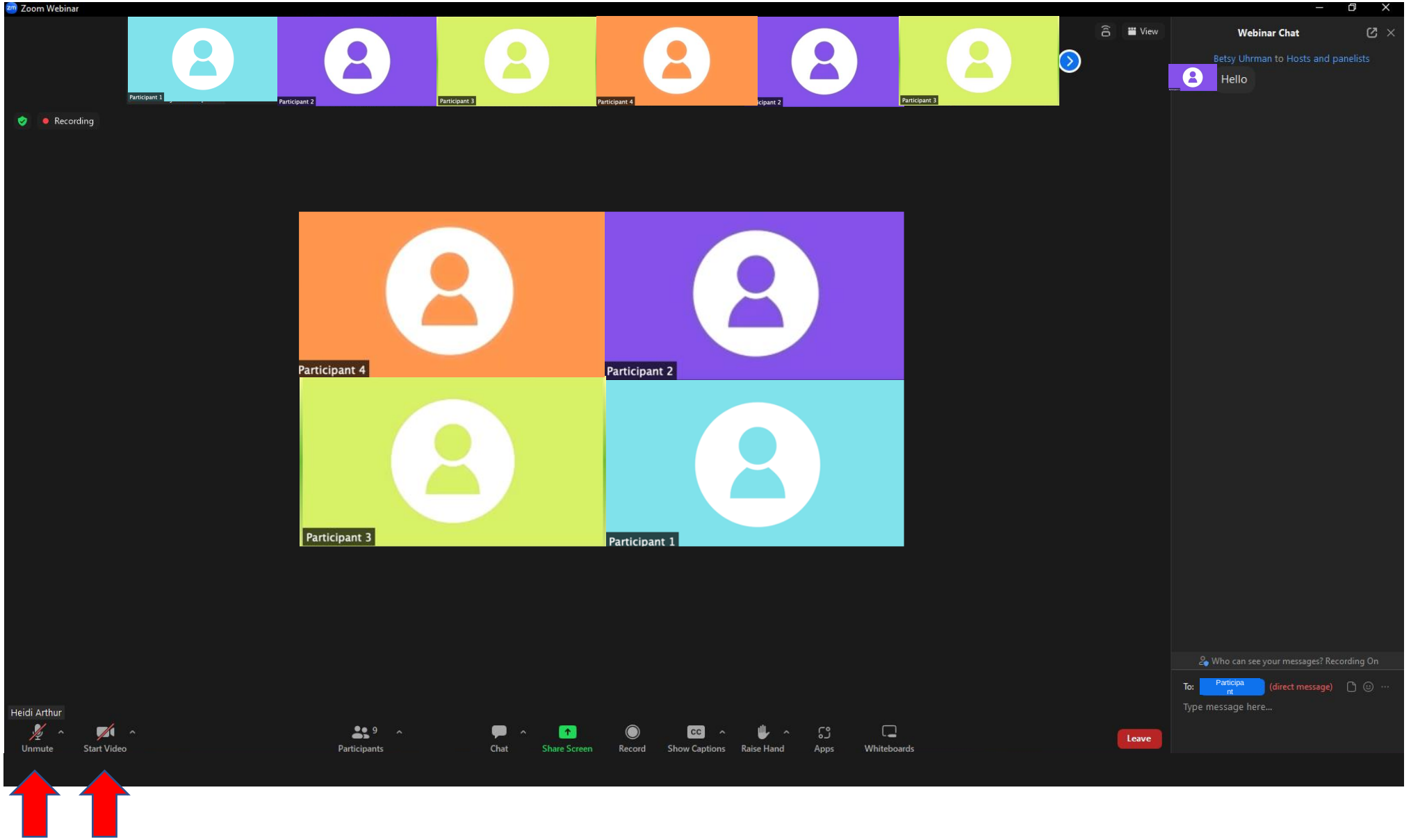
CalHHS

Workgroup 1: Comprehensive Assessment

Meeting 4, April 11, 2024

Webinar: Panelist View



Webinar View: Attendee

The chat is available for workgroup members.

Note that the chat transcript will be included in the meeting summary, which will be posted on the CalHHS 988 Policy Advisory Group website.

Agenda

1. Review of Agenda and Session Objectives (5 Minutes)
2. Timing of Implementation (5 Minutes)
3. Brief Review of Previous Meeting and Populations of Focus (5 Minutes)
4. Input from Workgroup Discussion
5. Public Comment Period
6. Next Steps

Public Comment Overview

- **All comments—whether written or spoken—will be shared with the Workgroup in the meeting minutes.**
- We will take comments in the order in which we receive sign-ups
- If you are on Zoom and would like to make a public comment, please raise your hand
- Each person will have 2 minute to speak. If you have a condition that may require an accommodation (such as additional speaking time), please notify the project team and we will do our best to provide that accommodation.
- If you would like to make a comment but prefer not to do it in front of a camera or microphone, you may email your written comment to the project email address: AB988Info@chhs.ca.gov

Meeting 4:

- Meeting 3 Summary Highlights
- Context for Populations of Focus

Timing of Implementation

- An outcome of our work – in conjunction with the work of the Policy Advisory Group, other Workgroups, the 988 Project Team, and others – is the creation of a 5-Year Implementation Plan.
- The 5-Year timeframe recognizes that change does not happen overnight.
- Activities will be sequenced so as to continue our progress toward a crisis system that meets the needs of *all* Californians, without overwhelming the system during the process.

Meeting 3 Summary

- Shared aggregate data on emergency department visits related to behavioral health
- Reviewed preliminary data points on Someone to Come/Response
  - Shared BHCIP data points on mobile crisis services
  - Gathered input from members on non-Medi-Cal mobile crisis models and known bright spots from across the state (partnerships, funding sources and data sources)
- Reviewed preliminary data points on Somewhere to Go/Stabilizing Crisis
  - Shared information and definitions of places where persons experiencing a behavioral health crisis can go
  - Probed for more information about non-licensed crisis stabilization facilities, including those that serve non-Medi-Cal beneficiaries

Workgroup 1: Assessment of the Behavioral Health Crisis Services System

- Required Recommendation Areas Per AB 988:
  - (12) Findings from a comprehensive assessment of the behavioral health crisis services system that takes into account infrastructure projects that are planned and funded. These findings shall include an **inventory of the infrastructure, capacity, and needs** for all of the following:
    - (A) Statewide and regional 988 centers.
    - (B) Mobile crisis team services, including mobile crisis access and dispatch call centers.
    - (C) Other existing behavioral health crisis services and warm lines.
    - (D) Crisis stabilization services.
  - (7) Resources and policy changes to address statewide and regional needs in order to meet population needs for behavioral health crisis services

What does the data say about certain populations: youth/elderly

System Inventory: where else might we look or who might we connect with?

Populations of Focus (1)

- Taxonomy for Today
  - Youth
    - LGBTQ+ youth
    - System-impacted youth
    - Black, indigenous, and people of color (BIPOC)
  - Older adults
    - Veterans
    - Individuals with disabilities
    - Rural

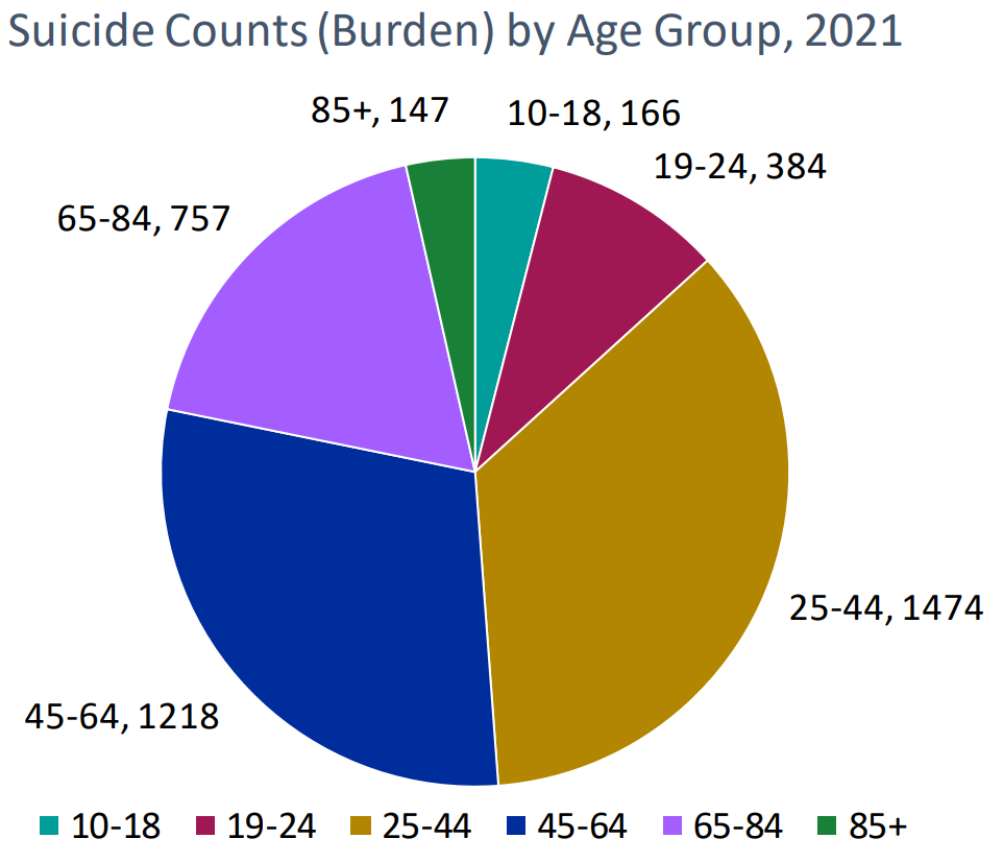
- *Populations of Focus from Crisis Care Continuum Plan*
  - *Youth*
  - *LGBTQ+ youth*
  - *System-impacted youth*
  - *Black, indigenous, and people of color (BIPOC)*
  - *American Indian/Alaska Native and other native populations*
  - *Older adults*
  - *Veterans*
  - *Individuals with specific language needs*
  - *Individuals with intellectual and/or developmental disabilities (IDD)*
  - *Individuals who are deaf or hard of hearing*
- *Other Populations identified by Behavioral Health Task Force*
  - *Rural communities*
  - *Unhoused*
  - *College Aged students*

