REPORT

Words to Deeds XVI *Crisis Response and the Implementation of 988* November 2-3, 2022

More than 100 leaders and stakeholders gathered face-to-face and virtually at the Mental Health Oversight and Accountability Commission building in Sacramento to discuss California's plans to build a robust behavioral health crisis response system as an integral part of a successful, wholistic crisis continuum of care program. The continuum promotes upstream crisis intervention and prevention, including the successful integration of the national 988 Suicide and Crisis Lifeline. The conference focused on three areas of any client's behavioral health situation, "Preventing Crisis—Someone to Call," "Responding to Crisis—Someone to Come" and "Stabilizing Crisis—Somewhere to Go." Participants shared developing strategies and solutions in each of these areas and heard from those building the required technical infrastructure to ensure that anyone who calls 988 receives the appropriate services when they need them.

Following is a summary of Words to Deeds XVI speaker presentations. All were content-rich and included many helpful suggestions and summaries of successful behavioral health service programs offered throughout the state of California.

Recordings of the presentations can be found at: https://www.fmhac.org/w2d-2021-conference-192010-229951-619389.html

Session 1: *California's Behavioral Health Crisis Continuum of Care Overview*

Moderator and Presenter: Stephanie Welch – Deputy Secretary of Behavioral Health, California Health and Human Services Agency SLIDES

Erika Cristo – Assistant Deputy Director, Community Services and Licensing and Certification, Behavioral Health, Department of Health Care Services SLIDES

Budge Currier – 911 Branch Manager, Statewide Interoperability Coordinator, Office of Emergency Services SLIDES

Legislature declined to pass AB 988 last year, Governor Gavin Newsom posed the challenge, "Do we have an overall vision for what the state's behavioral health continuum *should* look like?"

As the state works to define the goals and objectives for the CCC-P, Welch described the current situation:

- More than one million individuals attempt suicide each year. More than 4,000 individuals died by suicide in California in 2020

Preliminary Takeaways of the Current State of Crisis Care in California:

⇒ There have been many local and statewide efforts related to crisis care; however, there is room for improved coordination among crisis prevention, response and stabilization

⇒ Across CA counties, there are different approaches to crisis prevention, stabilization and response with considerable geographic variation in the availability of services, particularly in county-run warm lines

⇒ Focusing on 988, CA appears to meet readiness standards within the Lifeline Network-affiliated contact centers. However, there may be opportunities to ensure coordination and readiness across the broader network of call lines.

- There are existing challenges to accessing crisis care, including capacity, coordination and coverage
- To address existing access challenges, federal and state stakeholders are prioritizing crisis care:
    - ◊ SAMHSA described a 5-year vision for 988, following the July 2022 launch as a new 3-digit number to access the National Suicide Prevention Line
    - ◊ California AB-988 passed on September 30, 2022, which requires CHHS to develop a detailed implementation plan by the end of 2023.

Responding to the governor's challenge as well as these contextual issues, the goals of the CCC-P are to:

- Develop a robust vision for addressing California's behavioral health crisis
- Ensure that behavioral health services are available to all Californians
- Better recognize and utilize the state's investment in the behavioral health treatment system
- Prevent behavioral health crises in the high-risk population and the negative outcomes that can accompany these crises such as arrests, 5150 holds and suicides
- Overall, simplify the behavioral health services model to prevent crisis, respond to crisis and stabilize crisis.

Welch added that the real goal is preventing crises in high-risk populations and to accomplish that goal, the model must be simple. Behavioral Health crisis systems strive to serve anyone, anywhere, anytime and fall along a continuum: Preventing Crisis. Responding to Crisis. Stabilizing Crisis.

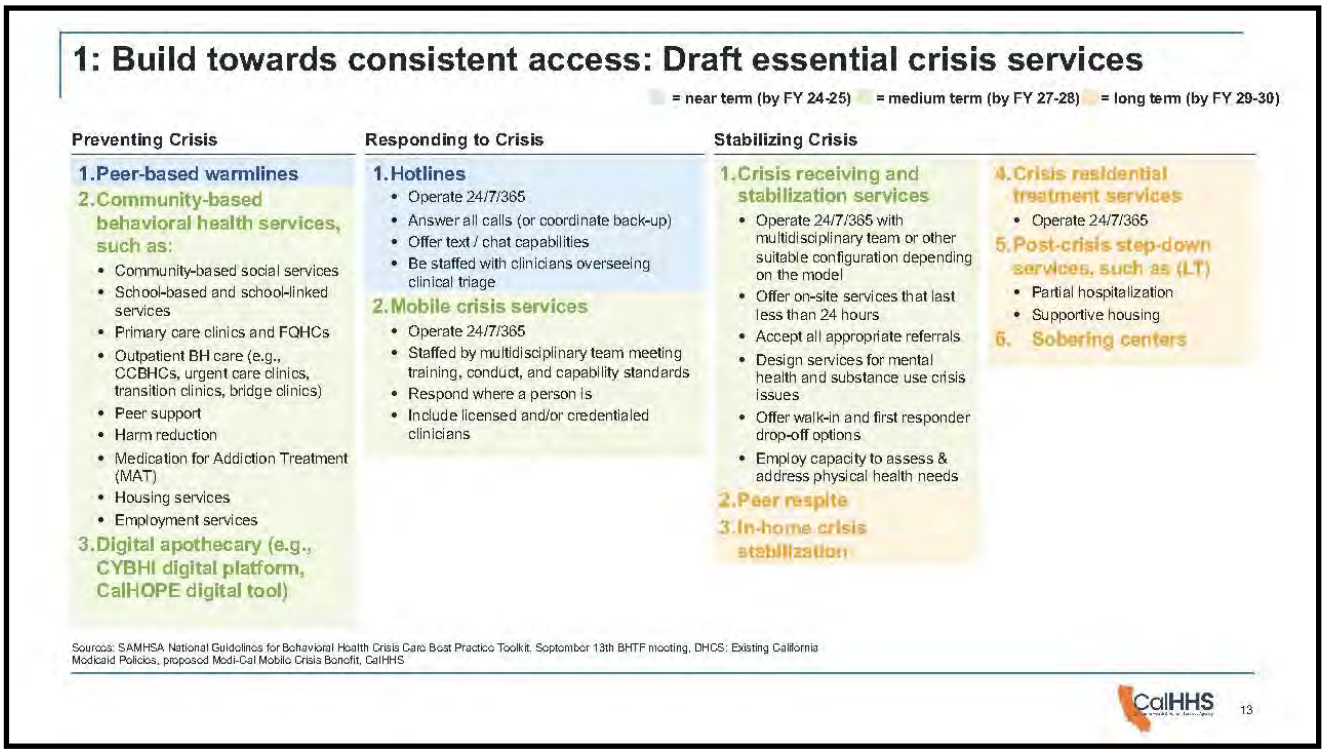
CHHS Role—Crisis Care Continuum Blueprint and Roadmap:

- Identify the statewide vision for a full set of services for individuals experiencing crisis: interactions among 988, 911, Medi-Cal mobile crisis response, crisis receiving facilities, long-term crisis residential services
- Articulate statewide minimum standards and metrics
- Define models and prototypes of how statewide services could be implemented locally, recognizing different models will be needed in different counties and communities
- Provide a high-level view of resources required, or current investments that could be used, to support implementation of a robust crisis care response system
- Outline a governance model to support future implementation
- Identify approaches to reach major milestones (the "how-to"), including what would be needed in terms of legislative authority, funding and approximate timing—a roadmap over several years of capacity-building efforts.

According to Welch, the preliminary takeaways of California's performance against national standards for crisis systems are two-fold:

- Existing national guidance documents primarily focus on responding to and stabilizing crises. California may consider prioritizing crises in the context of ongoing public health initiatives in the area.
- When compared to national guidance documents for responding to and stabilizing crises, California meets expectations for hotlines. However, there are inconsistencies for other crisis services operated at the county level.

"We recognize that different communities have different challenges, and there are different ways to achieve the same outcomes," Welch said. "How we communicate about all of this is top of mind to all of us in this room."



Good News Going Forward

Erika Cristo summarized the behavioral health targeted services in Rounds 1-4 of the Behavioral Health Continuum Infrastructure Program (BHCIP). She then outlined application requirements for Round 5 funding, currently open with $480 million available through competitive grants to construct, acquire and rehabilitate real estate assets that will expand service capacity for crisis and/or behavioral health facility infrastructure.

- The target population is vulnerable Californians of all ages, including Medi-Cal beneficiaries.
- Counties, cities, tribal entities, nonprofit and for-profit organizations may apply.
- The application portal is open. Deadline for applications is January 17, 2023, 11:59 p.m. PT. For more information go to: https://www.infrastructure.buildingcalhhs.com/

Medi-Cal Mobile Crisis Services Opportunity:

- American Rescue Plan Act (ARPA) funding is now available for qualifying mobile crisis services between April 2022 and April 2027.
- DHCS will submit a State Plan Amendment that establishes a new Medi-Cal mobile crisis benefit as soon as January 2023.
- DHCS envisions that its mobile crisis service will align with the state's other efforts to support individuals experiencing a behavioral health crisis.
- DHCS is designing a mobile crisis services benefit to ensure all Medi-Cal members have access to coordinated crisis care 24 hours a day, 7 days a week, 365 days per year.

