BEHAVIORAL HEALTH ADVISORY BOARD
General Meeting
Monday, December 14, 2020, 1:00 – 3:30 PM
VIRTUAL MEETING VIA ZOOM

Zoom Participation

The following information referenced below and on page two of this Agenda is provided to you in support of your attending the upcoming BHAB General Meeting via Zoom:

Join the Zoom meeting in the following way:

Join Zoom Meeting: https://us02web.zoom.us/j/83332714732?pwd=bE43OUJqRHhHa0ExSlR5L1VLMWMyQT09
Meeting ID: 833 3271 4732
Password: 149553
Dial-In: 669-900-9128

AGENDA

I. Call to Order

II. Roll Call

III. Welcome and Introductions

IV. Approval of the Agenda – **ACTION** (Roll Call)

V. Approval of the November 16, 2020 Minutes – **ACTION** (Roll Call)

VI. Public Comments (3 min. per speaker)

VII. Chair Comments (5 min.)

VIII. Director's Report – Dr. Sevet Johnson (15 min.)

IX. Board Member Comments and Announcements (10 min.)

X. Secretary's Report – Mary Haffner (5 min.)

XI. BHAB Committee Reports (5 min. each)
- A. Adult Services Committee – Nancy Borchard, Co-Chair / Gane Brooking, Co-Chair
- B. Prevention Committee – Janice Gardner, Chair

XII. Old Business
- A. 2020 Data Notebook Update – Elizabeth R. Stone (15 min)

XIII. New Business
- A. Reducing Disparities in Levels of Service – Request for Creation of Disparities Reduction Committee/Workgroup – Supervisor Linda Parks – **ACTION** (Roll Call) (15 min.)
- B. County's Annual Behavioral Health Legislative Platform – Review and Discuss – Supervisor Linda Parks (10 min.)
- C. Quality Improvement Committee Attendance and Quarterly Reports – Mary Haffner (10 min.)
- D. Meeting Presentations – Reconsider Hosting Objective-Related Presentations – Discussion - (10 min.)
- E. Peer Specialist Collaboration Workgroup – Request for Creation of Workgroup – Discussion - **ACTION** (Roll Call) (10 min.)
- F. Gaps in Services Submissions – Establish a Voting Method to Create a Priority List – Discussion – (20 min.)

Members of the public making oral presentations to the Board in connection with one or more agenda or non-agenda items at a single meeting are limited to a cumulative total time not to exceed (5) minutes for all of their oral presentations at such meeting unless otherwise provided. Public comments on agenda items must be made prior to board member deliberations of agenda items. The entire public comment period is limited to no more than (20) minutes total for all speakers. NOTE: The Chair may limit the number or duration of speakers on a matter. In compliance with the Americans With Disabilities Act, if you need special assistance to participate in this meeting, please contact Behavioral Health Administration at (805) 981-6830. Reasonable advance notification of the need for accommodation prior to the meeting (48 hours advance notice is preferable) will enable us to make reasonable arrangements to ensure accessibility to this meeting.

G. Presentation Requests

H. Recognition Award Recommendations

XIV. Contracts

A. Board of Supervisors Approved Agreements – November 10, 2020

1. Fiscal Year (FY) 2020-21 Netsmart Technologies, Inc. (Netsmart) Agreement
2. FY 2020-21 Casa Pacifica Centers for Children and Families (Casa Pacifica) Agreement and Three Aspiranet Agreements. FY 2019-20 Casa Pacifica Amendment

XV. Public Comments (3 min. per speaker)

XVI. Adjourn

Happy Holidays to all and wishing for a better year in 2021.

Next Meeting: Monday, January 25, 2021

(4th Monday versus 3rd Monday)

Zoom Participation Information - continued

Please note the following important information related to supporting your participation in the upcoming meeting:

1. Zoom will initially start with a "**waiting room**"—you will be "admitted" into the meeting room when the meeting starts.
2. The meeting is recorded and available on the VCBH.org website at the following link: https://vcbh.org/en/general-meeting?own=0
3. All participants are muted upon entry to minimize any unintended disruption of background sounds. Please keep yourself on mute unless you are speaking.
4. Note the following regarding the public comments portion of the agenda:
   a. Public comments are made by **"raising your hand"** in one of the following ways:
      i. If you are joining the meeting via video/audio, you join the comment queue by clicking on the participant window at the bottom of the Zoom screen and then click on the **"raise hand"** feature in that participant window. *Your raised hand will appear in the order it was received.*
      ii. If you are joining the meeting by telephone only, you can join the comment queue by pressing ***9**. When it is your turn to make your comment, press ***6** to unmute and then again to mute yourself.
   b. Comments are taken in the order they are received in the queue/participant window.
   c. When it is your turn to make a comment, you will be asked to unmute yourself.
   d. Public comments may be up to 3 minutes during the public comment period, or before an agenda item, with a cumulative total time not to exceed 5 minutes.
   e. The assigned timekeeper will track each public comment time as well as the total time per speaker. When your time is up, the timekeeper will interrupt to let you know that you have reached the 3-minute maximum as well as when you have reached your total allotted time.
   f. At the end of the three minutes and/or allotted time, the mic will be opened to the next person in the comment queue.

CBHPC 2020 Data Notebook for California Behavioral Health Boards and Commissions

Compiler's note:

The document that follows has been reformatted from the version sent to counties to complete. That version was copied from an online survey. This document has been modified so that explanatory text has been moved to the rear, and is referenced at the point it was originally placed, where the reader is directed to the page in the appendix with the accompanying explanation. All footnotes in the original narrative have been moved to the final page of this document.

Furthermore, most answers to the survey were offered as a list of choices. To preserve that structure, when applicable, the list of choices follows the question. If an answer option is ***BOLD***, ***ITALIC*** and ***LARGER FONT***, that indicates the County has selected that answer option as relevant, or in the case of a prompt for "OTHER," the wording has been provided by staff or the identified respondent and has been supplied verbatim.

Thank you to the numerous VCBH staff who gave their time to gather and share the data and to complete the translation into Spanish (coordinated by Cynthia Salas, Equity Services Manager), as well as BHAB and community members who offered their opinions on the concerns within. (*ers*)

(please see *Cover Page and Introductory information* at Appendix p. 19)

Part I:
Standard Annual Questions for Counties and Local Advisory Boards

(please see *Standard Annual Questions* information at Appendix p. 20)

1.
Please identify your County / Local Board or Commission.

Ventura County Behavioral Health Advisory Board (BHAB)

Adult Residential Care (ARFs)

(please see *Adult Residential Care* information at Appendix p. 20)

2.
For how many individuals did your county behavioral health department pay some or all of the costs to reside in a licensed Adult Residential Facility (ARF) during the last fiscal year? ***UNDUPLICATED***

347 individuals

3.
What is the total number of ARF bed-days paid for these individuals, during the last fiscal year?

94,792 ARF bed-days

4.
Unmet needs: How many individuals served by your county behavioral health department need this type of housing but currently are not living in an ARF?

500 individuals

(Per JS: looking at what we reported in 2019 and exchanging some emails with our Fiscal staff, the questions seem identical. I do not see basis to changing our estimated need. It is speculative, but five hundred (500) more B&C beds would allow us to bring those living in out-of-county B&C back home to Ventura County and provide for those who are currently "going without" but could benefit from access to this level of care.)

5.

Does your county have any "Institutions for Mental Disease" (IMDs)?

- ***No***
- Yes (If Yes, how many IMDs?)

6.
For how many individual clients did your county behavioral health department pay the costs for an IMD stay (either in or out of your county), during the last fiscal year? ***UNDUPLICATED***

- In-County: ***0***
- Out-of-County: ***15 individuals***

7.
What is the total number of IMD bed-days paid for these individuals by your county behavioral health department during the same time period?

3949 total IMD bed-days

Homelessness

(please see *Homelessness*: *Your County's Programs and Services* information at Appendix p. 21)

8.
During the most recent fiscal year (2019-2020), what **new programs** were implemented, or existing programs were expanded, in your county behavioral health department to serve persons who are both homeless and have severe mental illness? (Mark *all that apply*)

all comments from SWW, VCBH Housing Mananger

- Emergency Shelter
  VCBH refers to the County's 4 year-round shelters and provides motel subsidies for clients as needed
- Temporary Housing
  VCBH offers temp housing in the form of rental assistance for sober living facilities. This program, however, is not new nor was it expanded in FY 2019-20.
- Transitional Housing
  VCBH refers to TPF, RAIN and Salvation Army
- ***Housing/Motel Vouchers***