Disparities in Suicide by Age: Burden for Youth and Older Adults

United States

- Adults aged 35–64 years account for 46.8% of a suicides in the United States, and suicide is the 8th leading cause of death for this age group
- **Youth and young adults** ages 10–24 years account for 15% of all suicides (11.0 per 100,000). While a lower rate than other age groups, **suicide is the second leading cause of death and increased 52.2% between 2000-2021**
- **Adults aged 75 and older have one of the highest suicide rates** (20.3 per 100,000). Men aged 75 and older have the highest rate (42.2 per 100,000) compared to other age groups

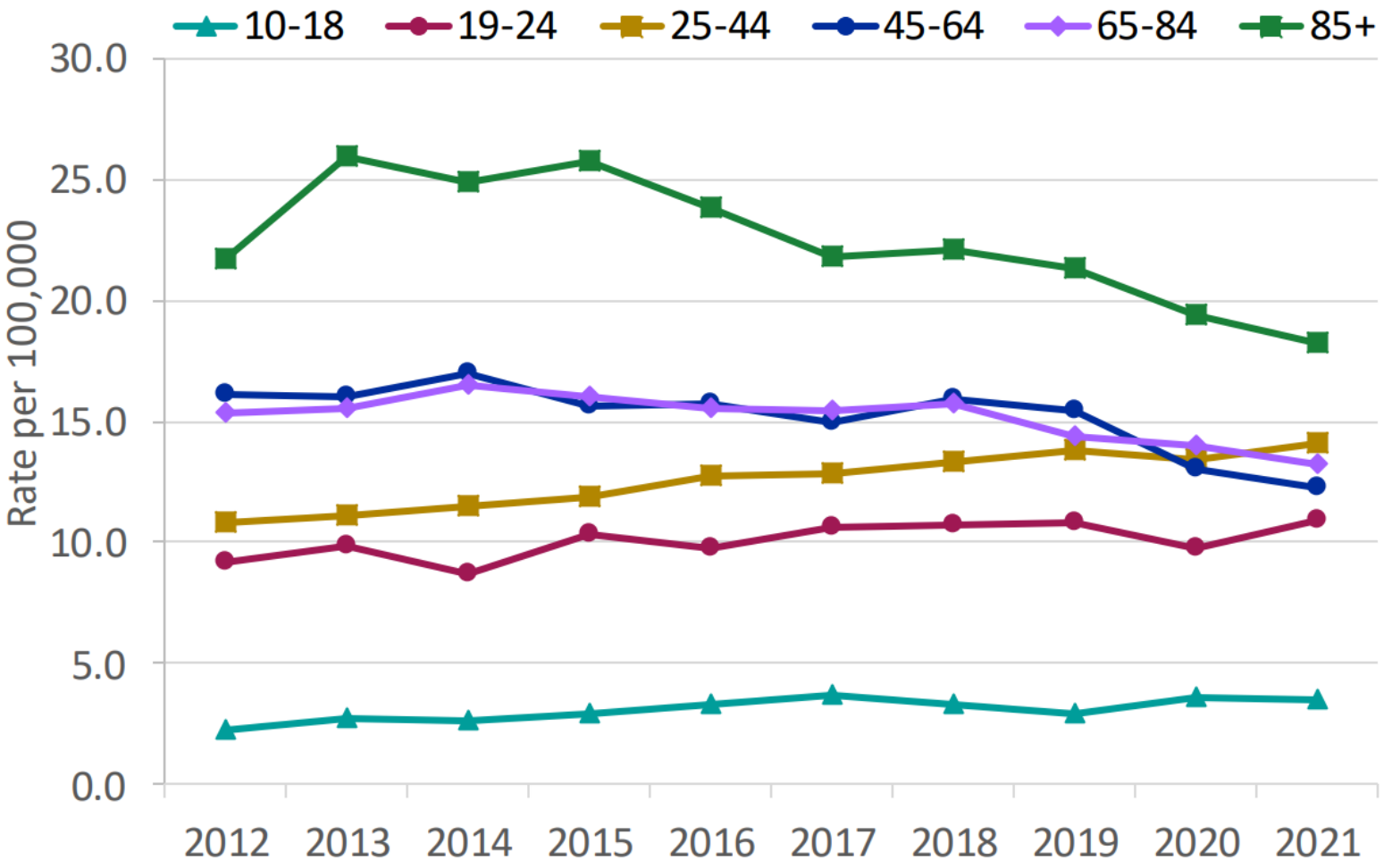
California



http://wonder.cdc.gov/mcd-icd10-expanded.html

Crisis Services for Youth and Intersections with LGBTQ+ and BIPOC Communities

California Suicide Rates by Age Group, 2012-2021 (1)

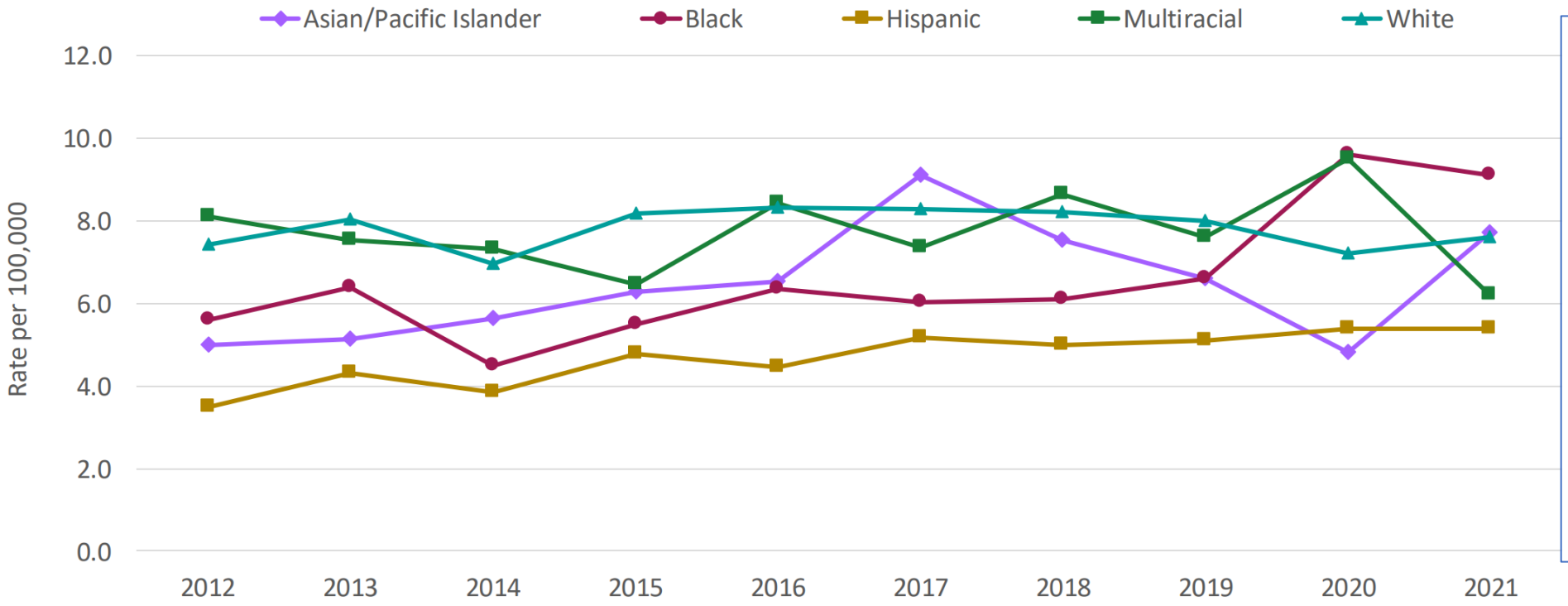


Between 2020 to 2021,

- **Youth aged 19-24 saw the largest increase in suicide rates**, compared to other age groups

2011-2013 deaths: CDPH, Death Statistical Master File (DSMF); 2014-2021 deaths; CDPH, CA Comprehensive Master Death File (CCMDF); 2012-2021 population: CA Department of Finance P-3 Population Projection File (2010-2060); July 2021 Release

California Suicide Rates among Youth (Ages 10-24) by Race/Ethnicity, 2012-2021



Between 2020-2021, among youth aged 10-24,

- **Black youth have the highest rates of suicide**
- Asian and White youth also saw an increase in suicide

2011-2013 deaths: CDPH, Death Statistical Master File (DSMF); 2014-2021 deaths; CDPH, CA Comprehensive Master Death File (CCMDF); 2012-2021 population: CA Department of Finance P-3 Population Projection File (2010-2060); July 2021 Release

LGBTQ Youth: BH Crisis Needs

United States

- High school students who identify as sexual minorities have higher rates of suicide attempts compared to heterosexual students
- In 2021, those identifying as lesbian, gay, or bisexual reported attempting suicide at a rate five times higher than among heterosexual students (26.3% vs. 5.2%)

Jones SE, Ethier KA, Hertz M, et al. Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021. MMWR Suppl 2022;71(Suppl-3):16–21.
DOI: http://dx.doi.org/10.15585/mmwr.su7103a3

California

- 44% of LGBTQ youth seriously considered suicide in the past year, including 54% of transgender and nonbinary youth.
- 4% attempted suicide in the past year, including 19% of transgender and nonbinary youth.
- 62% wanted mental health care in the past year and were not able to get it, including 58% of transgender and nonbinary youth.
- 70% reported that they have experienced discrimination based on their sexual orientation or gender identity.