Proposed Benefit Design: SPA Structure & Reimbursement Methodology

DHCS intends to add new pages to the Rehabilitative Services section of the California State Plan to cover mobile crisis services.

- DHCS intends to define a **new Medi-Cal mobile crisis services benefit**, distinct from existing crisis intervention, crisis stabilization, and SUD crisis intervention services.
- Mobile crisis services will be covered in **all three county BH delivery systems**: SMHS, DMC and DMC-ODS
- DHCS is developing a **new reimbursement rate** that effectively covers the cost of delivering 24/7 mobile crisis services. The rate will be designed to account for the unique aspects of mobile crisis, such as:
  - Down time of teams;
  - 24/7 availability of teams;
  - Variable volume of crisis episodes across time of day and geographies; and
  - Follow-up services and connections to ongoing supports.

Benefit Design: Staffing Requirements & Required Service Components

Staffing Requirements

- **During the initial onsite mobile crisis response, the mobile crisis team shall consist of at least two qualified providers** (see BHIN 22-064).*
- At least one of the onsite team members must be trained to administer naloxone to reverse opioid overdoses.
- To ensure appropriate clinical support is available, at least one of the onsite team members should be an LPHA or a Licensed Mental Health Professional. If they are not available onsite, the mobile crisis team must have immediate access to an LPHA or Licensed Mental Health Professional via telehealth.
- During the initial mobile crisis response or as part of follow-up, the mobile crisis team must have access to an individual who can prescribe MAT or psychotropic medications, as needed.

Service Components

- Each qualifying mobile crisis services encounter must include, at minimum:
  - Mobile crisis response;
  - Initial face-to-face crisis assessment;
  - Crisis planning, or documentation in the beneficiary's progress note of the rationale for not engaging in crisis planning; and
  - A follow-up check-in, or documentation in the beneficiary's progress note regarding any exceptions.
- When appropriate, each encounter should also include:
  - Referrals to ongoing services; and/or
  - Facilitation of a warm handoff.

**As part of the implementation process, counties may request DHCS approval to permit mobile crisis services to be delivered by a team of one onsite team member and one or more additional team member(s) immediately available via telehealth (synchronous audio/video or audio-only). See BHIN 22-064 for details.*

Background: Medi-Cal Mobile Crisis Services

Mobile crisis teams offer community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a mental health or substance use crisis.

Under the American Rescue Plan Act (ARPA), **states are eligible for an 85% enhanced FMAP for qualifying mobile crisis services** for 12 quarters between April 2022 and April 2027.*

DHCS **submitted a State Plan Amendment (SPA) to CMS that establishes a new Medi-Cal mobile crisis benefit**, effective as soon as January 2023.

DHCS' mobile crisis services benefit aligns **with the state's other efforts** to support individuals experiencing a behavioral health crisis.

DHCS' mobile crisis services benefit is designed to ensure all Medi-Cal members have access to coordinated crisis care **24 hours a day, 7 days a week, 365 days per year.**

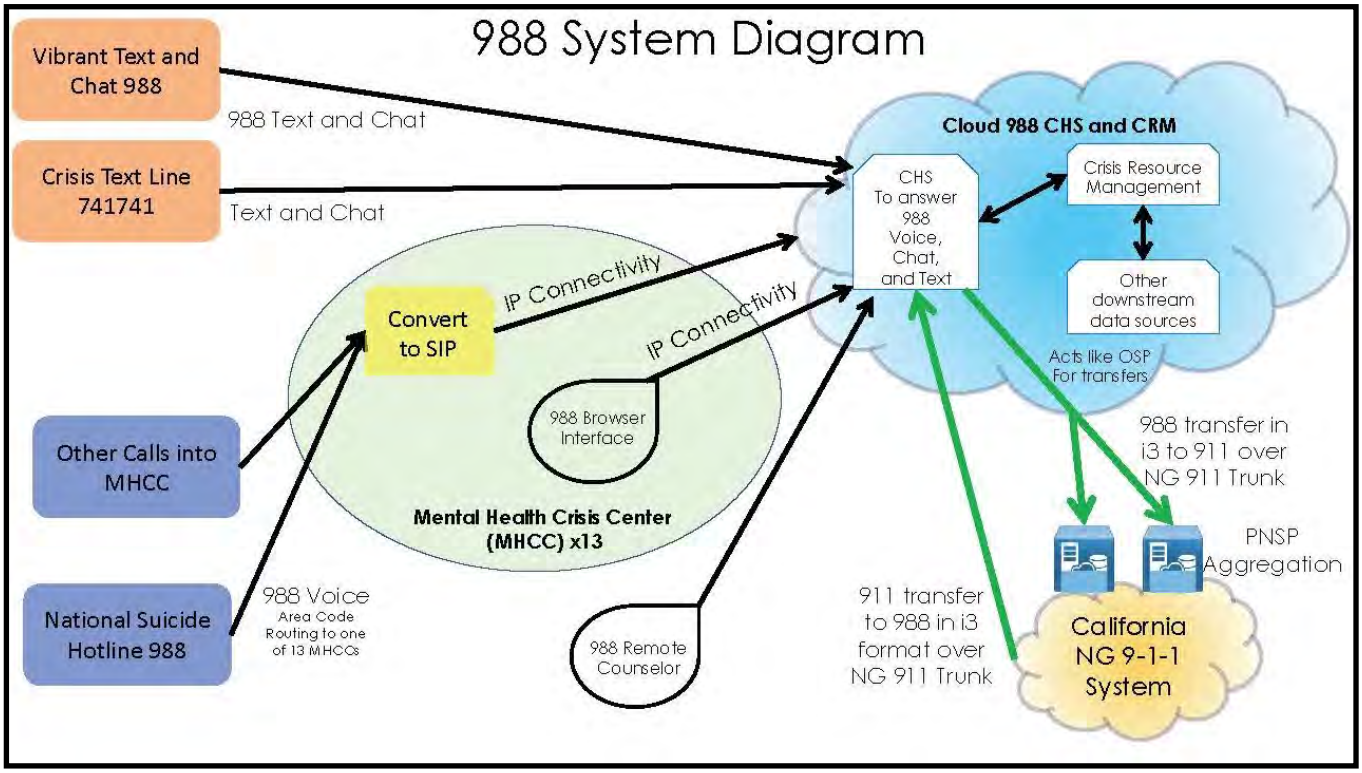
*Medi-Cal behavioral health delivery systems shall begin implementing the mobile crisis benefit as soon as January1, 2023, and shall have the **benefit fully implemented by December 31, 2023.***

Technology Challenges to 988 Call Integration into Behavioral Health Crisis Continuum of Care

Budge Currier kicked off this portion of the session by asking, "How do we integrate all technology needed for emergency communications and put tools into the hands of the people who do the work?"

He added:

- California's Office of Emergency Services (OES) is developing a technology infrastructure and implementation guidelines to enable effective, consistent local level crisis response.
- Equipment installation for 911/988 integration will occur from 2023-2025, although the contract requirements for the technology development and implementation are still in development.



Q & A:

Q: Who is developing the policies for transfers from 911 to 988 and vice-versa?

A: Your local organizations will develop those based on guidelines provided by the Office of Emergency Services.

Q: In developing the Mobile Crisis Response, Law Enforcement was not included. Is that a state goal or up to the county?

A: It was not intended that Law Enforcement would be the only responder through this MediCal Mobile Crisis Response service. There will be teams established and they can involve law enforcement if they need to.

Q: Will Behavioral Health or Law Enforcement be able to bill for services?

A: MediCal will reimburse counties for behavioral services provided by behavioral health professionals through mobile response teams.

Session 2: *Preventing Crisis – Someone to Call*

Moderator: Tom Orrock – Chief, Community Engagement and Grants, Mental Health Services Oversight and Accountability Commission
Jim Kooler – Special Consultant, Office of Strategic Partnerships, CalHOPE, Department of Health Care Services
Shari Sinwelski – Vice President, Crisis Care, Didi Hirsch Mental Health Servics SLIDES
Stacy Kuwahara – Behavioral Health Director, Kern Behavioral Health and Recovery Services, Kern County

Tom Orrock began the session commenting that the Mental Health Services Oversight and Accountability Commission (MHSOAC) is pleased that mobile crisis teams are becoming more prevalent throughout the state. He added that since the legislative changes were made to SB 82, the Commission is now able to provide crisis triage funding providing services to:

- those aged 0-5
- older adults
- early psychosis intervention programs
- youth drop-in centers for ages 12-25.