VCBH provided over $400,000 in hotel subsidies for clients in FY 2019-20 owing to a large grant from the State. Following the completion of that project, VCBH has developed practice guidelines for motel subsidy requests

- ***Supportive Housing***
  VCBH added 7 new units of PSH for families in FY 2019-20
- Safe Parking Lots
  VCBH does not operate any safe parking lots. I believe the cities of Santa Paula and Ventura may.
- Rapid re-housing
  VCBH offered some rapid re-housing assistance in FY 2019-20 in the form of rental assistance. This program was not new or expanded.
- ***Adult Residential Care Patch/Subsidy***
  VCBH developed a BHAB Housing Sub-committee who has focused on advocacy for ARFs. The number of ARFs that VCBH contracts with decreases each year.

Other (please specify):

- ***VCBH established a "living situation" field in the electronic health record so that we can quantify homelessness among our clients.***
- ***VCBH referred 66 clients to Project Roomkey, a Covid-related program for high-risk individuals experiencing or at risk of homelessness (info link!!)***

STRTP: Short-Term Residential Treatment Program (Foster Children in Congregate Care)

(please see *Child Welfare Services: Foster Children in Certain Types of Congregate Care* information at Appendix p. 21)

9.
Do you think your county is doing enough to serve the children/youth in group care?

- ***Yes***

from DO, VCBH manager:

- ***VCBH has a long history of collaborating and contracting with Group Care via STRTPs to provide comprehensive mental health services for youth needing this level of care.***

In addition, Ventura youth have access via referral to psychiatric assessment and treatment, Wraparound services, Therapeutic Behavioral Services and Intensive Home Behavioral Services which augment the treatment services. In addition, Ventura has a specialized group care provider linked to a Crisis Stabilization Unit which allows for a smooth transition into a STRTP; this ensures continuity of care for our highest risk youth. In addition, a Joint Management & Governance is in place with Behavioral Health, the Human Service Agency and Probation Department that place youth in group care to receive mental health services; this allows for cross system coordination and intensive care coordination. An Interagency Placement Committee is also in place for all agencies to participate in placement decisions as youth and their families often intersect all the county agencies. Key to the success of additional contracting of additional providers as per CCR legislative mandates, are standing quarterly Group Home meetings with providers and on-going technical assistance to group homes transitioning into STRTPs.

from JG, BHAB member:

- ***Yes, VCBH has an entire division devoted specially to Children/Youth and their needs.***

- ***No***

(If No, what is your recommendation? Please list or describe briefly):

from CA, BHAB member:

- ***County services needed for young people who are diagnosed with both a mental illness and developmental disorders.***
- ***In conjunction with school districts, parents of teens should receive education about the early signs of mental illness. This could offered during Back to School nights and provided in multiple languages as needed.***

- ***Mental health services should be available on high school campuses.***

(please see *STRTP* information at Appendix ??)

10.
Has your county received any children needing "group home" level of care from another county?

- No
- ***Yes***

  (If Yes, how many?): ***209 children***

comment from DO, VCBH manager:

- ***Ventura County has several Group Homes and STRTPs with capacity that exceed our local youth's needs due to low out of home placement. There are nine Group Home/STRTP in Ventura with a total capacity of 192 beds at any given time. During fiscal year 2019-2020, over 209 children were placed in Ventura from other Counties including Los Angeles, Riverside, Sacramento, San Bernardino, and Santa Barbara. (source = STRTP External Tracking/State Dashboard).***

11.
Has your county placed any children needing "group home" level of care into another county?

- No
- ***Yes***

(If Yes, how many?): ***14 children***

comment from DO, VCBH manager:

- ***Ventura County has a low number of youth placed outside the county due to efforts related to the Pathways to Wellbeing initiative and Congregate Care Reform efforts; keeping youth local to remain connected with family and their local community is always a priority. For fiscal year 2019-2020, Human Service Agency/Child & Family Services placed 11***

youth out-of-county and the Probation Department placed 3 youth out-of-county. (information provided by HSA/CFS and Probation Administration)

~ ~

Part II:
Telehealth Technology for Behavioral Health

(please see *Background and Context*, *What is Telehealth?*, *The History of Telehealth*, *Telehealth and Health Equity*, and *Telehealth in Behavioral Health* information at Appendix pps. 22-25)

12.
Was your County using telehealth to provide behavioral health services prior to the Covid-19 public health emergency?