The Trevor Project: https://www.thetrevorproject.org/wp-content/uploads/2022/12/The-Trevor-Project-2022-National-Survey-on-LGBTQ-Youth-Mental-Health-by-State.pdf

California's Master Plan for Kids' Mental Health

An integrated multi-year effort uniting historic investments across disciplines to more holistically serve the state's diverse children, youth, and families. KidsMentalHealthMasterPlan_8.18.22.pdf (ca.gov))

- **CYBHI is at the Core** of the Master Plan
- **$4.7B so every Californian aged 0-25 has increased access** to mental health and substance use supports

Additional investments and initiatives in coordination and collaboration with the CYBHI.

- $4.1B on a **community schools'** strategy to connect kids and families to essential services including health screenings, meals and more, as well as expanded learning opportunities
- $5B on a Medi-Cal initiative, **CalAIM,** to better integrate health and behavioral health services for low-income kids and improve child health outcomes, including prevention
- $1.4B to build the **healthcare workforce** that expands our capacity to meet the health needs of Californians, including children and families.
- Additional State budget investments in school-based behavioral health workforce, such as school counselors

Children and Youth Behavior Health Initiative
Four Strategic Areas with 20 Workstreams

Most Directly Relevant to Crisis Services

Workforce Training and Capacity	Behavioral Health Ecosystem Infrastructure	Coverage Architecture	Public Awareness
Wellness Coach Workforce (HCAI)	School-Linked Partnership and Capacity Grants (DHCS)	Enhanced Medi-Cal Benefits – Dyadic Services (DHCS)	Public Education and Change Campaigns (CDPH)
Broad Behavioral Health Workforce Capacity (HCAI)	Behavioral Health Continuum Infrastructure Program (DHCS)	Statewide Multi-Payer School-Linked Fee Schedule (DHCS/DMHC)	ACEs and Toxic Stress Awareness Campaign (CA-OSG)
Trauma-informed Training for Educators (CA-OSG	Student Behavioral Health Incentive Program (DHCS)	N/A	**Targeted Youth Suicide Prevention Grants and Outreach Campaign (CDPH)***
Early Talents (HCAI)	**Youth Suicide Reporting and Crisis Response* (CDPH)**	N/A	Parent Support Video Series (DHCS)
Behavioral Health Virtual Services Platform and Next Generation Digital Supports (DHCS)			
Healthcare Provider Training and e-Consult (DHCS)			
Scaling Evidence-Based and Community-Defined Practices (DHCS)			
CalHOPE Student Services (DHCS)			
Mindfulness, Resilience and Well-being Grants (DHCS)			
Youth Peer-to-Peer Support Program (DHCS)			

https://cybhi.chhs.ca.gov/

Essential Crisis Services Span the Continuum – Children and Youth

= Near term (by FY 23-24) = Medium term (by FY 26-27) = Long term (by FY 28-29)

Preventing Crisis

Peer-Based Warmlines

Digital Apothecary

- CYBHI digital platform: Brightlife and Soluna

Community Based Behavioral Health Services:

- Community-based social services
  - Certified Wellness Coaches (2021-25)
- School-based and school-linked services
  - CalHOPE Student Support
  - Student BH Incentive Program (2022-25)
  - School-Linked Health Center
- Primary care clinics and FQHCs
- Outpatient BH Care
  - Community Mental Health Clinic
  - Community Wellness/Youth Prevention Center
- Peer support
  - Youth Peer-to-Peer Support Program
- Medication Assisted Treatment
  - California Youth Opioid Response

Responding to Crisis

Hotlines

- CA Youth Crisis Line)
- 988 LGBTQ+ youth
- Operate 24/7/365
- Answer all calls (or coordinate back-up)
- Offer text / chat capabilities
- Be staffed with clinicians overseeing clinical triage

Mobile Crisis Services

- Operate 24/7/365
- Staffed by multidisciplinary team meeting training, conduct, and capability standards
- Respond where a person is
- Include licensed and/or credentialed clinicians
- Mobile Response Stabilization Services (MRSS)

Stabilizing Crisis

Crisis receiving and stabilization services

- Operate 24/7/365, offer on-site services that last less than 24 hours
- Crisis Stabilization Unit (outpatient)

In-home crisis stabilization

Crisis residential treatment services

- Operate 24/7/365

BHCIP:

- Adolescent Residential Treatment
- Facility for Youth with SUD
- Crisis Residential Program
- Perinatal Residential SUD Facility
- Short-Term Residential Therapeutic Program
- Acute Psychiatric Hospital
- Adult Residential Treatment Facility for SUD

Post-crisis step-down services

- Partial hospitalization (e.g. in a psychiatric health facility)
- Supportive housing

Behavioral Health Continuum Infrastructure Program (BHCIP) Round 4: Children and Youth

Children's Crisis Continuum Pilot Program: https://www.cdss.ca.gov/inforesources/childrenscrisiscontinuumpilotprogram

Children and Youth BH Initiative: https://cybhi.chhs.ca.gov/

CalHHS
California Health & Human Services Agency

Sources: SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. September 13th BHTF meeting, DHCS: Existing California Medicaid Policies, proposed Medi-Cal Mobile Crisis Benefit, CalHHS

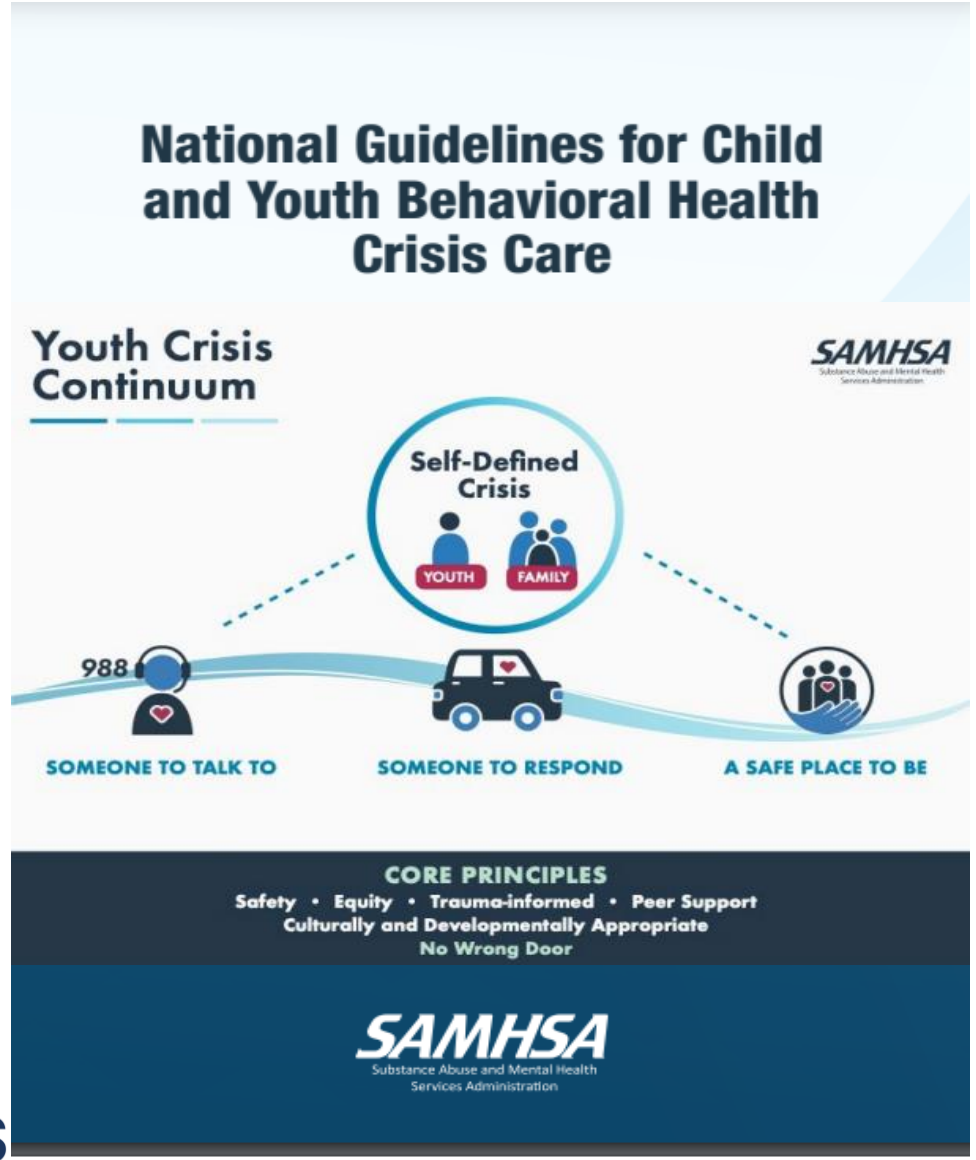
Children and Youth: Somewhere to Go - Variations in Resources