Jim Kooler explained that CalHOPE evolved from observing how FEMA responds following a crisis. Following the FEMA example, the organization evolved and expanded to reaching "Anyone. Anytime. Anywhere." This approach has led to providing:

- Access to chat services – Crisis counselors are available on Warm Lines and can refer the caller to other resources.
- Pre-clinical services – Meeting people where they are and working to help them before they need further services.
- Prevention services – Addressing behavioral health crises before people feel the need to call 988 because they are in a desperate situation.

Stacy Kuwahara emphasized the different capabilities of each California county. For example, Kern County is one of two counties operating a 988 Call Center. Kern County is establishing a mobile response system, including co-response units as well as a crisis stabilization center. She stated, "Really engaging local stakeholders and creating a space for sharing is vital to success."

Lessons Learned from Kern County

⇒ Mobile response is decades in the making
⇒ Inherent trust and collaboration are vital to successful partnerships
⇒ Details may seem like barriers, but it is important to find collaborative solutions to them
⇒ Connectedness is the key.

Shari Sinwelski cited communication as one of the keys to success in 988 implementation while maintaining effective response to those needing assistance during the transition. "We must communicate to the person on the other end of the line (or chat or text) what to expect NOW," she said. "The responsibility is on our shoulders to communicate in a way that we can get them where they need to go. We're at a crucial juncture."

Technology, opportunity and connectedness quickly evolved as common themes for these three panelists discussing "Someone To Call."

Technology:

- The integration of 988 services with county and city services must continue.
- 988 is normalizing the opportunity to improve our services to diverse communities, making mobile response team training even more important.
- Now that we are moving forward with integrating communications systems, how do we measure system effectiveness? It is important to think about this *now*.

Opportunity:

- COVID-19, weather-related crises and the political/economic issues in the world have brought previously unrecognized or unsurfaced behavioral health issues to the forefront during the last few years.
- CalHOPE evolved and expanded behavioral health care services to "Anyone, Anytime, Anywhere," modeling the FEMA disaster response system.
- With a digital apothecary of applications and resources at our fingertips, technology will help us reach people when and where they need assistance.
- This is a good time to recruit service providers who are patient, kind and know how important it is to also take care of themselves.
- We should promote that this is a profession where service providers can truly change peoples' lives every day.

Connectedness:

- We are making it easier for people to ask for help.
- We are finally understanding the importance of cultural curation messaging, reaching people where they are—providing messengers that look and sound like them.
- We need to keep identifying the right people to do the work of deescalating behavioral health crises.
- We must identify consumer expectations about what they anticipate when they reach out for help and then coordinate our messaging accordingly.
- It is time to ensure that we train all responders to be empathetic, not robotic.
- Behavioral health responders need the encouragement and support of fellow care providers to make the time to care for themselves.

Q & A:

Q: Will 211 be connected with 911 and 988?

A: At this time, Kuwahara responded that Kern County has not integrated 911. Kooler responded that there are no wrong "front doors" to 988. The key is how to weave them all into the fabric to meet needs in our communities.

Q: Is this approach going to reach communities of diversity?

A: Kuwahara responded that 988 is normalizing the opportunity to provide our services to diverse communities.

Q: How does this impact Workforce Development?

A: Kuwahara responded that Kern County behavioral health professionals are required to hold a B.S. degree.

A: Discussion around this and other questions led panelists to reiterate the characteristics of a good call recipient staff member working at 988 call centers:

- Be a good listener
- Be empathetic
- Have the ability to meet the person where they are at
- Have patience and be kind
- Be able to take good care of themselves.

Session 3: *Responding to Crisis – Someone to Come*

Moderator: Karen Larsen – Chief Executive Officer, The Steinberg Institute
Bill Brown – Sheriff-Coroner, Santa Barbara County
Dr. Cherylyn Lee – Behavioral Services Manager, Santa Barbara County Sheriff's Department SLIDES
Leticia Galyean – Chief Executive Officer, Seneca Family of Agencies SLIDES
Karleen Jakowski – Assistant Director Health and Human Services/Mental Health Director, Yolo County Health and Human Services Agency SLIDES

Discussion among this panel centered around the provision of behavioral health crisis services to different audiences in various settings.

Panelists agreed that the benefits of Co-Response Teams include:

- Ensuring the safety of clinicians *and* the safety of the person in crisis.
- Providing a better understanding of mental health and an approach to crisis response that helps keep people who need behavioral health care out of the criminal justice system.
- Offering services endorsed by the National Association on Mental Illness (NAMI).

Santa Barbara County Adopts *The Stepping Up Initiative*

Sheriff Brown and Dr. Lee presented Santa Barbara County's Co-Response Program which pairs Crisis-Intervention-Trained sheriff's deputies with licensed mental health clinicians.

With the simple goal of "Reducing the number of people with mental illness in our jails," Santa Barbara County implemented this program developed in partnership among The Council of State Governments Justice Center, the National Association of Counties and the American Psychiatric Association Foundation

Within the program, the Sheriff's Office:

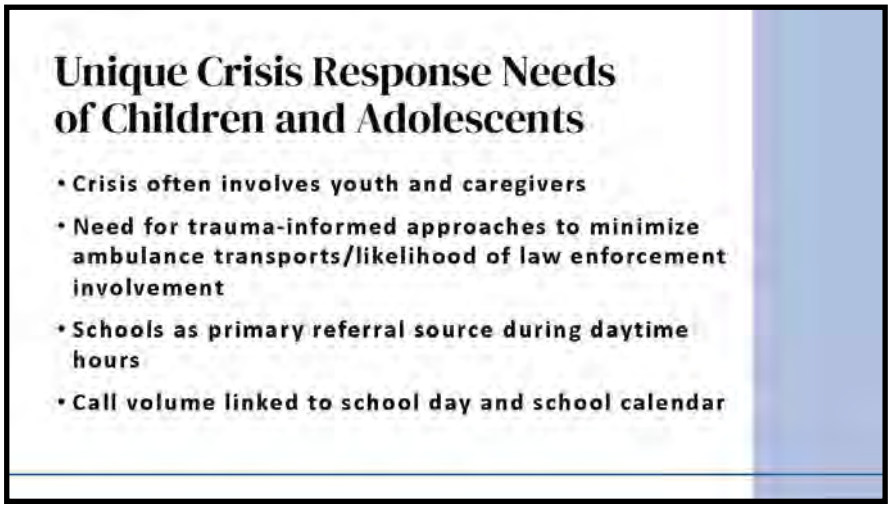
- Initiated a 40-hour intervention training program for three response teams
- Required the response teams wear street clothes as opposed to full law enforcement uniforms
- Provided unmarked department vehicles for the teams to use.

In the first year, the teams responded to 1,606 calls flagged by 911 as mental health issues, resulting in only 11 arrests. The teams worked with those needing assistance to meet basic needs such as food, shelter, transportation and other support services.

Dr. Lee said that one challenge was the department culture. “Police don’t speak clinician, clinicians don’t speak police. That’s why the funding and time for cross-training is so important.” She added that this program works because it is evidenced-based, data-driven.

Within the first six months of using this team approach, Santa Barbara County law enforcement bookings were reduced by 41%, only 13% of those encountered were arrested. Twenty-four percent more individuals than the previous year were engaged in mental health services, most of which were non-crisis, according to Dr. Lee.

Dr. Lee and Sheriff Brown closed with a moving story about how their response team helped save a young man’s life. Because of the clinician’s prior professional relationship with the young man, the emergency response team reached him within seconds of his suicide attempt. Four days later he and his parents visited the sheriff’s office to express their appreciation. Dr. Lee was pleased to share, “We. Saved. Lives.”



Seneca Family of Agencies was founded 37 years ago as a residential treatment facility and served six young people. Today, Seneca serves over 18,000 youth and families annually. Specifically, the Seneca Mobile Response Teams (MRT) provide unique crisis response to children and adolescents, Leticia Galyean said.

- MRTs are comprised of teams of two of the following for in-person crises:
  - ◊ Master’s-level crisis clinicians
  - ◊ Crisis counselors
  - ◊ Peer partners
- The ideal team includes one clinician, one counselor
- Peers predominantly provide follow-up support
- Licensed master’s-level staff provides supervision.

The ideal team, Galyean said, is one clinician and one counselor. Peers provide follow-up support. Each team is supervised by licensed, master’s-level staff.