No

Yes*

(If yes, how were telehealth services funded prior to the Covid-19 public health emergency?):

- ***Medi-Cal***
- ***Mental Health Specialty $$***

*If Yes, skip to Question 14

13. (skipped)
Did your county decide to offer telehealth services after the Covid-19 public health emergency began?
Yes / No

14.
Did the Covid-19 public health emergency cause your county to modify or adapt your service in any way?

Yes

No*

*If No, skip to Question 16.

15.
Which of the following changes to your services were made? (Please *select all that apply*)

- ***Increased availability of telehealth services***
- ***Expansion of the kinds of services provided via telehealth***

(esp. Crisis Team assessments)

- ***Telehealth training for staff and providers***
  (HIPPA training)
- ***Changes to staffing to facilitate telehealth coordination***
  (reorganization)
- ***Changes to technology/software to facilitate telehealth***
  (Zoom accounts, additional cameras, adding MS Team platform)
- ***Community outreach to promote telehealth services***

Other (please specify):

- ***capacity -> add'l MDs***
- ***Crisis Team conducting assessments for individuals at medical hospitals exclusively by telehealth***

16.
Is your county able to serve both adults and children with behavioral health telehealth services?

Adults only
Children only
Both

17.
Are telehealth services in your county provided by an "in house" provider that is either on contract or an employee of Behavioral Health Services?

Yes
No

18.
Does your county have a contract with an organizational provider out of your area to provide behavioral health telehealth services?

No (SUS)
Yes (MH)
(If Yes, what is the name of the provider organization?):

- ***additional psychiatrists (MH)***

19.
How are consumers able to receive behavioral health telehealth services in your county? (please *select all that apply*)

- ***On personal home computers***
- ***On mobile devices such as a cell phone or tablet***
- ***On a landline phone***
- ***At community clinics or wellness centers***

Other (please specify)

- ***Crisis Team using county cell phones (MH)***
- ***Medical hospital staff providing tablets to individuals on-site for Crisis Team assessments***

20.
What challenges do consumers in your county have regarding accessing and utilizing telehealth services? (please *select all that apply*)

- ***Lack of computer or mobile devices to access telehealth services***
- ***Lack of availability of internet services in the area*** ***(issues of reliability - MH)***
- ***Inadequate internet connection/bandwidth to use telehealth services***
- ***Cannot afford internet service or mobile data plan***
- ***Lack of privacy in the home***
- ***Distrust of telehealth services (MH only)***
- ***Lack of knowledge regarding the availability of telehealth services (SUS only)***
- Difficulty filling/receiving prescriptions that are prescribed via telehealth services

Other (please specify)

- ***decrease in billed minutes as number of contacts have increased, but length of contact has decreased (MH)***
- ***difficulty accessing meds when out of county (MH)***

21.
Does your county provide any of the following accommodations to assist consumers who have barriers to accessing telehealth services? (please *select all that apply*)

- ***Language interpretation for telehealth services***
- ***Text-based services for consumers who are deaf or hard of hearing (TTY)***
- ***Clinic, wellness center, or community-based telehealth access sites***
- ***Assistance in securing a mobile device or internet connection, including equipment loans***

Other (please specify)

- ***in the field during crisis situations (MH)***

22.
Which of the following does your county have difficulty with when it comes to providing behavioral health telehealth services to consumers? (please *select all that apply*)

- ***Technology/software***
- ***Network bandwidth to support secure and quality connection***
- Telehealth training for staff and providers
- Scheduling and coordinating telehealth services
- ***Getting provider buy-in (VCMC: MS Teams vs. Zoom security concerns for crisis assessments)***
- ***Encouraging consumer/community adoption and utilization (SUS)***
- Difficulty navigating regulations regarding telehealth

Other (please specify)

- ***Privacy concerns at working site (MH)***
- ***Bilingual capacity (MH)***

23.
Who normally schedules and coordinates telehealth services in your county? (please *select all that apply*)

- Dedicated telehealth coordinator
- ***Case manager***

- ***Social worker, counselor, or other licensed mental health professional***
- ***Nurse***
- ***Individual medical providers***

Other (please specify)

- ***Office Assistants*** ***(OA = administrative staff) (MH)***
- ***Medical hospital staff for crisis assessments***

24.
While your county has been using telehealth to provide behavioral health services, have you noticed any changes in your no-show/cancellation rates for the following age groups?

	Increase in no-shows/cancellations	Decrease in no-shows/cancellations	No change
Children (age 15 or below)			***MH / SUS***
Transition-Age Youth (16-21)			***MH / SUS***
Adults (22-64)		***MH / SUS***	
Older Adults (65+)		***MH / SUS***	

25.
Has the use of telehealth increased access to behavioral health services for any of the following groups? (please *select all that apply*)

- ***Rural or distant communities***
- ***Low-income communities***
- ***Racial/ethnic minorities (MH)***
- ***Older adults***

Other (please specify)

- ***Individuals who are at an Inpatient facility (MH)***
- ***By reducing response time for Crisis Team, staff availability is greater and more people have been served***

26.
Has your county experienced any of the following benefits of using telehealth to provide behavioral health services? (please *select all that apply*)

- ***Increased consumer outreach and engagement***
- ***Increased appointment attendance***
- ***Improved case-management for consumers with high needs (providing this has been challenging on the MH side due to social distancing requirements)***
- ***Improved clinical workflow and overall practice efficiency (SUS)***
- Providers can serve more patients
- ***Easier to connect with families with small children***
- Increased staff morale/decreased burnout

Other (please specify)

- ***Logrando Bienestar ('Achieving Wellbeing' program ** removed location info) has benefitted (MH)***

27.
Is your county having any billing/reimbursement issues regarding behavioral health telehealth services?

No

Yes (if yes, please explain):

28.
How confident is your county that behavioral health services provided via telehealth are being billed in an appropriate and accountable manner?

- ***Very confident (SUS)***
- ***Somewhat confident (MH)***
- Neutral/unsure
- Not so confident
- Not at all confident

29.
When the Covid-19 public health emergency is over, do you expect your county will want to continue with telehealth to deliver behavioral health services?

- ***Yes***
- No

30.
Please explain ***why*** or why not:

- ***Clients like it (MH)***
- ***More effective access (MH)***
- ***Client preference (SUS)***
- ***Improved access (SUS)***
- ***Client appointment flexibility (SUS)***
- ***Median response time for Crisis Team has been reduced by 20-30 minutes, allowing greater number of people needing services greater access***
- ***Efficiency has been enhanced within the Crisis Team so fewer people are waiting or choose to call 911 in situations perceived to be more urgent***
- ***Safety has increased for Crisis Team, especially by eliminating the need for physical presence in some situations, thereby mitigating the potential for spreading Covid***

31.
Does your county have any additional input concerning the use of telehealth to deliver behavioral health services?

- ***Long-term outcomes remain to be ascertained; especially since the quality of the therapeutic relationship is the key to healing (MH & SUS staff)***
- ***VCBH has done a remarkably nimble pivot, especially given its size and historical challenges to shifting***

from CA, BHAB member:

- ***Telehealth is a great strategy, but barriers remain for those who lack access to technology and wifi. In particular, the County has a substantial population of indigenous farm workers and their families, many of whom do not use e-mail, do not speak English or Spanish, and some of whom are illiterate. Telehealth strategies should adapt to include technologies immigrants are already familiar with, such as WhatsApp using cell phones.***

from JF, BHAB member:

- ***At Aspire Counseling Services, Inc (In which I serve as the Executive Director of Behavioral Health Services), we recognize that telehealth presents many challenges in the delivery of behavioral health services. We use a hybrid model upon which some clients attend onsite (utilizing universal precautions) while others participate through telehealth. Although I am certainly grateful for the telehealth option, I do recognize that therapeutic work, interventions, getting a visceral feel for what clients are going through, building rapport, etc.…have all been challenging with telehealth. However, it is not without benefit in that it is a communication medium that seems to have potential and is better than nothing.***

from JG, BHAB member:

- ***VCBH uses Telehealth for online mental health care, but have noticed that clients do not enjoy staying online for as long as it takes for a therapy session.***

Post-Survey Questionnaire

(please see *Post-Survey Questionnaire* information at Appendix 26)

