SACRAMENTO STATE
COLLEGE OF CONTINUING EDUCATION

CALHHS BEHAVIORAL HEALTH AND TASK FORCE MEETING

**Meeting Summary**

TUESDAY, JUNE 14, 2022, 10AM – 3PM

## SUMMARY PURPOSE

This document provides a summary of key input provided by Behavioral Health Task Force (BHTF) members. This summary of participant input is an accompaniment to the full meeting summary, presentation slide deck, and meeting recordings, all available for review on the BHTF webpage, along with other meeting materials.

## BREAKOUT DISCUSSIONS

Attendees participated in breakout discussions during the afternoon portion of the meeting, sharing input on the Crisis Care Continuum (CCC) and 988 to inform the State's CCC Plan. Key themes from the breakout discussions and report outs are summarized below.

### BREAK DOWN SILOS

Many groups discussed the importance of breaking down silos to better keep people from falling through the gaps between systems, including building bridges between crisis prevention, response, and stabilization, as well as coordinating payers and data sharing.

- Create **bridge services** to build connection all along the continuum of care, which is currently fragmented
    - From crisis lines to crisis response services like mobile crisis units
    - From crisis response services to further community-based services
    - Improve hand-offs and provide follow-up support after crisis, including with parents and family members
- Align crisis services across funding streams and payers for a "**no wrong door**" approach
    - Develop MOUs to better coordinate between systems and ensure communication between all providers and payers
- **Integrate** across programs and services, including **data sharing**
    - Better integration between existing crisis lines and access phone numbers (911, 988, County-based 24/7 access numbers, suicide prevention call centers, FURS, friendship line, etc.)
    - Link school system to other parts of CCC – enhance data sharing between schools and medical systems, following existing models
        - For example, there are many students that need services and struggle to pay for the care they need but are not Medi-Cal eligible
- Take a **public health approach** to prevention and upstream response
    - Consider how to support isolated individuals that do not have existing care providers
- **Clarify roles** and responsibilities and increase **transparency**

  - Have a clear delineation of available services, ensuring a universal array in every community
  - Clearly communicate the support available
  - MCP vs. County LPS role
  - Strengthen monitoring and enforcement
- Role of **hospitals**
  - Hospitals need to provide additional support, training, and resources to be part of a truly integrated system
  - More needs to be done to support hospital emergency departments so that they can be a welcoming and helpful space for people in crisis

## EQUITY AND CULTURALLY APPROPRIATE CARE

Many groups discussed equity issues in the CCC, highlighting the need for cultural humility and culturally appropriate care that is non-traumatizing for disproportionately impacted communities. One group noted that all services, at all levels of care across the continuum, should have equity as a key consideration, with transparency about how it is addressed from the process of designing services through implementation. Groups gave a variety of recommendations for addressing equity issues such as building trust and accessibility for community members, engaging with community-based organizations, and building up a workforce that is representative of the range of communities in the State. One group raised a guiding question of "how do we empower marginalized populations?"

- Be **transparent** about the equity lens
  - Be explicit in naming disproportionate impacts within the crisis response system (e.g., institutional racism impacting POC queer and trans communities; gender equity)
    - Many underlying barriers (economic, digital, etc.) particularly impact Black and Brown communities
  - There should be an equity focus within the process of designing and building services, which will help ensure that the services themselves are more responsive and effective
  - Incorporate feedback from users in development of services to prevent access barriers and improve utilization
  - Decrease emphasis on data, which can reproduce systemic issues
- **Non-traumatizing, anti-racist** crisis response options are needed for BIPOC, LGBTQ+, and other communities in crisis
  - Recognize trauma and cultural differences
  - Address Restrictive licensing requirements (e.g., at RCFE, SNF, etc.) that require calling 911 rather than appropriate behavioral health responses