The Referral Sources for Seneca’s MRT are:

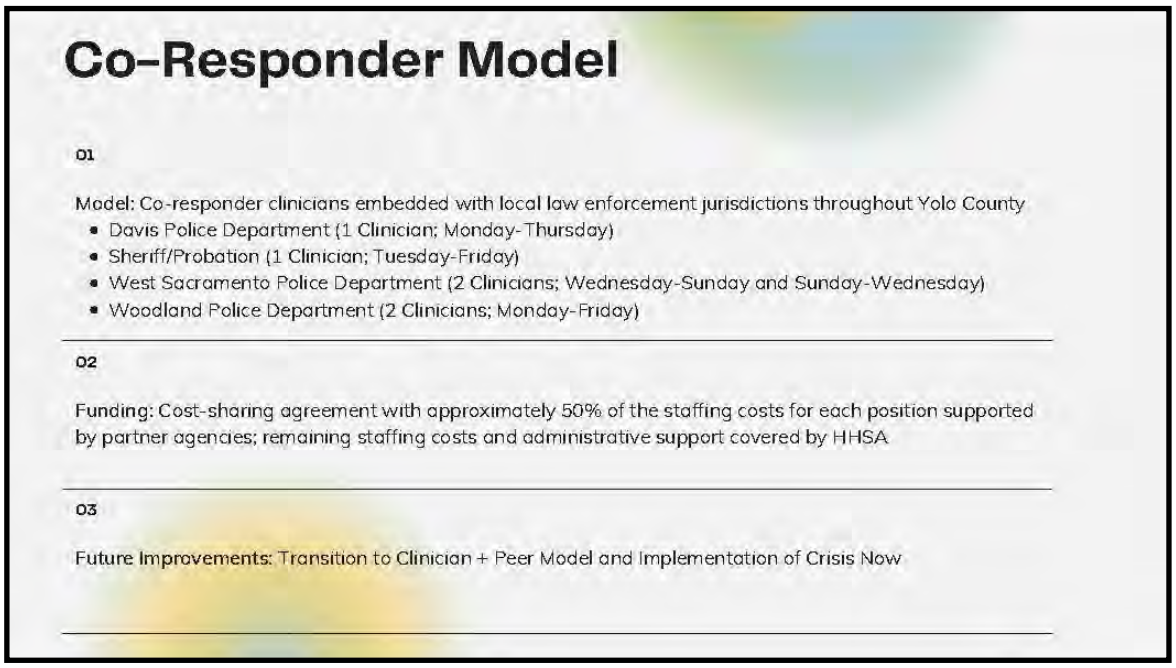
- Youth and family members who can call directly
- Foster youth and caregivers who call the statewide Family Urgent Response Services (FURS) hotline which then dispatches the FURS team
- School staff, emergency services/hospitals, short-term residential therapeutic program (STRTP) staff, mental health professionals and child welfare workers.

Also, according to Galyean, Seneca's Mobile Response Teams are contracted through County Mental Health Plans and serve Medi-Cal youth primarily. In some counties they can serve all youth, regardless of insurance type. The FURS are contracted through County Social Service Agencies. Other primary revenue sources include; Early and Periodic Screening, Diagnostic and Treatment (EPSDT), FURS allocation and other county funding.

Seneca's MRT outcomes:

- ⇒ 40% of calls require in-person, mobile response
- ⇒ 80% of youth in crisis are successfully stabilized and diverted from hospitalization
- ⇒ 80% of youth moved to a lower or the same level of service
- ⇒ 21% of youth moved to lower level of service.

Yolo County implemented its Co-Responder Program model in 2020. In various jurisdictions within the county, at least one clinician is dispatched with the local law enforcement agency on potential behavioral health services calls. Jakowski highlighted the county's development of specialized crisis response vehicles so that clinicians can meet with clients on-scene, in a non-threatening space.



Future Improvements planned will feature implementation of Crisis Now and transition to a clinician and peer model.

Panelists Identified Benefits of Co-Response Teams:

- Ensures safety of both clinicians and the person in crisis
- Reduces arrests
- Provides participants a better understanding of mental health
- Reinforces the knowledge that jails are not an ideal situation for people who need behavioral health treatment

Q & A:

Q: What are your strategies for recruitment and retention of co-responders?

A: Brown responded that his office has "spread a wider net" in recruitment efforts including targeting military staff and generally, "people who want to make a difference."

Lee added that Santa Barbara County also works hard to retain current employees by providing good benefits.

Galyean: Seneca's Flex Up/Flex Out program and salaries.

Jakowski responded in saying that Yolo County promotes the roles as, "fulfilling, a job where there is immediate and positive feedback and Yolo County invests in its staff."

Q: Where is the biggest gap in your communities and in the state for this type of treatment?

A: Santa Barbara County—resources for inpatient/outpatient behavioral health treatment and sustainable funding for places to go.

Jakowski: Funding for: Mobile Response Teams and a place to go.

Galyean: Children's services and acute placement options.

Q: How do we sustain successful models in an economic downturn?

A: Galyean: Become experts in leveraging Federal funding for the state and local level.

A: Jakowski: 1) use the blended funding approach; 2) leverage dollars available; 3) be more intentional about what we're investing in; 4) quantify cost savings, use data to get more funding.

Session 4: *Stabilizing Crisis – Somewhere to Go*

Moderator: Brenda Grealish – Executive Officer, Council on Criminal Justice and Behavioral Health
Amy Ellis – Adult system of Care Division Director, Health and Human Services, Placer County - The Lotus Center SLIDES
Scott Zeller – Vice President, Acute Psychiatry, Virtuity - Sacramento County EmPATH Program SLIDES

The primary focus of this panel discussion was to address the "extreme lack of capacity" and provide broader and more accessible care when patients initially present with behavioral health issues.

LOTUS Behavioral Health Crisis Center recently opened on Placer County's Adult System of Care Campus Roseville, filling a gap in the county's array of mental health services. With the addition of LOTUS Behavioral Health Crisis Center, the county now offers a one-stop approach for those in need of services.

Placer County's Adult System of Care Campus now offers:

- Primary Care
- Outpatient Care (including Wellness Center)
- 30-Day Crisis Residential Capacity (voluntary)
- Psychiatric Hospitalization (involuntary)
- Urgent Crisis Services (voluntary) (LOTUS Center)

Additional services offered on-site include:

- Adult Protective Services
- Public Guardian
- In-Home Support Services.

At the LOTUS Center, residents will work with trained clinicians in a calm environment to create a plan to access additional services necessary when discharged. These include housing, social services and, if necessary, substance abuse treatment. Placer County adults needing behavioral health assistance can call a 24-hour phone line for screening and assistance. Adults can also be referred to LOTUS Center by law enforcement, healthcare professionals, local, state and federal agencies and other partners.

The following differentiate the LOTUS Center from other levels of care:

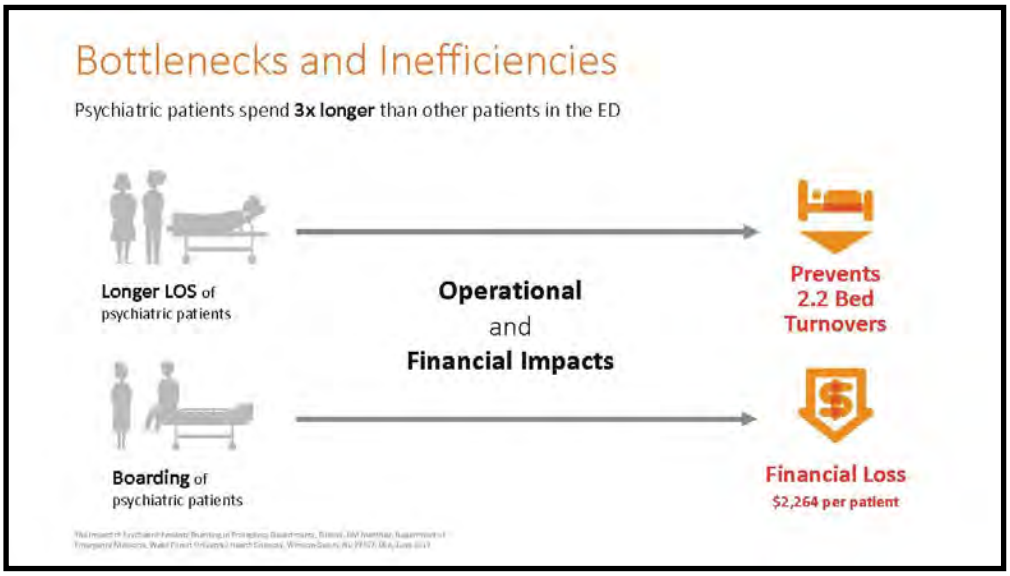
- Homelike environment with linkage to follow-up care
- Low barrier to entry
- Eligible to Placer residents
- Insurance type not exclusionary
- Operational support is provided by North Valley Behavioral Health.

According to Ellis, adding the LOTUS Center to its other services:

- Alleviates a burden of people presenting with behavioral health issues in emergency departments
- Reduces behavioral health crises-related contact with law enforcement officials
- Expedites access to other services and resources for those with behavioral health needs
- Provides a voluntary and safe option for consumers needing time to create a long-term care plan
- Improves outcomes for clients.

The center is funded by the MHSOAC, Sutter Health, Kaiser Permanente, Anthem Blue Cross and California Health and Wellness.