32.
What process was used to complete this Data Notebook? (please *select all that apply*)

- ***MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions***

- ***MH Board completed majority of the Data Notebook***
- ***Data Notebook placed on Agenda and discussed at Board meeting***
- ***MH board work group or temporary ad hoc committee worked on it***
- ***MH board partnered with county staff or director***
- ***MH board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function***
- Other (please specify):

33.
Does your board have designated staff to support your activities?

- No
- ***Yes***
  (if Yes, please provide their job classification):

- Management Assistant III
- Program Administrator III
- Office Assistant III
- Management Assistant II (x4)

34.
Please provide contact information for this staff member or board liaison.

- Name : **Vickie Poliquin,** Management Assistant III
- County : **Ventura** BHAB Members' support, and BHAB General and BHAB Executive Meetings support
- Email Address : victoria.poliquin@ventura.org
- Phone Number : 805-981-6830

- Name : **Courtney Lubell,** Program Administrator III
- County : **Ventura** BHAB General Meeting Zoom Engineer
- Email Address : Courtney.Lubell@ventura.org
- Phone Number : 805-981-5453

- Name : **Mariella Aguilar,** Office Assistant III
- County : **Ventura** BHAB General Meeting Zoom Engineer
- Email Address : Courtney.Lubell@ventura.org
- Phone Number : 805-981-5453

- Name : **Joanna Peterson,** Management Assistant II
- County : **Ventura** BHAB Executive Meeting Zoom Engineer/Alternate Engineer for BHAB Committee Meetings
- Email Address : joanna.peterson@ventura.org
- Phone Number : 805-981-1881

- Name : **Kayla Fisher,** Management Assistant II
- County : **Ventura** BHAB Adults Services Committee support
- Email Address : kayla.fisher@ventura.org
- Phone Number : 805-981-2294

- Name : **Gracie Lopez,** Management Assistant II
- County : **Ventura** BHAB Youth and Family Services Committee support
- Email Address : gracie.lopez@ventura.org
- Phone Number : 805-981-2240

- Name : **Cari Kawell,** Management Assistant II
- County : **Ventura** BHAB Prevention Services Committee support
- Email Address : cari.kawell@ventura.org
- Phone Number : 805-981-6831

35.
Please provide contact information for your Board's presiding officer (Chair, etc).

- Name : Jerry Harris
- County : Ventura
- Email Address : jmharris007@roadrunner.com
- Phone Number : 805-990-7433

36.
Do you have any feedback or recommendations to improve the Data Notebook for next year?

from ERS, BHAB member:

- ***While entering data online to transmit to CBHPC may be easier as a survey, the regulation to review and share information among numerous parties rendered the PDF version supplied by***

CBHPC unusable, resulting in an unnecessarily onerous process of reformatting and copying the form and data.

- ***It is unconscionable that a statewide agency of such major responsibility would fail to have available to Counties, nor for statewide consumption, a version of the survey and statewide results in Spanish in addition to English.***

APPENDIX

CBHPC 2020 Data Notebook for California Behavioral Health Boards and Commissions

Prepared by the Performance Outcomes Committee of the California Behavioral Health PlanningCouncil

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies, and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally and linguistically responsive, and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

For information, you may contact the following email address or telephone number:
DataNotebook@CMHPC.ca.gov
(916) 701-8211

Or, you may contact us by postal mail at:
Data Notebook
California Behavioral Health Planning Council
1501 Capitol Avenue, MS 2706
P.O. Box 997413
Sacramento, CA
95899-7413

Introduction: Purpose and Goals: What is the Data Notebook?

The Data Notebook is a structured format to review information and report on each county's behavioral health services. A different part of the public behavioral health system is focused on each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for individuals across the lifespan.

Local behavioral health boards/commissions are required to review performance outcomes data for their county and to report their findings to the California Behavioral Health Planning Council (Planning Council). To provide structure for the report and to make the reporting easier, each year a Data Notebook is created for local behavioral health boards to complete and submit to the CBHPC. The discussion questions seek input from the local boards and their departments.
These responses are analyzed by Council staff to create an annual report to inform policy makers, stakeholders and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates[1] to review and comment on the county's performance outcome data, and communicate its findings to the CA Behavioral Health Planning Council;
- To serve as an educational resource on behavioral health data;
- To obtain opinion and thoughts of local board members on specific topics;
- To identify unmet needs and make recommendations.

The 2020 Data Notebook is focusing on telehealth and other strategies to provide services during the COVID-19 public health emergency. This topic comprises only part of the Data Notebook. We also have developed a section (Part I) with questions that are addressed each year to help us detect any trends. Monitoring these trends will assist in identification of unmet needs or gaps in services which may occur due to changes in population, resources available, or public policy.

The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing responses for the Data Notebook. This is an opportunity for the local boards and their county behavioral health departments to work together to identify important issues in their

community. This work informs county and state leadership about local behavioral health programs, needs, and services. This information is used in the Planning Council's advocacy to the legislature and for input to the state mental health block grant application to SAMHSA[2].

Part I:
Standard Annual Questions for Counties and Local Advisory Boards

In recent years, major improvements in data availability now permit local boards and other stakeholders to consult extensive Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services and Substance Use Disorder Treatment. Similar data are analyzed each year to evaluate county programs and those reports can be found at *www.CalEQRO.com*. Additionally, Mental Health Services Act (MHSA) data can be found in the 'MHSA Transparency Tool' presented on the Mental Health Services Oversight and Accountability Commission (MHSOAC) website.

In addition, members of the Planning Council would like to examine some county- level data that are not readily available online and for which there is no other publicly-accessible source. The items of interest include data that are collected by the counties because they need to know how much they are spending in these service categories and for how many clients. Collecting these data will help us analyze aspects of the behavioral health system that are not currently tracked.

Please answer these questions using information for fiscal year (FY) 2019-2020 or the most recent fiscal year for which you have data. Not all counties will have readily available data for some of the questions asked below. In that case, please enter N/A for 'data not available.'

Adult Residential Care

There is little public data available about who is residing in licensed facilities on the website of the Community Care Licensing Division at the CA Department of Social Services. This makes it difficult to determine how many of the licensed

Adult Residential Care Facilities (ARFs) operate with services to meet the needs of adults with chronic and/or serious mental illness (SMI), compared to other adults who have physical or developmental disabilities. In 2019, legislation was introduced that would authorize and require collection of data from licensed operators about how many residents have SMI and whether these facilities have services these clients need to

support their recovery or transition to other housing. This bill has been passed by the Legislature and is on the Governor's desk for action.

The Planning Council would like to know about the ARFs and Institutions for Mental Diseases (IMDs)[3] located in your county to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs.

Homelessness: Your County's Programs and Services

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at-risk of becoming homeless. California's recent natural disasters and public health emergency have exacerbated the affordable housing crisis and homelessness. Federal funding was provided to states that could be used for temporary housing for individuals living on the streets as a method to stop the spread of the COVID-19 virus. Additional policy changes were made to mitigate the rate of evictions for persons who became unemployed as a result of the public health crisis.

Studies indicate that approximately only 1 in 3 individuals who are homeless also have serious mental illness and/or a substance use disorder. While the Council does not endorse the idea that homelessness is caused by mental illness nor that the public behavioral health system is responsible to fix homelessness, financially or otherwise, we know that recovery happens when an individual has a safe, stable place to live.

The past several months have been like no other we have seen in recent history. We understand that the public behavioral health system has had to drastically change how it does business and possibly halt a number of activities that may have been in the works for implementation this year. That said, we are interested in what types of actions counties may be taking to assist individuals who are homeless and have serious mental illness and/or a substance use disorder.

Child Welfare Services:
Foster Children in Certain Types of Congregate Care

About 60,000 children, under the age of 18, in California are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receives foster children but a small number of the children need a higher level of care and are placed in a 'Group Home'. California is striving to move away from the use of long-term group homes, and prefers to place all youth in family settings, if possible. California has

revised the treatment facilities for children whose needs cannot be safely met initially in a family setting. Group homes are to be transitioned into a new facility type called Short-Term Residential Treatment Program (STRTP). STRTPs will provide short-term, specialized, and intensive treatment individualized to the need of each child in placement.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your board to talk with your county director about what is happening in your county for children in foster care who are not yet able to be placed in a family setting or who are in a family setting and experience a crisis which requires short-term intensive treatment. Many counties do not yet have STRTPs and may place children/youth in another county. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

Part II: Telehealth Technology for Behavioral Health

Background and Context

Another goal of this 2020 Data Notebook is to examine the role of telehealth technology to deliver behavioral health services. The COVID-19 public health emergency has led to a swift change in the methods of the healthcare delivery model to meet the needs of consumers, providers, and communities. Adoption of remote technology has been necessary to provide healthcare services in a way that is safe for both patients and staff.

The Centers for Medicare and Medicaid Services (CMS) have instituted time- limited policy changes that expand the definition of medical visits to include telemedicine visits, allowing for much greater freedom in reimbursement of such services4. CMS has also relaxed limitations on using video and text-based applications to communicate and conference with clients. This freedom has allowed local behavioral and mental health departments to expand the use of telehealth services very quickly. Gathering data on the prevalence, benefits, and challenges of telehealth delivery methods will help inform practice and policy at the local and statewide levels as California continues to deal with the COVID-19 public health emergency – and beyond.

What is Telehealth?

The terms "telehealth" and "telemedicine" are closely related, and sometimes still used interchangeably. "Telemedicine" most often refers to traditional clinical diagnosis and remote monitoring using technology. "Telehealth" is becoming a more commonly used

term and encompasses a wider range of health care services that includes diagnosis, care management, education, counseling, and other care that is delivered by technology and telecommunications5.

Definitions of telehealth vary by agency and organization. California law defines telehealth as:

> "The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."[6]

Telehealth methods can incorporate a broad range of telecommunications technology, including but not limited to:

- Telephone communications
- Mobile device communications, including text messages and smartphone applications
- Real-time video conferencing for remote consultation and counseling
- Digital patient education via text, images, and video
- "Remote Monitoring", a method by which providers can track patient's health in real time using technology like heart-rate monitors or glucose monitors
- "Store and forward" telemedicine, also called "asynchronous telemedicine", wherein providers can share patient information in a secure manner

The History of Telehealth

The use of technology to extend health care into the home setting is an older idea than one might think. It extends as far back as the mid to late 19th century when telephone wires were used to transmit electrocardiograph data.7 In 1879, an article in a medical journal called The Lancet discussed using the telephone to reduce the number of office visits. The radio has been used to provide medical advice to clinics on ships since the 1920s, and an image on the cover of Science and Invention imagined using devices for video examination of patients in 1925.[8]

The modern form of telemedicine emerged in the 1960s, with some of the first instances of telemedicine initially developed for the Mercury space program, allowing NASA to monitor physiological health at a distance. The use of telemedicine in psychiatry goes

back to this time as well. In fact, one of the earliest milestones of modern telehealth was the use of closed-circuit television to allow for psychiatric consultations between the Nebraska Psychiatric Institute and the Norfolk State Hospital. This shows just how central mental/behavioral health has been in the development of technology-based healthcare delivery[5].

Since then, technology has advanced dramatically, creating many possibilities for remote health care delivery. Digital methods of communication and a drop in the cost of these technologies in the past decade has resulted in advancements around the world, including in developing countries and underserved regions. The development of the internet in particular has expanded the scope of telemedicine into a broader realm of telehealth, allowing for remote consultations and conferences, and multimedia approaches to education[4].

Telehealth and Health Equity

Telehealth has the potential to increase access to quality healthcare to underserved communities. Rural and remote communities have well-documented health disparities, including worse health outcomes and lower-quality health care services than communities with higher populations. Rural communities also often have larger populations of older adults, and higher poverty rates[9]. Properly implemented, telehealth can overcome access barriers in rural areas and reduce costs associated with transportation and lost work time. It can also extend the reach of existing behavioral health providers to bring services to areas with workforce shortages[10].

However, there are also new challenges to be addressed regarding telehealth as a delivery model. There are existing disparities regarding digital literacy and access to technology that need to be acknowledged and addressed. These disparities are found more frequently in rural communities, racial/ethnic minority populations, lower income communities, and among older adults[11]. If these barriers are not addressed, a telehealth approach could end up reinforcing existing disparities rather than reducing them.

Broadband internet access is a key resource that makes telehealth services possible. Advocating for expanded access to broadband internet and assisting patients in acquiring affordable internet services and digital devices are key strategies to increasing the accessibility of telehealth services[12]. Digital literacy can be increased by providing resources and assistance to patients who are new to the devices or platforms being used. