serve African American (AA) youth living in urban environments, such as the Cities of Richmond and Oakland, CA. Experience Hope for Teens addresses traumatic stress as a result of exposure to violence among AA youth – a need specifically described in the CRDP African American Population Report. Adolescents confronted with chronic exposure to violence face serious risks to their mental health and, if left untreated, traumatic experiences can lead to the onset or worsening of debilitating mental illness and other mental health consequences. High levels of community violence, poverty, and trauma exposure are distressingly commonplace among both Oakland's and Richmond's AA populations. According to recent congressional briefings by the CDC Director of the Division of Violence Prevention, low income youth living in inner cities show a higher prevalence of post-traumatic stress disorder (PTSD) than soldiers in combat zones. These children are in fact "living in combat zones," where exposure to violence may be prolonged and repeated in multiple environments (Spivak, 2012). Ongoing, repeated exposure to trauma has extremely negative effects on both individual students and the overall academic environments at local schools.

The Village Project, Inc. — Monterey County

Emanyatta Project

The Village Project, Inc.'s Emanyatta Project is a prevention and early intervention program that is intended to prevent and/or reduce symptoms of clinical depression and anxiety in children from kindergarten to 4th grade. The project necessarily involves families of these children for the purposes of support in these efforts as well as to strengthen the resilience and internal strengths of the children. It is through this involvement that the Phase I priority of family psycho-education is achieved. An additional component to strengthen the internal resources of the children is the project's focus on building pride in cultural and ethnic heritage as a means of achieving higher levels of academic achievement and self-esteem.

West Fresno Health Care Coalition—Fresno County

Sweet Potato Project

The Sweet Potato program at the West Fresno Family Resource Center is a prevention program that aims to prevent and/or reduce school drop-out, gang involvement, and substance use initiation for African American youth ages 12-15 by decreasing internalized oppression, hopelessness, and low collective efficacy, while increasing engagement in collective economic activity, college intentions, mentoring, and leadership development. It is designed to address the Phase I African American strategic recommendations to focus PEI (Prevention and Early Intervention) on community-based efforts specifically addressing African American culture and to address the co-occurrence of mental health conditions and socioeconomic challenges.

The following are a few examples of IPPs within the Asian and Pacific Islander Hub:

Cambodian Association of America—Los Angeles County, Orange County

Community Wellness Program

Cambodian Association of America (CAA) has been working to better establish the underserved Cambodian population across America for over 40 years. CAA is partnering with Families in Good Health and United Cambodian Community in Long Beach, and The Cambodian Family in Santa Ana, as the Cambodian Advocacy Collaborative. The collaborative pilot project is the neighborhood-based API Strength-Based Community Wellness Program, which provides an array of prevention activities to Cambodian refugees who have suffered trauma and depression.

East Bay Asian Youth Center—Sacramento County

EBAYC Sacramento Program

The East Bay Asian Youth Center (EBAYC) in Oakland has been operating as a Drop-In Center for underserved Asian youth for 40 years. The pilot project is “GroundWork”, which serves at-risk Southeast Asian youth in Sacramento through one-on-one counseling, groups, and home visits. EBAYC works in formal partnership with Luther Burbank High School (Sacramento), Hiram Johnson High School (Sacramento), and the Sacramento County Probation Department to identify and access GroundWork's target population. EBAYC supports and guides youth to foster critical protective factors, including sustained relationships with supportive and caring adults, positive cultural identity, and knowledge of and access to family support services.

The Fresno Center—Fresno, San Joaquin and Merced Counties

Hmong Helping Hands Intervention

The Fresno Center implements this pilot project with Merced Lao Family Community and Stockton Lao Family Community Development. The Hmong Helping Hands intervention is a direct prevention and early intervention program that aims to reduce depression, anxiety and acculturation stress in Hmong adults and elders by improving their physical, psychological, social and spiritual well-being and increasing their knowledge and

awareness of mental health issues. Key components include culturally relevant activities, community navigation and exploration, and a spiritually oriented approach to health and healing.

Mental Health Equity Fund

AB 74 (Budget Committee, Chapter 23, Statutes of 2019) authorized $8 million to provide training and technical assistance to county behavioral health departments to increase their expertise in cultural humility, health equity, stakeholder engagement, language access, workforce diversity, and trauma-informed care and to assist them in the development of population-specific and community-driven approaches to reducing disparities and offering culturally-responsive care.

CDPH entered into an agreement with DHCS for $3 million, called the Community Mental Health Equity Fund, to implement a grant program addressing strategies and interventions aimed at reducing disparities in access to health and behavioral health care.

DHCS will extend a contract to implement technical assistance, trainings, consultation services and learning networks for the CMHEP. The focus of assistance will be the development of a technical assistance program enabling county behavioral health plans and DHCS staff to understand the core needs of beneficiaries and design behavioral health services that are data-driven, culturally-responsive, trauma-informed, and include community-defined practices targeted to reduce behavioral health disparities and ensure equitable care. DHCS intends to sign a contract and for the work to begin April 1, 2021.

DHCS solicits applications from entities that can provide population-specific and community driven training and technical assistance services to local county health departments statewide to identify and reduce health and behavioral health disparities, practice cultural humility build a diverse workforce, and counter the effects of structural racism.

STAFF COMMENTS/QUESTIONS

The state (nation, world) faced a behavioral health crisis even before the pandemic. Sadly, the pandemic has exacerbated the crisis, increasing inequalities and tragedies. The silver lining may be that the pandemic is shining a light on conditions and circumstances that many Californians face, a crisis that warrants the attention, resources, leadership, and empathy of state leaders. Institutionalized individuals, including the incarcerated and State Hospital patients, may be the most vulnerable of all, and therefore deserve our collective commitment to their health and safety.

Staff Recommendation: Recommend the Subcommittee: 1) support short-term bridge funding for CRDP projects in order to maintain continuity until the statewide evaluation is available; 2) request evidence from DSH that all necessary and appropriate protections of patients have been implemented, and implemented equally across all five state hospitals.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 2: BEHAVIORAL HEALTH SERVICES FOR YOUTH

OVERVIEW

This issue (Issue 2) covers:

A. DHCS Access to School Services proposal and BCP.
B. OAC Mental Health School Services Act proposal and BCP.
C. OAC Updates on Youth Drop-in Centers and Early Psychosis Initiative.
D. CDPH Update on All Children Thrive.
E. General discussion of youth access to behavioral health services, including via telehealth.

PANELISTS – PRESENTERS & QUESTIONS FOR EACH DEPARTMENT

Department of Health Care Services

- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs, State Medicaid Director

1. Please present the DHCS school services proposals.
2. Please describe in detail how DHCS will ensure that this funding will be distributed in an equitable way.
3. Please describe how the administration is coordinating with CDE and the OAC, and if you can ensure that these proposals work together to maximize the state's response.
4. Please describe how DHCS monitors, assesses, and seeks to improve access to behavioral health care for youth.
5. Please describe how tele-behavioral health opportunities have been increased specifically for youth during the pandemic.

Mental Health Services Oversight and Accountability Commission

- **Toby Ewing**, Executive Director

1. Please present the school mental health partnership BCP and provide updates on the existing school partnership program, youth drop-in centers and the early psychosis initiative.

2. Please explain how the proposed $25 million is likely to be used, and how much funding would be needed to fully-fund all counties interested in participating in this program.
3. Please share any information you have about the level of community trauma being experienced by youth as a result of the pandemic, and how the state should respond to this trauma.

California Department of Public Health
- **Monica Morales**, Deputy Director, Center for Healthy Communities

1. Please provide an overview of the All Children Thrive (ACT) program, an update on its progress, and the administration's plans for the future of this program.
2. How has ACT, and ACEs in general, been affected by the pandemic?

County Behavioral Health Directors Association of California
- **Michelle Doty Cabrera**, Executive Director
- **Dr. Veronica A. Kelley**, DSW, LCSW, Behavioral Health Director, San Bernardino County, CBHDA President

1. Please share any information you have about the level of community trauma being experienced by youth as a result of the pandemic, and how the state should respond to this trauma.
2. Please provide any examples of counties implementing new ways to improve youth access to behavioral health services.
3. Please describe challenges, within both Medi-Cal and MHSA, to youth accessing high-quality behavioral health services.

California Association of Health Plans
Jedd Hampton, Legislative Advocate

1. How do health plans, both Medi-Cal and commercial, monitor, assess, and seek to improve access to behavioral health services for youth?
2. What have health plans done to increase access to services during the pandemic?
3. What role would health plans like to play in the delivery of school-based services?
4. How can commercial health plans contribute to the building of a school/community-based behavioral health infrastructure that will serve all youth, regardless of health insurance status?

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

1. Please provide your analysis, concerns and questions on the school-based services proposals, and on any other youth behavioral health issues and proposals.

PANELISTS – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director – Behavioral Health
- **Lindy Harrington**, Deputy Director – Health Care Financing

California Department of Public Health
- **Stacy Alamo**, Chief, Injury and Violence Prevention Branch

Mental Health Services Oversight and Accountability Commission
- **Norma Pate**, Deputy Director

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Jack Zwald**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal & Policy Analyst
- **Mark Newton**, Deputy Legislative Analyst

A. DHCS INCREASED ACCESS TO STUDENT BEHAVIORAL HEALTH SERVICES BUDGET CHANGE PROPOSAL

The budget proposes one-time funds of $400 million total funds ($200 million General Fund) to implement an incentive program through Medi-Cal managed Care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services. This funding would be available over multiple years. DHCS will be proposing trailer bill language to increase access to student behavioral health services.

With this BCP, DHCS requests one-time $11,014,000 ($5,507,000 General Fund (GF) and $5,507,000 Federal Fund (FF)) in fiscal year (FY) 2021-22, available over four years, to support the equivalent of 12.0 positions to address the workload for increased access to student behavioral health services. This proposal includes corresponding statutory changes and provisional language.

The administration provided the following background:
The consequences of not addressing child and adolescent mental health conditions often extend to adulthood. According to the World Health Organization (WHO), half of all mental health conditions start by 14 years of age but most cases are undetected or untreated.

Child and adolescent mental health hospitalizations and suicide rates have increased over the last decade, many say we are reaching a youth mental health crisis in the U.S. Additionally, COVID-19, stay-at-home orders, and school closures have impacted children and adolescents in an unprecedented manner, causing additional stress and anxiety. It is imperative to enhance access to behavioral services and address the mental well-being of children and adolescents.

Schools are a critical point of access for preventive and early-intervention behavioral health services, as children are in school for many hours a day, for approximately half the days of the year. Early identification and treatment through school-affiliated behavioral health services can reduce emergency room visits, crisis situations, inpatient stays, and placement in high-cost special education settings and/or out of home placement. Furthermore, African American, Native American, and Pacific Islander students are more likely to be chronically absent, suspended, or expelled. LGBTQ students are two times more likely to report depression and three times more likely to report suicidal ideation than non-LGBTQ peers. Development of a cross-system partnership focused on increasing access to behavioral health services in school and school-affiliated settings is critical for improving these outcomes. Schools often lack on-campus behavioral health resources and find it challenging to recognize and respond appropriately to children's mental health needs, particularly in the absence of school mental health professionals.

Medi-Cal pays for medically necessary health and related services provided in schools when covered services are provided to Medi-Cal-enrolled students. To receive Medi-Cal payment for behavioral health services, school-affiliated providers must be enrolled Medi-Cal providers. Some school systems directly employ health professionals to provide these services. Other schools contract with school-affiliated behavioral health providers to provide services to students. School-affiliated behavioral health providers can contract with managed care organizations or county behavioral health departments to be included in their provider networks. Schools can be reimbursed for administrative costs associated with contracting and coordinating with managed care plans and county behavioral health departments through School-Based Medi-Cal Administrative Activities (SMAA) funding. Better integrating behavioral health services in schools may help break down historic siloes and stigma while investing in greater prevention and earlier identification may enhance learning and student wellness. Additionally, with over 50% of California children enrolled in Medi-Cal, a significant investment in the infrastructure of behavioral health access in schools for Medi-Cal students may indirectly build needed capacity and access for non-Medi-Cal students.

Furthermore, this proposal supports the goals of CalAIM, where people served by Medi-Cal programs are more likely to have longer, healthier and happier lives. CalAIM aims to implement a whole-system, person-centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. CalAIM seeks to achieve an integrated "wellness" system,

which aims to support and anticipate health needs, prevent illness, be more equitable, improve social determinants of health, and reduce the impact of poor health.

This proposal seeks to implement a $389.0 million ($194.5 million GF, $194.5 million FF) local assistance incentive program through Medi-Cal Managed Care Plans, in partnership with schools and county behavioral health departments, to increase the number of K-12 students receiving preventive, early intervention, and behavioral health services from school-affiliated behavioral health providers. Additionally, to incentivize funds to be provided by the state, partnerships are encouraged to maximize all available additional funding sources, including but not limited to, School-Based Medi-Cal Administrative Activities, Mental Health Services Act, Mental Health Student Services Act, and Local Control Funding Formula funds.

In order to build infrastructure, partnerships, and capacity statewide, DHCS will implement incentive payments for a variety of interventions, including but not limited to:

- Local planning efforts to review existing plans and documents that articulate student needs in the area; compile data; map existing behavioral health providers and resources; identify gaps, disparities and inequities; convene stakeholders and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for students. These planning efforts will include Medi-Cal managed care plans, county behavioral health departments, schools, and other key local stakeholders.

- Medi-Cal managed care plans and/or county behavioral health departments will execute contracts with schools to provide preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers. The contracts will provide for:

    - Incrementally higher incentives for reaching threshold levels of schools in their service area.

    - Higher incentive for three-way contracts between managed care plans, county behavioral health departments, and schools.

- Build stronger partnerships between schools, managed care plans, and county behavioral health departments so that more Medi-Cal reimbursable services are provided to students. Managed care plans should provide or contract for technical assistance, training, toolkits, and/or learning networks for schools to build new or expanded capacity of Medi-Cal services for students, integrate local resources, implement proven practices, ensure equitable care, and drive continuous improvement.

- Develop or pilot behavioral health wellness programs to expand greater prevention and early intervention practices in school settings. Examples of these programs include Mental Health First Aid and Social and Emotional Learning. Medi-Cal managed care plans and county behavioral health departments will build a dedicated school behavioral health team to engage schools and address issues for students with behavioral health needs.

- Expand the workforce by using community health workers and/or peers to expand the surveillance and early intervention of behavioral health issues in school-aged children. Particular focus on grades 5-12 when children spend less time at primary care because the periodicity calendar changes for visits.

- Increase behavioral health telehealth services in schools, including app-based solutions, virtual care solutions, and within the community health worker or peer model.

- Ensure all schools and students have appropriate levels of access to equipment to provide or receive telehealth services, like a dedicated room or access to tablets or phones, within their school, with appropriate technology.

- Implement Adverse Childhood Experiences (ACEs) screenings and referral processes in schools (completed by a behavioral health provider). When positive screenings occur, providers will take immediate steps, including providing brief interventions (e.g., motivational interviewing techniques) and ensuring access or referral to further evaluation and evidence-based treatment, when necessary.

- Implement a school suicide prevention strategy.

- Implement culturally appropriate and community-defined interventions and systems to support initial and continuous linkage to behavioral health services in schools.
    - Higher incentive payments may be earned for closing health equity gaps. African American, Native American and Pacific Islander students, are more likely to be chronically absent, suspended, or expelled. LGBTQ students are two times more likely to report depression and three times more likely to report suicidal ideation than non-LGBTQ peers. Managed care plans, county behavioral health departments, and schools will develop a cross-system partnership focused on improving education and health outcome measures.

- Increase access (based on utilization rates and/or quality outcomes) of behavioral health services in schools.

  - Higher incentive payments may be earned for services provided to students who are living in transition, homeless or involved in the child welfare system, including screening, referring and coordination with county behavioral health services.
- Increase prenatal and postpartum access to mental health and substance use disorder screening and treatment for teen parents.

- Improve performance and outcomes-based accountability for behavioral health access and quality measures through local student behavioral health dashboards or public reporting.

- Increase access to substance use disorder prevention, early intervention and treatment, including Medication Assisted Treatment (MAT) where feasible, and co-occurring counseling and behavioral therapy services for adolescents.

- Care teams that can conduct outreach, engagement, and home visits, as well as provide linkage to social services (community or public) to address non-clinical needs identified in behavioral health interventions.

- Providing evidence-based parenting and family services for families of students that have a minimum of "promising" or "supported" rating in the Title IV-E Clearinghouse Prevention Services or the California Evidence-Based Clearinghouse for Child Welfare.

- Implement information technology and systems for cross-system management, policy evaluation, referral, coordination, data exchange, and/or billing of health services between the school, the managed care plan and county behavioral health department.

The BCP states: "While this proposal focuses on children and youth served by the Medi-Cal program, developing more robust opportunities to provide school prevention, early intervention, and behavioral health services may also lead to improvements for children and youth who have commercial health plan coverage."

The LAO completed an analysis of this proposal, which includes the following key takeaways:

- "Further Specifics of the Proposal Needed. The Governor's budget proposes providing $200 million General Fund ($400 million total funds) one time to provide incentive payments to Medi-Cal managed care plans to increase the number of students receiving behavioral health services. Additional details such as (1) the methodology that would be used to determine how incentive payments would be

allocated to managed care plans, and (2) how funding made available would flow to schools or county behavioral health are necessary to fully evaluate this proposal. Furthermore, the proposed use of budget bill language (which typically lacks specificity when compared to trailer bill language) is insufficient for establishing a new program of this magnitude and complexity. We suggest the Legislature adopt trailer bill language to govern the implementation of this program and provide more opportunities for oversight.

- Proposal May Have Merit, but Clarification Is Needed on What Service Gaps Managed Care Plans Will Fill. Managed care plans can provide a broader array of behavioral health services through Medi-Cal than schools that bill Medi-Cal directly, and their involvement with student behavioral health services under this proposal could provide an additional opportunity to access federal funding through Medi-Cal for students. However, the exact nature and extent of behavioral health service gaps for students across the state is unknown. To assist the Legislature in its evaluation of this proposal, the administration should clearly articulate what specific services managed care would be able to provide to students that cannot be currently provided by schools directly or through county behavioral health.

- Need for State Strategy to Coordinate and Clarify Roles. The delivery system for behavioral health services (including for children) in the state is fragmented. Therefore, looking beyond this proposal, there is a broader need for a robust state-level strategy for coordinating the responsibilities between managed care plans, county behavioral health, and schools. This could include exploring the feasibility of establishing clearer responsibilities for managed care plans and county behavioral health for children's Medi-Cal behavioral health services."

B. OAC MENTAL HEALTH STUDENT SERVICES ACT PARTNERSHIP GRANT PROGRAM AUGMENTATION BUDGET CHANGE PROPOSAL

The OAC requests $25 million one-time Mental Health Services Fund, available over five years, for the Commission to augment the Mental Health Student Services Act Partnership Grant Program, which funds partnerships between county mental health plans and schools. This proposal includes corresponding provisional language.

The administration provided the following background:

Triage Grant Program for County-School Partnerships
Pursuant to SB 82 (Budget and Fiscal Review Committee, Chapter 34, Statues of 2013), the Commission administers the Investment in Mental Health Wellness Act of 2013. The

Act requires the Commission to provide annual grant funding from the Mental Health Services Fund (MHSF) to counties or counties acting jointly, except as otherwise provided, to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. Such grants include funding to support partnerships between county behavioral health departments and schools. This is referred to as the Triage Grant Program. Between 2013-14 and 2017-18, the Commission received a $32 million MHSF annual appropriation. Beginning in 2018-19, the annual appropriation was re-based to $20 million MHSF to reflect historic actual expenditures.

In 2017-18, the Commission allocated 50 percent of the Triage Grant Program funds to programs dedicated to children and youth aged 21 and under. Additionally, the Commission set aside approximately $20 million for four School-County Collaboration Triage grants with the aim of 1) providing school-based crisis intervention services for children experiencing or at risk of experiencing a mental health crisis and their families/caregivers, and 2) supporting the development of partnerships between behavioral health departments and educational entities.

Under that funding program Humboldt County, Placer County, Tulare County Office of Education, and California Association of Health and Education Linked Professions Joint Powers Authority in San Bernardino were awarded $5.3 million annually over four years. The four School-County partnership programs are supporting strategies to 1) build and strengthen partnerships between education and community mental health, 2) support school-based and community-based strategies to improve access to care, and 3) enhance crisis services that are responsive to the needs of children and youth, all with particular recognition of the educational needs of children and youth.

In addition to the four School-County partnership grantees, the Commission awarded Triage grants to counties to operate school-based Triage programs in Berkeley, Humboldt, Riverside, Sacramento, and San Luis Obispo.

Out of the $20 million available for the Triage Grant Program, the Commission allocated $1.2 million in 2018-19, $1.15 million in 2019-20, and $685,000 in 2020-21 to supporting the development of partnerships between behavioral health departments and educational entities.

Mental Health Student Services Act Partnership Grant Program

SB 75 (Budget and Fiscal Review Committee, Chapter 51, Statutes of 2019), established the Mental Health Student Services Act (MHSSA), to further support partnerships between County Mental Health or Behavioral Health Departments and educational entities. The 2019 Budget Act (specifically Chapter 363, Statutes of 2019) included $40 million one-time and $10 million in ongoing MHSF to support the MHSSA. Of the $10

million MHSF ongoing, $1.2 million is for state operations and the remaining $8.8 million is for local assistance grants.

In September, October and November of 2019, the Commission held listening sessions on the MHSSA. The purpose of the listening sessions was to make local behavioral health and education leaders aware of the opportunity to receive MHSSA funds, the parameters of those funds and the anticipated timelines. Listening sessions were held in Sacramento, Richmond, Fresno and Los Angeles.

One concern raised during the listening sessions was the challenges facing communities that do not currently have school-county partnerships for school mental health. Participants raised concerns that communities with existing partnerships may have an advantage in responding to a Request for Application (RFA) compared to those with no existing partnership. Local school and mental health leaders also expressed concern that $50 million was not sufficient to respond to local needs and encouraged the Commission to explore options to make available additional resources.

In response to those concerns, in November 2019 the Commission approved the outline of the RFA which provided $75 million in funding ($48.83 million in 2019-20, $8.83 million in 2020-21, 2021-22, and $8.51 million in 2022-23). The RFA funding was made available in two categories: 1) funding for counties with existing school mental health partnerships ($45 million), and 2) funding for counties developing new or emerging partnerships ($30 million). Within each category, funds are made available based on the size of a county, as follows: Applicants are limited to county, city, or multicity mental health or behavioral health departments, or a consortium of those entities, including multicounty partnerships, in partnership with one or more school districts and at least a county office of education or charter school. Counties competed within their size designation; small, medium, large. See the below table for details.

MHSSA Partnership Grant Program – Round 1 County Apportionment

County Size	County Apportionment
Small County (less than or equal to 200,000 population)	6 Grants @ $2.5m ea = $15m total
Medium County (greater than 200,000-750,000 population)	6 Grants @ $4m ea = $24m total
Large County (greater than 750,000 population)	6 Grants @ $6m ea = $36m total
Total Grants and Funding	18 Grants = $75m Awarded ($45m to existing partnerships, and $30m to new or emerging partnerships)

The table below lists the 38 county partnerships that applied for the MHSSA grants, including the 18 which were awarded and the 20 which were not awarded. Language was included in the RFA that allows the Commission to award additional grants, if additional funds became available.

Of the 20 counties that submitted applications for Category 1, 10 received awards in April 2020. The remaining 10 did not receive awards due in part to funding constraints, totaling $45,469,441 in requested funds. Of the 18 counties that submitted applications for Category 2, 8 were awarded grants in July 2020. The remaining 10 did not receive awards due in part to funding constraints, totaling 35,000,000 in requested funds.

MHSSA Partnership Grant Program - Round 1 Grant Applications

Applicant County Name	Size	Category	Awarded (18)	Not Awarded (20)
Amador	Small	2		X
Calaveras	Small	2	X	
Contra Costa	Large	2		X
Fresno	Large	1	X	
Glenn	Small	1		X
Humboldt	Small	1	X	
Imperial	Small	2		X
Kern	Large	1	X	
Lake	Small	1		X
Los Angeles	Large	1		X
Madera	Small	2	X	
Marin	Medium	1		X
Mariposa	Small	1		X
Mendocino	Small	1	X	
Monterey	Medium	1		X
Nevada	Small	2		X
Orange	Large	1	X	
Placer	Medium	1	X	
Riverside	Large	2		X
Sacramento	Large	1		X
San Bernardino	Large	1		X
San Diego	Large	1		X
San Francisco	Large	1		X
San Luis Obispo	Medium	1	X	
San Mateo	Large	2	X	
Santa Barbara	Medium	2	X	
Santa Clara	Large	2	X	
Santa Cruz	Medium	2		X
Shasta	Small	2		X
Solano	Medium	1	X	
Sonoma	Medium	2		X
Sutter-Yuba	Small	2		X
Tehama	Small	2	X	
Trinity-Modoc	Small	2	X	
Tulare	Medium	1	X	
Tuolumne	Small	2		X
Ventura	Large	1	X	
Yolo	Medium	2	X	

C. YOUTH DROP-IN CENTERS

The OAC provided the following background and update:

The 2019 Budget Act includes $14.6 million in one-time Mental Health Services Act (MHSA) funds to support the development of youth drop-in centers that provide integrated mental health services for individuals between the ages of 12 and 25 years of age and

their families. The centers will operate with a focus on vulnerable and marginalized youth and disparity populations including, but not limited to, LGBTQ, homeless, and indigenous youth.

In December 2019 and January 2020, the Commission held two listening sessions involving youth with lived experience, county behavioral health departments, youth program operators, and representatives from educational organizations to gather feedback regarding the best approach to allocating funds and supporting the development of youth drop-in centers based on the allcoveTM model. In those listening sessions, participants called for a significant investment in technical assistance to support implementation of the allcoveTM youth drop-in center model.

On January 23, 2020, the Commission approved the outline of a Request for Applications (RFA) which allocated $10 million to establish allcoveTM youth drop-in centers and $4.6 million to provide technical assistance to grantees and other interested organizations over a four-year term. The Commission released the RFA on February 12, 2020 and awarded five grants of $2 million each on May 28, 2020.

Grant recipients include:

- Wellnest (Los Angeles County)
- Peninsula Health Care District (San Mateo County)
- University of California, Irvine in partnership with Orange County Wellness and Prevention Center
- Sacramento County Behavioral Health Services
- Beach Cities Health District (Los Angeles County)

The Commission also entered into a short-term contract with Stanford University to provide technical assistance to the five grant recipients and other counties interested in developing the youth drop-in center model using the allcoveTM framework. The Commission is currently working with Stanford University to develop a longer term technical assistance and support contract that will facilitate widespread adoption of model. The challenge the Commission is working to address is how to ensure fidelity to the model, which is trademarked, while creating widespread public access to the intellectual property associated with the model. A number of legal and programmatic models support these goals and the Commission hopes to move forward with a full array of technical assistance in the coming months.

D. EARLY PSYCHOSIS INITIATIVE

The OAC provided the following background and update:
In 2015 the Commission funded an exploratory analysis of the availability of evidence-

based services to respond to an initial diagnosis of psychosis. Research suggests that early intervention following a diagnosis of psychosis can support a reduction in symptoms, enhanced recovery and improved outcomes. In response to that analysis, the Commission provided $100,000 in grant funds to the University of California, Davis to support the development of an innovation proposal to improve early psychosis services. At the same time, the Legislature passed and the Governor signed AB 1315 (Mullin, Chapter 414, Statutes of 2017), which directed the Commission to appoint an Early Psychosis Advisory Body with the intent to raise private funds to improve early psychosis services. With guidance from that planning grant, and growing support from the advisory body, in 2018 four counties elected to invest $8.5 million in county MHSA innovation funds to launch a multi-county innovation collaborative focused on improving access to care and the quality of care for persons in the early stages of psychosis. Two additional counties joined the project in 2019 using county funds.

Subsequent to that effort, the Budget Act of 2019 provided the Commission with $19.5 million in one-time Mental Health Services Act (MHSA) funds to support, through a competitive selection process, the expansion of early psychosis programs and ensure that they operate with fidelity to a model known as Coordinated Specialty Care.

The Commission has awarded five contracts to counties totaling $10 million to launch early psychosis programs focused on Coordinated Specialty Care services and $3.9 million to the University of California, Davis to support implementation. The Commission is preparing a second RFA this spring to solicit additional applicants for the balance of available funding.

The five counties that received grants include: (1) Kern; (2) Lake; (3) San Francisco; (4) Santa Barbara; and (5) Sonoma.

With guidance from the Commission's advisory committee, the remaining funds will be dedicated to further program expansion ($4 million), addressing equity concerns in awareness of the early psychosis workforce ($1.0 million) and research initiatives to identify barriers and improve access to care ($565,000).

In addition to this work, the Commission is partnering with Kaiser Permanente, Northern California to explore opportunities to promote access to the Coordinated Specialty Care model through commercial insurance plans.

E. ALL CHILDREN THRIVE

All Children Thrive ("ACT") is a statewide campaign helping California cities prevent and mitigate the impact of Adverse Childhood Experiences (ACEs). Pilot funding of $10 million for 3 years was included in the 2018 Budget Act (January 2019 – December 2021) and

CDPH contracted with Public Health Advocates and the UCLA School of Public Health to lead the project. ACT has the following four goals:

1. *Shape Perspective*. Help cities prevent ACEs, promote child well-being, and co-design solutions together with residents (youth and adults) and CBOs.

2. *Innovate through Collaboration*. Cities network with each other to share, learn, and create innovative solutions.

3. *Shift Power*. Embed community voices into policy development, systems change, and program planning.

4. *Make Change Sustainable*. Enacting policies, tapping into sustainable funding, and transforming systems so All Children Thrive.

ACT includes the following key action areas:

- Creating protective environments
- Promoting health child development
- Access to safe and stable housing
- Strengthening economic supports
- Youth development and civic engagement
- Mental Health and wellness

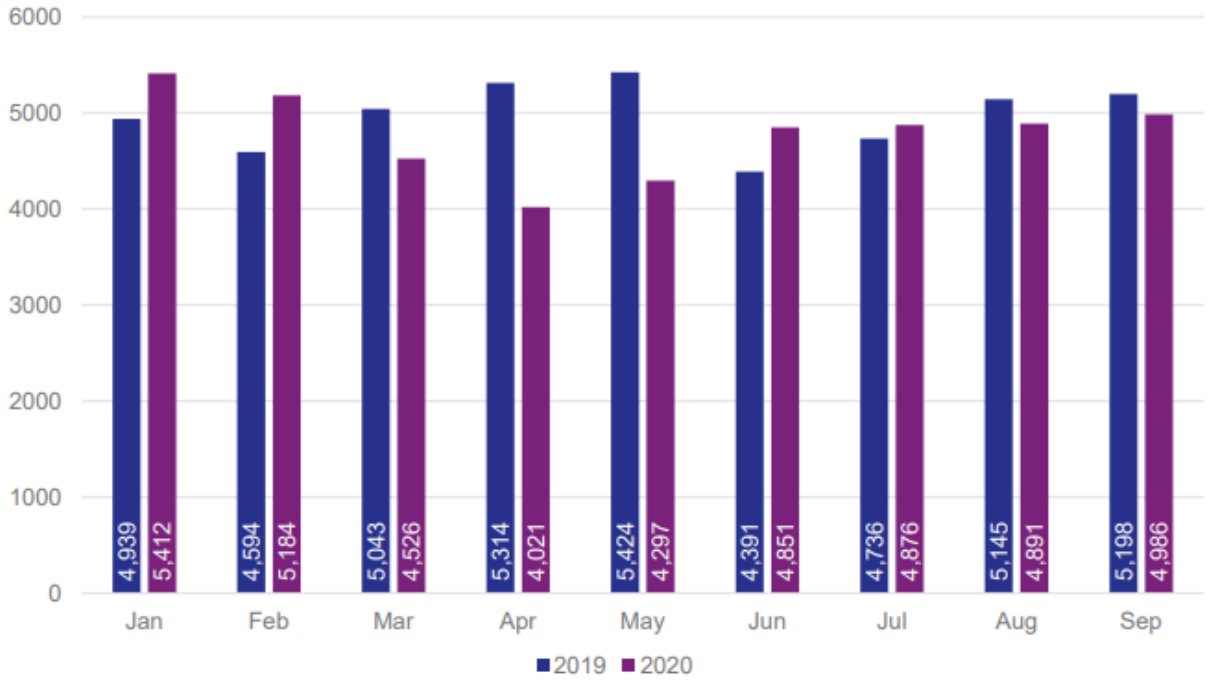
Public Health Advocates reports that the following 21 cities are participating in this pilot project: Antelope Valley, Antioch, Bakersfield, Coachella, Compton, East Palo Alto, Fresno, Huntington Park, Lakeport, Maywood, Modesto, Oxnard, Richmond, Sacramento, Salinas, Santa Ana, Santa Paula, Stockton, Ukiah, Vallejo, Watsonville, and Yuba County.

F. YOUTH ACCESS TO BH SERVICES

DHCS provided the data in the following charts that compare 2019 to 2020 utilization of behavioral health services by youth (younger than 21).

Non-specialty Mental Health Visits

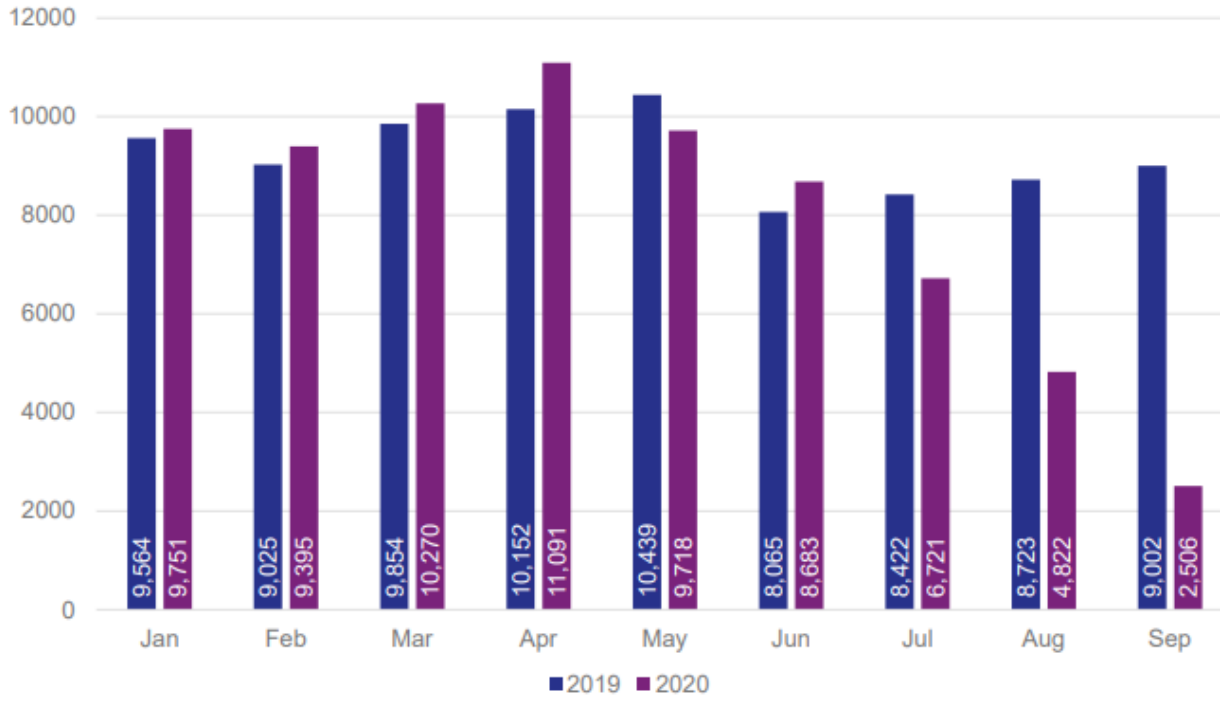
Visits per 100,000 beneficiaries under 21 years old



Preliminary Data as of 01/2021

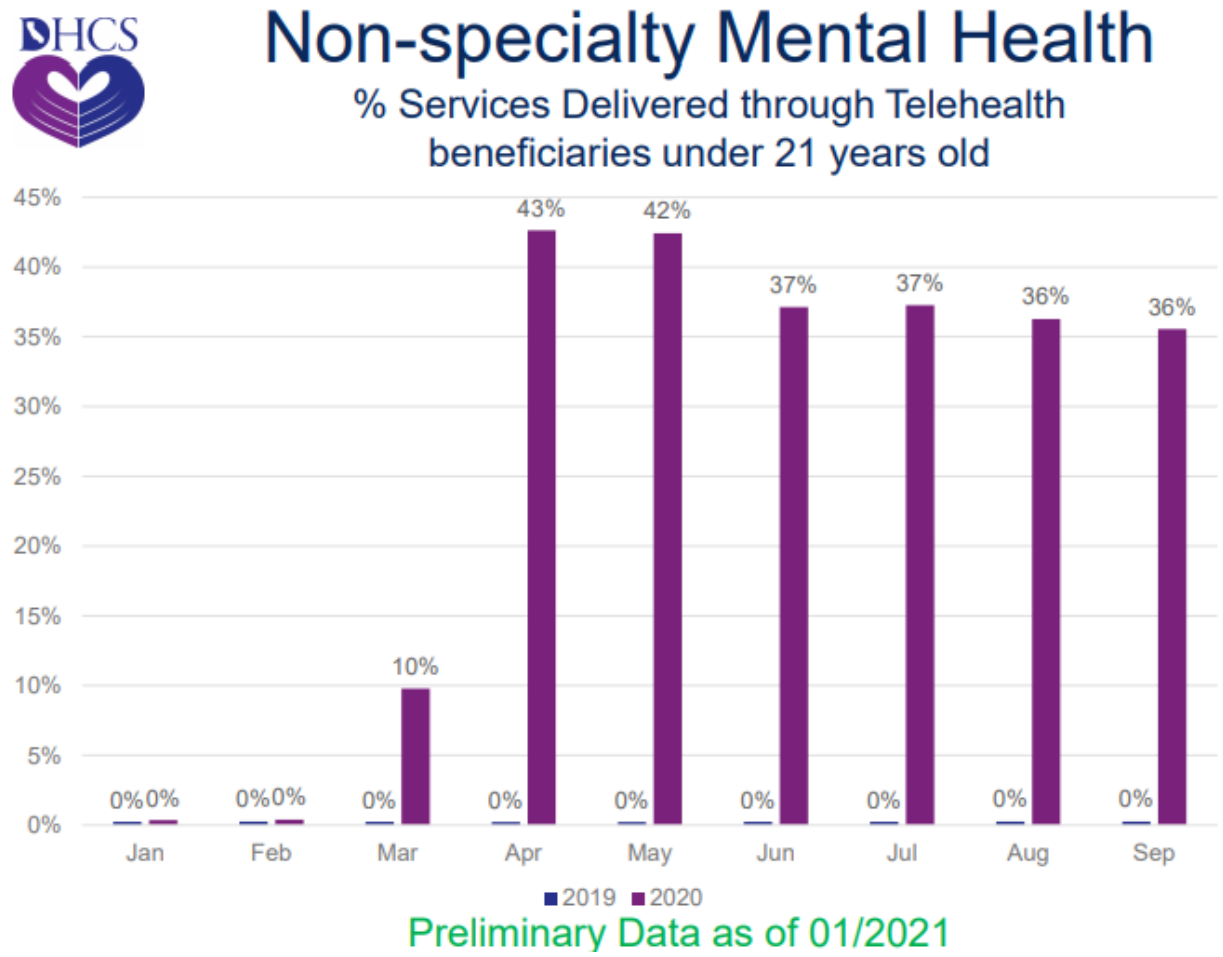
Specialty Mental Health Visits

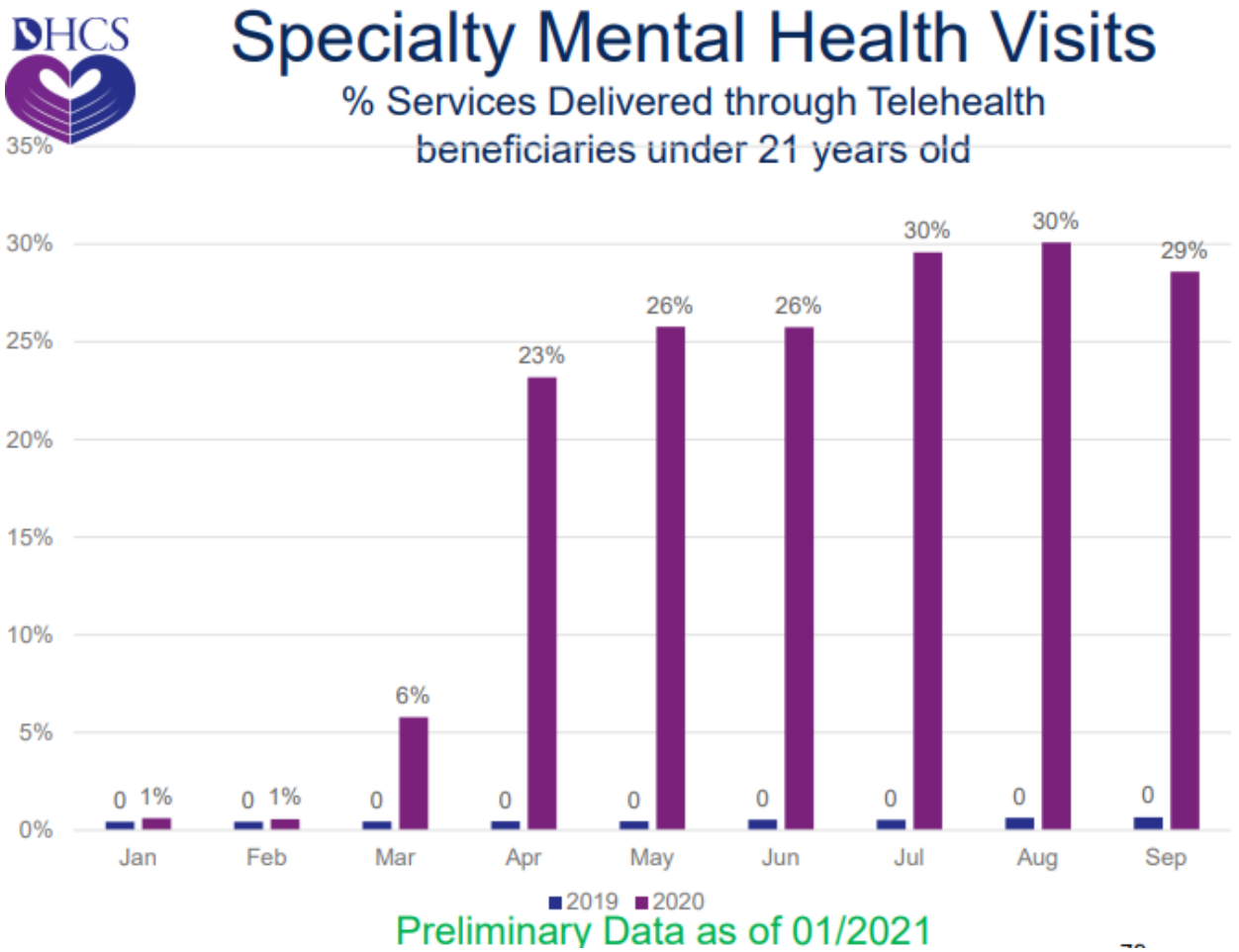
Visits per 100,000 beneficiaries under 21 years old



Preliminary Data as of 01/2021

The following charts show the dramatic increase in 2020 in the use of behavioral telehealth services (both Specialty and Non-Specialty Mental Health) by youth:





STAFF COMMENTS/QUESTIONS

The pandemic has had an enormous, and enormously complex, impact on kids, parents, teachers, and all of us. It hasn't been the same for everyone and not all bad either. For some parents, particularly of teens, stress levels have decreased considerably. At last, parents have gotten a break from worrying about where their kids are, who they're with and what they're doing; they're always home. Similarly, many teenagers normally experience social anxiety, and those who do are not suffering (greatly) from social isolation. Some parents actually dread the re-opening of schools; they don't miss worrying about school shootings.

Nevertheless, while some families should be grateful for less worry and stress, many (perhaps most?) kids and parents are enduring an immense amount of stress and desperately need schools to re-open. As a state, we need to recognize and respond to the many layers of struggle, some that people are experiencing now, and others when schools and businesses re-open. Kids who have enjoyed staying home may have a hard time reintegrating into school/social environments, while kids living in unhealthy or unsafe

homes may be reeling from the many months (years?) of isolation and increased family violence or stress at home.

In order to most effectively support kids, we need to support those who support kids – parents and teachers. Inevitably, teachers who are stressed out will be less able to be supportive of, and helpful to, their students. School administrators who feel unsupported or unsafe, won't be able to support teachers, who then won't be able to support kids. Behavioral health services and prevention strategies need to be brought to schools, for kids, for teachers, for entire school communities, and they must be well-organized, well-resourced, and the priority-focus of school re-openings.

Staff Recommendation: Recommend the Subcommittee: 1) request the California Health and Human Services Agency lead a coordination effort across state government on school-based health, including DHCS, CDPH, CDE, OAC, OSG, and others as appropriate; 2) urge the administration to engage with health plans on how both Medi-Cal and commercial health plans can support school-based health services; and 3) support administration proposals to invest in school-based services and efforts to increase access to behavioral health services for youth.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 3: SUICIDE AND DRUG OVERDOSE PREVENTION

OVERVIEW

This issue (Issue 3) covers:

A. The State Suicide Prevention Strategic Plan and Suicide Prevention Work at the OAC.
B. AB 2112 (Ramos, Chapter 142, Statutes of 2020) – establishing a State Office of Suicide Prevention.
C. Suicide Prevention Work at CDPH.
D. Suicide Prevention Work at DHCS.

PANELISTS – PRESENTERS & QUESTIONS FOR EACH DEPARTMENT

Mental Health Services Oversight and Accountability Commission

- **Toby Ewing**, Executive Director

1. Please provide an overview of *Striving for Zero, California's Strategic Plan for Suicide Prevention 2020-2025*, including its primary recommendations for the state.
2. Please describe the OAC's suicide prevention work.
3. Please share any new recommendations on urgent strategies the state should consider supporting to curb the pandemic-induced rising suicide rates, particularly among youth.

California Department of Public Health

- **Monica Morales**, Deputy Director, Center for Healthy Communities

1. Please provide an overview of the most current state data available on suicides and drug overdose deaths.
2. Please describe the suicide prevention work being undertaken by CDPH (as described in this Issue in the agenda).
3. What is the implementation timeline for this new federal grant?
4. Please share the administration's view of AB 2112, and the establishment of a State Office of Suicide Prevention, especially in light of the federal grant CDPH received for a nearly identical purpose.

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs, State Medicaid Director

1. Please provide an overview of CalHOPE and any other suicide prevention efforts underway at DHCS.
2. What is the implementation timeline for CalHOPE?
3. Has DHCS launched any new programs or strategies to address rising rates of substance abuse and overdose deaths as a result of the pandemic?

County Behavioral Health Directors Association of California
- **Michelle Doty Cabrera**, Executive Director
- **Dr. Veronica A. Kelley**, DSW, LCSW, Behavioral Health Director, San Bernardino County, CBHDA President

1. Please describe any innovative suicide prevention programs or strategies being undertaken by counties, either within Medi-Cal, or through county MHSA programs.
2. What recommendations can you make to the state with regard to suicide prevention, particularly for youth.

PANELISTS – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director – Behavioral Health
- **Lindy Harrington**, Deputy Director – Health Care Financing

California Department of Public Health
- **Stacy Alamo**, Chief, Injury and Violence Prevention Branch

Mental Health Services Oversight and Accountability Commission
- **Norma Pate**, Deputy Director

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Jack Zwald**, Principal Program Budget Analyst

Legislative Analyst's Office
- **Sonja Petek**, Principal Fiscal & Policy Analyst
- **Mark Newton**, Deputy Legislative Analyst

A. THE OAC STATE SUICIDE PREVENTION PLAN AND SUICIDE PREVENTION WORK

In 2017 Budget Act included $100,000 (MHSA State Administration Fund) and Supplemental Reporting Language for the OAC to develop a Statewide Suicide Prevention Strategic Plan.

In September 2020 the Commission adopted *Striving for Zero*, California's strategic plan for suicide prevention. In 2020, the Governor and Legislature authorized the Commission to dedicate $2 million in one-time, redirected funds to support suicide prevention. In September, 2020, the Commission authorized the release of these funds to support five primary initiatives:

- Advance Local Strategic Planning and Implementation $535,000
- Increase Lethal Means Safety $200,000
- Accelerate Standardized Risk Assessment Training/Support $215,000
- Deliver Standardized Suicide Risk Screening Training $150,000
- Create and Implement a Suicidal Behavior Research Agenda $500,000

The Commission has begun work on the first contract listed above to support local suicide prevention strategic planning. The remaining four contracts are in the process of being signed.

B. AB 2112 (RAMOS, CHAPTER 142, STATUTES OF 2020) ESTABLISHING A STATE OFFICE OF SUICIDE PREVENTION

AB 2112 authorizes CDPH to establish the Office of Suicide Prevention (OSP) to, among other functions, provide information and technical assistance to statewide and regional partners regarding best practices on suicide prevention policies and programs and conduct and convene experts and stakeholders to encourage collaboration and coordination of resources for suicide prevention. AB 2112 allows that if OSP is established, CDPH may focus resources on groups with the highest risk, including the youth and Native Americans. While the Governor signed this bill last year, there is no funding included in the Governor's proposed January budget.

In recognition of the critical role and necessity for strong state leadership, one of the highest priority recommendations in *Striving for Zero, California's Strategic Plan* is the establishment of a State Office of Suicide Prevention. Consistent with both the Plan

recommendation and AB 2112, the OAC strongly supports the establishment of this Office with necessary funding.

C. SUICIDE PREVENTION WORK AT DHCS

DHCS received a federal grant from FEMA and SAMHSA to implement a California crisis-counseling program called CalHOPE. Crisis counseling uses peer level individuals that provide support and guidance to people feeling stressed and anxious from the public health emergency and the laying of other societal challenges. CalHOPE provides no clinical services. Each effort is designed to de-escalate the need for people to need a more intensive service. The total investment in the program is approximately $70 million and almost all of the funds are contracted out. There are three main elements of CalHOPE- Media, Web and Support, as described by DHCS below:

1. **CalHOPE Media** provides education, prevention messaging, and connection to resources, including the Warm Line and CalHOPE Support crisis counseling, managed through an ISP contract with Media Solutions. The RSP contract with Media Solutions would continue broad population messaging and add a deeper reach into specifically targeted high risk communities. ($30 M)

2. **CalHOPE Website** is complimented by the Together for Wellness site to add enhancements designed to help users navigate their way to support and wellness tools, including apps to learn coping and stress-management skills, supported by a partnership with UCLA, UCD and community groups. The ISP work is with DHCS staff, and the RSP work continues with DHCS and is enhanced with contract through CalMHSA to UCLA. ($733 K)

3. **CalHOPE Support** continues the emotional support services offered in the CalHOPE Warm Line and adds additional counseling interventions by phone or live video with trained counselors concordant for culture and language, specifically focused on the highest-risk communities.

    - **CalHOPE Warm Line**- Crisis Counselors with lived experience will provide phone and chat support of people in need. ($2.7 M)
    - **CalHOPE Support** - The majority of crisis counseling will be supported through a contract with CalMHSA, which will subcontract to county behavioral health departments and community-based groups to reach specific populations. ($26 M)
    - **CalHOPE School Support** uses Communities of Practice (COP) that will engage the schools and behavioral health community in supporting students and families during the time of distance learning and return to schools. The UCB Center for Greater Good is preparing tools for the schools to utilize to enhance the social and emotional learning environment for students. This element will be funded through

CalMHSA and implemented by Sacramento County Office of Education (SCOE). SCOE will partner with Orange County Office of Education to support the 58 County Offices of Education in hosting COPs. ($6.82 M)

- A separate contract with the California Consortium for Urban Indian Health (CCUIH) will provide crisis counseling for the American Indian and Alaskan Native (AIAN) communities. ($761 K)

D. SUICIDE PREVENTION WORK AT CDPH

The CDPH Injury and Violence Prevention Branch (IVPB) is one of nine recipients of the Comprehensive Suicide Prevention Program Cooperative Agreement award from the Centers for Disease Control and Prevention (CDC). The purpose of the five-year award (September 2020 to August 2025) is to implement and evaluate a public health approach to suicide prevention, including adoption and implementation of evidence-based suicide prevention practices and policies at the local level. Efforts will focus on vulnerable populations that have higher suicide rates than the general population and account for a significant proportion of the suicide burden.

CDPH/IVPB plans to fund up to four local health departments and provide training and technical assistance for up to 13 that meet specific criteria (i.e., higher rates of suicide than the state overall, higher rates of emergency department visits for self-harm, and participation in the California Violent Death Reporting System). Funding and/or technical assistance will be provided to support adoption and implementation and evaluation of evidence-based suicide prevention strategies, with the goal of reducing suicide rates and self-harm rates in those counties by 10%.

CDPH/IVPB utilized data on suicide rates and self-harm emergency department (ED) visits as the primary criteria for identifying eligible counties. Eligible counties met the following criteria:

- Have higher rates of suicide deaths than that state overall.
- Have higher rates of self-harm ED visits than the state overall.
- Participate in the California Violent Death Reporting System (CalVDRS) (which links Coroner/Medical Examiner reports and Law Enforcement data with vital statistics in order to better understand the circumstances surrounding these deaths).

The following counties met these criteria as of November 2020:

		Suicides 2016-2018			Self-Harm ED Visits 2018		
County	High Suicide Rate	Age-Adjusted Rate	3-year Count	High Self-Harm ED Visit Rate	Rate	1-year Count	Participate in CalVDRS
Amador	Yes	27.0	33	Yes	312.0	116	Yes
Butte	Yes	20.1	142	Yes	137.4	313	Yes
Humboldt	Yes	22.0	90	Yes	140.4	192	Yes
Kern	Yes	13.2	344	Yes	134.8	1,225	Yes
Lake	Yes	30.0	57	Yes	183.0	119	Yes
Lassen	Yes	28.5	27	Yes	156.6	48	Yes
Placer	Yes	12.6	156	Yes	112.5	435	Yes
Sacramento	Yes	12.8	604	Yes	115.5	1,776	Yes
Santa Cruz	Yes	15.2	131	Yes	95.9	267	Yes
Shasta	Yes	24.1	136	Yes	152.0	272	Yes
Siskiyou	Yes	19.6	29	Yes	185.5	82	Yes
Sonoma	Yes	12.7	215	Yes	108.0	548	Yes
Tehama	Yes	22.6	45	Yes	106.9	69	Yes
California		10.4	12,860		79.4	31,712	

CDPH reported that they would be reaching out to local health department representatives from these 13 counties to gauge interest in participating in the Suicide Prevention Program in January 2021.

STAFF COMMENTS/QUESTIONS

Over the past ten to twenty years, the state's response to suicide has been herky-jerky at best. The former Department of Mental Health maintained an Office of Suicide Prevention, yet this office and its resources did not seem to survive the transition to the Department of Health Care Services. The Legislature and Governor approved of approximately $4 million to replace county funding that ended for suicide hotlines, yet it took the administration nearly three years to get the money to the hotlines. Various types and amounts of state funding have helped finance a new suicide deterrent system currently being constructed on the Golden Gate Bridge. Nevertheless, the state for many years has lacked a coherent, long-term, statewide strategy that prioritizes effective, evidence-based interventions. With strong leadership and a serious commitment from the state, a lot of lives could be saved.

Staff Recommendation: Recommend the Subcommittee urge: 1) the Governor to include in the May Revise any new funding needed to officially establish an Office of Suicide Prevention at CDPH, officially endorse *Striving for Zero* as the State's Suicide Prevention Strategic Plan, and direct resources towards emergency interventions to prevent youth suicides; 2) the California Health and Human Services Agency to convene a multi-agency task force to develop urgent suicide and overdose prevention strategies.

4260 DEPARTMENT OF HEALTH CARE SERVICES
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ISSUE 4: BEHAVIORAL HEALTH SERVICES FOR THE HOMELESS AND OTHER HIGH-NEED POPULATIONS

OVERVIEW

This issue (Issue 4) covers:

A. DSH Community Care Demonstration Project proposal.
B. DSH Mental Health Diversion Program update.
C. DHCS Community Infrastructure funding proposal.
D. Medi-Cal proposals and efforts to address the needs of the homeless population – Whole Person Care, In Lieu of Services, Enhanced Care Management.
E. Mental Health Services Act Full Service Partnerships.

PANELISTS – PRESENTERS & QUESTIONS FOR EACH DEPARTMENT

Department of State Hospitals

- **Stephanie Clendenin**, Director
- **Chris Edens**, Deputy Director, Forensics Division

1. Please present the Community Care Demonstration Project proposal and the Diversion program updates and proposals.
2. What impact do you expect this program to have on the IST waiting list, and when?
3. Please explain the justification for seeking resources to expand the Diversion program when there have been significant delays in implementing the existing program due to the pandemic.
4. Is the Diversion program being formally evaluated? If so, what is the timing of the evaluation and should the state not wait for such an evaluation before expanding the program?
5. Please describe how different departments, such as DSH and DHCS, are working together to address the mental health needs of the homeless and criminal justice-involved populations, in order to avoid duplication of services and to improve coordination and efficiencies.

Department of Health Care Services

- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs, State Medicaid Director

1. Please present the proposal for $750 million for infrastructure funding and the CalAIM proposed benefits that will replace Whole Person Care, and any other Medi-Cal proposals related to serving populations with high-behavioral health needs.
2. Given that DHCS is proposing to award this funding to counties on a competitive basis, and requiring a local match, how will DHCS ensure that funding will go to the counties with the least resources and most significant needs?
3. Is DHCS undertaking a gap analysis of behavioral health services? If so, what is the timing of the analysis?
4. How can we ensure that this funding will prioritize services for foster youth?
5. Please describe how different departments, such as DSH and DHCS, are working together to address the mental health needs of the homeless and criminal justice-involved populations, in order to avoid duplication of services and to improve coordination and efficiencies.

Mental Health Services Oversight and Accountability Commission

- **Toby Ewing**, Executive Director

1. Please provide an overview of Full Service Partnerships, and an assessment of their strengths and weaknesses.
2. How can FSPs coordinate and complement similar Medi-Cal services?
3. Is MHSA funding used effectively to address the needs of the homeless and criminal justice-involved populations?
4. What recommendations do you have on how the state can more effectively address the behavioral health needs of these populations?

County Behavioral Health Directors Association of California

- **Michelle Doty Cabrera**, Executive Director
- **Dr. Veronica A. Kelley**, DSW, LCSW, Behavioral Health Director, San Bernardino County, CBHDA President

1. What challenges and successes have counties experienced recently in addressing the behavioral health needs of high-need populations?
2. How has the pandemic affected these populations?
3. What about Medi-Cal and MHSA funding is working well, and not working well, in addressing the needs of these populations?

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst
  1. Please share any analysis that you have done, and/or concerns or questions on any of the proposals discussed in this Issue.

PANELISTS – Q&A ONLY

Department of Health Care Services (Q&A only)
- **Kelly Pfeifer**, Deputy Director – Behavioral Health
- **Lindy Harrington**, Deputy Director – Health Care Financing

Mental Health Services Oversight and Accountability Commission
- **Norma Pate**, Deputy Director

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Sonal Patel**, Finance Budget Analyst

Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst

A. DSH COMMUNITY CARE DEMONSTRATION PROJECT FOR FELONY ISTS BUDGET CHANGE PROPOSALS

DSH requests 4.0 positions and $233.2 million General Fund in FY 2021-22 and 4.0 positions and $136.4 million General Fund in FY 2022-23 and ongoing to establish the Community Care Demonstration Project for Felony Incompetent to Stand Trial (IST) (CCPD-IST), for the department to contract with counties to provide a continuum of services to felony ISTs in the county as opposed to state hospitals. This proposal includes corresponding statutory changes and provisional language.

The administration provided the following background:
The counties will assume responsibility for the treatment and restoration of felony IST defendants as soon as July 1, 2021. The goal of this proposal is to promote a community-based continuum of care for felony IST defendants in the state. It seeks to demonstrate the effectiveness of streamlining responsibility to drive improved outcomes (reduced incarceration, recidivism and homelessness) for individuals with serious mental illness.

This proposal requests funding to support contracts with several counties of various sizes to participate in CCDP-IST. DSH will provide an update at May Revision of the counties identified to participate in CCDP-IST. Additionally, DSH may need to shift a portion of funding from this proposal to provide for the continued operation and administrative support of new Community-Based Restoration (CBR) program beds in 2021-22 and ongoing.

Beginning in FY 2012-13, DSH began to experience an increase in the number of IST patients referred to the department. In the following years, the number of ISTs referred to the department has continued to increase, leading to a pending placement list. As of November 30, 2020, the number of IST individuals pending placement into a DSH facility or JBCT program was 1,306 patients. While the high number of individuals pending placement can be partially attributed to protective measures implemented by DSH in response to COVID-19, the number of ISTs pending placement to a DSH program prior to COVID-19 was over 800. This was primarily because the volume of new IST referrals to DSH continues to outpace the beds available within the DSH system.

To address the increasing referrals to its system, DSH has expanded capacity within its system of care by over 900 beds over the past eight years ending FY 2019-20. This expansion includes activating additional state hospital beds, implementing jail-based treatment, and implementing multiple efficiencies within its hospitals to restore ISTs to competency as expeditiously as possible. The department has activated multiple beds throughout the state hospitals over the years to respond to the increasing number of referrals. Most recently, DSH completed the Increased Secure Bed Capacity project at DSH-Metropolitan, to add security infrastructure to an existing patient building to make over 200 additional beds available for IST treatment. In Fiscal Year 2019-20, 92 beds from this project were activated for IST treatment. The remaining beds have been temporarily placed on hold due to the department's response to COVID-19 pandemic. Throughout the years, the department has also been partnering with County Sheriff Offices and to date, established over twenty JBCT programs across the state that provide competency restoration treatment in a jail setting.

The 2018 Budget Act included funding for DSH to contract with counties to develop new or expand existing programs to provide diversion opportunities for individuals who have been or are likely to be found incompetent to stand trial on felony charges. Currently DSH is working with 25 counties to establish the Incompetent to Stand Trial Diversion Program (Diversion) which places defendants in community treatment with the goal of preventing future interactions with the justice system, dismissing charges when specific criteria are in place, and linking them into ongoing community care.

The 2018 Budget Act also included funding for DSH to establish its first Community-Based Restoration Program (CBR) in partnership with the Los Angeles County Office of Diversion and Reentry. In this program, ISTs that would otherwise be referred to DSH or

a JBCT are restored to competency in the community in the least restrictive setting possible. ISTs who successfully complete treatment in CBR and after criminal proceedings, are eligible for continued community placement through the permanent supportive housing program. This model of care bridges a significant gap often experienced by individuals, especially those with mental health conditions, re-entering the community after incarceration, and offers both hope for the individuals and a decreased likelihood of recidivating.

Even with these interventions over the years, the number of ISTs pending placement to DSH has remained unsustainably high. As a result of a continued high waitlist, DSH faces ongoing pressure from the courts to admit additional individuals into its system of care. Recently, new timelines for admission were ordered by the Superior Court. DSH continues to seek alternative solutions to increase current capacity in order to meet this ongoing pressure to the state hospital system.

In California, counties are responsible for almost all mental health treatment for low-income Californians with serious mental illness, except for felony forensic commitments which includes the felony IST population. Counties are currently responsible for providing treatment to individuals deemed IST on misdemeanor charges. Given that competency restoration treatment for misdemeanor ISTs is generally the same for felony ISTs, the counties are well positioned to assume responsibility. In addition, counties are well positioned to braid multiple funding sources to support the felony IST population. For example, local MHSA funding may be used to support the adult forensic mental health population through Full-Service Partnerships (FSPs) designed to serve this higher need population, incorporating intensive case management and a “whatever it takes” approach to mental health service delivery. Counties also demonstrated promising outcomes through the Whole Person Care (WPC) Pilot Programs, which are set to conclude December 31, 2021. WPC Pilots were developed in various communities to provide comprehensive and coordinated care for high-utilizing Medi-Cal recipients, including those reentering from correctional settings. Almost half of approved WPC Pilot plans focus on individuals released from institutions including correctional settings (Council of Criminal Justice and Behavioral Health). The WPC Pilots are helping to build a foundation for an integrated approach to coordinating medical care, behavioral health treatment and social services to improve health outcomes, that are proposed to be continued with the California Advancing and Innovating Medi-Cal (CalAIM) proposal, included in the 2021-22 Governor’s Budget. CalAIM proposes to provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges. Both FSPs and the programming developed for WPC Pilots, that will continue through CalAIM, are examples of the types of treatment that participating counties may implement or build upon to successfully transition felony ISTs to community care.

B. DSH MENTAL HEALTH DIVERSION PROGRAM UPDATE

The 2018 Budget Act included $100 million one-time General Fund, for 2018-19 through 2022-23, to establish the incompetent to stand trial (IST) Diversion Program, which authorized DSH to contract with counties to develop new, or expand existing, Diversion programs for individuals with serious mental illnesses, diagnosed with schizophrenia, schizoaffective disorder, or bipolar disorder with the potential to be found IST on felony charges.

Of the $100 million, $91 million was earmarked for the 15 counties with the highest referrals of felony ISTs to DSH: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Solano, Sonoma, and Stanislaus.

Initially, $8.5 million was made available to other counties on a competitive basis, and funding was awarded to: Del Norte, Marin, Placer, San Francisco, San Luis Obispo, Santa Cruz and Yolo. A second round of competitive grants were awarded with $4.4 million in program savings from the original 15 counties to: Humboldt, San Mateo, Siskiyou and Ventura counties.

Progress as of December 2020:

- Thirteen counties have activated their Diversion programs.
- Seven additional counties have fully executed contracts with DSH and planned activation dates for winter 2021.
- One county has a contract pending county approval.
- Four counties are currently in contract negotiations with DSH.
- Stanislaus County chose not to participate.

Participating counties anticipate diverting 841 felony ISTs over the time-period of their programs.

DSH provide all participating counties with technical assistance and training opportunities. As of September 30, 2020, DSH has provided 67 hours of in-person and web-based training to counties. Technical assistance initially focused on county planning and implementation efforts, and more recently:

- Appropriate medications and psychopharmacology considerations for prescribers in Diversion programs
- How to use risk assessments to inform client treatment plans

- Case plan review sessions with DSH psychiatrists, external experts and other county staff to assist counties in evaluating more difficult cases

As required by statute, DSH is collecting data on all county IST Diversion Program participants. As of June 30, 2020, 144 individuals have been diverted to a county-run program.

New Diversion Requests:
DSH is requesting $46.4 million one-time General Fund to expand the program in both participating and new counties.

DSH also requests to extend the availability of funding for the program by 12 months; DSH estimates that up to $8 million General Fund will not be encumbered by the existing deadline of June 30, 2021 based on the following:

- $4 million from one county which declined to participate in the program and two other counties that have contracted for less than the maximum funding available to them
- $3 million from one county at risk of not participating
- $1 million in potential savings from counties not yet contracted with DSH who may elect to take less than their full allotment

DSH explains that most of the county Diversion programs have been delayed as a result of COVID-19. Identifying potential Diversion candidates across the state has become more difficult because of COVID outbreaks in local jails, mass-releases of inmates, and policies that limit outside visitors. The temporary closure of courts during the first few months of the pandemic also caused delays in activations. Additional delays may result.

DSH is also requesting permanent position authority and five-year limited-term funding for the 3.0 staff positions. The original resources approved for the pilot program included three years of limited-term funding and no position authority; DSH was instructed to redirect and fill current vacant positions in a limited-term capacity. State departments can only use limited-term positions with the same incumbents and duty statement for 12 months.

DSH requests five-year limited-term funding for research and data collection efforts. In the original request, DSH assumed that an online portal could be developed which counties would use to directly input their data reports. However, development of such a portal turned out to be unfeasible and, instead, DSH is collecting and consolidating county data manually. DSH is working with UC Davis to consolidate and analyze all data received from participating counties. To adequately track recidivism data after all pilot programs are completed, DSH is requesting $2.5 million as follows:

UC - Davis Research Team Funding						
Staffing	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	Total Requested
3.5 FTE	$ 472,499	$ 496,332	$ 509,148	$ 522,474	$ 536,334	$ 2,536,787

DSH requests five-year limited-term funding of $100,000 to contract with national experts to provide technical assistance and training to counties implementing felony pre-trial Diversion programs.

The total resources request for state support of the program is summarized here:

Support Resources for DSH Diversion Expansion					
	BY	BY+1	BY+2	BY+3	BY+4
Staff Svcs Mgr II	$ 179,000	$ 179,000	$ 179,000	$ 179,000	$ 179,000
Sr. Psych (Supvr)	$ 238,000	$ 238,000	$ 238,000	$ 238,000	$ 238,000
Assoc Govtl Prog Analyst	$ 142,000	$ 142,000	$ 142,000	$ 142,000	$ 142,000
Travel	$ 75,000	$ 75,000	$ 75,000	$ 75,000	$ 75,000
UC Davis Research	$ 472,499	$ 496,332	$ 509,148	$ 522,474	$ 536,334
Consulting	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000
TOTAL	**$ 1,206,499**	**$ 1,230,332**	**$ 1,243,148**	**$ 1,256,474**	**$ 1,270,334**

C. DHCS COMMUNITY INFRASTRUCTURE PROPOSAL

The Budget proposes $750 million General Fund, available over three years, for DHCS to invest in critical gaps across the community-based behavioral health continuum, including the addition of at least 5,000 beds, units, or rooms to expand such capacity. These resources would provide a comprehensive continuum of services to address short-term crisis stabilization, acute needs, peer respite, and other clinically enriched longer-term treatment and rehabilitation opportunities for persons with behavioral health disorders, in the least restrictive and least costly setting. Funding would be made available to counties via a competitive application process and could be used for acquisition and/or rehabilitation. Counties would be required to provide a match of local funds.

DHCS provided this background information:
California's behavioral health community-based continuums have worsened progressively over the years, leading to a significant infrastructure deficit. As a result of insufficient infrastructure, outpatient treatment options are scarce and oversubscribed and counties are often left without appropriate step down options to less restrictive, community-based, residential settings of care. The Budget proposes to capitalize on a potentially unique moment in time to efficiently and cost-effectively acquire real estate

assets to expand the community continuum of behavioral health treatment resources, allowing individuals to live and be treated in a stable environment which leads to better health and behavioral health outcomes. As the state builds up the service spectrum through approaches like CalAIM and pursuit of the Serious Mental Illness/Serious Emotional Disturbance Institutions for Mental Disease (IMD) Waiver, DHCS aims to reduce homelessness, incarceration, unnecessary hospitalizations, and inpatient days by appropriately utilizing community-based models of care.

The LAO did an analysis of this proposal, which can be found on their website, and it includes the following key takeaways:

- "Further Specifics of the Grant Program Proposal Needed. The Governor's budget proposes $750 million General Fund one time to provide competitive grants to counties to acquire or renovate facilities for community behavioral health service delivery. Additional details such as (1) the structure of the grant program (for example, what specific milestones counties would have to meet to receive grant awards), and (2) what oversight and evaluation activities the Department of Health Care Services would conduct for the grant program are necessary to fully evaluate this proposal. Furthermore, budget bill language (which typically lacks specificity when compared to trailer bill language) is insufficient for establishing a new program of this magnitude and complexity. We suggest the Legislature adopt trailer bill language to govern the implementation of this program and provide more opportunities for oversight.

- Available Data Indicate Expanding Capacity for Behavioral Health Services Likely Has Merit. The administration projects growth in short-term mental health crisis services in the Medi-Cal program. In addition, the number of inpatient psychiatric beds available statewide relative to population indicates the supply of these beds likely is not meeting the state's needs. The number of facilities that can provide short-term mental health crisis services as an alternative to inpatient psychiatric beds also is low. Together, these factors indicate that an expansion of capacity for community behavioral health services (through securing additional facilities) likely is warranted.

- Proposal Has Some Overlap With Other State Grant Programs, Providing Opportunity to Apply Lessons Learned. There is overlap between this proposal and other state grant programs that provide grants to counties for behavioral health facilities. This proposal provides an opportunity to apply lessons learned from challenges that these other state grant programs have experienced, which have led to (1) delays in funds disbursement, (2) forfeiture of grant funds, and (3) reduced interest in applying for facility grants. Incorporating these lessons learned into the design of this proposed state grant program could help the state avoid similar challenges."

D. MEDI-CAL PROPOSALS FOR ADDRESSING HOMELESSNESS

The Subcommittee will be jointly sponsoring two informational hearings with the Assembly Health Committee on CalAIM, on March 9th (BH) and March 16th. There will be sufficient time in those hearings to delve deeply into the many and complex CalAIM proposals. Nevertheless, the behavioral health CalAIM proposals are also mentioned here, more generally, given their relevance to this hearing.

CalAIM key behavioral health proposals:

- Create new enhanced care management (ECM) benefit.
- Ensure enrollment assistance for individuals transitioning from incarceration.
- Reimburse managed care plans to provide nonmedical "in lieu of services" (ILOS).
- Require managed care plans to develop population health management programs.
- Convene foster care workgroup.

The administration provided the following background on ECM and ILOS:

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care pilots, and transitions those pilots to this new statewide benefit to provide a broader platform to build on positive outcomes from those programs.

Target populations include, but are not limited to:

- High utilizers with frequent hospital or emergency room visits/admissions;
- Individuals at risk for institutionalization with Serious Mental Illness, children with Serious Emotional Disturbance or Substance Use Disorder with co-occurring chronic health conditions;
- Individuals at risk for institutionalization, eligible for long-term care;
- Nursing facility residents who want to transition to the community;
- Children or youth with complex physical, behavioral, developmental and oral health needs (i.e. California Children Services, foster care, youth with Clinical High Risk syndrome or first episode of psychosis);
- Individuals transitioning from incarceration; and
- Individuals experiencing chronic homelessness or at risk of becoming homeless.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under Whole Person Care, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a managed care plan will integrate into its population health strategy. These services are provided as a substitute, or to avoid, other services such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with Case or Care Management for members at high levels of risk and may fill gaps in state plan benefits to address medical or social determinants of health needs. Examples of in lieu of services include but are not limited to: housing transition and sustaining services, recuperative care, respite, home and community based wrap around services for beneficiaries to transition or reside safely in their home or community, and sobering centers.

The use of in lieu of services are voluntary, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building an integrated managed long-term services and supports (MLTSS) managed care program by 2026 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the State must use its ability to provide our Medi-Cal managed care plans with financial incentive payments established to drive plans and providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

The LAO has done an analysis of the CalAIM proposals, available on their website, which includes the following chart of ILOS Benefits:

Figure 4

Proposed "In Lieu of Services" Benefits

Benefit	Description
Services to Address Homelessness and Housing	
Housing deposits[a]	Funding for one-time services necessary to establish a household, including security deposits to obtain a lease, first month's coverage of utilities, or first and last month's rent required prior to occupancy.
Housing transition navigation services[a]	Assistance with obtaining housing. This may include assistance with searching for housing or completing housing applications, as well as developing an individual housing support plan.
Housing tenancy and sustaining services[a]	Assistance with maintaining stable tenancy once housing is secured. This may include interventions for behaviors that may jeopardize housing, such as late rental payment and services, to develop financial literacy.
Services for Long-Term Well-Being in Home-Like Settings	
Asthma remediation[b]	Physical modifications to a beneficiary's home to mitigate environmental asthma triggers.
Day habilitation programs	Programs provided to assist beneficiaries with developing skills necessary to reside in home-like settings, often provided by peer mentor-type caregivers. These programs can include training on use of public transportation or preparing meals.
Environmental accessibility adaptations	Physical adaptations to a home to ensure the health and safety of the beneficiary. These may include ramps and grab bars.
Meals/medically tailored meals	Meals delivered to the home that are tailored to meet beneficiaries' unique dietary needs, including following discharge from a hospital.
Nursing facility transition/diversion to assisted living facilities[c]	Services provided to assist beneficiaries transitioning from nursing facility care to community settings, or prevent beneficiaries from being admitted to nursing facilities.
Nursing facility transition to a home	Services provided to assist beneficiaries transitioning from nursing facility care to home settings in which they are responsible for living expenses.
Personal care and homemaker services[d]	Services provided to assist beneficiaries with daily living activities, such as bathing, dressing, housecleaning, and grocery shopping.
Recuperative Services	
Recuperative care (medical respite)	Short-term residential care for beneficiaries who no longer require hospitalization, but still need to recover from injury or illness.
Respite	Short-term relief provided to caregivers of beneficiaries who require intermittent temporary supervision.
Short-term post-hospitalization housing[a]	Setting in which beneficiaries can continue receiving care for medical, psychiatric, or substance use disorder needs immediately after exiting a hospital.
Sobering centers	Alternative destinations for beneficiaries who are found to be intoxicated and would otherwise be transported to an emergency department or jail.

[a] Restricted to use once in a lifetime, unless managed care plan can demonstrate cost-effectiveness of providing a second time.
[b] New benefit introduced this year. Restricted to lifetime maximum amount of $5000, unless beneficiary's condition changes dramatically.
[c] Includes residential facilities for the elderly and adult residential facilities.
[d] Does not include services already provided in the In-Home Supportive Services program.

The LAO report also includes the CalAIM budget summary below:

Figure 5

Proposed CalAIM Funding—Governor's 2021-22 Budget

(In Millions)

	2021-22		2023-23		2023-24[a]		2024-25 and Ongoing[a]	
	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund
Plan incentives[b]	$300	$150	$600	$300	$600	$300	—	—
Enhanced care management	188	94	467	233	481	240	$480	$242
In lieu of services	48	24	115	58	118	60	118	60
Dental services	113	57	227	114	234	117	233	118
Behavioral health QIP	22	22	32	32	32	32	—	—
Benefit and population delivery system transitions[c]	403	175	-10	-5	-10	-5	-10	-5
Local Assistance Subtotal	($1,074)	($521)	($1,431)	($732)	($1,454)	($744)	($822)	($415)
DHCS state operations	$24	$11	$28	$13	$25	$12	$24[d]	$11[d]
Grand Totals	**$1,098**	**$532**	**$1,459**	**$745**	**$1,479**	**$756**	**$846**	**$426**

[a] LAO estimates. While the grand totals correspond to the figures listed in budget documents, the amounts going to the different CalAIM components are LAO projections based on available information.

[b] To assist with the establishment of enhanced care management and in lieu of services.

[c] Not included in last year's proposal.

[d] While the 2024-25 costs are as listed, ongoing costs are proposed to be $20 million total funds, $10 million General Fund.

Note: Totals may not add due to rounding.

QIP = Quality Incentive Payments and DHCS = Department of Health Care Services.

E. MHSA FULL SERVICE PARTNERSHIPS

Proposition 63 (2004) provides increased funding through the Mental Health Services Act (MHSA) to support mental health services for underserved and previously unserved individuals within the context of the public mental health system. Prop 63 includes the following funding components: Prevention and Early Intervention (PEI); Workforce Education and Training (WET); Capital Facilities and Technological Needs (CF/TN); Innovation (INN); and Community Services and Supports (CSS), which includes Full Service Partnership (FSP). CSS is designed to serve individuals with severe mental illness (SMI) or serious emotional disturbance (SED). There is a requirement that "the County shall direct the majority of its Community Services and Supports funds to the Full-Service Partnership Service Category," and that clients be served with "whatever it takes."

The OAC estimates that counties spend $800-$900 million of Prop 63 revenue per year on FSPs. As with other programs described in this issue in the agenda, FSPs seek to provide comprehensive, wrap-around services to very high-need people with serious/severe mental illness. This population is largely made up of homeless individuals.

The effectiveness and value of the FSPs is unclear, as is the redundancy or duplication with Whole Person Care. Whole Person Care (under DHCS/Medi-Cal) is ending and DHCS proposes to replace it with new benefits, such as In Lieu of Services (ILOS) and Enhanced Care Management, that can be offered on a statewide basis.

STAFF COMMENTS/QUESTIONS

It does not appear that there is any real communication or coordination between various departments seeking substantial funding amounts, to engage in very similar activities, to serve the same populations. Without ongoing communication and coordination, redundancies and inefficiencies seem inevitable.

Staff Recommendation: Recommend the Subcommittee: 1) urge the California Health and Human Services Agency to facilitate communication, coordination and collaboration between state departments and agencies on addressing the behavioral health needs of the homeless and other high-need populations; and 2) consider adopting supplemental report language requesting DHCS provide further explanation and commitment to legislative priorities for the infrastructure funding – such as foster youth and equity.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: MEDI-CAL BEHAVIORAL HEALTH

OVERVIEW

This issue (Issue 4) covers:

A. Access to behavioral health services, including telehealth.
B. CalAIM behavioral health proposals– payment reform, medical necessity, behavioral health integration, and Drug Medi-Cal Organized Delivery System (ODS) expansion.
C. Drug Medi-Cal Parity

PANELISTS – PRESENTERS & QUESTIONS FOR EACH DEPARTMENT

Department of Health Care Services
- **Will Lightbourne**, Director
- **Jacey Cooper**, Chief Deputy Director Health Care Programs, State Medicaid Director

1. Please present a high-level overview of the various other behavioral health Medi-Cal proposals included in the budget not already discussed elsewhere in this agenda.
2. Please highlight key issues in increasing access to behavioral health services, for both youth and adults, such as via telehealth and peer support.
3. Please describe DHCS's role in peer support certification; who will certify peer support specialists?
4. Please present the Drug Medi-Cal Parity proposal.
5. Does the state have a long-term behavioral health workforce shortage strategy?

County Behavioral Health Directors Association of California
- **Michelle Doty Cabrera**, Executive Director
- **Dr. Veronica A. Kelley**, DSW, LCSW, Behavioral Health Director, San Bernardino County, CBHDA President (Presenter)

1. Please provide reactions and recommendations regarding the various behavioral health Medi-Cal proposals in the budget.
2. What are the most significant barriers for Medi-Cal enrollees to access behavioral health services?
3. What recommendations do counties have with regard to behavioral health workforce shortages?

Legislative Analyst's Office
- **Corey Hashida**, Fiscal & Policy Analyst

1. Please provide any analysis, concerns or questions you have regarding Medi-Cal behavioral health budget proposals.

PANELISTS – Q&A ONLY

Department of Health Care Services
- **Kelly Pfeifer**, Deputy Director – Behavioral Health
- **Lindy Harrington**, Deputy Director – Health Care Financing

Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst
- **Sonal Patel**, Finance Budget Analyst

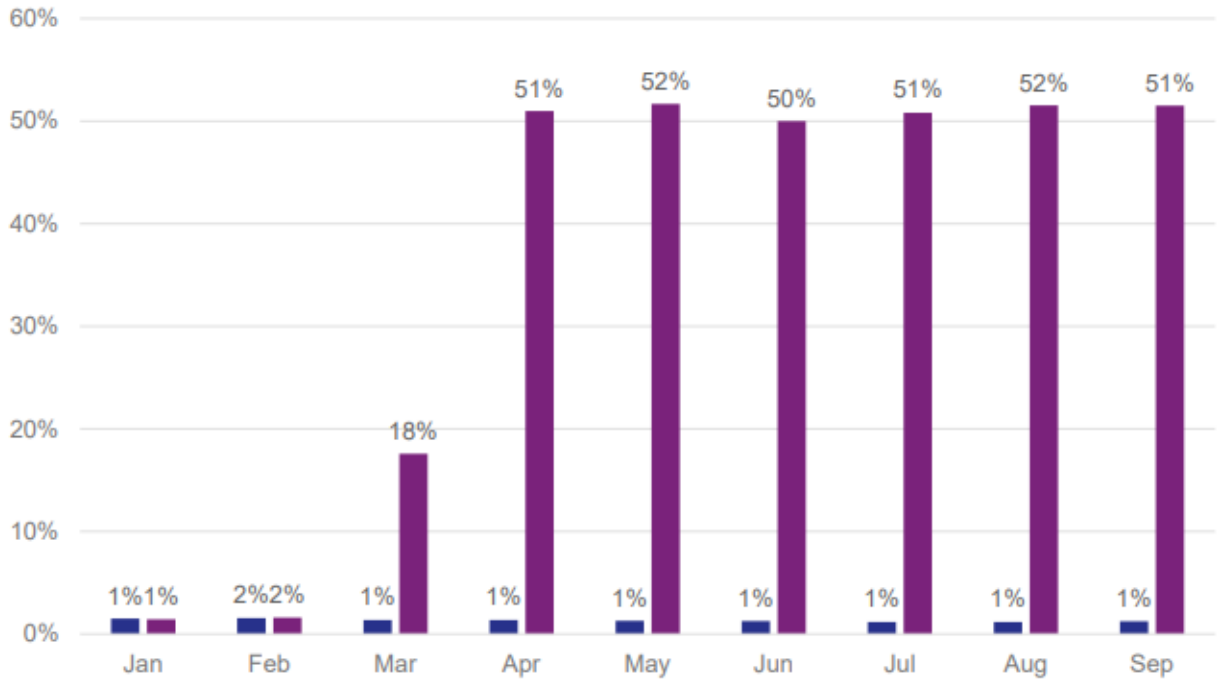
Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst

A. ACCESS TO BEHAVIORAL HEALTH SERVICES, INCLUDING TELEHEALTH

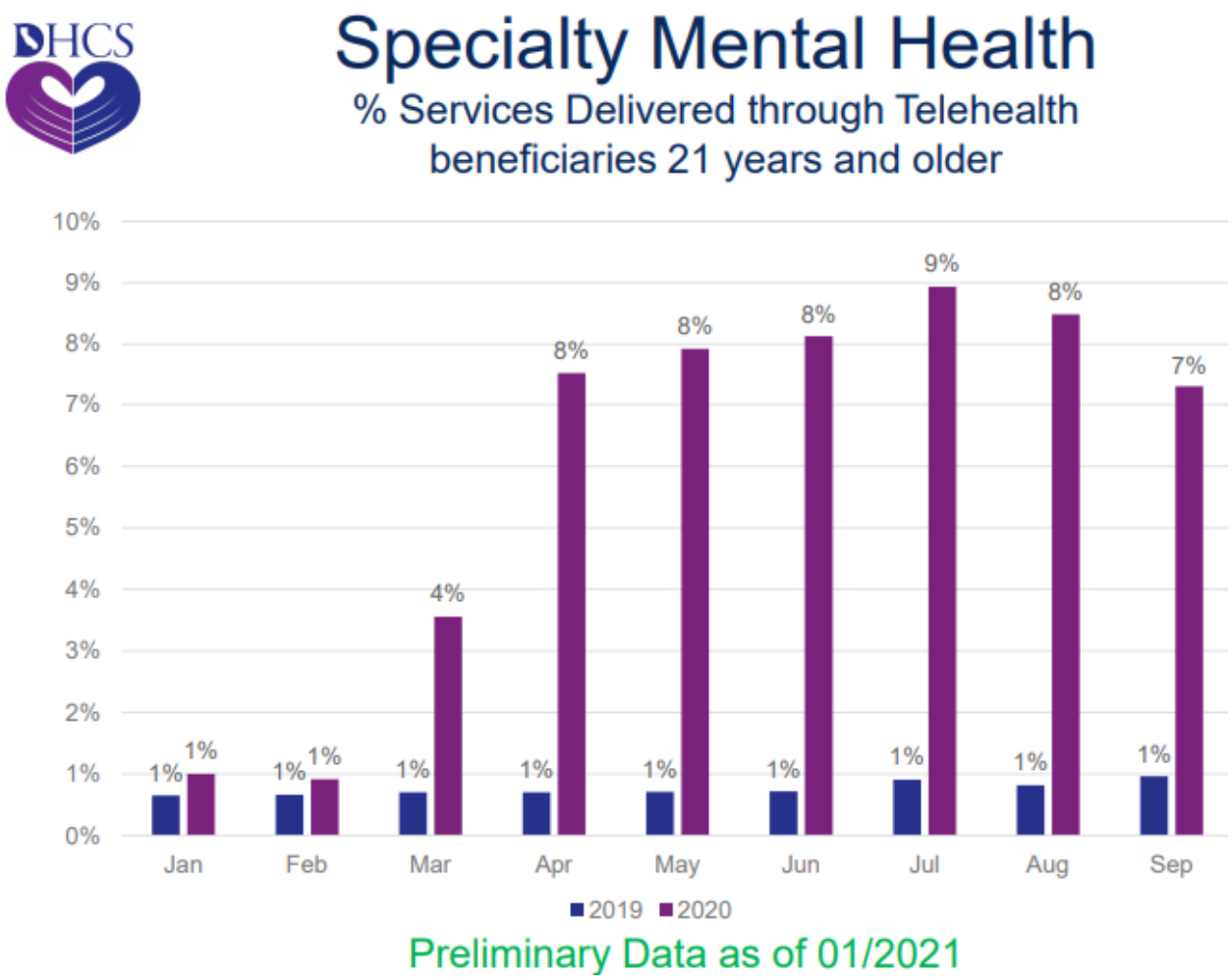
DHCS was able to significantly increase access to telehealth on a short-term (emergency) basis during the pandemic. The budget also includes proposed trailer bill to extend some of these new telehealth flexibilities. Telehealth will be discussed in more detail at the Subcommittee's hearing on March 8th, as well as at an Assembly Health Committee informational hearing on Tuesday, February 23rd. Here, the focus is on the specific value of telehealth to behavioral health. The charts below show the dramatic increase in the use of telehealth by adults for behavioral health services in 2020 as compared to 2019.

Mild to Moderate Mental Health

% Services Delivered through Telehealth
beneficiaries 21 years and older



Preliminary Data as of 01/2021



Peer Support

Last year the Legislature passed and the Governor signed SB 803 (Jim Beall, Chapter 150, Statutes of 2020), which establishes a peer support specialist certification program for behavioral health services and adds peer support services as a Medi-Cal covered benefit for counties that choose to provide this important service.

Peer support is an evidence-based, cost-effective model of care proven to reduce costly hospitalizations and homelessness, increase participation in treatment, and improve service experience. Peer support specialists, people who self-identify as having lived experience of a mental health and or substance use condition, who use their lived experience along with skills learned in formal training to assist others in their recovery from mental illness. Forty-eight states recognize their value and have a certification process in place or in development for mental health peer support specialists.

B. CALAIM BEHAVIORAL HEALTH PROPOSALS

The following are additional key CalAIM behavioral health proposals:

- Streamline behavioral health financing.
- Seek new federal funding opportunity for residential mental health services.
- Change medical necessity criteria for beneficiaries to access services.
- Implement "no wrong door" approach for children obtaining mental health services.
- Integrate county administration of specialty mental health and substance use disorder services.
- Expansion of the Drug Medi-Cal Organized Delivery System.

C. DRUG MEDI-CAL PARITY

The budget includes $4.4 million total funds ($1.5 million General Fund) for local assistance to support work by counties to perform utilization review and quality assurance activities related to parity requirements for State Plan Drug Medi-Cal. Effective July 1, 2021, the Department will standardize and align requirements for State Plan Drug Medi-Cal services with the requirements for medical/surgical health services to ensure parity across all delivery systems.

STAFF COMMENTS

It is extremely challenging for the Legislature to understand the extent to which Californians do or do not have good access to high quality behavioral health services. It would be very helpful to have DHCS compile information into a singular report that shows how access and network adequacy are monitored and assessed, both for managed care plans as well as Specialty Mental Health provided by counties.

Staff Recommendation: Recommend the Subcommittee: 1) consider adoption of supplemental report language that requests DHCS to propose potential new models for communicating data on access to behavioral health services to the Legislature; 2) attend the joint hearings with Assembly Health Committee on CalAIM on March 9th and 16th in order to gain a deeper understanding of CalAIM and its potential impacts on behavioral health and on Medi-Cal in General.

NON-PRESENTATION ITEMS

The Subcommittee does not plan to have a presentation of the items in this section of the agenda, unless a Member of the Subcommittee requests that an item be heard. Nevertheless, the Subcommittee welcomes ***public comment*** on these items at the end of the hearing.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 6: BEHAVIORAL HEALTH PLAN 274 EXPANSION PROJECT BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DHCS, Community Services Division (CSD), requests two-year limited-term (LT) expenditure authority of $1,080,000 ($108,000 General Fund (GF); $972,000 Federal Fund (FF)) in fiscal year (FY) 2021-22 and in FY 2022-23 to support contract costs for the provision of technical assistance to counties during the implementation of the X12 274 Health Provider Directory (274 HPD) standard expansion to behavioral health plans (mental health plans, Drug Medi-Cal Organized Delivery System counties, and DMC State Plan counties).

The 274 HPD standard expansion is a department-wide initiative to standardize the format, content, and transmission of Medi-Cal managed care provider network data to support the alignment of data with federal requirements. The Health Provider Directory will replace the existing Network Adequacy Certification Tool (NACT) used by county behavioral health plans to submit provider data needed by DHCS for annual network monitoring and certification.

The proposed two-year contract authority is needed to support 5 IT contractor staff (one technical lead and four testing analysts) to provide technical support for implementation of the 274 HPD. The state funding match is a condition of the approved, enhanced federal funding match.

The 274 HPD Expansion Project is a department-wide initiative to standardize the format, content and transmission of Medi-Cal managed care provider network data. The 274 HPD standard is an Electronic Data Interchange (EDI) standard adopted by DHCS so that managed care provider network data is consistent, uniform, and aligns with national standards. This data national standard is HIPPA compliant and has been approved by CMS for use across DHCS programs. DHCS has implemented the 274 HPD standard for the Medi-Cal medical and dental managed care plans and is currently implementing this standard for the DHCS behavioral health managed care delivery systems, which include

the County Mental Health Plans (MHPs), the Drug Medi-Cal Organized Delivery System (DMC-ODS) plans, and the DMC State Plan counties.

DHCS has already implemented the Health Provider Directory standard expansion for Medi-Cal medical and dental managed care plans. Implementation of the expansion to Medi-Cal medical managed care plans utilized four contractor staff. The scope of the implementation effort for the Behavioral Health Provider Directory standard expansion is larger given the greater number of county behavioral health plans and the increased variation in county behavioral health plan data systems and vendors. Implementing the 274 HPD requirements is highly technical work and DHCS does not have the staff needed to develop the requirements for the behavioral health managed care delivery systems.

The 2020 Budget Act included ongoing resources to support four permanent positions (2.0 Health Program Specialists, 1.0 Research Data Specialist I, and 1.0 Research Data Specialist II) and 4.0 two-year LT positions (4.0 Research Data Specialist I) to address the increased state workload associated with the federal network adequacy certification requirements, including planning and remediation activities for the Behavioral Health Provider Directory standard expansion.

DHCS is requesting funds for contracting costs for qualified California Multiple Award Schedules (CMAS) contractors to provide four (4) user acceptance testing/data analysts and one (1) user acceptance testing/data analyst lead. Contract staff will work closely with DHCS staff to conduct user acceptance testing support and data analysis, data validation and testing, data issue resolution and data quality management support functions for the implementation of the CMS X12 274 standard for provider network data (referred to as the 274 Expansion Project).

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 7: MENTAL HEALTH SERVICES ASSISTED OUTPATIENT TREATMENT (AB 1976) BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DHCS Community Services Division (CSD) requests $288,000 General Fund in fiscal year (FY) 2021-22 and $270,000 General Fund in FY 2022-23 and in FY 2023-24. The resources are needed to implement the Assisted Outpatient Treatment (AOT) program pursuant to AB 1976 (Eggman, Chapter 140, Statutes 2020). Under existing law, DHCS is statutorily mandated to provide training and technical assistance (TTA), provide an annual data analysis, track AOT program implementation for all 58 California Counties and submit an annual legislative report.

Among significant reforms in mental health care, the Lanterman-Petris-Short (LPS) Act (Chapter 1667, Statutes of 1967) created criteria in which an individual could be committed involuntarily to a locked inpatient facility for an assessment. LPS criteria is met when an individual is deemed to be a danger to themselves, a danger to others, or gravely disabled due to a mental illness and unable to care for their own daily needs. The LPS Act was created to eliminate arbitrary hospitalizations of individuals with the goal of allowing local communities to provide mental health treatment and support to discharged patients with mental health conditions. Following the LPS Act, several state hospitals closed in 1973 to reduce the numbers of individuals housed in hospitals. Due to limited mental health funding, counties were unable to secure the resources necessary to provide adequate treatment or services within their communities. As a result, many of the individuals released from the hospitals became homeless or imprisoned with very little or no mental health treatment.

AB 1421 (Thomson, Chapter 1017, Statutes of 2002) established the AOT Demonstration Project Act of 2002, known as Laura's Law. AOT provides for court-ordered community treatment for individuals with a history of hospitalization and contact with law enforcement. Laura's Law is named after a woman who was one of three people killed in Nevada County by an individual with mental illness who was not following his prescribed mental health treatment plan. The legislation established an option for counties to utilize courts, probation and mental health systems in order to address the needs of individuals unable to participate in community mental health treatment programs without supervision. Under the LPS Act, the Welfare and Institutions Code (WIC) sections 5346-5349.1 outlines the requirements for county implementation of the program, the eligibility requirements for individuals to participate, the court process to obtain court orders and the provision of services.

Participants in AOT are individuals with serious mental illness (SMI) and who are at-risk of institutionalization or would otherwise be served in an institutional setting (e.g. hospitals, jails/prisons). AOT utilizes a patient-centered approach that includes low staff to client ratios and highly trained staff to provide intensive treatment within the community. Counties work with local stakeholders during the initial stages of implementation to determine the type, intensity, and frequency standards of AOT services provided to participants within 180 days of treatment. In accordance to WIC Section 5348, all programs provide client-centered services, which are culturally, gender, and age appropriate. AOT programs offer a full array of multidisciplinary services such as substance use disorder (SUD) treatment, employment, and housing services. The AOT program includes the participant's support system and promotes whole-person wellness and recovery.

In 2008, the first AOT program was implemented in Nevada County. In 2012, program oversight was transferred from the former Department of Mental Health to DHCS and incorporated into DHCS' county Mental Health Performance Contracts (MHPCs). During this time, Nevada County operated the only AOT program until the passage of SB 585 (Steinberg, Chapter 288, Statutes of 2013), that authorized counties to utilize specified funds for Laura's Law services, as described in WIC Sections 5347 and 5348.

In recent years, DHCS has seen an incremental increase in county participation in the program. The following 20 counties have received Board of Supervisor (BOS) approval to implement Laura's Law: Alameda, Contra Costa, El Dorado, Kern, Los Angeles, Marin, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Shasta, Solano, Stanislaus, Ventura and Yolo.

With the enactment of AB 1976, all California counties are required to offer AOT services, beginning July 1, 2021. Counties that do not wish to provide AOT services can opt out of the program through the passage of a resolution, adopted by the Board of Supervisors, that identifies the reasons for opting out and any facts or circumstances used in making that decision. Participating counties may now offer AOT services either independently, or in partnership with neighboring counties. Counties choosing to implement AOT in collaboration with other counties are required, under this law, to execute a memorandum of understanding (MOU), as specified.

DHCS is the state department solely responsible reporting AOT data outcomes, evaluating program efficacy and monitoring the funding requirements related to AOT services. These activities will include, but are not limited to: the development and implementation of an internal standardized data collection process for all participating counties, statewide data extraction and analysis, reviewing each counties' MHPC, individualized and statewide technical assistance and training, and stakeholder engagement.

Pursuant to WIC Section 5348, effectiveness of AOT programs is evaluated by determining whether persons served by these programs:

- Maintain housing and contact with treatment;
- Have reduced or avoided hospitalizations; and
- Have reduced involvement with local law enforcement and the extent to which incarceration was reduced or avoided.

To the extent data is provided by participating counties, DHCS must also report on the following:

- Adherence to prescribed medication;
- Participation in employment and/or education services;
- Victimization;
- Incidents of violent behavior;
- Substance use;
- Type, intensity and frequency of treatment;
- Other indicators of successful engagement;
- Required enforcement mechanisms;
- Improved level of social functioning;
- Improved independent living skills; and,
- Satisfaction with program services.

In the 2018-2019 annual report to the Legislature and Governor, DHCS reported 914 individuals were referred to AOT and served. Seventy five percent, 686 participants, responded to the initial invitation to voluntary services, and did not require a court petition or process. The remaining 228 individuals entered AOT as a result of court orders or settlements. The aggregate outcomes for court-involved participants are reflected below.

- Homelessness decreased by 30 percent;
- Hospitalization decreased by 33 percent;
- Contact with law enforcement decreased by 43 percent;
- Some individuals were able to secure employment or obtain volunteer positions;
- Victimization was reduced by 85 percent;
- Violent behavior decreased by 64 percent;
- Clients presenting with a co-occurring mental health and substance use disorder reduced substance use by 34 percent;
- Most counties reported improvements in clients social functioning and independent living skills; and,
- Client and family satisfaction surveys indicated satisfaction with AOT services.

Current data suggests that there are several benefits of AOT program participation. Prior to AOT, an individual with SMI may have experienced mental health treatment in an institution or hospital. Upon entering the AOT program, many clients have reported forming relationships with support staff and receiving intensive services outside of a locked setting. Several counties have noted an increase in crisis interventions, as opposed to psychiatric hospitalizations of participants. The overall reduction of reoccurring hospitalizations and incarceration of individuals with SMI receiving AOT services has been consistently reported to DHCS. In turn, counties have noted substantial monthly reductions in cost of acute hospitalizations and incarcerations.

As a result of the COVID-19 pandemic, physical and behavioral health issues have increased. Social distancing in particular has proven to have a negative impact on the mental health of many Californians. The Center for Disease Control and Prevention has reported a national increase in social ideation, anxiety and depression. According to the article, “The impact of COVID-19 on individuals living with Serious Mental Illness, “social distancing can make individuals with SMI experience significant emotional distress, and relapse of psychotic symptoms, resulting in increased risk of re-hospitalization in this population.” In addition, many individuals with SMI have experienced a disruption of services or inability to access care during COVID-19. DHCS anticipates that AOT programs will experience increases of individuals in need of treatment in the foreseeable future.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 8: SUBSTANCE USE DISORDER RECOVERY RESIDENCES (SB 406) BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DHCS requests 4.0 permanent positions and $594,000 General Fund in fiscal year (FY) 2021-22 and $558,000 General Fund in FY 2022-23 and ongoing to implement SB 406 (Pan, Chapter 302, Statutes of 2020) by taking action on complaints against disclosed recovery residences, associated with a licensed residential substance use disorder treatment facility or certified program, that provide licensable services without first obtaining licensure or certification from DHCS.

With the enactment of SB 406, DHCS will provide oversight to enforce the provisions of this bill and take action against on a complaint against a recovery home that has been disclosed to be owned or controlled by a DHCS licensed or certified facility, or for which the licensed or certified facility has a financial interest. In addition, SB 406 requires DHCS to develop and implement regulations, monitoring protocols, and compliance reviews and investigate complaints, and also authorizes DHCS to refer a substantiated complaint against a recovery residence to other enforcement entities as deemed appropriate under state and federal law.

DHCS has the sole authority to license, certify, and monitor alcohol and other drug (AOD) treatment facilities to ensure the health and safety of program clients pursuant to Health and Safety Code (HSC) Division 10.5, Chapter 7.5, §11834.01 and §11834.30. DHCS is responsible for all activities associated with facility licensure and/or certification, compliance with statutory and regulatory requirements, and client-related health and safety issues. These activities include, but are not limited to, initial facility application and on-site reviews, renewal processes, on-site monitoring compliance reviews, and complaint investigations of facilities and counselors.

Recovery residences are alcohol and drug-free living environments that promote recovery from alcohol and other drug use and associated problems. They are commonly used to help individuals transition from the structure of licensed residential treatment facilities to a less restrictive everyday living environment. Recovery residences do not provide treatment services, and therefore, are not regulated by DHCS or any other government entity. Oversight of recovery residences is peer-based within the home (residents are self-monitoring or accountable to each other) or provided by a senior resident, house manager, or staff member. Structure is often implemented in the form of weekly meetings, house rules or standards.

Licensed residential substance use disorder (SUD) treatment facilities provide services to individuals who are recovering from problems related to SUD misuse or abuse. Licensure is required when one or more of the following treatments services is provided: incidental medical services, detoxification, individual sessions, group sessions, educational sessions, or SUD treatment or recovery planning. These services can be provided by a variety of health care providers including alcohol and drug counselors, mental health therapists, social workers, psychologists, nurses, and physicians. Currently, there are over 1,600 licensed and/or certified residential and outpatient programs that require monitoring and guidance. Upon the implementation of SB 406, there is an increased level of monitoring and oversight and includes a level of compliance review that was not previously required.

In recent years, drug and alcohol use has garnered national attention with drug overdoses increasing nationwide and that has demonstrated an increased demand for residential treatment services. With the nationwide rise in the opioid epidemic coupled with the behavioral health impacts of the COVID19 pandemic, the need for SUD treatment services is at an all-time high.

Prior to the chaptering of Health and Safety Code (HSC) Section 11833.05(d), there have been reports of unlicensed residential treatment facilities operating in violation of licensing regulations. This practice can place clients in harm as there is no direct oversight or approval of the level of care occurring in the facility. Unlicensed treatment services are dangerous and sometimes result in a client overdose or death, especially if the detoxification period is not closely monitored and managed. In addition, providing unlicensed and non-evidence-based services can be damaging to individuals seeking treatment services and can derail sobriety, especially if incorrect information is shared by unlicensed counselors (commonly, these sober living home staff insist that use of medications for addiction and/or mental health conditions means the patient is not “sober,” which has led to client deaths from discontinuing life-saving medication treatments). Individuals with SUD are very vulnerable during the engagement and retention phases of their recovery and should not be subjected to inaccurate information. In addition, some treatment facilities affiliate with recovery residences to commit insurance fraud through inappropriate billing for residential treatment services.

Within the last three years, DHCS has started receiving increasing numbers of complaints with allegations specific to issues of the illegal practice of clients receiving licensable treatment services in unlicensed settings such as recovery residences. Following the chaptering of SB 406, DHCS anticipates a significant increase in complaints related to the issues described above, both related to unlicensed services and fraudulent billing.

SB 406 provides DHCS the authority to investigate allegations of unlicensed services conducted by a recovery residence facility when it is associated with a facility licensed or certified by DHCS. Some of these allegations are founded, and DHCS’s investigations

can prevent harm or client deaths. Sometimes these allegations are unfounded, since stigma is still quite common relating to people with SUDs and the provision of SUD treatment. Currently, DHCS receives many complaints against recovery residences with allegations that those facilities are operating illegally in an attempt by neighbors to remove people in recovery from neighborhoods (commonly framed as "not in my backyard"). The publicity around SB 406 and the prominent national discussion about SUD treatment is likely to lead to increased attention to good facilities operating in residential neighborhoods, as well as to facilities operating illegally. DHCS is the sole authority for investigating allegations of unlicensed treatment; however, there is no still governmental oversight of recovery residences. If a complaint is received that a facility is operating as unlicensed facility, even if it is a recovery residence, DHCS would still be required to conduct an investigation. The chaptering of SB 406 will increase DHCS' unlicensed facilities complaints and investigations.

If DHCS determines, as the result of its investigation, that an unlicensed facility is operating in violation of the law, DHCS serves the unlicensed provider with a notice notifying the operator of the facility that the facility is operating without a required DHCS license. DHCS also orders the operator of the unlicensed facility to cease operation immediately upon receipt of the notice and requests, within fifteen days of receipt of the notice, a response in writing that the facility has ceased providing all alcoholism or drug abuse recovery or treatment services. If the unlicensed facility fails to cease operation immediately upon receipt of the notice of operation in violation of law or fails to notify DHCS of such cessation within the required timeframe, on the 16th day DHCS begins the assessment of a civil penalty of $2,000 dollars per day. The civil penalty will continue to accrue against the operator of the unlicensed facility until the unlicensed facility operations have ceased and DHCS has been properly notified.

DHCS' Licensing and Certification Division has two sections, the Licensing and Certification Section and the Complaints Section, which are responsible for ensuring the compliance of SUD licensed or certified program laws, regulations and standards. The Licensing and Certification Section currently has 27 analysts and the Complaints Section has 20 analysts.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 9: DELAYED SUSPENSION OF MEDI-CAL POSTPARTUM CARE EXTENSION TRAILER BILL

BACKGROUND

DHCS proposes trailer bill to delay the potential suspension of Medi-Cal postpartum extended eligibility by 12 months to December 31, 2022.

The administration provided the following information:
Pursuant to federal requirements, the Medi-Cal Program offers eligible beneficiaries coverage for pregnancy and pregnancy-related services as well as postpartum care. Services include prenatal care, labor, delivery, care after delivery, family planning services, care related to pregnancy loss and services for conditions that might complicate the pregnancy. Additionally, mental health services are also included in the coverage. Previously, due to income limitations and other eligibility factors, postpartum care would terminate 60 days after the last day of pregnancy.

SB 104 (Committee on Budget and Fiscal Review, Chapter 67, Statutes of 2019) extended Medi-Cal postpartum care for up to 12 months after the last day of the pregnancy to an eligible individual who is receiving pregnancy-related services and is diagnosed with a mental health condition.

Existing state law requires the expansion of provisional postpartum care to be suspended on December 31, 2021, unless the estimates of General Fund revenues and expenditures exceed the projected annual General Fund expenditures in the 2021–22 fiscal year and the 2022–23 fiscal year by the sum total of the General Fund money appropriated for all programs suspended pursuant to the 2019 Budget Act.

Specifically, DHCS proposes to amend the Welfare and Institutions Code section 14005.18 to extend the expansion of the provisional postpartum care from December 31, 2021 to December 31, 2022.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 10: MEDI-CAL SCREENING FOR MISUSE OF OPIOIDS AND OTHER DRUGS TRAILER BILL

BACKGROUND

DHCS proposes trailer bill to repeal the section for Medi-Cal adult primary care screenings, brief intervention, and referral for treatments of misuse of opioids and other drugs and associated December 31, 2021 suspension date because it is a federally required Medicaid State Plan benefit for all adults as of June of 2020.

The administration provided the following information:
Pursuant to federal requirements, the Medi-Cal Program covers all preventive services consistent with the following: 1) United States Preventive Services Task Force (USPSTF) Grade A and B recommendations, as well as Advisory Committee on Immunization Practices (ACIP) recommended vaccines; 2) preventive care and screening for infants, children, and adults recommended by Health Resources and Services Administration's (HRSA) Bright Futures program/project, including conducting an assessment of children aged 11 and over at well-child visits for tobacco, alcohol and drugs; and 3) additional preventive services for women as recommended by the Institute of Medicine (IOM). Since 1996, the USPSTF assigned a Grade B recommendation for Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care, and recommends that clinicians screen adults ages 18 years or older for alcohol misuse and provide adults ages 18 years or older engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

SB 78 (Committee on Budget and Fiscal Review, Chapter 38, Statutes of 2019) required DHCS to expand the Medi-Cal benefit for adult Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care to include screening for misuse of opioids and other drugs, in order to strengthen linkages and referral pathways between primary care and specialty substance use disorder treatment. The expanded benefit is subject to suspension on December 31, 2021.

In June of 2020, the Medi-Cal benefit to screen for misuse of opioids and other drugs was assigned a Grade B recommendation by the USPSTF, making it a required Medicaid State Plan benefit for all adults. To align with the new federal requirement, the proposed statutory changes repeal the department's obligation to seek federal approval to expand the Medi-Cal benefit for adult Alcohol Misuse Screening and Behavioral Counseling Interventions in Primary Care to include screening for misuse of opioids and other drugs and the existing suspension date. Specifically, DHCS proposes to repeal Welfare and Institutions Code section 14021.37, which would be effective July 1, 2021.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 11: MENTAL HEALTH SERVICES ACT FLEXIBILITIES TRAILER BILL

BACKGROUND

DHCS proposes trailer bill to extend certain temporary adjustments to the Mental Health Services Act (MHSA) through June 30, 2022 to increase funding flexibility for counties to respond to the COVID-19 public health emergency.

The administration provided the following information:
The MHSA was enacted by California voters in 2004, which established a one percent income tax on personal income in excess of $1 million per year to expand and transform California's mental health system of care for those with a mental illness and their families. The MHSA addresses a broad continuum of prevention, early intervention, and treatment service needs, as well as the necessary infrastructure, technology and training elements that effectively support the system. MHSA funds are distributed to counties by the State Controller's Office on a monthly basis for the five funding components, which are: Prevention and Early Intervention (PEI), Community Services and Supports (CSS), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technology Needs (CFTN).

As part of the 2020 Budget Act, AB 81 (Budget Committee, Chapter 13, Statutes of 2020) was enacted to allow specified temporary flexibilities for counties with respect to the MHSA requirements due to the COVID-19 public health emergency. Specifically, AB 81:

- Authorizes counties to spend down their local MHSA prudent reserves, as opposed to submitting a request to DHCS as required through regulation (Welfare and Institutions Code (WIC) Section 5847(i)).

- Authorizes counties to spend funds within CSS program component regardless of category restrictions to meet local needs (WIC Section 5892(b)(3)).

- Authorizes counties to use their existing approved Three-Year Plan or Annual Update to expend local MHSA funds through 2020-21, if a county behavioral health director certifies to DHCS that they were unable to submit their new Three-Year Plan due to COVID-19-related reasons (WIC Section 5847(h)(1)).

- Extends the reversion deadline for unspent county funds subject to reversion as of July 1, 2019, and July 1, 2020, to July 1, 2021 (WIC Section 5892(i)).

- Authorizes DHCS to implement, interpret, or make specific the temporary flexibilities provided during the PHE by means of all-county letters or other instructions without taking further regulatory action (WIC Section 5847(j)).

As the public health emergency continues, counties continue to provide urgently needed mental health services at the same level or above to meet demand, especially outreach and engagement services not covered by other funding sources. In order to support these efforts to help meet local needs, DHCS proposes to extend the current flexibilities (as outlined above) for an additional year, *with the exception of the reversion period*. DHCS' proposal also includes uncodified language that would declare that the proposal is in furtherance of the MHSA and make the provisions of the proposal severable.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 12: INCREASED COURT APPEARANCES AND PUBLIC RECORDS ACT REQUESTS BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DSH requests $777,000 General Fund in Fiscal Year (FY) 2021-22 and in FY 2022-23 to support 5.5 two-year limited term (LT) positions for the Legal Division (LD) to address the sustained increase in workload of court hearings at which DSH attorneys are required to appear throughout the state and the sustained increase in workload of Public Records Act (PRA) requests to which DSH must respond.

Starting in 2014, the number of persons found incompetent to stand trial (IST) under Penal Code section 1370 and committed by the courts throughout the State to be admitted to DSH or its contracted Jail Based Competency Treatment (JBCT) programs to receive competency treatment began to increase. Since 2014, the number of IST referrals exceedingly outpaces the number of DSH, JBCT or other contracted beds available for these patients, generating a waitlist for admission.

Figure 1: IST Waitlist

YEAR	# OF PATIENTS WAITING FOR ADMISSION TO DSH HOSPITALS OR JBCT	YEARLY WAITLIST INCREASE
2014	371 – as of 7/7/14	N/A
2015	340 – as of 7/6/15	- 8%
2016	463 – as of 7/4/16	36%
2017	528 – as of 7/3/17	14%
2018	836 – as of 7/2/18	58%
2019	854 – as of 7/1/19	2%
2020	1204 -as of 7/6/20*	41%
TOTAL INCREASE FROM 2014 TO 2020	**833**	**225%**

* This increase in referrals is a result of DSH's 60-day suspension of admissions of IST patients due to COVID-19 as described below.

As a result of the increasing IST waitlist, DSH began experiencing a shortage of beds. DSH statutorily must provide reports to the committing criminal court within 90 days of a patient's commitment order, advising the court whether it is likely or not that a patient will regain competency, so they can be returned to court and stand trial, or if the court should order continued competency treatment. As the IST waitlist has continued to grow, the timelines for admission to DSH have significantly increased, with many patients not being admitted for competency treatment until shortly before the statutorily-required 90-day report, or later. Consequently, the superior courts have questioned the amount of time ISTs wait in county jail before they are admitted to DSH to receive competency restoration treatment and returned to trial.

On March 4, 2020, the Governor issued a proclamation of a State of Emergency due to the outbreak of COVID-19. On March 21, 2020, the Governor issued Executive Order N-35-20 authorizing the Director of DSH to waive statutes that affected the execution of laws related to the care, custody, and treatment of persons with mental illness committed to DSH. On March 23, 2020, the DSH Director suspended admissions and discharges of almost all patients, including ISTs to its facilities to prevent the introduction of COVID19 in to DSH's 5 hospitals. During the first 30-day suspension, DSH implemented CDC and California Department of Public Health (CDPH) recommended infection control measures across its system to help reduce the risks of COVID-19 for patients and employees. DSH extended this suspension of admissions and discharges of IST patients for another 30 days until allowing it to expire on May 22, 2020. During this next 30 day period, DSH consulted the CDPH Healthcare Acquired Infections group, to develop an admissions process that would help reduce introduction of COVID-19 during the process of admitting patients to its hospitals. DSH now only admits smaller groupings of patients in a cohort fashion to an observation unit, where they are serially tested before being released to a housing unit, so as to limit the possibility of a newly admitted patient being COVID positive and spreading the infection to others throughout the hospital. This cohorting process has increased the number of days defendants wait in jail before being admitted to a hospital which in turn has and will continue to result in an increase in the number of Orders to Show Cause (OSC) set by the courts.

As a result of the ongoing and growing waitlist of IST patients, DSH has experienced a significant amount of litigation including:

- The county public defenders filing motions seeking OSCs why DSH should not be held in contempt for not timely admitting the IST patients, and seeking sanctions against DSH;
- The county public defenders filing motions under Code of Civil Procedure section 177.5 seeking sanctions against DSH for not complying with the superior court orders to admit these patients by a date specified;
- Superior courts issuing OSCs seeking to sanction DSH for not timely admitting IST patients or violating court orders to admit patients;
- The courts setting status conferences, with mandatory appearances by DSH, to explain why the patients have not been transported, or admitted to its hospitals, or considering whether to hold DSH in contempt;
- County public defenders filing motions seeking standing orders requiring that DSH admit Defendants by a specified time-frame (for example, order requiring patients be admitted within 60 days of commitment in Contra Costa County under In Re Loveton (2016), 244 Cal.App.4th 1025);
- County public defenders filing writs of habeas corpus, writs seeking release of Defendants held in jail awaiting admission to DSH, and writs of mandate requiring DSH to comply with various specified time-frames for patient admissions; and

- The ACLU and private law-firms filing state and federal civil-rights cases seeking injunctive relief and damages for alleged violations of IST defendants' constitutional rights.

DSH attorneys must respond, object, appear, or serve as staff counsel to represent DSH in each of these types of motions, status conferences, OSCs, standing-order requests, writs, and civil-rights litigation. The courts oftentimes provide DSH less than one-week notice that they must appear to defend DSH against an OSC, and it is not uncommon for DSH to be provided only 24 or 48-hour notice of a contempt hearing. DSH attorneys are required to constantly be ready to travel on short notice anywhere from two to four hours away to appear on DSH's behalf in county superior courts, to advocate against findings of contempt or sanctions.

Initially, the Health, Education, and Welfare (HEW) Section of the Attorney Generals' Office (AGO) represented DSH in all OSCs. In 2009, HEW advised DSH that it could no longer appear at all OSCs, due to the increasing number of hearings. DSH and AGO agreed that for OSCs and status conferences, DSH attorneys would make the appearances, and that for more complex or contentious appearances, including OSC evidentiary hearings, AGO would appear on DSH's behalf with LD staff counsel assistance.

DSH attorneys have worked on dozens of such OSC evidentiary hearings with the AGO related to IST admissions or the on-going complex litigation previously described, in addition to appearing in the other OSC appearances identified. The legal landscape of IST-related litigation is fast-paced, complex, and spans almost every county superior court, several district courts of appeal, and federal court, under a variety of different causes of action and legal theories.

Prior to the increase in hearings, LD already represented DSH in due process hearings before Administrative Law Judges and in superior courts for patients needing the administration of involuntary medications or treatment, besides its routine in-house counsel work. In 2014, LD also began petitioning and appearing in proceedings for patients found unlikely to be restored to competency needing conservatorship. With the additional assumption of court appearances on IST OSCs, the attorneys' workload steadily increased, without any increased positions dedicated to performing this work.

Prior to receiving position authority in FY19-20 for 3 two-year limited term attorney positions, DSH's staff of 25 staff attorneys were unable to manage the accelerating number of court appearances. However, Superior Court judges continue to order DSH's attorneys to appear to show cause as to why DSH should not be held in contempt due to the waitlist of patients needing admission to the hospitals for competency treatment. This work is unique to DSH as few, if any, departments require its attorneys to appear in

superior court in 58 counties throughout the state to defend its interests. Without any increase in positions dedicated to this work until the 2019 Budget Act, DSH attorneys were required to appear in a steadily increasing number of court matters as detailed below in Figure 2:

Figure 2: Number of Matters Appeared in Per Year

YEAR	# OF MATTERS APPEARED IN
2014	1,730
2015	1,871
2016	3,117
2017	3,614
2018	3,972
2019	2,112

The 2018 appearance rate more than doubled 2015's monthly average. The data demonstrates that each of LD's attorneys appeared, on average, in 74 matters per year in 2016, in 172 matters per year in 2017, and in 158 matters per year in 2018.

Beginning in 2019, the Los Angeles County Superior Court Mental Health Court discontinued its practice of ordering DSH to appear in court to show cause as to why it should not be held in contempt due to the waitlist of patients needing admission to the hospitals for competency treatment. At that time, the Court had previously issued four rulings imposing monetary sanctions against DSH for delayed admissions of IST patients. DSH appealed all four rulings. Due to the pending legal question before the Second District Court of Appeals, the Los Angeles County Superior Court chose to forgo further OSCs while this issue was under appellate review in late 2018 throughout 2019. On March 4, 2020, the Second District Court of Appeals issued its ruling upholding all the lower court's rulings sanctioning DSH.

As a result of this temporary reduction in OSCs by Los Angeles County while the underlying legal questions were on appeal, DSH saw its OSC workload momentarily decrease. In the six-month timeframe from October 1, 2017 to March 31, 2018, DSH appeared in 758 OSC matters in Los Angeles County as compared to appearing in only 161 OSC matters in Los Angeles County in the corresponding six-month timeframe from October 1, 2018 to March 31, 2019. However, as a result of the March 4, 2020 Appellate Court ruling upholding the Los Angeles County Superior Court's sanctions orders, the resumption of DSHs admission of IST patients at the end of May 2020 following a 60-day suspension due to COVID-19, as well as the resumption of trial court proceedings in criminal matters after a temporary suspension due to COVID-19, LD anticipates a return to the sustained high workload requirements for its attorneys to appear in OSC hearings in Los Angeles County Superior Courts.

In September 2016, the Contra Costa County Superior Court began issuing OSCs at the request of the Contra Costa County Public Defender's Office, seeking sanctions against DSH, pursuant to Code of Civil Procedure (CCP) section 177.5, for violation of the 60-day admission from commitment standing order following the decision in In re Loveton. Specifically, the Public Defender's Office sought sanctions for each day DSH was in the violation of the Loveton order when IST defendants were not admitted to a DSH facility within 60 days from an IST defendant's date of commitment, with a statutory limit of a $1,500 sanction per defendant.

As a result of the OSCs, DSH appeared numerous times to contest the imposition of sanctions pursuant to CCP 177.5, arguing that DSH was not a party to the criminal proceeding. The Court denied DSH's request for an evidentiary hearing and imposed sanctions for 12 defendants, totaling $16,500.

DSH appealed the sanctions orders to the California Court of Appeal, First Appellate District regarding the lack of due process to DSH resulting from the Court's denial of an evidentiary hearing and the applicability of using CCP 177.5 to sanction DSH, a non-party to the criminal proceedings.

After briefing and oral argument on September 30, 2019, the Court of Appeal affirmed the lower Court's imposition of sanctions as to all but one defendant, thereby reducing the total sanctions to $15,000 for 10 defendants. The Court upheld the use of CCP 177.5 to impose sanctions on DSH, a non-party. As a result of this additional recent ruling, LD anticipates a continuation of the sustained workload requirements related to OSCs.

Since this resumption of IST patient admissions in late May 2020 following the 60-day suspension due to COVID-19, courts and Public Defenders across the state have increased their inquiries to DSH as to when IST defendants are going to be admitted, either through email inquiries or by Public Defender's requesting courts issue OSCs. As the wait time for admission for IST defendants to a DSH facility lengthens to support safe admission protocols, Public Defenders and courts are already, and will likely increasingly issue OSCs to pressure faster admissions, despite the public health risks of doing so. For example, upon the Yolo County Public Defender's request the court issued OSCs seeking to hold DSH's Director personally in contempt for not admitting IST defendants within 60-days of commitment. Similarly, DSH is currently responding to six OSCs in Santa Barbara County regarding wait times for admission of IST defendants to DSH. DSH LD sees the total number of OSCs, and the number of counties issuing OSCs, continuing to grow as the COVID-19 pandemic has no clear end in sight.

Recently, a handful of courts throughout the state have also issued OSCs against DSH in regard to wait times for Sexually Violent Predators. Public Defenders have also filed writs of habeas corpus seeking release of Defendants found Not Guilty by Reason of Insanity (NGI) for wait times related to their delayed admissions. As the COVID-19

pandemic continues to require DSH cohort patient admissions in a limited fashion to keep patients and staff safe, the number of OSCs and writs regarding wait times for these additional commitments will likely increase across the state, necessitating DSH LD respond and appear for these court appearances.

As such, LD anticipates that in the coming year, the average number of attorney appearances will likely resume or sustain at the prior high workload levels of 2018. If LD is not able to retain the 5.5 positions authorized to perform this work, it will force DSH attorneys to forgo their other work in order to appear when ordered.

Amplifying the workload of attorney appearances in OSCs is the fact that many of the superior courts require in-person appearances, usually at long distances from LD's office in Sacramento. Until 2018, all LD attorneys were based in Sacramento. In December 2018, LD established an office at DSH-Metropolitan in Norwalk, and over time, moved three Attorney positions and one Assistant Chief Counsel (ACC) position from Sacramento to reduce the time spent traveling to Southern California for court appearances. By successfully opening the Southern California office, this effectively mitigated LD's travel costs and reduced the time attorneys spend traveling.

To more accurately reflect the time attorneys spend traveling to hearings, LD implemented a system to track such time beginning in January 2019. This tracking does not account for the time spent by attorneys and support staff reviewing the OSCs, researching the facts relevant to each patient to draft a response, preparing responses and declarations to OSCs, corresponding with our clients, or filing the responses. Nor does it include the time spent serving as staff counsel assisting the Attorney General's Office in preparing for those OSCs that go to an evidentiary hearing, for an appeal, civil litigation cases involving the IST waitlist, or the travel associated with attending proceedings alongside the Attorney General's Office as staff counsel.

The burden placed on LD attorneys of spending almost three working days per month traveling has also created a retention issue, with several knowledgeable and experienced attorneys seeking positions with other departments that require less travel. During COVID-19 many courts allowed for the use of video appearances by DSH attorneys which helped ease the travel burden. However, now that many courts have resumed regular court proceedings, we anticipate resumption of the requirements that DSH attorneys appear in-person.

DSH has made great efforts to address the IST waitlist, including adding more than 1,000 beds to its hospitals, and contracted programs since 2012-2013, as well as receiving $120 million in additional funding in the Governor's 2018-2019 budget to develop and implement programs targeted at addressing the IST patient population, including IST diversion and community-based IST restoration. However, to date, these undertakings have only been able to partially offset the increase in IST referrals and a doubling of the

waitlist. As such, LD must continue to defend DSH in superior courts throughout the state and advocate that DSH is committed to the timely treatment of all patients, and should not be held in contempt, nor sanctioned for its waitlist.

Similarly, without any increase in positions dedicated to this workload until the 2018-2019 limited term positions, the workload associated with responding to PRA requests remains at levels significantly above that of 2012 as demonstrated by Figure 6 below:

Figure 6: Number of PRA Requests Received Per Year

YEAR	# OF PRA REQUESTS	YEARLY INCREASE
2012	171	N/A
2013	191	12%
2014	239	25%
2015	226	-5%
2016	239	5%
2017	255	7%
2018	503	97%
2019	319	-36%
2020	220 as of 5/31/2020 528 - PROJECTED	65%

The highest percentage of PRA requests (28% of requests received in 2019 and 30% of requests received for the first five months of 2020) were seeking more complex series of documents such as e-mails, costing and budgeting data, trainings, meeting minutes, facility memos, plans, studies, protocols, audits, grants, log books, programs, and catalogs. The second highest percentage of PRA request were for more simple information such as DSH's staff information such as staff e-mail addresses, phone numbers, positions, titles, license numbers and internet use (approximately 24% of 2019's requests) or policies and procedures (27% of 2020's requests received so far). A smaller percentage request readily available information such as DSH's contracts (approximately 19% of 2019's requests), or statistical information such as bed counts, patient counts, census, or specific data points such as the number of patients or employees found with contraband (approximately 16% of 2019's requests).

The other way PRA requests have evolved is that DSH patients, especially those from DSH-Coalinga, continue to file voluminous requests seeking a variety of records including various hospital records, meeting minutes, e-mails, logs, policies, procedures, work orders, etc. DSH-Coalinga patients constitute the overwhelming majority of patient-generated PRA requests. Of the 320 PRA requests received for 2019, 43% of them requested records from DSH-Coalinga, compared to less than 15% of the requests requiring records from each of the other 4 hospitals, with that number increasing to 55% seeking DSH-Coalinga records for the first five months of 2020 as compared to less than 6% requiring records from each of the other four hospitals.

The LD AGPA who handles these requests used to have anywhere between 5 to 15 requests open at one time and could closely monitor each one. Now, LD has 52 open requests, and without extending these resources, will be unable to continue to meet all deadlines or maintain contact with each requestor, due to the increased volume.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 13: MEDICAL AND PHARMACEUTICAL BILLING SYSTEM BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DSH requests $794,000 General Fund in Fiscal Year (FY) 2021-22 and $774,000 annually in FYs 2022-23, 2023-24 and 2024-25 to support 1.0 permanent position and contract resources equivalent to 2.0 consultants. The resources will be used to enhance system functionality for the Cost Recovery System (CRS) to capture, bill and recover eligible patient cost of care reimbursements until DSH has successfully implemented an Electronic Health Record (EHR).

CRS is housed within the Department of Developmental Services (DDS) and is the electronic billing system for DDS and DSH that is utilized for tracking, documenting, billing, and recovering funds for patient cost of care. This request will provide the necessary technical resources to allow DSH to improve the CRS functionality to increase revenue, comply with Federal and State mandates, and reduce the risk of inaccurate billing. The enhancement of the CRS system will allow DSH to bridge the gap between the current CRS limitations and the implementation of a full EHR solution scheduled for implementation in 2025, while allowing for increased revenue collection during this interim period. The proposed programming of CRS does not directly impact EHR or Pharmacy Modernization. Upon implementation, CRS will be replaced by the standard cost recovery functionality that is incorporated into the EHR System.

DDS was traditionally responsible for administering DSH's third-party billing system. In the 1980s, DDS and the then-Department of Mental Health (DMH) entered into a Memorandum of Understanding (MOU) agreement to identify its respective roles. DMH would provide administrative services regarding state hospital cost reporting, patient trust, patient billing for third party payers, conservatorship, and collection services and DDS would be responsible for developing hospital billing rates, compliance services, claims resolutions, and risk management. DMH would be responsible for the accuracy of data submitted to DDS for Medicare billing and rate development, respond timely to audit inquiries, and perform quarterly internal audits and quality control reviews of state hospital records.

Due to resource constraints, it was challenging for DDS to perform the services outlined in the MOU, and as the population served by DSH increased, DSH did not have sufficient staff to perform the functions formally performed by DDS. The MOU has since been replaced with an Inter-Agency Agreement (IAA). The IAA stipulates that DSH will reimburse DDS for California Department of Technology (CDT) data storage and Experian Health claim processing fee.

Table 1: Reimbursement Revenue, FY 2016-17 to FY 2019-20

Reimbursement Type	*FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Medicare Part A and B	$753,688	$838,397	$516,104	$471,776
Medicare Part D	$921,048	$1,091,620	$1,130,527	$1,045,330
Private Pay	$3,480,176	$2,574,851	$2,538,219	$1,741,061
**Other	$4,992	$109,204	$117,971	$47,609
Totals	**$5,159,904**	**$4,614,072**	**$4,302,821**	**$3,305,776**

* DDS received and processed DSH's reimbursement revenue for the first three months of the FY. DDS charged DSH $55,584 for this service.
** Other Reimbursement Types include reimbursements from Supplemental Medicare Insurance and excess fund payments from patient trust accounts (Welfare and Institutions Code (WIC) § 7281).

The 2014 Budget Act authorized DSH to create PCRS, which included 15.0 full-time limited term positions, to develop and implement a standardized and streamlined third-party billing system that would include accounts management, billing and collection, assets determination, policies and procedures, compliance and auditing. A third-party billing system refers to an entity performing billing services as an intermediary between two parties. PCRS acts as an intermediary to recuperate charges related to a patient's cost of care from any applicable insurance or private pay parties. All moneys collected from the established third-party billing system are remitted to the State General Fund. The intent of establishing PCRS was for DSH to assume the responsibility for all billing and collections functions previously performed by DDS through the MOE.

The 2015 Budget Act authorized the limited term positions to become permanent as of July 1, 2016. DSH continues the process of assuming the third-party billing responsibilities from DDS with the goal of maximizing revenue from Medicare, private pay, and insurance collections by providing technical assistance to the state hospitals regarding billing, Medicare compliance reviews, managing patient trust accounts, performing patient benefit and insurance enrollment, provider enrollment, asset determination, and pursuing legal efforts in private payer collections.

Due to CRS system limitations, DSH continues to see a decline in revenue. With the addition of the system programmers, DSH will be able to prioritize DSH system change requests more timely which will enable DSH to have the ability to bill for services that are not being captured or billed such as Medicare Part A, Skilled Nursing Facilities (SNF), durable medical equipment (DME), and telemedicine.

The enhancement of the CRS system will allow DSH to bridge the gap between the current CRS limitations and the implementation of a full EHR solution. The EHR project is in the planning phase and is expected to receive final approval of the Stage 2 Alternatives Analysis by the California Department of Technology (CDT) in early January2021. The current timeline anticipates submitting a draft Request for Proposal to CDT in December 2021, awarding an implementation contract in the spring of 2023, and beginning installation at all five hospitals in mid-2025. One of the critical requirements of the HER solution – and a feature that is standard in all major EHR software products – is

a comprehensive billing and cost recovery module that will replace the need for the CRS application. The new billing solution would become effective immediately upon EHR Go Live in 2025. Through the interim, the Common Business Oriented Language (COBOL) programming solution will allow for increased revenue collection while working towards addressing the CRS limitations listed below.

DSH's patient population has an added layer of complexity due to the changing legal classifications and corresponding Medicare eligibility for billing those classifications. DSH patients are more complex than typical community hospital patients due to the number of admissions, transfers, and discharges; length of stay; complicated legal requirements and forensic dispositions; and the severity of their mental disorders. CRS is currently not customized for the complex DSH patient population. Workarounds and custom programming are necessary to navigate the changing environment that DSH is faced with considering the different types of health insurances and patient eligibility. DDS' patient population varies significantly from DSH; however, the same billing system is utilized for both departments.

Inaccuracies of submitted claims may be construed as false claims. This is of significant concern as there is a large volume of claims that need to be corrected for a variety of technical errors. Claims may contain multiple errors and as of FY 2019-20 there are approximately 16,314 claims with errors.

DSH's current business environment with CRS presents challenges in developing and implementing more rigorous processes, claims resolution, and technical training for state hospital staff. PCRS staff have minimal control over CRS functionality due to no dedicated resources from DSH collaborating with DDS on CRS. Also, DDS is reducing its resident population and potential need for CRS, while DSH's patient population remains steady and dependent on CRS. DDS does not have the current resources to address all DSH requests related to CRS. The increasing DSH requests places added pressure on DDS' limited resources and hinders DSH from improving current processes. Utilizing CRS and depending on DDS (given their resource challenges) for billing impacts PCRS' ability to achieve its mission of increasing revenue in order to offset pressures to the state GF.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 14: PATIENT EDUCATION BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DSH requests 3.0 permanent positions and $352,000 General Fund in Fiscal Year (FY) 2021-22 and ongoing to expand patient education services at DSH-Coalinga. DSH's goal is to offer comparable education services for DSH-Coalinga patients as it does at its other hospitals and improve patient outcomes. Education and related services are a critical component of in-patient treatment and help patients successfully re-establish life in their community upon hospital discharge.

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 12,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily censuses of 6,143and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

DSH-Coalinga served 1,547 patients in 2018-19 and had an average daily census of 1,366 patients. This hospital serves individuals committed as Sexually Violent Predators and Offenders with Mental Health Disorders. Sexually Violent Predators (SVP) and Sexually Violent Predator Probable (SVPP) patients are committed to DSH-Coalinga after serving prison terms in California Department of Corrections and Rehabilitation. SVPs and SVPPs have an average length of stay in the state hospitals of nine years. Offenders with Mental Health Disorders treated at DSH-Coalinga have been committed to another DSH hospital following the completion of their prison term. If after their initial commitment in the state hospital and the individual's parole term is ending, if they are determined by a court to continue to require continued treatment, they may remain at the original state hospital for treatment or be transferred to DSH-Coalinga for treatment. Offenders with Mental Health Disorders have an average length of stay of four years. The average age of the patients at Coalinga is 47, however, the Coleman Unit treats patients 20 years and older.

DSH facilities, including DSH-Coalinga, provide treatment for individuals with serious mental health issues. The state hospitals serve individuals with a civil or forensic commitment and diagnosis of major mental, emotional, physical, psychological limitations

or illness. Patients in state hospitals present widely varied skills and functional cognitive abilities. Patients at DSH-Coalinga have varying educational backgrounds, such as not being able to read up to a college education. Of the 1,366 patients at DSH-Coalinga, 305 of them have some form of college level education, 279 completed up to grade 12, and 204 patients have obtained a GED. There are 578 patients that have an education that ranges between grades two thru eleven.

To help patients overcome these limitations, DSH provides educational services at their hospitals which includes the administration of Special Education, Adult Basic Education (ABE), Vocational Education (Voc Ed), and High School Equivalency (HSE) programs and courses. Section 504 of the Rehabilitation Act of 1973 requires all students admitted to a state hospital under age 22 to have a free appropriate public education offered to them if they have previously received past special education services. To remain compliant with this requirement, all newly admitted patients 22 years of age or younger are interviewed by the DSH education departments at each hospital upon admission. If students self-report that they received past special education services or it is determined by some other means (i.e., transcript confirmation) that they have received special education, DSH enrolls students in education services.

Education services for patients 22 years and older are provided in the ABE and Vocational Services programs. ABE includes educational services that teach basic literacy or to work towards their HSE. ABE also includes academic skill building and developing life skills. DSH offers the Arts in Mental Health (AIMH) program to develop their arts education through art fundamentals, theater arts, poetry/creative writing, design and illustration, and Taiko drumming. They also offer Vocational Services in a pre-vocational class or Industrial Therapy assignment. Other services offered within these programs include computer skills, occupational skills, treatment program courses, and substance recovery programs, to name a few.

DSH-Napa, DSH-Patton, DSH-Atascadero, and DSH-Metropolitan state hospitals offer the full complement of the adult education, vocational programs, High School Equivalency (HiSET), and diploma programs to their patients. Specific requirements for many of these programs are set forth in the following legislation: 1) the Federal Individuals with Disabilities Education Act (IDEA, Part B); 2) Workforce Innovation and Opportunity Act (WIOA); 3) Proposition 98 General Fund allocations per California Education Code; and 4) Code of Federal Regulation, Title 34, Section 300.32. More specifically, DSH received notice of their regular grant approval for the 2020-23 Workforce Innovation and Opportunity Act (WIOA), Title II: Adult Education and Family Literacy Act (AEFLA) to provide adult Basic Education (ABE), Vocational Adult Basic Education (learning job skills), ESL, Vocational ESL, and HiSET. This grant provides supplemental funding to participating schools. It provides funding for educational supplies, equipment and some training. It also provides the data collection software and testing materials and training through the California Adult Student Assessment System (CASAS), some professional

development and technical assistance for curriculum development. Once DSH establishes the education programs at DSH-Coalinga, they will contact the California Department of Education and request to add DSH-Coalinga to the California State School Directory at the beginning of a school year. Individual state hospital funding is based on payments points that are generated by progress made by students on the CASAS testing. Points are earned when students move up a level in testing and when they attain a high school equivalency certificate. Funding per payment point varies from year to year as it is dependent on the amount of funding Congress allocates for adult education. Generally funding per payment point is around $250-$300 for each level attained and $500 for earning a high school equivalency certificate.

DSH-Coalinga, due to limited resources, does not offer the same level of educational services to its patients as the other four hospitals. They provide hooked on phonics and college distance learning through Coastline College, but do not offer additional ABE programs similar to the other hospitals, high school equivalency programs, nor Special Education programs. With DSH planning to include DSH-Coalinga in the WIOA grant in the future, they need support and resources to match the education programs provided at the other four locations to meet requirements for funding. Most importantly, DSH-Coalinga strives to reduce recidivism rates through educational services that help patients achieve success in their communities upon discharge.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 15: PROTECTED HEALTH INFORMATION PERMANENT IMPLEMENTATION BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DSH requests $986,000 General Fund in Fiscal Year (FY) 2021-22 and FY 2022-23 to extend 8.0 limited-term positions for an additional two years. DSH has a need to continue the processing of invoices and payments from external medical providers containing Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the consolidation of DSH's financial operations into a single budget unit. This request will help DSH to more effectively process payments for outside medical services without jeopardizing access to PHI and quality patient care as well as standardizing the process for capturing medical invoice data and minimizing redundant key data entry.

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and employs nearly 12,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2019-20, DSH served 10,962 patients within state hospitals and jail-based facilities, with average daily censuses of 6,143 and 333 respectively. The CONREP program maintains an average daily census of approximately 650.

In FY 2019-20, DSH processed over 63,000 outside medical invoices and more than 80 percent of these (51,000) contained PHI. DSH patients have unique and acute medical and clinical needs that oftentimes require visits to specific external providers (i.e. specialists, emergency services, etc.). These medical providers' invoices in turn contain a combination of patient information (i.e. patient's name, patient identification number, diagnosis, medical service received, date of service, etc.) to document services rendered to DSH patients. Invoices that contain PHI are governed by mandated HIPAA requirements. Each state hospital receives direct invoices from outside medical providers for services rendered to its patients. Every invoice is adjudicated by the appropriate DSH accounting and program staff.

New electronic systems introduce the need to develop protection measures to prevent exposure of PHI, including auditing and incident response to safeguard internal controls. As noted previously, a significant portion of DSH's invoices contain confidential and sensitive information, including patient data that falls under mandated HIPAA compliance.

Security experts estimate data breach costs ranging from $150 to $350 per record. These costs include required fines that the state would pay and services for the individuals impacted that include phone service to answer questions, advertising to publicize the breach, and credit monitoring services if social security numbers (SSN) are involved. A data breach would be detrimental to those whose data is compromised and costly to the State.

In July 2018, a new statewide Accounting system called Financial Information System for California (FI$Cal) was implemented at DSH to replace the legacy system, California State Accounting and Reporting System (CalSTARS). To increase transparency of the state's financial reporting and information, the FI$Cal and State Controller's Office (SCO) implementation brought in additional processes and requirements to statewide accounting practices. The PHI solution to FI$Cal required the development of operating policies such as workflow, records retention and SCO audit procedures. During the first year of implementation SCO performed a review of each of the state hospitals outside medical invoice payment processes and determined that DSH had followed the proper program rules and guidelines for issuing payment.

However, one area of vulnerability for a security breach is processing payments for external medical providers. FI$Cal was not configured to accept PHI and given DSH's approximate annual volume of 36,000 PHI invoices, the risk of information security breaches is high. Prior to FI$Cal implementation, the California Office of Health Information Integrity (CalOHII) was a key advocate on behalf of the California Health and Human Services Agency (CHHSA) and DSH requesting an extension to implement FI$Cal since the system was not HIPAA compliant. DSH updated CalOHII while developing the Medical Claims Processing (MedCP) data base system so they were aware of home grown system that allowed for HIPAA compliancy and still used FI$Cal to create voucher payments. As such, DSH developed a HIPAA compliant process for procurement, claim adjudication, and claim payments of invoices to external providers. The MedCP data base system, developed by DSH, standardized the process of capturing medical invoice data. MedCP de-identifies PHI so payments can still occur timely, but will not include any PHI, consequently reducing DSH's risk of an information security breach. DSH includes the minimum information necessary for vendors to reconcile their invoice to the voucher and reduce the number of vendor inquiries regarding vouchers.

In addition to implementing FI$Cal (PeopleSoft Platform), DSH consolidated its organization structure shifting from six Organization Codes or Business Units (BU) to one. Historically, all DSH locations have done their own accounting and SCO reconciliation. Reports used for reconciliation purposes contained only transactions which pertained to the individual BUs. With the shift to one BU, those reconciliation tools now contain data for all six locations, which makes the accounting reconciliations much more complex and requiring more resources. Additionally, accounting data for all five facilities resides under

a single program because all facilities now fall under one program In 2018-19 DSH was authorized 8.0 three-year limited-term positions to address the increased workload associated with payment of invoices containing PHI and the increased workload associated with reconciliations.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 16: ONE-TIME DEFERRED MAINTENANCE ALLOCATION BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DSH requests one-time $15 million General Fund, available over three years (until June 30 2024), to address critical deferred maintenance, special repairs/replacement, and regulatory compliance projects at DSH's five hospitals. The planned projects include those related to fire and life safety, critical infrastructure, and any facilities modernization required to complete major repairs and systems replacements.

DSH entered into an Architecture and Engineering Retainer contract with the firm J.C. Chang to develop a comprehensive plan to address and prioritize the Department's deferred maintenance projects.

DSH has conducted a current needs identification and prioritization of all special repair (deferred maintenance) projects required to address major building repairs and site-wide infrastructure needs. Accordingly, DSH conducted an analysis of deferred maintenance projects and created a matrix of pending repair projects by category (roof repairs, duct maintenance, painting, landscaping, utility infrastructure repairs, road repairs, etc.). Each project was then assigned a criticality score based upon the hospital's assessment of the need for repair and prioritized based upon the potential impact to the hospital operations. Of this list, DSH has identified 19 critical infrastructure projects submitted for consideration herein. For reference, the 2019 Budget Act, Control Section 6.10 included $15 million General Fund, available over three years, to support deferred maintenance projects as follows:

Hospital	Allocation
DSH-Atascadero	$ 9,00,000
DSH-Coalinga	$ 200,000
DSH-Napa	$ 7,600,000
DSH-Patton	$ 6,300,000
Total	**$15,000,000**

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 17: COALINGA: HYDRONIC LOOP REPLACEMENT CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DSH requests $50,528,000 General Fund for the construction phase of the DSH-Coalinga Hydronic Loop Replacement project. This project replaces the severely corroded and deteriorated existing below-grade hydronic loop piping system with a completely new hydronic loop. The degrading pipelines are caused by the corrosive grounds. The new hydronic loop will provide a complete distribution loop, connecting to six (6) existing buildings and nine (9) existing, below-grade points of connection. The work also includes demolition, soil compaction, material testing, asphalt, welding, inspections, and all other elements to complete the project.

Total project costs are estimated at $53,735,000 including study ($120,000), preliminary plans ($993,000), working drawings ($2,094,000), and construction ($50,528,000). The construction amount includes $44,100,000 for the construction contract, $3,088,000 for contingency, $1,790,900 for architectural and engineering services, and $1,550,000 for other project costs.

The DSH-Coalinga campus is a 1.2 million gross square foot acute psychiatric hospital designed to accommodate 1,500 forensic patients. The facility opened in 2005 and is comprised of 34 buildings that are located across 320 acres. The campus was constructed with a centralized heating and cooling system with the Central Plant housing the water boiler and chillers located outside of the Secure Treatment Area (STA). From the Central Plant, the hot and chilled water is distributed via underground, direct buried pipelines, routed within the STA and branching to all individual buildings and/or building clusters, both inside and outside the STA. The hydronic loop is specific to hot water used for heating and heating hot water. Since the hospital's opening, it has experienced numerous catastrophic leaks due to extensive corrosion of the piping. DSH conducted studies of the system in 2014 and 2016 in order to evaluate the overall condition of the hydronic loop, determine the cause for the accelerated deterioration of the system, and choose appropriate replacement options. Studies included geotechnical soil testing, extensive evaluation of system components and joints by manufacturer's representatives, various engineering professional's evaluation, and collaboration with the plant engineers that operate the hydronic loop. As noted, the proposed loop replacement will be both above and below ground. Using the information from the completed studies and additional studies that are underway, the final design will best determine how to avoid corrosion issues with the required underground sections necessary for the loop to go under crossing roads and paved areas.

Corrosion under thermal insulation is a well-known and documented mode of failure in hydronic loop pipelines. The thermal insulation is jacketed with an outer layer of Polyvinyl Chloride (PVC). Once water penetrates the outer layer of PVC, it tends to penetrate the thermal insulation and stays inside the space between the carrier pipe and outer jacket, causing serious corrosion issues. This is compounded by the higher temperatures, which increases the corrosion rate. On some occasions, the corrosion is further exacerbated by the thermal insulation material that contains high levels of chlorides that leaches out and increases the corrosion rate significantly.

Additionally, corrosion continues to be exacerbated by other pipeline deficiencies. When steel is buried in a medium, such as a wet thermal insulation, the thermal insulation will be the electrolyte for the electro-chemical process. This results in the corrosion rate of steel, in an electrolyte, to normally increase as resistivity decreases. Since the pipelines are also exposed to highly corrosive soil, which was confirmed by laboratory testing, it worsens the corrosion. The Department performed a test on the thermal insulation material and found that the piping had a high chloride content in the “severely corrosive” category. Also, the hydronic loop contains controlled liquid, similar to saltwater which will continue to be lost whenever a leak occurs. The hydronic loop system has a saline solution that should remain constant within system, assuming there are no leaks.

The first leak was discovered in 2007. Since then, nine more leaks have been identified on the hydronic loop heating water system. The pipe joints on the hot water pipe appear to have flanged connections and are not coated or insulated. The accelerated deterioration of the existing system has caused unplanned maintenance and significant repairs requiring extensive excavation including digging trenches down to 20-30 feet below grade, which creates a hazardous work environment. Four additional incidents were reported with valves and fittings failures.

Relocation of patients to different buildings was required for safety and to avoid interruption of patient care. Moving patients is a complicated process which jeopardizes the safety of staff and patients, as well as use of courtyards and other treatment spaces due to increased risks and exposure to areas outside of patient housing. Repairs made using DSH staff takes the hospital staff away from regular maintenance duties. Additionally, the existing loop is not a complete loop which limits the facility’s ability to isolate the damaged portion of the loop for repairs and maintenance requiring shutdowns of the entire system. The excavation for repairs exposed the utility systems installed above the hydronic loop to damages, causing additional outages and unforeseen costs.

Given the number of failures and the risk to patient safety and care, DSH-Coalinga faces the risk of non-compliance with CMS standards. DSH-Coalinga has not received any citations to date; however, future CMS inspections may find the existing condition of the hydronic loop at critical risk of noncompliance with CMS’s operational, life, and safety standards including required patient environment of care.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 18: METROPOLITAN: CONSOLIDATION OF POLICE OPERATIONS CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DSH requests $22,024,000 for the construction phase of the consolidation of police operations at Metropolitan-SH.

The project includes construction of a new building to serve as a centralized hospital police operations center. Total project costs are estimated at $25,134,000, including preliminary plans ($1,527,000 including $200,000 moved from working drawings phase), working drawings ($1,583,000), and construction ($22,024,000). The construction amount includes $17,170,000 for the construction contract, $859,000 for contingency, $1,303,000 for architectural and engineering services, $856,000 for agency retained items, and $2,692,000 for other project costs. Construction is scheduled to begin in September of 2021 and will be completed in June of 2023.

The project includes constructing a new building to accommodate DSH-Metropolitan's Department of Police Services (DPS), Office of Special Investigations (OSI), and the Emergency Dispatch Center. These offices are currently located in the existing buildings and they have significant health and safety issues. These issues include asbestos in floor tiles and a Seismic Risk Assessment of Level V, which indicates that the building does not meet the code requirements for seismic safety for hospitals and police facilities. Additionally, the configuration of these existing buildings were not originally designed as police facilities, which impacts quality, efficiency, and security of police operations.

The current buildings do not qualify as Essential Services Buildings. California Administrative Code (2013, Title 24, Part 1, Chapter 4, Article 1, Section 4-207) defines an Essential Services Building as "any building…used or designed to be used as a fire station, police station, emergency operations center, California Highway Patrol office, sheriff's office or emergency communication dispatch center." The same section further defines police station as meaning "any building that contains the operational facilities and the alarm and communications equipment necessary to respond to police emergencies." The code dictates that such buildings must be "capable of providing essential services to the public after a disaster," and "be designed and constructed to minimize fire hazards and to resist, insofar as practical, the forces generated by earthquakes, gravity, and winds."

Both the Administration Building and the 206/208 Building house the hospital's police functions and do not meet the Essential Services Building threshold. The main hospital police and investigation center is located in Building 206/208, which is far removed from the patient population and administration and results in longer response time. Both

buildings have a lengthy list of vulnerabilities including seismic deficiencies. Consolidation of all hospital police functions into one location will provide greater efficiency of police operations. Relocating the hospital police will be advantageous because of its closer proximity to the hospital's designated Secured Treatment Area and the Administration building.

A study completed by the Intelligence Building Infrastructure Group in September 2014 evaluated how best to accomplish consolidating police operations into an Essential Services Building. Due to the limited number of buildings large enough to accommodate police operations staff and the amount of work needed to renovate an existing building to qualify as an Essential Services Building, the study concluded that new construction would be the most cost-effective way to meet the project objectives, saving five percent over renovation.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 19: STATEWIDE: ENHANCED TREATMENT UNITS CAPITAL OUTLAY BUDGET CHANGE PROPOSAL

BACKGROUND

The administration provided the following information:
DSH requests $3,792,000 for construction of Enhanced Treatment Units. The project includes renovating existing facilities at two state hospitals in order to provide 49 Enhanced Treatment Units at Atascadero state hospital and Patton state hospital. Total project costs are estimated at $22,728,000 ($929,000 for preliminary plans, $1,004,000 for working drawings, and $20,796,000 for construction). The construction amount includes $10,469,000 for the construction contract, $4,429,000 for contingency, $2,456,000 for architectural and engineering services, $3,367,000 for other project costs and $75,000 agency retained.

In accordance with AB 1340 (Achadjian, Chapter 718, Statutes of 2014), DSH is constructing ETUs at Atascadero and Patton State Hospitals that will provide a more secure environment for patients that become psychiatrically unstable, resulting in highly aggressive and dangerous behaviors. Patients in this state of psychiatric crisis require individualized and intensive treatment of their underlying mental illness, while reducing highly volatile and violent behavior. The proposed ETUs will create secure locations within the existing hospitals to provide a safe treatment environment for both staff and patients. Patients will be housed individually and provided with the heightened level of structure necessary to allow progress in their respective treatment.

The DSH patient population has shifted over the past twenty years to a population that is more aggressive and committed via the criminal justice process. The shift to a greater forensic population has resulted in an increase in the rate of aggressive acts by patients towards other patients and staff. Aggressive acts can require first aid treatment, hospitalization, or result in death. At least two murders have occurred within the state hospital system since 2008, in addition to thousands of incidences of aggression. Additionally, DSH has seen an increase in aggressive acts for the civilly committed population that resides outside of secure treatment areas.

The DSH Enhanced Treatment Program Project will provide 39 secured ETUs beds (male only) at Atascadero State Hospital and 10 ETUs (female only) at Patton State Hospital. The Atascadero ETU project is currently under construction and is approximately 35% complete. Of the requested augmentation, $3,413,000 is needed for Atascadero. Atascadero has entered into an eight month project suspension necessary to address issues identified after construction began. These include: Office of the State Fire Marshal revisions; required field changes; design errors and omissions, and unforeseen site conditions. The project suspension will run from November 30, 2020 to July 30, 2021 to

provide sufficient time to address these issues. Construction will resume on August 1, 2021.

In addition, the increased costs at Patton are primarily related to COVID-19 impacts which prompted the Department to issue a six-month project suspension during the summer of 2020. The suspension of the project created difficulties for the contractor to resume work on-site and also delayed the construction administration performed by the architectural/engineering group. These issues have resulted in the need to provide additional funding of $379,000 General Fund to complete the construction of the project at Patton. The Patton project suspension began in June 2020 for six months but is now expected to end in July 2021. Construction of the remainder of the project will continue for a duration of 12 months. These issues have resulted in the need to provide a total funding of $3,792,000 General Fund to complete construction of the project at Atascadero and Patton.

The completion of the ETU project is critical for DSH. Further delay of the project would result in the following:

- Continued use of suboptimal secured treatment space for the most violent patients in the DSH system.
- Continued use of restraints and other securing procedures that are suboptimal for this population.
- Continued behavioral threats toward patients and staff.
- Increased project costs related to a delay of the project.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

ISSUE 20: SUICIDE PREVENTION VOLUNTARY TAX CONTRIBUTION FUND

BACKGROUND

The administration provided the following information:
The 2021 Governor's Budget includes $409,000 in 2020-21 and $239,000 in 2021-22 from the continuously-appropriated Suicide Prevention Voluntary Fund for the Mental Health Services Oversight and Accountability Commission to support partnerships between National Suicide Prevention Lifeline crisis centers with local health care systems and hospitals and to establish a follow-up program for people seen in those settings for suicide-related services.

AB 984 (Lackey, Chapter 445, Statutes of 2019) established the Suicide Prevention Voluntary Tax Contribution Fund. AB 984, under the personal income tax law, allows a taxpayer to make a voluntary contribution to the suicide prevention voluntary tax contribution fund on the state personal income tax return. Revenues generated are to be used to support programs designed to prevent suicide in rural and desert communities located in the state and crisis centers located in the state that are active members of the National Suicide Prevention Lifeline. The Suicide Prevention Voluntary Tax Contribution Fund first appeared on the 2019 California individual income tax return for returns filed on or after January 1, 2020.

The suicide prevention voluntary tax contribution fund is continuously appropriated and allocated first to the Commission, Franchise Tax Board, and State Controller's Office for reimbursement of all costs incurred in connection with their responsibilities under AB 984. Any remaining funds are allocated to the Commission for disbursement to crisis centers located in the state that are active members of the National Suicide Prevention Lifeline in the following manner:

- Fifty percent of the funds shall be awarded through a project-specific grant process to crisis centers to fund programs that are designed to provide suicide prevention services to rural and desert communities. Crisis centers applying for the grants shall submit an application to the Commission in a manner prescribed by the commission.

- Fifty percent of the funds disbursed pursuant to this paragraph shall be disbursed to crisis centers for the sole purpose of providing suicide prevention services. When disbursing funds pursuant to this subparagraph, the Commission shall, to the extent feasible, consult with Didi Hirsch Mental Health Services. The

Commission shall disburse to each crisis center, from the disbursements required by this subparagraph, an amount proportional to the proportion that the annual number of calls the crisis center answers bears to the annual number of calls answered by all crisis centers located in the state that are active members of the National Suicide Prevention Lifeline.

Under AB 984, the Commission is required to report on its internet website information on the process for awarding money, the amount of money spent on administration, and an itemization of how program funds were awarded, including, but not limited to, the recipients of grants made with funds.

Marketing: Using existing resources, the Commission entered into a contract with Didi Hirsch Mental Health Services to strategically develop an outreach and marketing plan to increase awareness for the opportunity available to all Californian taxpayers to donate to suicide prevention efforts via the California State tax form and to provide a strategic marketing plan with recommended promotional methods and timeline for implementation. Marketing methods will include, but are be limited to, social media campaigns, email marketing, website promotion and other digital forms of outreach. The contract was executed on June 29, 2020 and will terminate on January 31, 2021. The Commission expects to receive the strategic marketing plan by December 31, 2020.

Local Assistance: The Commission intends to use funds generated from the Suicide Prevention Voluntary Tax Contribution Fund to expand the capacity of National Suicide Prevention Lifeline crisis centers to partner with local health care systems and hospitals and establish a follow-up program for people seen in those settings for suicide-related services, particularly crisis centers that serve rural and desert communities. The purpose of the follow-up program is to connect people seen in health care settings, particularly emergency departments and hospitals, to trained culturally and linguistically competent providers prior to discharge from those settings to establish trust, rapport, and consent for contact, such as postcard, phone call, text message, and email, after receiving suicide-related services. These “caring contacts” have been empirically studied and have demonstrated evidence of effectiveness, including cost effectiveness.

Capacity building for crisis centers includes, but is not limited to, establishing infrastructure for deploying providers prior to discharge from a health care setting of a person at-risk, if possible, and establishing protocols and practices to include provisions detailing how informed consent will be obtained and how follow-up care will reflect a collaborative, transparent approach with the person at risk. Services delivered by the program include delivering follow-up (in a method directed by the person at-risk for family member, if under 18 years of age), establishing care linkages prior to discharge, and ensuring ongoing monitoring and support. Services also should include support for transitioning students back into schools and adults back into the workplace after hospitalization for suicidal behavior, when applicable and possible.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.