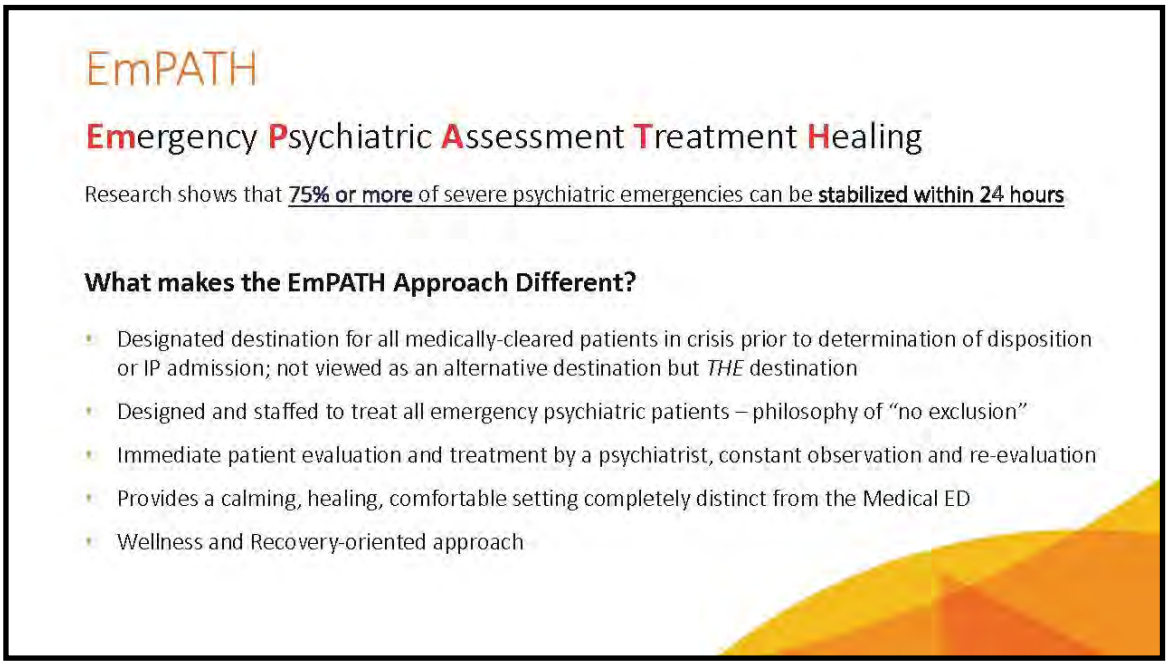
Sacramento County's EmPATH Program addresses the increase of behavioral health patients nationwide, 1 in every 7, presenting at hospital emergency departments. EmPATH works within hospital systems to enhance the care behavioral health patients receive when they initially step into the emergency department—developing a hospital-based Crisis Stabilization Unit (CSU).



"Emergency rooms are not set up for behavioral health emergencies," Zeller said. "They provide unpleasant experiences and result in longer (hospital) stays. EmPATH provides the least

restrictive level of care for high acuity/comorbidities. It is a patient-centric, trauma-informed program."

"Between 12 and 15 percent of all emergency department visits nationwide are mental health related," Zeller said. "At least 7 to 8 million emergency psychiatric assessments are made each year in the U.S. and behavioral health stays in the emergency department often average over 30 hours."



According to Zeller, an EmPATH program offers a multidisciplinary team approach to behavioral health care comprised of:

- Psychiatrists/Psychiatric Providers
- RNs
- Social Workers
- Psychiatric Assistants
- LVNs/LPTs
- Peer Support Specialists.

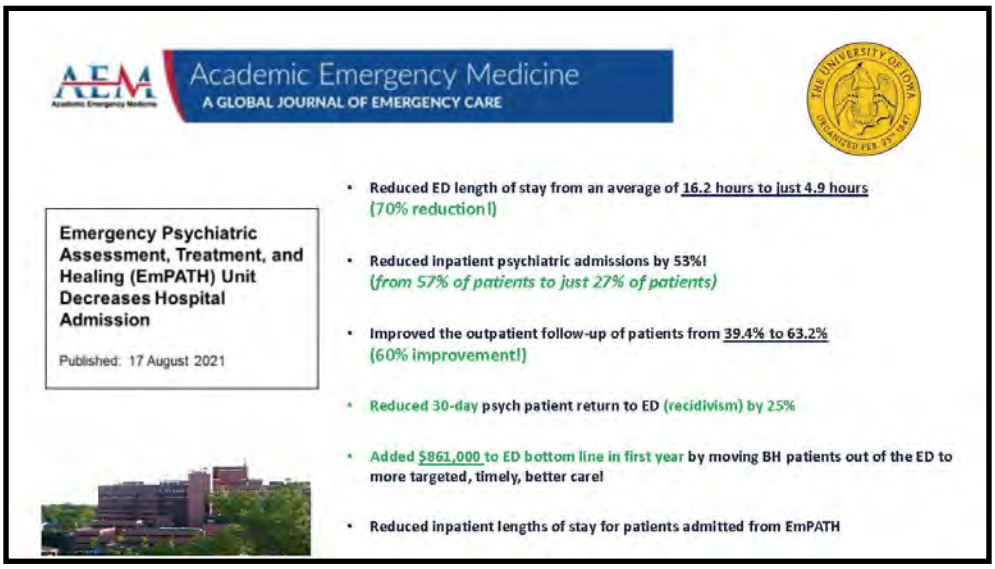
The EmPATH model includes a dedicated physical space designed to provide a calming, healing environment that prioritizes safety and freedom. Space should allow for at least 80 square feet total per patient, a large, open space with high ceilings and ambient light, fold-flat recliners, an open nursing station with instant access to staff and voluntary calming rooms.

Zeller added that the patient benefits to the EmPATH model are:

- Trauma-informed Unit in a home-like care setting
- Calming environment; patients can serve themselves snacks and beverages
- Multi-disciplinary treatment team involved from arrival to disposition
- Constant observation
- Rapid evaluation by psychiatrists; comprehensive care plan development
- Restraint elimination (less than 1%).

Similarly, the benefits for a hospital utilizing the EmPATH model include:

- EMTALA-compliant
- Emergency Department capacity creation
- Reimbursement options
- Eliminates unnecessary admissions (up to 80%)
- Reduces payer denials for inpatient psychiatric units
- Cost-effective implementation.



Q & A:

Q: Is there a review of information about the reduction of incarceration through this program?

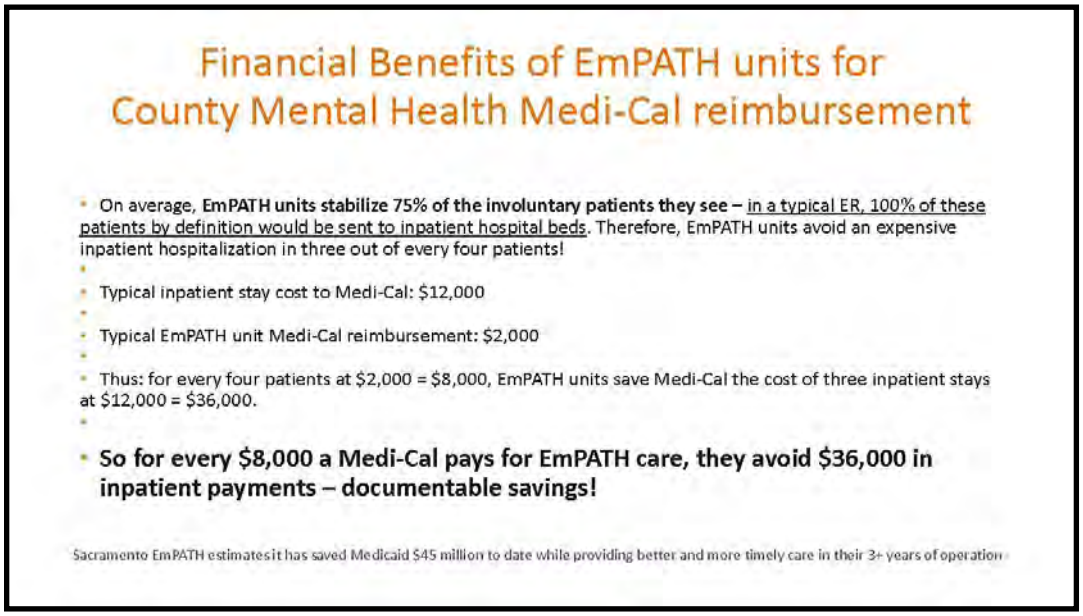
A: Zeller said there was no data available on this subject.

Q: What does "transition to care" mean in this program?

A: Zeller said it means taking the patient to a less restrictive level of care whenever possible—not necessarily hospital -based; when appropriate, in coordination with community services.

Q: Is there any reimbursement for the EmPATH program?

A: Zeller said there is some among CMS and private payers (see information below).



Thursday, November 3

Taking Action! Deep Dive, Blue-Sky Sessions - What Keeps You Up at Night?

Session 1: *Beyond the Crisis—Step Down Residential Services and Permanent Housing*

How do we DO it? Continuing from Day 1, exploring challenges and solutions.

