California Health and Human Services Agency (CalHHS)

988-Crisis Policy Advisory Group Meeting Summary

Wednesday, December 13, 2023; 10:00 AM – 3:00 PM PST

AMENDED TO APPEND ADDITIONAL PUBLIC COMMENT

Attendees:

POLICY ADVISORY GROUP MEETING PARTICIPANTS (In-person):

- **Amanda Levy**, Deputy Director for Health Policy and Stakeholder Relations, California Department of Managed Health Care (DMHC)
- **Budge Currier**, Assistant Director, Public Safety Communications California Governor's Office of Emergency Services (CalOES)
- **Chad Costello**, Executive Director, California Association of Social Rehabilitation Agencies (CASRA)
- **Christine Gephart**, Deputy Director Clinical Services, CA Dept. of Developmental Services as alternate for Nancy Bargmann, Director, California Department of Developmental Services
- **Christine Stoner-Mertz**, Chief Executive Officer, CA Alliance of Child and Family Services
- **Erika Cristo**, Assistant Deputy Director, California Department of Health Care Services (DHCS)

- **Kenna Chic**, Health Equity Fellow, State Health Policy, California Health Care Foundation
- **Keris Jän Myrick**, Vice President of Partnerships, Inseparable (Mental Health Advocacy and Programs)
- **Lan Nguyen**, Division Manager, Crisis and Suicide Services, County of Santa Clara Behavioral Health Services Department
- **Lee Ann Magoski**, Director of Emergency Communications, Monterey County
- **Lei Portugal Calloway**, Certified Medi-Cal Peer Support Specialist, Peer Team Lead, AOT/CARE Court, Telecare Corporation
- **Melissa Lawton**, Chief Program Officer, Seneca Family of Agencies
- **Michael "Mike" Tabak**, Lieutenant, San Mateo County Sheriff's Office
- **Michelle Doty Cabrera**, Executive Director, County Behavioral Health Directors Association (CBHDA)
- **Phebe Bell**, Behavioral Health Director, Nevada County
- **Rayshell Chambers**, Commission Member, Mental Health Services Oversight and Accountability Commission (MHSOAC)
- **Rebecca Bauer-Kahan**, Assembly Member (AD-16)/Author of AB 988
- **Robb Layne**, Executive Director, California Association of Alcohol and Drug Program Executive, Inc (CAADPE)
- **Roberto Herrera**, Deputy Secretary, Veterans Services Division, California Department of Veterans Affairs (CalVet)
- **Ryan Banks**, CEO, Turning Point of Central Valley, Inc.
- **Shari Sinwelski,** Vice President of Crisis Care, Didi Hirsch
- **Stephanie Welch**, Deputy Secretary of Behavioral Health, California Health and Human Services Agency (CalHHS)
- **Tara Gamboa-Eastman**, Director of Government Affairs, Steinberg Institute

- **Taun Hall**, Executive Director, The Miles Hall Foundation

POLICY ADVISORY GROUP MEETING PARTICIPANTS (Virtual):

- **Anete Millers**, Director of Regulatory Affairs, California Association of Health Plans (CAHP)
- **Bianca Christian**, Associate Therapist, California Coalition for Youth
- **Dr. Jana Lord**, Chief Operating Officer, Sycamores
- **Jennifer Oliphant**, Hope for Tomorrow Program Director, Two Feathers Native American Family Services
- **John Boyd**, Vice President Behavioral Health and Wellness, Kaiser Permanente, NCAL
- **Le Ondra Clark Harvey**, Chief Executive Director, California Council of Community Behavioral Health Agencies (CBHA)
- **Miguel Serricchio**, Executive Vice President, LSQ Funding Group
- **Robert Smith**, Chairman, Pala Band of Mission Indians
- **Susan DeMarois**, Director of California Department of Aging (CDA)

POLICY ADVISORY GROUP MEETING PARTICIPANTS (Absent):

- **Ashley Mills**, Assistant Deputy Director, Community Wellness, California Department of Public Health (CDPH)
- **Brenda Grealish**, Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH)
- **Hernando Garzon**, Acting Medical Director, California Emergency Medical Services Authority (EMSA)
- **Jeff Hebert**, 911 Communications Coordinator, San Diego Sheriff's 911
- **Jessica Cruz**, Chief Executive Officer, NAMI - California
- **Kirsten Barlow**, Vice President, Policy, California Hospital Association (CHA)

PROJECT TEAM:

- Ali Vangrow, Senior Program Analyst, Office of Policy and Strategic Planning, CalHHS
- Anh Thu Bui, MD, Project Director, 988-Crisis Care Continuum, CalHHS
- Betsy Jones, Health Management Associates
- Betsy Uhrman, Health Management Associates
- Brittany Thompson, Health Management Associates
- Jaafar Salim, Health Management Associates
- Jamie Strausz-Clark, Third Sector Intelligence (3Si)
- Justin Letsinger, Health Management Associates
- MaryEllen Mathis, Health Management Associates
- Nicholas Williams, Health Management Associates
- Suzanne Rabideau, Health Management Associates

Meeting Summary:

WELCOME, INTRODUCTIONS, AND TECHNOLOGY REVIEW

Jamie Strausz-Clark, 3Si, convened the meeting and reviewed use of Zoom features and expectations for meeting participants and public observers. Dr. Mark Ghaly, Secretary of CalHHS, delivered an energizing speech about the importance of the Policy Advisory Group. Rebecca Bauer-Kahan, Assembly District 16, called for commitment to mental health care improvements in California and to continue the work of AB 988.

MEETING OBJECTIVES, AGENDA, AND LOGISTICS

Jamie reviewed the meeting agenda and objectives for each agenda item. This meeting of the 988 Policy Advisory Group Meeting had six objectives:

1. Meet Policy Advisory Group members and the project team and lay the foundation for collaboration and productive working relationships.
2. Understand the process for developing the five-year implementation plan:
    a. How we will build on prior work (the CalHHS Behavioral Health Crisis Care Continuum Plan).
    b. The Policy Advisory Group's role, composition, timeline, and draft meeting schedule.
    c. The workgroups, including the role and focus of each workgroup and the opportunity for Policy Advisory Group members to participate.
    d. The role of CalHHS in developing the five-year implementation plan and how they will consider and address the input of the Policy Advisory Group and workgroups.
3. Discuss, revise as needed, and affirm Policy Advisory Group Charter.
4. Learn more about the workgroups, including which workgroup(s) each Policy Advisory Group member would like to join. Gather Policy Advisory Group members' input to inform the key questions and issues each workgroup should consider addressing in the coming year.
5. Confirm action items and next steps.
6. Hear public comment.

Jared Goldman, General Counsel of CalHHS, introduced and reviewed Bagley-Keene rules. Jamie also introduced the process and rules for public comments, for both virtual and in-person participation. Dr. Anh Thu Bui, Project Director, 988-Crisis Care Continuum, CalHHS, shared a personal story to provide connection to the work of the Policy Advisory Group. Dr. Bui presented the recommendation process for the five-year implementation plan for a comprehensive 988 system, highlighting the crisis care continuum and objectives of AB 988, as well as the workgroups that will focus on the required recommendation topics.

DISCUSSION: POLICY ADVISORY GROUP CHARTER

Jamie introduced discussion plans to generate ideas for potential recommendations for the Policy Advisory Group Charter. Recommendations from the members of the Policy Advisory Group included:

- Adding implementation of key milestones to the charter
- Including stakeholders from the community, specifically engaging youth voices, considering the range of youth ages, and implementation of youth input in the process (i.e., adding youth liaisons to the workgroup)
- Considering how crisis center members can contribute outside of the workgroups
- Analyzing groups that have elevated risk of suicide and considering targeted approaches driven by data and statistics
- Providing other stakeholders outside of the Policy Advisory Group to be included in workgroups

BREAKOUT SESSIONS

After the lunch break, attendees dispersed to attend sessions and participate in discussion topics. After breakout sessions concluded, participants came together to debrief their breakout sessions as project team leads provided brief summaries of each workgroup.

Workgroup 1: Comprehensive Assessment of Behavioral Health Crisis Services

In Workgroup 1, participants expressed an interest to see further emphasis on peer support, connectivity of the system, regional differences for learning, measurement of capacity to report data, and SUD prominence. Questions raised during this discussion included learning what data currently exists and identifying what is needed, identifying indicators for a healthy Crisis System, and how to measure prevention in the Crisis System. Concerns expressed included the need for more shared understanding, vocabulary, and definitional clarity in talking about "crisis," as well as ensuring the assessment is looking at the whole system, rather than just Medi-Cal eligible.

Workgroup 2: Statewide Standards and Guidance

In Workgroup 2, participants identified that level-setting should be an early-stage priority to ensure shared understanding among members of the current state. Such level-setting discussions should include current federal and state standards that apply to all call centers, activities/lessons learned from other states, and the process to maintain call center status. The group also identified certain components to address, including the scope of the discussion, core functions, standards related to call volume, response times, minimum time spent on calls, staffing standards (with emphasis on funding, representation, and workforce pipeline), leveraging technology for access and engagement and processes for measuring progress.

Workgroup 3: 988-911 Behavioral Health Crisis Continuum Integration

In Workgroup 3, participants discussed the need to understand the intersection between 911 and 988 and build the relationships, protocols, and guidance across the continuum so that they are responsive and addresses the needs of the community; better understand how funds will be distributed between the call centers; and how to build trust as it is critically important to upstream services, as well as addressing biases built into the system. The group also identified the connection to the data workgroup and the importance of data collection and sharing to address disparities in timeliness and access of services by geographical areas.

Workgroup 4: Communications

In Workgroup 4, participants agreed that "communications" is an umbrella term that covers a range of needs and activities such as raising public awareness about 988, the 988 user experience, and the broader crisis continuum. After additional discussion, it was suggested that the communications plan should include the following strategies: provide targeted, population-based messaging, to reach people where they are

(both physically and virtually), leverage trusted community leaders, and proactively seek community input to mitigate community fear and mistrust.

Workgroup 5: Data and Metrics

In Workgroup 5, participants discussed that they would like data and metrics to provide accountability and oversight, demonstration of system improvement, key transition points in the system, and the right incentives. While not specific to the Data and Metrics Workgroup, participants wanted to see improvement in the timeliness of the system (such as answering all 988 calls) and increased data sharing. Questions raised by participants included the use of technology/AI to better streamline data collections, how to classify substance use crises appropriately, and how to ensure that all health plans are meeting their responsibilities to provide essential behavioral health crisis services. Concerns expressed by participants included leveraging sufficient resources, balancing needs for data with clients/customers and the need for privacy/trust, and ensuring that 988 is welcoming in hopes that people return.

Workgroup 6: Funding and Sustainability

Workgroup 6 focused on sources and uses of funding, highlighting the need to understand how the system is currently funded and identify the gaps and ways to bring the greatest amount of resources to the 988 system including federal funding and insurance reimbursement. The workgroup identified basic topics that would be helpful to provide, such as how AB 988 fee is funded and the services that will be funded.

DEBRIEF BREAKOUTS

Participants reconvened to debrief from their breakout discussions as project team leads provided brief summaries of each workgroup. The breakout discussions identified the need to develop a shared understanding of standards, context, and scope of the work; implement best practices, protocols, and

alignment across the system; address the biases built into the current crisis response system that contributes to the fear and mistrust among many communities; and design a data strategy that articulates the purpose of the data collected and how it will be used to measure broader health outcomes and impact.

PUBLIC COMMENT PERIOD

There we no public comment sign-ups in person or virtually.

MEETING ADJOURNED

OTHER PUBLIC COMMENTS RECEIVED

Comment Start:

> Dear colleagues,
>
> First and foremost, thank you all for your commitment to equitable, continuous access to care for those with behavioral health challenges and experiences of a crisis, including and especially our children, LGBTQIA2S+, and BIPOC communities. When I supported AB988 while CEO of Didi Hirsch, co-chaired LA County's unwieldy crisis care continuum efforts, and worked with local officials and law enforcement to fund California's premier 911 to 988 diversion program keeping our communities and officers safe, I almost did not believe such a robust policy process and stakeholder group could come together.
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> Congrats and thank you(!!) to Secretary Ghaly, Deputy Secretary Welch, Assemblymember Bauer-Kahan, Taun Hall (bless you!) and so many others who brought this to fruition "negotiating" as we do in California for the greater good!

In that vein, and as someone who's studied and influenced national and state healthcare finance reforms for many years, I can't stress enough the importance of payment and coverage equity and parity in this system, pursued like all other aspects of behavioral healthcare. We've known for some time from public Didi Hirsch analyses that 988 calls and texts are disproportionately geolocated in Beverly Hills. As the Assemblymember highlighted this morning, there must be private payer investment into this system and accountability for covering the costs of their members' needs. That Medi-Cal and other state dollars are inappropriately spent on high-income individuals in crisis is inherently unjust - it robs those with lower incomes from sufficient services. Medi-Cal members are disproportionately individuals and families of color, as the California Pan-Ethnic Health Network's recent data brief highlights: communities of color represent 64% of California's total population, but they are 80% of Medi-Cal enrollees. To maintain overreliance on taxes and phone surcharges, rather than pursue private payer contribution, would be to perpetuate this inequity.

Additional payer accountability needed that often flies under the radar in public discourse due to its unpalatable and politically risky nature, is that of our county behavioral health (BH) plans. This 988 crisis policy advisory group and its achievement of a sustainable, seamless, equitable crisis care continuum envisioned, fundamentally requires county BH plan transparency and accountability to the public - in terms of access, quality, and financial metrics (including use of federal match across all BH services) - as envisioned in the Behavioral Health Services Act (BHSA) reform. California's counties are incredibly and disproportionately influential in Sacramento negotiations and legislation, and most of their subcontracted providers are afraid to say so openly for fear of losing vital funding for services. In Los Angeles, for example, our County decided to give MHSAOAC back $15 million for essential crisis care management, in a

successful pilot bridging mobile response to outpatient care, ostensibly so that its directly operated mobile crisis teams could have more job opportunities and so the county could further control the crisis continuum (the open-to-the-public crisis care continuum initiative I once co-chaired is no longer held openly…). County BH plans who exhibit such anti-competitive behavior are not only anti-progress (even if crisis continuums will look different by locale), they highlight an inherent conflict of interest of being both payers and providers of services. The 988 crisis care advisory group and BHSA cannot falter if we are to overcome these historically entrenched, inequitable systems and their backward incentives keeping Californians in crisis and with more severe behavioral health challenges from care.

Lastly, BH policy experts like myself involved with the state's first-in-the-nation Adverse Childhood Experiences (ACEs) initiative, ACEs Aware, agree that building on ACEs Aware, as envisioned in the Behavioral Health Crisis Care Continuum PLAN is spot on and applaud this all-of-government-investments approach. The fact that we've screened over 1.5 million Californians to date for ACEs in the last few years and counting, means we have incredibly predictive data of suicidal crisis risk that is not currently being used for that purpose by anyone who could (as shared with me recently by CDPH and LA County's Department of Public Health as well as managed care plans). Yes, integrated BH in primary care can enhance opportunities for crisis prevention and handoff from crisis services to a medical home or treatment hub and yes primary care providers need to learn about the crisis care continuum and how to manage behavioral health crises including referring to crisis continuum providers. But also, the CYBHI digital platforms need to be screening for ACEs, as do community-based and school-based/linked BH services providers.

Trauma-informed care includes collecting and using trauma data effectively for prevention. We applaud the inclusion of ACEs in the Department of Health Care Services' Population Health Management Program recommendations for managed care plans, and would encourage that that be extended to commercial plans (now required to cover ACE screening by CA law) and county BH plans, so that we have comprehensive data on crisis risk that can be used by primary care, specialty behavioral health providers, and all plans together. Of all ACE-associated health conditions, suicide is by far the most influenced/primed by childhood trauma (with overdose not far behind). The 988 policy advisory group could put forth legislation and recommendations that make our state and other key partners combine ACEs Aware and 988/crisis care continuum data and use it to optimally save and transform lives.

Gratefully and ever sincerely yours,

Jon

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Jonathan Goldfinger, MD, MPH, FAAP

Comment End