    - There is a lack of culturally competent providers and services that acknowledge systemic racism. Targeted resources are needed.
- Community-based care
    - Establish multi-sectoral crisis collaboratives in each community
    - Existing community-based mutual aid entities already serve as trusted, community-embedded crisis prevention and responses
    - Work with trusted individuals within the community to share programs, skills, and information
    - Work with trusted community members for technical assistance related to when, where, and how to provide access points for services
    - The "Promotora" model has been successful in Latinx communities, where there is often cultural stigma surrounding MH treatment, which is deepened when government is the source of information and resources
- Culturally and linguistically appropriate care
    - The state needs to improve understanding of needs and services for different populations and where those can be accessed, understanding that there may be gaps in the service area
    - Translate resources
    - Consider providing therapy that is not "inclusive" but instead is focused on serving a specific community
    - Serving the deaf community
        - Lack of access and services for the deaf community – for example, there are no therapists in LA County who can communicate directly with deaf clients and many hotlines are not accessible (including texting, which requires people be able to communicate in written English)
        - Create a streamlined, developmental system to support the deaf community in all three areas of the continuum
        - Evaluate systems and interventions to ensure sufficient capacity to provide appropriate, well-matched services for each individual
- Training and integrating community practices
    - Provide community-focused trainings for behavioral health providers to help center cultural and lived experiences, making care more accessible and successful for community members
    - Incorporate ACEs and trauma-informed training
    - Need to integrate community practices into the medical model, not just more diverse hiring
    - Provide case managers with training on identifying providers and resources that will be a good fit

The issue of access and barriers arose in many groups. As one group said, to truly improve access, improvements need to be made in terms of capacity, access points, and cultural competency, with all these factors integrated in a community-based system of care.

- Access
    - Address fragmentation between delivery systems and payers
        - Align services across funding streams so there is "no wrong door" access to services and transitions are more seamless regardless of payer and coverage
        - Provide navigation support that spans the multiple delivery systems and payers, similar to CalAIM Enhanced Care Managers
    - Create pathways for real-time linkages to services, for example building on technological gains from the past few years through the peer-to-peer Cloud Nine system in Austin, TX, that connects individuals directly to telehealth providers
- Barriers
    - There are gaps in knowledge about signs and symptoms of mental health needs as well as information about resources to connect to
    - The 24-hour limitation for crisis stabilization services is a structural barrier
    - Economic issues, food insecurity, and the digital divide are important barriers and often impact Black and Brown communities disproportionately
- Community-based care is one key way to improve access
    - Improve local access to at least a minimal level of care
    - Support crisis response services as part of community centers and mutual aid efforts
    - Integrate wraparound services into the broader care model, with known team members providing crisis services
    - Create pathways beyond emergency departments and jails: identify individuals who would not be best served through current (law enforcement and emergency department-based) crisis/emergency channels, providing alternative locations to receive support
    - Existing models to build on
        - WellSpace crisis receiving program in Sacramento
        - Community Responder models with local responders
        - EMSA pilots
        - Peer respite model, e.g., Danielle's Place in Sacramento

## CAPACITY AND WORKFORCE

Many groups identified workforce capacity as an important way the system needs to be further built up. Even those who are able to find access points may still find themselves waiting for long periods of time before receiving services, which can endanger their lives. Groups shared challenges and opportunities related to workforce capacity, including creatively leveraging existing personnel to help deescalate and address crisis, enhancing the workforce pipeline, and ensuring key competencies are met.

- Capacity limitations & challenges
    - Difficulties securing appointments, particularly with specialists
    - Staffing regulations make more robust service models (e.g., 24 hour support) more challenging
    - CSUs and EDs unable to make appropriate placements
- Enhance the pipeline
    - Fully implement planned investments in the pipeline
    - Address both short-term solutions and long-term training and development
    - Address retention and pathways
        - Improve compensation to that it is more commensurate with the challenges of the work
        - Provide incentives to improve capacity (and thereby, access)
        - Create pathways for people with experience working in residential programs with children in foster care to become part of the CCC
- Competencies
    - Ensure the workforce has adequate competencies to address community mental health crises
    - Need providers that are able, willing, and adequately resourced to treat the most acute and complex individuals
    - Culturally and linguistically appropriate training, services and programs are needed
    - Better support CBOs that already work within communities to support cultural competence of services
- Expand the pool of providers supporting the CCC
    - Increase the number of providers in the system that accept Medi-Cal
    - Look into appropriate ways to leverage individuals in adjacent work and provide the needed training and support; for example, utilize the CDSS training initiative to provide career pathways for IHSS providers
    - Consider drawing on non-licensed community-based providers, health workers, etc.
    - Expand Supporter Role to help with transition processes; consider how those with commercial insurance can also receive this support
    - Leverage telehealth

  - Board Certified Behavior Analysts (BCBAs) can assist in stabilization as another source of support, that is already funded by health insurance. In many cases, an autism diagnosis is not required for health plans to fund BCBA support.
  - Applied Behavioral Analysis interventions

## TRANSPARENCY AND DATA

- Use data to prioritize and focus resources
  - Prioritize resources first to the populations with the highest needs and the communities facing the greatest disparities and inequities
  - Data is needed to help pinpoint the specific needs, and extent of need, for the range of populations, for example Medi-Cal/non-Medi-Cal, justice-involved, etc.
- Statewide resources and standardization of process
  - Develop a universal statewide intake/assessment process and questionnaire, assessment and progress report templates, and report quantitative data on progress toward goals
  - Develop a statewide provider directory
- Data reporting and sharing
  - Address data sharing needs to better support people as they move along the continuum of care
    - For example share data between State and local agencies, jails and prisons, and other entities that collect data
    - Develop a statewide database allowing sharing of information across agencies (e.g., so that first responders can know to bring a MH professional on calls to a given home)
  - Need consistent reporting on 5150 and outcomes, with stratification by race/ethnicity
  - Leverage DOJ reporting to increase consistent, statewide reporting
  - Is there existing data on who uses ED services (perhaps from HCAI)?
- Defining stability
  - Set goals and monitor progress
  - Need to define criteria for stability to be able to reach and maintain it

## FUNDING AND PAYERS

Throughout many of the group discussions, the issue of funding arose, with participants emphasizing the importance of ensuring that programs that are part of the CCC are fully and adequately funded. Many groups touched on the issue of the fragmentation of funding and payment for services, noting that funding is key to breaking down silos and helping people access services.

- Areas that need additional funding
    - Better fund crisis response options that are non-traumatizing, focusing on alternatives to law enforcement and ED-based approaches and the services that communities have identified as safe for them
        - For alternatives to law enforcement and ED-based approaches, liability issues also need to be addressed
    - Increase funding to support 24-7 crisis services
    - Make the needed financial investments (amounts and rates) to expand acute crisis, inpatient, and post-discharge services
- Interconnected services are often funded separately, which increases divisions and silos
    - Address the lack of private insurance payment for services
        - A key issue is that private insurance often does not sufficiently cover services for people with disabilities that require specific interventions
    - Look at the all-payer model in Arizona
- Funding opportunities
    - FMAP reimbursement for crisis response
    - MediCare as a means to extend Medi-Cal for other purposes, such as a 988 fee
    - Create a shared savings mechanism to fund alternatives to law enforcement and ED-based crisis response, balancing the various needed systems and addressing liability issues

## CHILDREN, YOUTH, AND FAMILIES

- Consider differences between adult and children needs in a CCC
    - Include child- and youth-specific stabilization services
    - Include parent partners and peers within mobile response stabilization services (MRSS)
- Cultural and linguistic appropriateness are key to ensuring engagement resonates with children and their families and meets their needs
- Prevention must start in childhood
- Support parents and caregivers
    - Support families throughout *and after* crisis
    - More support is needed for family members and family respite, which can support both stabilization and prevention
- There is a gap in resources in educational environments (e.g., counselors in schools)
    - WestEd is working with SBHIP to create an inventory of resources for students

## LEGAL AND LICENSING

- Need for CSU licensing category within CDPH
- Rework facility licensing requirements to ensure they are workable – e.g., change 24/7 nursing staff requirement, address licensing process and timelines for inpatient psychiatric hospital facilities

## CRISIS PREVENTION

- Need improved screening
- Expand diversion programs, including navigation support to utilize services and early identification to prevent high-level decompensation

## CRISIS RESPONSE

- Existing models to build on
    - Ohio-based model for quickly getting up to 4 sessions of crisis stabilization with a licensed provider or psychiatrist for individuals at risk of going to (or in) ED

## CRISIS STABILIZATION

- Mobile response stabilization services (MRSS) should be part of the CCC.

## OTHER

- Consider that words may mean different things in different spaces (for example the word “peer”), so consider how this might play out with respect to resources and services.
- Opportunities to better serve individuals found incompetent to stand trial
    - IST population should receive fully supportive services, yet they continue to cycle between systems. There are opportunities to reduce emergencies related to this by expanding robust, comprehensive diversion, services, and supports.
    - This population, like others, should receive navigation support spanning all systems and payers