Moderator: Brenda Grealish – Executive Officer, Council on Criminal Justice and Behavioral Health
Corrin Buchanan – Deputy Secretary of Policy and Strategic Planning, California Health and Human Services Agency NOTE 1 NOTE 2
Manuel Jiménez, Jr. – Regional Director, La Familia Central Valley – Step Down and Unique Housing Programs – Ever Well model
Veronica Kelley – Chief, Mental Health and Recovery Services, Orange County Health Care Agency – Step Down & Unique Housing Programs – Be Well Model SLIDES
Tyler Fong – Senior Director of Program Initiatives, Brilliant Corners – Permanent Housing Model SLIDES
Teresa Pasquini – Founder, Housing that Heals SLIDES VIDEO

Brenda Grealish introduced the session saying there are many models that present a unique opportunity to prevent criminal justice booking and stabilize the crisis. Once that is accomplished, those individuals will need longer term services and supports. Arguably, according to Grealish, these could also be used to prevent crisis in the first place.

Corrin Buchanan started the session explaining that "Housing is important to being able to provide services to behavioral health patients. They need stability and safety in their lives."

To do so, Buchanan said, "We really need to create low-barrier entry housing that is community-based and non-institutional. It should be welcoming and safe so that people want to be in it and feel like a part of the community. This is really about being able to address the whole person."

She added that a continuum of housing settings is imperative to solving the homelessness issue, keeping our eye on the prize of permanent supportive housing, our gold standard when addressing homelessness." One step is bridge-housing (short-term housing) for people who may be transitioning out of institutional settings or coming off the street.

"In my career I've always thought we also really need board and care settings for people with more complex care needs who can't live independently," she said. "We often create permanent supportive housing models where service is provided on site." Buchanan went on, "We could also use (more) scattered site housing where service providers visit clients in roving teams. We need project-based housing that looks different (from what it is now)."

Buchanan added a summary of "significant, historic funding and important work that has been happening in terms of significant budget investments around ending homelessness in the state of California."

Historically California has relied upon about $500 million per year in HUD Funding which typically goes to homeless housing settings that are already filled, according to Buchanan.

However, over the past two years, California has invested $15 billion in ending homelessness—30 times the normal funding usually available to do the work of ending homelessness.

"This is a big deal! Unfortunately, homelessness has recently also increased, based on two major limiting factors," she said. The first limiting factor is the work force. "We need to think creatively and innovatively in how we solve this. There are certainly some good models around the state for how to recruit new staff to come and help us do

this important work," Buchanan said.

The second issue impacting the increase in homelessness is housing stock and housing availability. "There are lots of innovative housing models in California," Buchanan said. The state needs to take what she calls, "the leave-no-stone-unturned approach." She cited hotel/motel and office space conversions, modular office space and existing, unused buildings as some options for housing for the homeless.

"We cannot miss this opportunity to make meaning of this $15 billion dollars," Buchanan added.

In order to accomplish that, she urged conference attendees to familiarize themselves with funding for community-based housing and with the topic of homelessness itself.

Major investments that are important to understand:

- Department of Social Services—Housing and Disability Advocacy Program, county level departments of Health and Human Services
- Community Care Expansion Capital Fund--$800M; available to not-for-profit, for-profit and local government organizations for new board and care settings as well as rehabilitation and operations subsidies of existing facilities
- Department of Health Care Services CalAIM—funds available for social drivers of health, particularly housing. New benefits include:
    - ◊ Enhanced Care Management (care coordination)
    - ◊ Community Supports (short-term housing, recuperative care, housing deposits, funds to help people stay in their homes);
- Behavioral Health Bridge Housing Fund--$1.5 billion that was made available in last year's budget to county behavioral health departments to support clinically enhanced shelters, board and care housing settings and housing subsidies for those with complex behavioral health diagnoses
- Department of State Hospitals--$500M available for those who have been found incompetent to stand trial for community-based diversion, housing and shelter settings.

Buchanan recommended that providers should get to know:

- Their local homeless continuum of care
- Department of Social Services at the county level
- Managed care plan representatives in your community or region
- A guide for state funding for Homelessness Services and a Homelessness 101 document which she is including in this session's notes section.

"Locked facilities are nobody's home," Manuel Jiménez, said, effectively summarizing the focus of the panel discussion about the importance of making housing available for those enduring a behavioral health crisis. He described the Ever Well model utilized by La Familia Central Valley, which includes community living support, crisis reconciliation, targeted residential treatment and extended care recovery programming.

"We have challenging clients that we serve in the county. When they get very challenged they start to climb the ladder of need for care," Jimenez pointed out. "Then there are two costs that we get concerned about: payroll and locked facilities."

Jimenez said that as he has worked throughout various areas and components of the behavioral health care

services system, he has always strived to get residents out of locked facilities so that they can learn how to care for themselves. “As counties we need to work for more board and care programs,” he said.

To that end, Ever Well provides an integrated residential program for people who may face significant mental, emotional and cognitive, and substance use programs. In the Stockton area, that includes five behavioral issues treatment enclaves that provide a comprehensive array of services including:

- Coordinated primary care
- Residential treatment
- Mental health services
- Medication management
- Short and long-term living and supportive services.

Ever Well’s healing community enclaves continue to be the front line of community treatment for multiple high needs, complex mental health and forensic clients. This is more cost-efficient than taking clients from where they live to another location for services, Jimenez added.

“Ever Well has a good step-down model, as well as a step-up model for limited time of care, according to Jiménez. “And even more importantly, Ever Well is an unlocked facility. It works.”

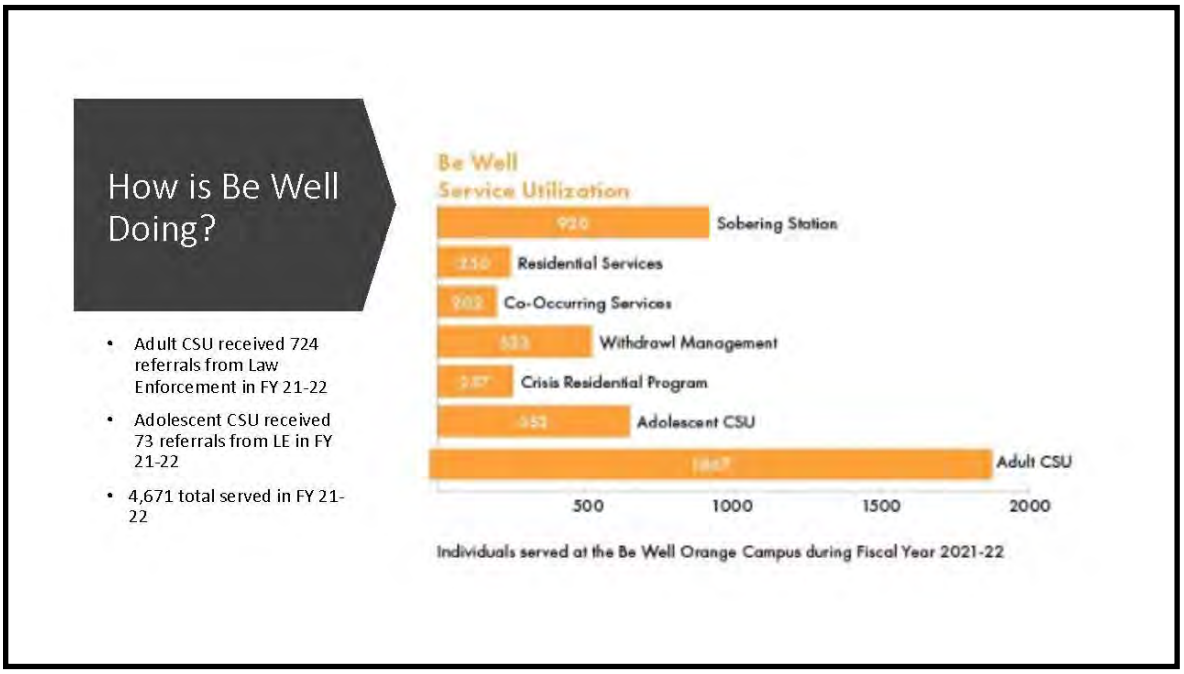
The Ever Well Treatment model is research based—serving people from the age of 18 to those receiving hospice and senior services. Currently, the youngest service recipient is 19 and the oldest is 93, all being served by multiple levels of primary, residence-based, short- and long-term cooperative living programs. “A lot of times after our clients have been in an Ever Well enclave we are able to place them in the community,” Jiménez concluded.

Veronica Kelley provided information about Be Well OC, a new treatment facility in Orange County that utilizes a Step-Down Crisis Continuum and offers coordinated behavioral health services to all Orange County residents regardless of payor. “I think we all know crisis is not a one-and-done. So after your 23 hours in a CSU you are not necessarily out of crisis, particularly if you are experiencing a serious mental illness or a substance abuse disorder,” Kelley said.

To address this need, Be Well OC’s range of services includes:

- Sobering Station (Orange County’s first)—a safe place for persons experiencing intoxication which includes monitoring and referrals to follow-up services for substance use disorders
- Residential Services—a non-institutionalized, 24-hour, short-term residential unit that provides rehabilitation services
- Co-Occurring Residential Services for Mental Health and Substance Use Disorders-treatment for individuals with both mental health and substance use disorder needs
- Withdrawal Management services—detoxification services, monitoring, counseling and referral to treatment and other services
- Crisis Residential Program with immediate admission for anyone unable to be stabilized—positive, temporary alternatives for those experiencing acute psychiatric episodes or intense emotional distress who might otherwise face voluntary or involuntary inpatient treatment
- Adolescent and Adult Crisis Stabilization Program—provides 24/7 psychiatric crisis stabilization services for adults and adolescents experiencing a behavioral health crisis.

Kelley said that Be Well OC has recently opened to residents from surrounding communities and because of need, the organization is investigating opening a Be Well Irvine facility. Be Well OC is payer agnostic. Currently, 75% of Be Well patients are covered by Medi-Cal, 10% are unfunded and 15% are private pay. In addition, according to Kelley, Be Well OC is supported by the county, local hospitals and private donors. "Everyone should have access to behavioral health services because everyone deserves dignity and respect," Kelley said.



Kelley cited opportunities and challenges:

- We've learned we need more of these facilities—Be Well OC's Crisis Stabilization Unit (CSU) is full at this site.
- Orange County owns 120 acres in Irvine but soil abatement issues require expensive removal before building will be permitted.
- Orange County needs more capacity for children—Be Well Irvine will be a children-and-family focused facility.
- Equitable services are needed in all areas of our county.
- People are refusing to enter other residential facilities so they can stay on the Be Well OC waiting list. That's not efficient or helpful.
- "Everybody and their mama" want to visit our site. Lots of photos, offers of money, encouragement.
- We have to demonstrate our outcomes and have people who want to work with us.
- Making sure people understand we are not a housing organization for the homeless. You don't come to Be Well to get a house, you come to get better so that you can get long-term housing.

Teresa Pasquini, founder of Housing That Heals, is also a "Mom on a Mission" to improve our country's mental health system. "That mission is also grounded in my determination to stop the suffering I have witnessed in my community, my state, my country and here in my own home. It is unnecessary and can be prevented if we would all be willing to stop protecting the status quo," Pasquini said.

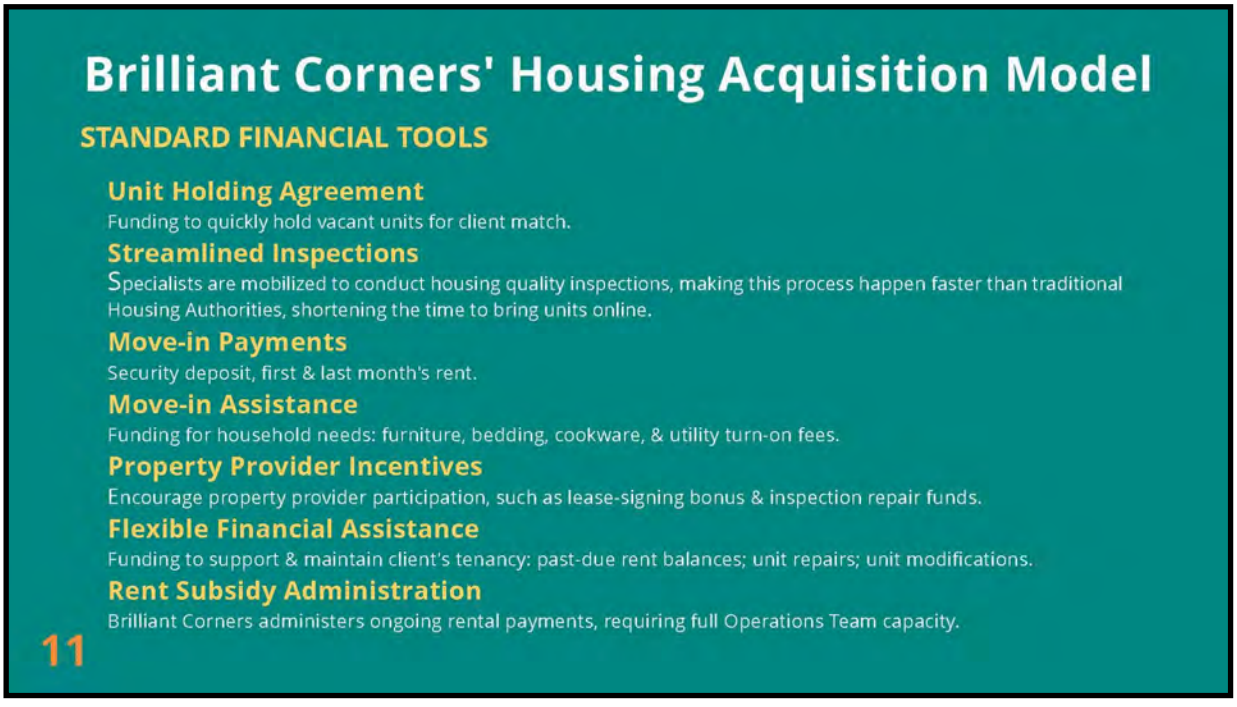
Pasquini shared her personal experience of more than 20 years of trying to find behavioral health services for her son, who, until fairly recently, spent the majority of his life in locked psychiatric facilities in nine different California counties. He was diagnosed in his teens with a serious mental health illness. “There was nothing civil, right or healing about his care,” she said. “Danny was jailed, failed and revolved through systems in nine California counties.”

Finally, Pasquini said her son was referred to the locked California Psychiatric Transitions (CPT) facility which was the right facility at the right time for Danny. At CPT he received the right care and has been on a path to better behavioral health ever since. “I will never forget the day when he called and said, ‘Mom, I have a mental illness’,” Pasquini said. Danny has since graduated from CPT and transitioned successfully to Synergy, an adult residential facility in a community setting. Synergy provides on-site clinical, medical and recovery supports. “This is prevention, intervention, person-and family-centered and value-based care,” Pasquini added.

But that hasn’t stopped this “Mom on a Mission.” “I call both CPT and Synergy ‘Housing That Heals’,” Pasquini said. So, in 2019, she and another mother of a child with behavioral health challenges, Lauren Rettagliata, toured 22 facilities in the state of California in search of a place where their sons could live in a place like home in safety, community and dignity. They subsequently wrote the Housing That Heals White Paper entitled, *Data of the Soul*, with policy recommendations. It was released on Mother’s Day, in May 2020. According to Pasquini, the response has been overwhelmingly positive.

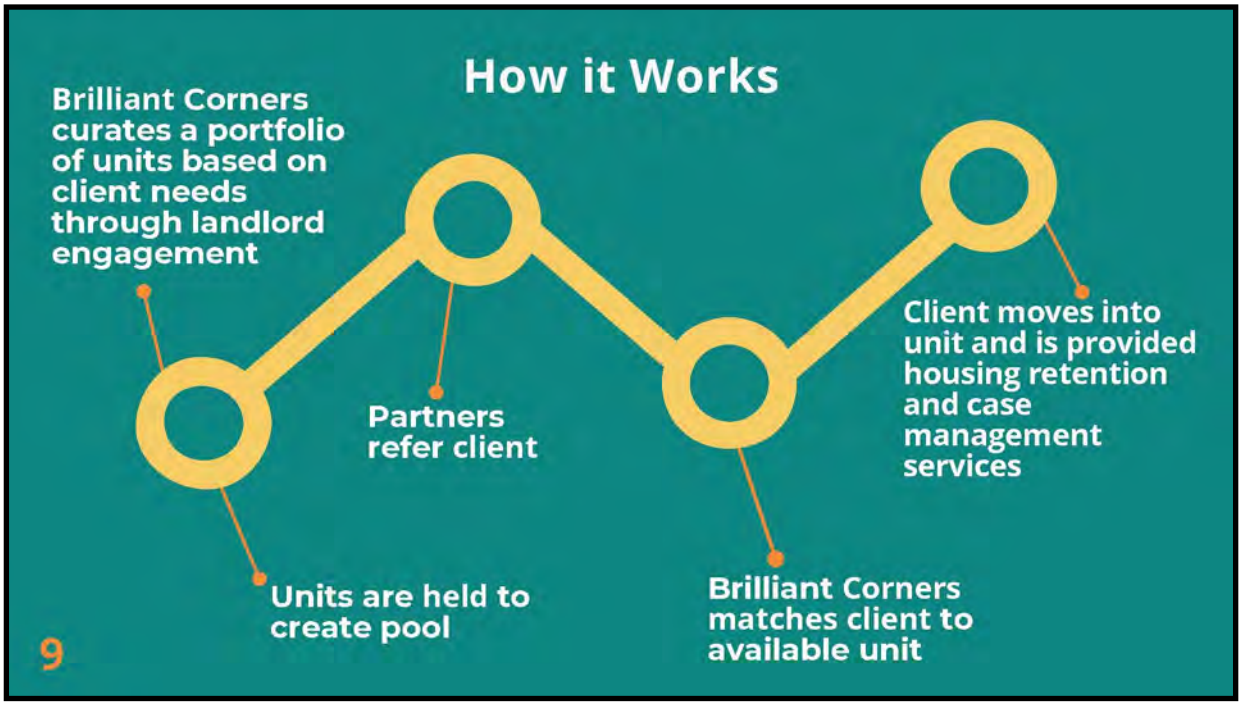
“This was the purpose of our Housing That Heals tour, to show that there are solutions to shatter the status quo and stop suffering,” she said. “The Housing That Heals model will save money, lives and possibly, our national soul. It will bring people home to help, hope and healing.”

“There are not broken people, just broken systems,” Tyler Fong of Brilliant Corners asserted. Brilliant Corners creates housing platforms that serve anyone who needs deeply affordable housing with wrap-around services, regardless of their position in the social safety net. The organization houses over 200 people monthly and successfully partners with 70 agencies. Since 2009, Brilliant Corners has helped house over 10,000 individuals.



"It's about collaboration and communication," Fong said. He highlighted the combination of housing locator services, tenancy support and wrap-around case management as Brilliant Corners' recipe for success in utilizing the nationally recognized Flexible Housing Subsidy Pool. He added that professionalizing these functions contributes to:

- Program impact
- Exceptional service for clients and landlord partners alike
- The ability to rapidly scale housing placements for thousands of our unhoused neighbors.



Brilliant Corners has a 94% housing rental retention rate, above the national average and an achievement Fong attributes to team effort and subsequently, landlords who are willing to work with a now well-established organization. "Our Tenancy and Case Management Support Team works especially hard to take care of potential issues before they become major ones," he said. "We understand that landlords want four things: 1) paid rent; 2) no vacancies; 3) damage mitigation; 4) support. We provide all of that and more."

Q & A:

Q: Veronica, how do you work with the EMS system? Are you actively included in the EMS system as an option to the emergency department?

A: "Yes, we meet with our EMS Coordinator regularly. Everyone knows about the campus so they know they can come to us (with residents needing services)."

Q: Board and Cares are so important, but they are closing quickly. What about senior citizens with serious mental health issues?

A: Corrin Buchanan: There has been a lot of advocacy around support for adult and senior care facilities that can serve people with behavioral health conditions and how to make sure that those facilities have sustainable funding

streams. I am happy to identify a few of those opportunities at the state level:

- Community Care Expansion Program—capital and capitalized operating subsidy funds
- Behavioral Health Bridge Housing funding—board and care costs
- Assisted Living Waiver Program—expanded capacity for those who need nursing care
- Department of State Hospital--incompetent to stand trial solutions
- MHSA funds
- Housing and Homelessness Assistance fund
- HomeSafe Program
- Housing Disability and Advocacy Program

Q: How do you handle a client who has a pet that creates damage?

A:Tyler Fong: In all honesty, we would cover it just like any other damage that occurred.

Q: Are there additional impediments for providing wrap-around services once a person has found housing and how do you overcome those, e.g., transportation and others.

A: Tyler Fong: Our Brilliant Corners staff travels throughout our communities to assist. We schedule transportation for our clients and we try to find housing locations close to public transportation. We do our best to meet our clients where they're at and will work with our clients to do whatever it takes to minimize these barriers.

Session 2: *Essential Technology – Links to Success*

What do we want and how do we build it?

Moderator: Jim Kooler – Special Consultant, Office of Strategic Partnerships, Department of Health Care Services
Budge Currier – 911 Branch Manager, Statewide Interoperability Coordinator, Office of Emergency Services
Jonathan Porteus – Chief Executive Officer, WellSpace Health SLIDES
Shari Sinwelski – Vice President, Crisis Care, Didi Hirsch Mental Health Services SLIDES

Jim Kooler opened the discussion by asking the group to think about the journey of a crisis-based call from the viewpoint of the caller, the person who needs assistance.

The 988 Suicide and Crisis Lifeline is not one large, national call center, but a network of approximately 200 independently operated, independently funded local and state call centers. Thirteen of these call centers are in California. In 2021, call center staff members answered 272,333 calls.

Shari Sinwelski said 3% of the 988 calls

At this time, 988 callers are provided three options:

- Press 1 to be connected to a line dedicated to veterans' services
- Press 2 for a line for Spanish-speaking callers
- Press 3 for a line for LBGTQ assistance.

If the caller does not choose a prompt, they are routed to their nearest local crisis center.

Individual Chat/Text requests sent to 988 are routed to a California counselor *if* the person reaching out provides their CA zip code. If a local center is not identifiable or not available, that person is routed to a national back-up center.

received at Didi Hirsch crisis center required a welfare check; Jonathan Porteus of WellSpace said 1.5% of the calls their crisis center received required a check of the same type.

Porteus outlined the values that drive WellSpace's crisis response:

- We are the first step in someone's recovery.
- We want to emphasize the role of people who have lived experience as we help others.
- As people move forward in the behavioral services treatment process, we make a commitment that it be to the least restrictive environment.

"In moving forward with the 988 system, we're like air traffic control," Porteus added. "First, we need agreement in values. Then it's about people and communications. We need to decide what we are going to communicate and how we should market it (the 988 call line), without overwhelming the system."

Porteus emphasized the National Guidelines for Behavioral Health Crisis Care established by SAMHSA:

1. 988 Regional Crisis Call Center—Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text, chat). Must meet National Suicide Prevention Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide and offer air traffic control (ATC)—quality coordination of crisis care in real time
2. Crisis Mobile Team Response—Mobile crisis teams available to reach any person in the service area in his or her home, workplace or any other community-based location of the individual in crisis in a timely manner
3. Crisis Receiving and Stabilization Facilities—Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

In meeting these criteria, WellSpace Health provided 988 call center services with 92,000 engagements last year. The organization had a 91% answer rate and its answers averaged 34 seconds. In addition to its Mobile Response Team services, WellSpace Health's Crisis Receiving for Behavioral Health provides:

- 24/7 services
- Up to 24-hours per session
- Both substance abuse and mental health crisis services
- Voluntary respite and engagement with a nurse, SUD Counselor, Mental Health Services Provider, Case Manager and more.

- Transportation to and from the center from partners or the mobile response team.

Similarly, Sinwelski shared, “We’re committed to improving crisis services and advancing suicide prevention by empowering individuals, advancing professional best practices and building awareness.”

Currier said that 988 was established at a federal level, with area code routing, so the states organizing at the state level work closely with the Federal Communications Commission (FCC) as well as the Substance Abuse and Mental Health Services Administration (SAMHSA). He outlined several of the challenges of integrating 988 with 911, emphasizing that the outcome must be to put tools into the hands of the people who do the work in responding to people during a behavioral health crisis.

The challenges going forward in integrating 911 and 988 systems include:

- How do we integrate all the technology needed for emergency communications and the Crisis Response Continuum?
- 988 calls and other crisis lines must enter Crisis Response Centers through one browser location.
- Crisis text and chat lines enter the system separately.

According to Currier, the technical requirements for the integration of 988 and 911 are currently being written, so a vendor has not yet been selected. Complete integration of the two systems will occur from 2023 to 2025.

988 in California Next Steps:

- Complete 988 procurement process—December 2022
- 988 call processing equipment installs 2023-2025
- Develop procedures and best practices on 988 to 911 transfer process and vice-versa
- Continue collaboration with local, state and federal stakeholders
- Update technology to support 988 implementation plan based on AB 988
- Identify and Integrate Mobile Crisis Teams and Technology Implications
- Identify and Integrate Entire Crisis Care Continuum and Technology Implications
- 988 Technical Advisory Board met for the first time on December 8, 2022

Q & A:

Q: Are warm line calls integrated into the new system?

A: That is difficult among 988 centers. More to come.

Q: Are there provisions to bring other people into a 988 call?

A: There will be. That is built into the contract requirements.

Q: What if there is a translation issue?

A: Live, Spanish speaking respondents will be on duty. For other languages we will bring in translation services.

Congratulations
2022 Paradigm Award Winners!

Law Enforcement Champion
Lisa Heintz – Director of Legislation and Special Projects for the Federal Court Receiver, California Department of Corrections and Rehabilitation

Community Champion
Sandri Kramer – Director of Community Relations and Special Projects, Didi Hirsch Mental Health Services

State Champion
Stephanie Welch – Deputy Secretary of Behavioral Health, California Health and Human Services Agency

More Information

For more information about *Words to Deeds* and FMHAC, visit www.fmhac.org or contact:

Forensic Mental Health Association of California
Kit Wall
W2D Project Director
kitwall@sprintmail.com
707.280.7133

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