Psych Bed for Children	**Sacra - mento**			**Santa Clara**			**Merced, San Joaquin, Stanislaus**		
	2022 Capacity	*Estimated Need*	*Plus/ Minus*	*2022 Capacity*	*Estimated Need*	*Plus/ Minus*	*2022 Capacity*	*Estimated Need*	*Plus/ Minus*
Acute	113	30-34	**90 Surplus**	17	32-72	**15-44 Shortfall**	26	36-41	**Modest Shortfall**
Subacute	0	28-32	**28-32 Shortfall**	NA	NA	**NA**	12	34-39	**15 Shortfall**
Community Residential	34	98-164	**64-130 Shortfall**	NA	NA	**NA**	181	116-196	**65 bed Surplus**

SUD Treatment	**Sacra - mento**			**Santa Clara**			**Merced, San Joaquin, Stanislaus**		
Beds	12	37-58	**25-46 Shortfall**	47	25-53	**20 Surplus**	0	43-69	**44-69 Shortfall**

RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Sacramento County, California, 2022
RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Santa Clara County, California, 2022
RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in California
Merced, San Joaquin, and Stanislaus Counties, 2022

National Guidelines for Child and Youth Behavioral Health Crisis Care



Core Principles across Youth Crisis Services

- Keep youth in their home and **avoid out of home placements** as much as possible
- Provide **developmentally appropriate services** and supports that treat youth as youth, rather than expecting them to have the same needs as adults
- **Integrate family and youth peer support providers** and people with lived experience in planning, implementing, and evaluating services.
- Meet the needs of all families by providing **culturally and linguistically appropriate, equity-driven services**

Discussion: What else is known or unknown?

- **Someone to Call (Warmlines/Hotlines)**
  - Specific Examples: What lines exists and who runs them? What are the partnerships? What are the sources of funding?

- **Someone to Come (Mobile Crisis Response)**
  - Specific Examples: What are the different models? What are the partnerships? What are the sources of funding?

- **Somewhere to Go/A Safe Place to Be (Crisis Stabilization)**
  - Specific Examples: (what are the different facilities)? What are the partnerships? What are the sources of funding?

Discussion: Youth Crisis Services (LGBTQ+, BIPOC, Systems Impacted) 1

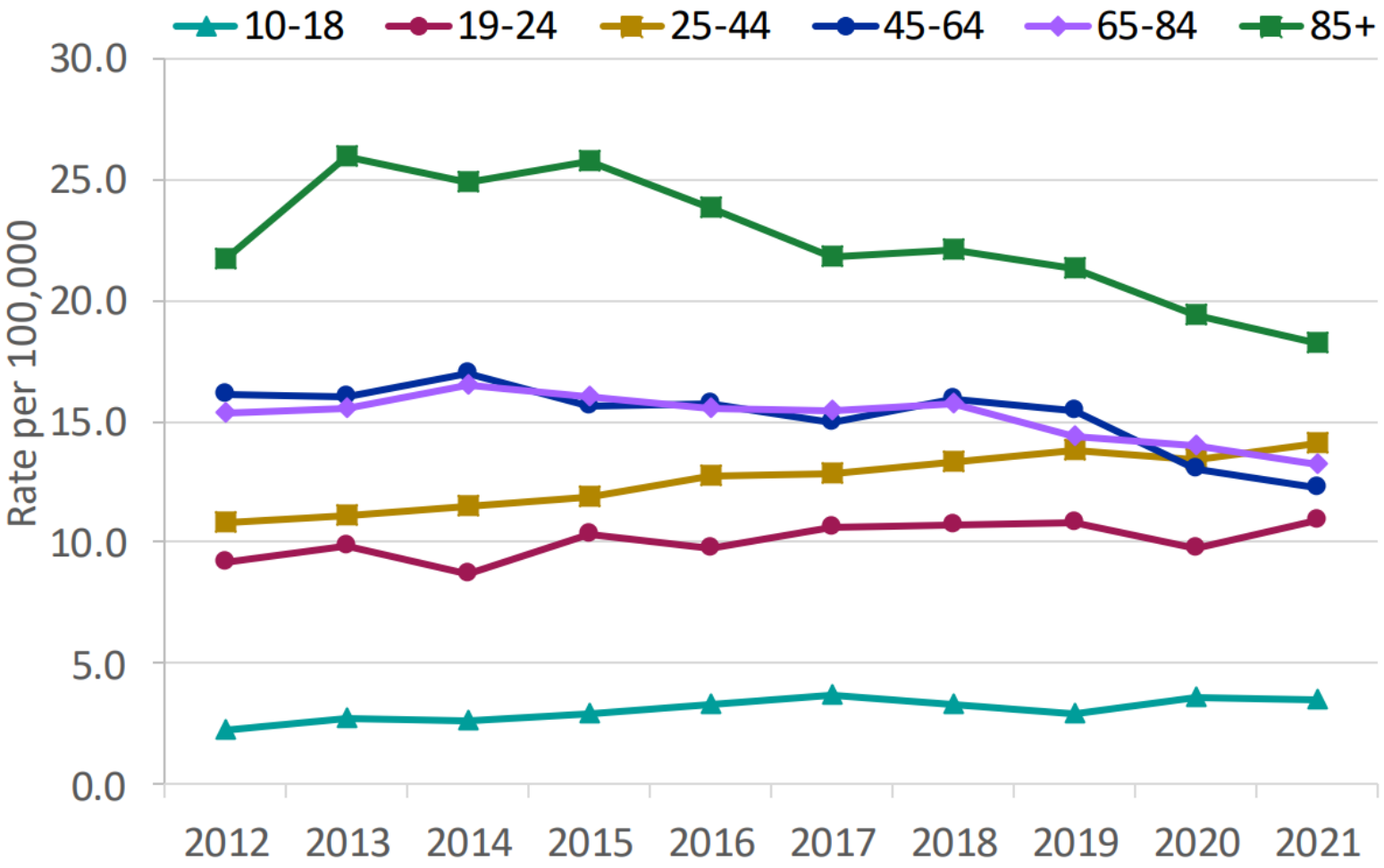
Specific Examples	Someone to Call	Someone to Come	Somewhere to Go/A Safe Place to Be/Other Services
Services Available Today (Known)	• Trevor Project/988 Partnership • Cal Hope Warmline • California Youth Crisis Line	• FURS (integrated into new Medi-Cal Mobile Crisis benefit)	• Adolescent Residential Treatment Facilities for Youth w/ SUD • Phoenix House SUD outpatient (LA and Orange Counties) • SUD side, Early Psychosis Programs (and others that are *youth-centric, **family-focused*** programs) • Children's Wraparound- Full-Service Partnership (FSP) • Psych Residential Treatment Facilities (PRTF) • School-based Wellness Centers
Partnerships/Funding	• Need a healthy robust array of payors • Opportunity for MH response units?		

Discussion: Youth Crisis Services (LGBTQ+, BIPOC, Systems Impacted) 2

Specific Examples	
Gaps/Considerations	• Limited services and supports, including beds and medication treatment, for youth with SUD (though this is changing with recent shift in Pinnacle work) • In building SUD capacity: Unique challenges with proximate, age-appropriate services • Child welfare policy changes impact array of available services • Right care, right time, right place without involving myriad of systems that children can get caught up in • Limited public awareness and knowledge of available services (inc. parents) • Unique needs and considerations for children and youth with co-occurring IDD, including need for respite care • TAY – Finding where to call is critical • Supply and demand challenge → system flow challenges and *selective denials* • Highlights the need for accountability for provider decisions regarding acceptance and denial • Need to recognize that MH or SUD are different and responses different for younger youth versus older • Limitations of commercial coverage (e.g., availability of specialty MH represents a failure of oversight and accountability) • Need for family systems perspective and family-focused approach • Need for respite for families • Virtual services platforms – raise questions for how children and families will be directed (“air traffic control”) • We need to ensure that there are more upstream care approaches that allow youth to explore BH care on their own up to a certain point. • We need to ensure that there are more upstream care approaches that allow youth to explore BH care on their own up to a certain point.
Leadership and Oversight	• Equitable distribution between public and private insurance systems • Enhance state efforts on plan accountability by including the availability of crisis, residential, and inpatient MH & SUD services in the state's timely access and network adequacy standards (both Medi-Cal and Knox Keene plans).

Crisis Services for Older Adults and Intersections with IDD, Veterans and Rural Populations

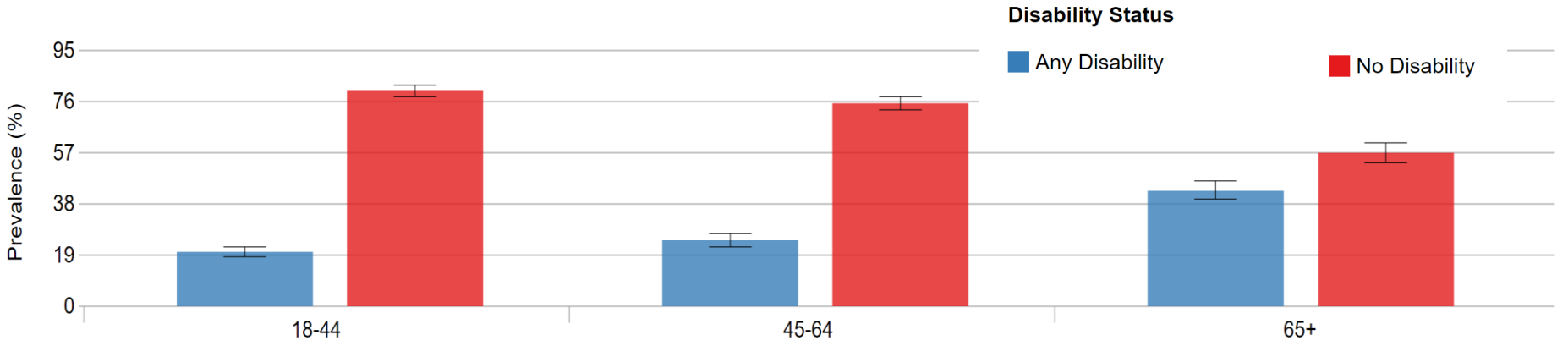
California Suicide Rates by Age Group, 2012-2021 (2)



Older adults have the highest suicide rates across all age groups.

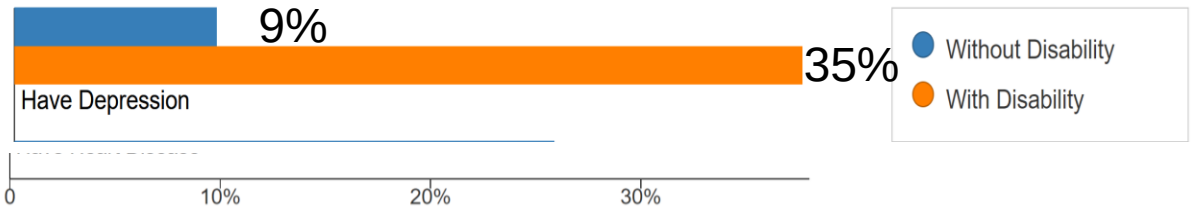
Disability

CA Disability Status Among Adults 18+ (2021)



Older Adults are more likely to have a disability

Adults with Disabilities in California and Depression



Persons with disabilities are more likely to have depression

Data Source: 2021 Behavioral Risk Factor Surveillance System (BRFSS).

Veterans

United States

- Suicide was the 13th leading cause of death among veterans overall, and the second leading cause of death among veterans under age 45 (1)
- Veterans have an adjusted suicide rate that is 57.3% greater than the non-veteran U.S. adult population (2)
- Veterans account for about 13.9% of suicides among adults in the United States (3)

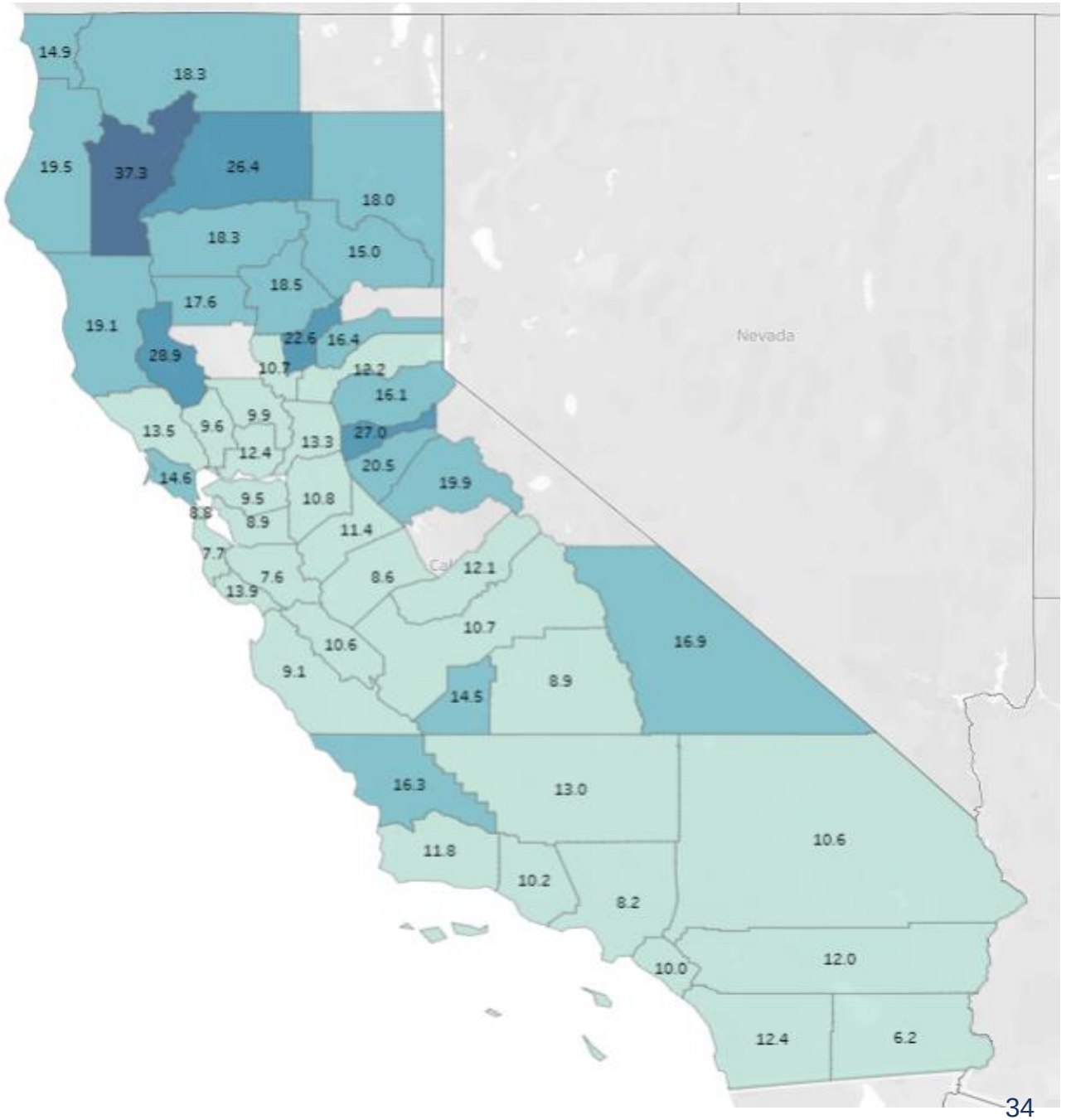
- **California** (4)
  - In 2020, veterans accounted for 15% of all suicides that year
  - 40% of veteran suicides were in the 65–84-year-old age group and 20% occurred in the 45–64-year-old age group 14% were in the oldest age group, 85 years and older.
  - The majority of veteran suicides were among Whites (80%) and Hispanics (10%)
  - Los Angeles and San Diego, the two most populous counties in California, had the largest number of suicide deaths among veterans, accounting for 28% in 2020

Rural Populations

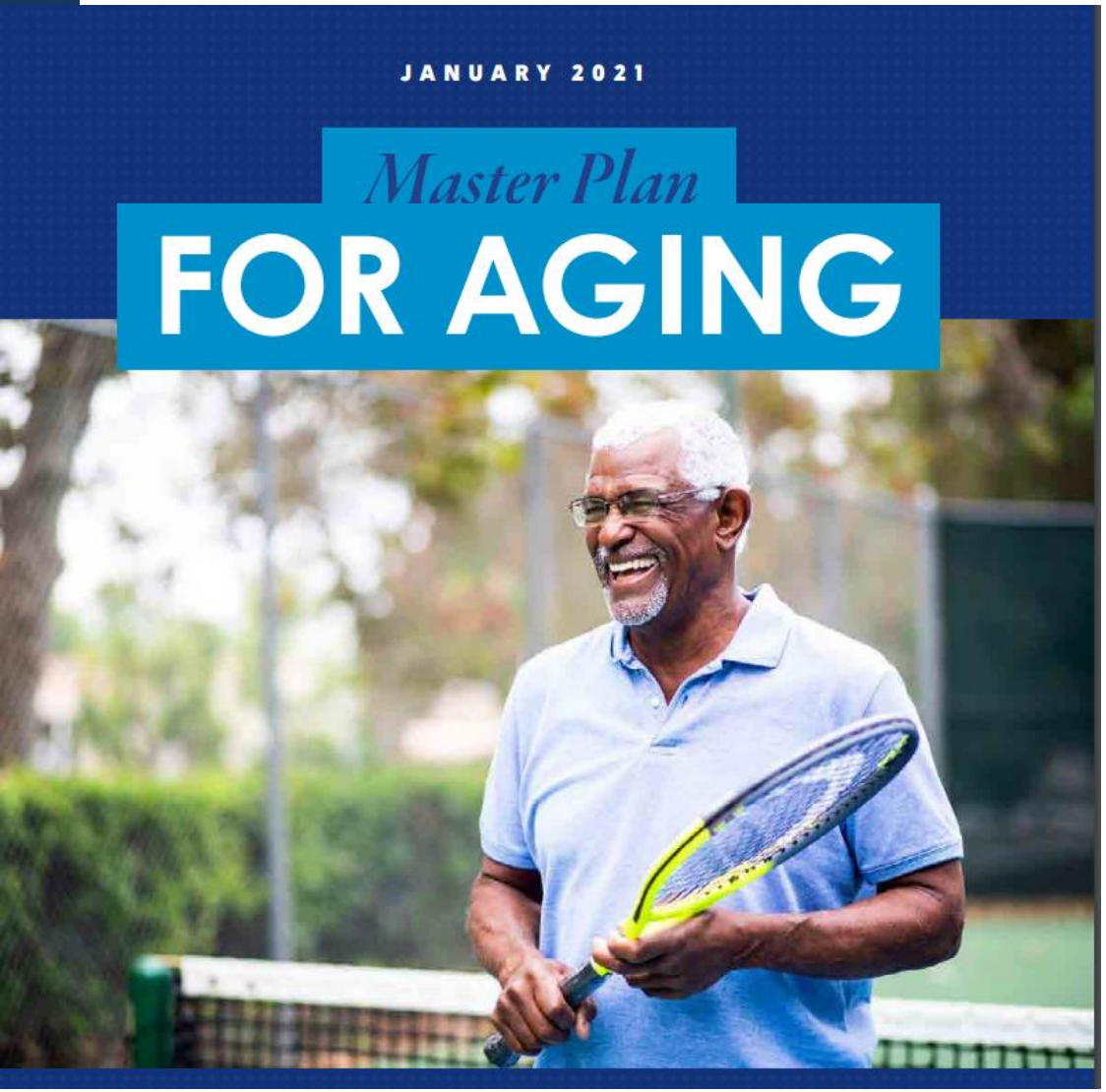
- Nationally, suicide rates correspond closely to population density (e.g., large central metropolitan: per 100,000 versus noncore (non-metro): 21.7 per 100,000)

- In California, suicide rates are higher in more rural a remote areas of the state
  - Trinity County (37.3 per 100k) (#54 in pop dens
  - Shasta County (26.4 per 100k)
  - Lake County (28.9 per 100k)
  - Amador County (27.0 per 100k)
  - Humboldt (19.5 per 100k)
  - Yuba (22.6 per 100k)
  - Inyo (16.9 per 100k)

- The median age of rural California residents is 51 (s years older than the median age of urban California residents).
- Overall, 18.4% of rural Californians are over 65, compared to 14.5% of urban Americans who are 65 older.



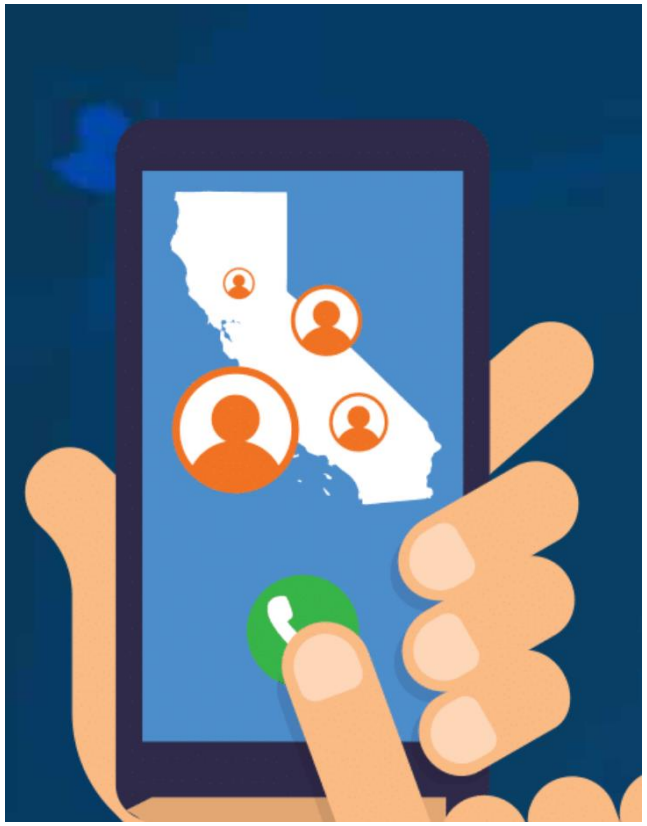
Key Strategies Focused on Prevention

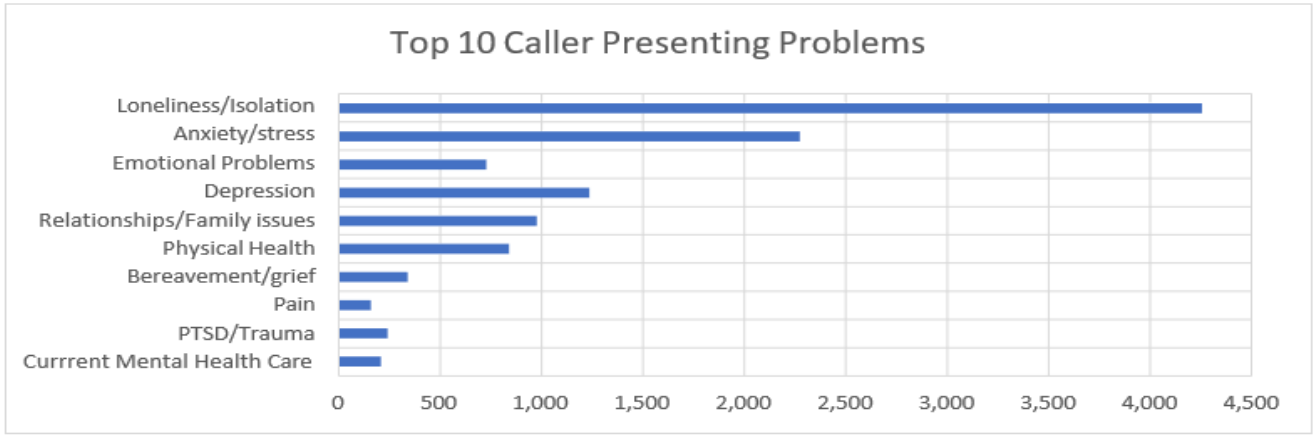


- Build public health/public education tools, with culturally competent and equity-targeted approaches, that promote brain health and address other healthy aging priorities (e.g., physical activity, nutrition, tobacco, oral health, mental health, substance abuse, and trauma).
- Identify federal funding for a friendship warmline for older adults to address isolation and loneliness needs, and partner with state departments who host crisis lines and access lines.
- Build in older adult focus to existing Suicide Prevention Programs
- Begin planning for growing skilled nursing and mental health needs in veterans' homes (per the Veterans Home Master Plan of Jan 2020)

Someone to Call

- California Department of Aging (CDA) reports that between April 2020 and November 2023 (43 months) **Friendship Line Volunteers** Responded to 295,148 calls, or approximately 6,800 calls per month
  - 54% of callers were female with 44% male, and 2% citing other gender identity.
  - 75% of callers identified as heterosexual and 25% as LGBTQIA.
  - Caucasian is the largest category of callers by ethnicity followed by Latino, Black, Asian /Pacific Islander.
  - Callers predominately identified as living alone and single.





Internal Data provided by MHASF “Friendship Line Snapshot”

Essential Crisis Services Span the Continuum

= Near term (by FY 23-24) = Medium term (by FY 26-27) = Long term (by FY 28-29)

Preventing Crisis

Peer-Based Warmlines
Friendship Line

Digital Apothecary

Community Based Behavioral Health Services:

- Community-based social services
- Primary care clinics and FQHCs
- Outpatient BH care
  - CCBHCs
  - Urgent care clinics
  - Transition clinics
  - Bridge clinics
- Peer support
- Harm reduction
- Medication for Addiction Treatment (MAT)
- Housing services
- Employment services

Responding to Crisis

Hotlines/988

- Operate 24/7/365
- Answer all calls (or coordinate back-up)
- Offer text / chat capabilities
- Be staffed with clinicians overseeing clinical triage

Mobile Crisis Services

- Operate 24/7/365
- Staffed by multidisciplinary team meeting training, conduct, and capability standards
- Respond where a person is
- Include licensed and/or credentialed clinicians

Stabilizing Crisis

Crisis receiving and stabilization services

- Operate 24/7/365, offer on-site services that last less than 24 hours
- Crisis Stabilization Unit (outpatient)

Peer Respite

In-Home Crisis Stabilization

Crisis Residential Treatment Services

- Operate 24/7/365

BHCIP:

- Crisis Residential Program
- Short-Term Residential Therapeutic Program
- Acute Psychiatric Hospital
- Adult Residential Treatment Facility for SUD

Post-Crisis Step-Down Services, such as (LT)

- Partial hospitalization
- Supportive housing

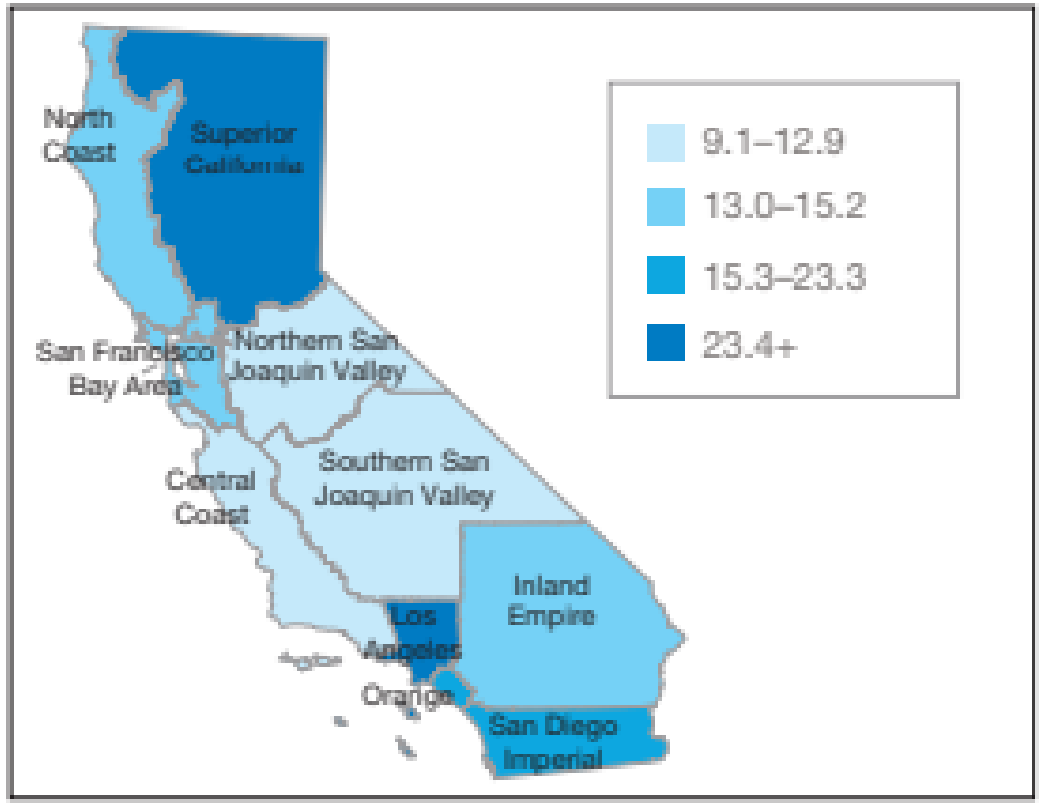
Sobering Center

Sources: SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. September 13th BHTF meeting, DHCS: Existing California Medicaid Policies, proposed Medi-Cal Mobile Crisis Benefit, CalHHS

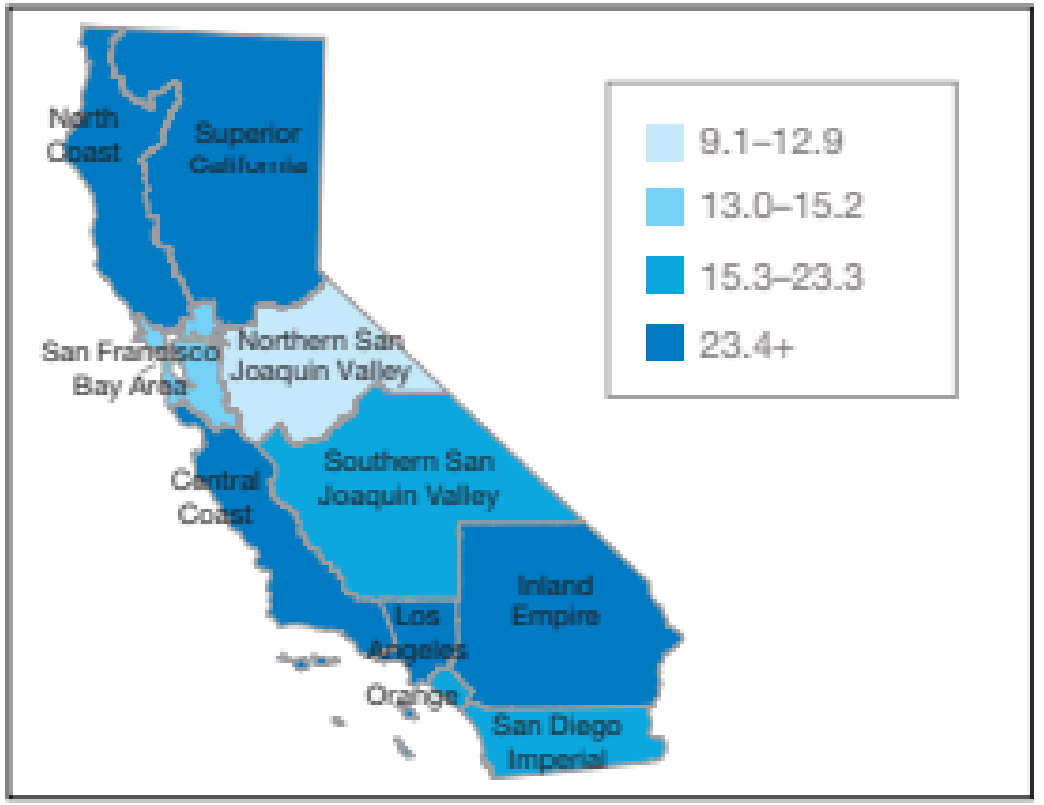
CalHHS
California Health & Human Services Agency

Adults: Somewhere to Go - Variations in Resources: Acute Level

A. Acute level: inpatient beds per 100,000 adults, *excluding* state hospitals



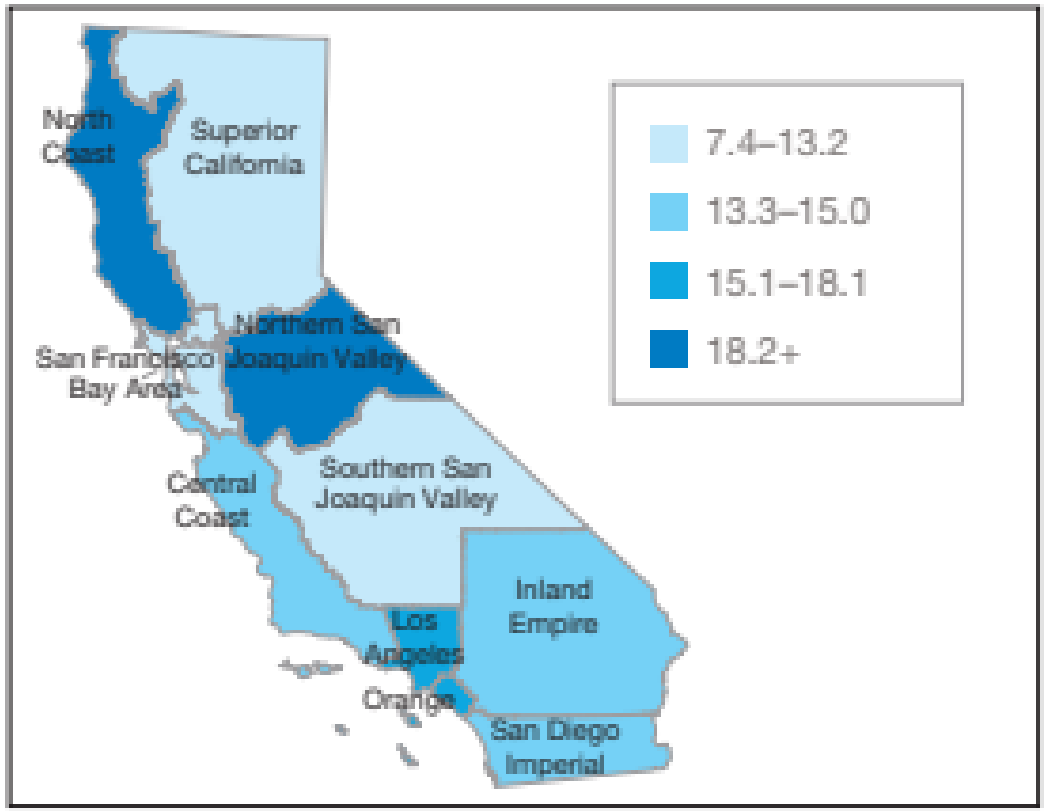
B. Acute level: inpatient beds per 100,000 adults, *including* state hospitals



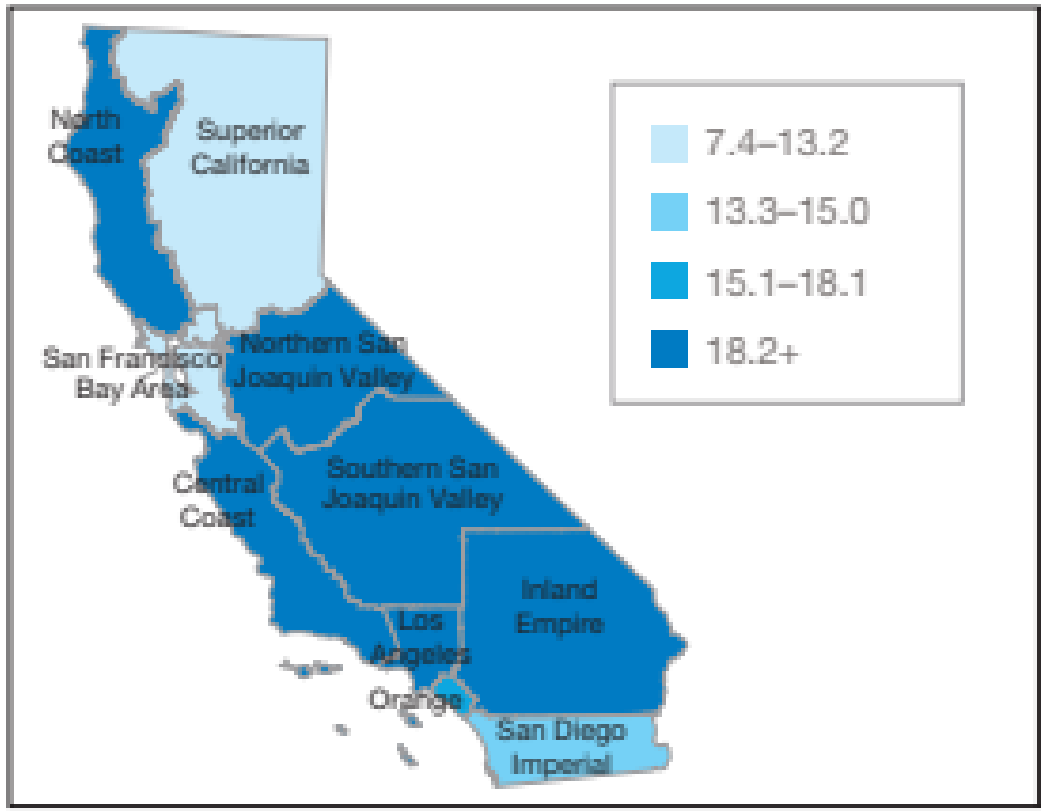
RAND, Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021

Adults: Somewhere to Go - Variations in Resources: Sub Acute Level

C. Subacute level: inpatient beds per 100,000 adults, *excluding* state hospitals

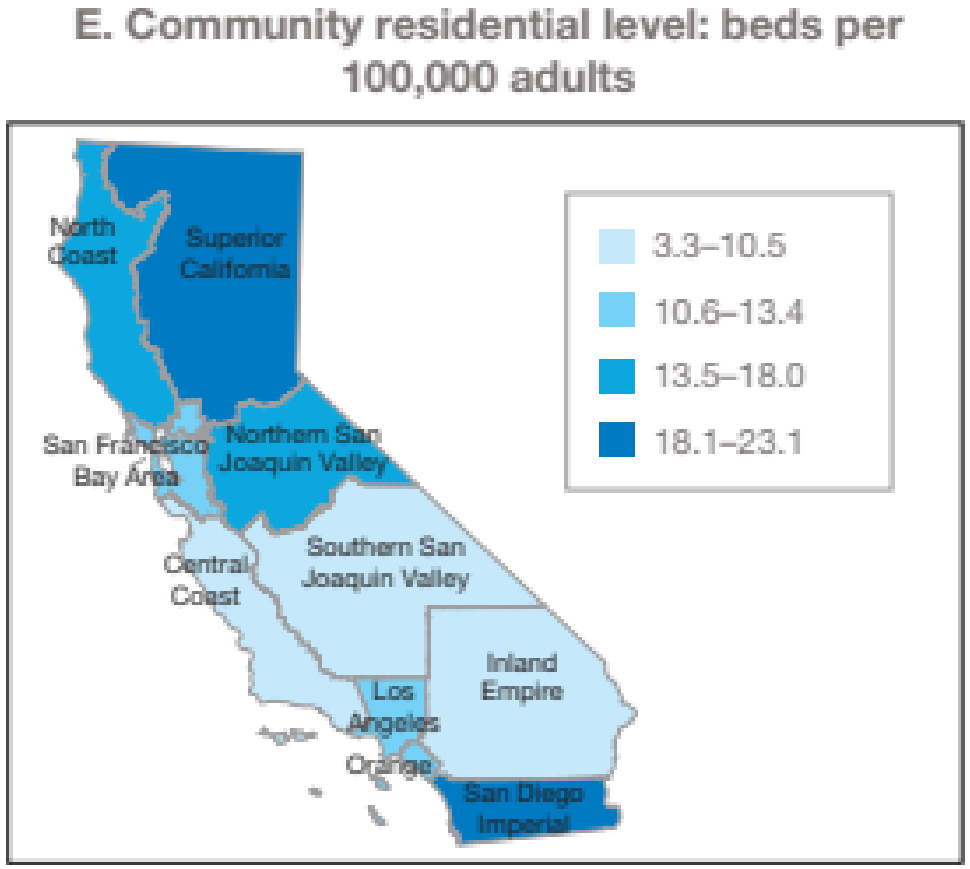


D. Subacute level: inpatient beds per 100,000 adults, *including* state hospitals



RAND, Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021

Adults: Somewhere to Go - Variations in Resources: Community Res.



RAND, Adult Psychiatric Bed Capacity, Need, and Shortage Estimates in California—2021

Adults: Somewhere to Go - Variations in Resources

Psych Bed for Adults	**Sacra - mento**			**Santa Clara**			**Merced, San Joaquin, Stanislaus**		
	2022 Capacity	*Estimated Need*	*Plus/ Minus*	*2022 Capacity*	*Estimated Need*	*Plus/ Minus*	*2022 Capacity*	*Estimated Need*	*Plus/ Minus*
Acute	113	30-34	**90 Surplus**	17	32-72	**15-44 Shortfall**	26	36-41	**Modest Shortfall**
Subacute	82	335	**253 Shortage**	216	372	**150-156 Shortage**	330	505	**174 Shortage**
Crisis Residential	NA	NA	NA	92	90	2 Surplus	NA	NA	NA
Community Residential	262	302	**40 Shortage**	602	525	77 Surplus	467	354	**113-302 Surplus**

RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Sacramento County, California, 2022
RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Santa Clara County, California, 2022
RAND, Psychiatric and Substance Use Disorder Bed Capacity, Need, and Shortage Estimates in Santa Clara County, California, 2022

Discussion

- **Someone to Call (Warmlines/Hotlines)**
  - Specific Examples: What lines exists and who runs them? What are the partnerships? What are the sources of funding?

- **Someone to Come (Mobile Crisis Response)**
  - Specific Examples: What are the different models? What are the partnerships? What are the sources of funding?

- **Somewhere to Go/A Safe Place to Be (Crisis Stabilization)**
  - Specific Examples: (what are the different facilities)? What are the partnerships? What are the sources of funding?

Discussion: Older Adult Crisis Services (IDD, Veterans, Rural) (1)

Specific Examples	
General Considerations	• Stigma is a huge issue and barrier to care. “Can’t do enough work on that front” • For rural populations, more likely to reach out to a known entity (e.g., health care provider) • [Youth and older adults] Importance of a social network/strong social connections and developing a sense of purpose • Someone to come: Transportation challenges when people are isolated or live alone • Someone to call: Technology challenges (cell phone access, internet access); needs to be simple • Diagnoses (BH or SUD) may make you ineligible for certain placements (e.g., skilled nursing) • Harm reduction (inc. addressing access to guns) • Need transparency around cost; medical debt is a fear that may limit people seeking support • Challenges of place to go those with co-occurring MH and ADRD; how do we keep people at lower levels of care?

Specific Examples	Someone to Call	Someone to Come	Somewhere to Go/A Safe Place to Be
Services Available Today (Known)	Friendship Line (Institute on Aging)	Review counties’ 3-year plans for examples of crisis-oriented services for older adults	Full-Service Partnerships (FSPs) El Hogar Senior Link PEI program Older Adult respite programs for caregivers Caregiver Resource Centers ECM (for those at-risk of higher level of care) Area Agencies on Aging

Discussion: Older Adult Crisis Services (IDD, Veterans, Rural) (2)

Specific Examples	
Partnerships/ Funding	• The State could develop provider incentives to develop more capacity to treat special populations (e.g., youth, older adults, medically complex). • Meal delivery programs (e.g., Meals on Wheels) – How to link those in their network to enhanced services
Leadership and Oversight	• Enhance state efforts on plan accountability by including the availability of crisis, residential, and inpatient MH & SUD services in the state's timely access and network adequacy standards (both Medi-Cal and Knox Keene plans). • Need for policy changes to better address *housing needs* of low-income older adults • System designed where accountability rests with who has the funding. Need greater ownership and oversight – money secondary to quality of care • Board and Care – need sustainable funding mechanism and capacity to grow

Discussion: How Can CA Develop Incentives/ Structures to Know the Unknown in the Future?

- Secret rolodexes/backdoor channels are a product of scarcity
- Need incentives to increase the volume of providers that accept insurance, notably for *prevention and comprehensive intervention* (don't want to inadvertently incentivize getting to crisis to get help)
  - Increased access to outpatient
  - Increased access to specialty providers
- Need to account for relationship between policies and incentives
- System designed that you have to be a "perfect fit"…and the public needs to know the (shifting) criteria
  - Treatment ecosystem is complex…and changing
  - Massive coverage gaps in what public payors will cover for MH and SUD… let alone private payors
  - Policies drive that variation and competition for resources
- Leverage existing platforms/resources that aggregate resources (e.g., County Warm Lines, 211…)
- Crisis systems could come together to map resources like sequential intercept mapping (from the justice involved system)

Public Comment Period

Public Comment Guidelines

- **All comments—whether written or spoken—will be shared with the Workgroup in the meeting minutes.**
- If you prefer, you may email your written comment to the project email address: AB988Info@chhs.ca.gov
- Each speaker is allocated 2 minutes to speak unless adjusted by the meeting facilitator.
- A speaker may not share or relinquish any remaining time they have not used to another speaker.
- Speakers may share one time during the public comment period.
- If time in the agenda remains after all individuals who signed up to speak have been called, the facilitator may invite other members of the public to raise their hand to speak. The facilitator will call individuals in the order they raise their hand.
- Speakers shall be civil and courteous in their language and presentation. Insults, profanity, use of vulgar language, or gestures or other inappropriate behavior are not allowed.
- Speakers should not ask questions of Workgroup members or ask Workgroup members to respond to their comments directly.

Action Items and Next Steps

Where We Go From Here

If you enjoyed this process, there are other ways to stay involved.

- All information from today's meeting will be posted on the CalHHS website on the 988-Policy Advisory Groups webpage
- Attend upcoming Policy Advisory Group meetings (next meeting is April 24).
- Consider joining or attending meetings of the next set of Workgroups:
  - Communications
  - Data and Metrics
  - Funding and Sustainability
- Continue to share your thoughts and perspectives! You can reach the project team through the AB988Info@chhs.ca.gov.

Adjourn

Populations of Focus (2)

- Focus (for Today)
  - Age
    - Youth
      - LGBTQ+ youth
      - System-impacted youth
      - Black, indigenous, and people of color (BIPOC)

Different Systems of Care and Funding

- School/Education System
- Foster Care Systems
- Department of Social Services
- Children's Special Services
- Medi-Cal

    - Older adults
      - Veterans
      - Individuals with disabilities
      - Rural

- California Department of Aging
- Department of Social Services
- Medicare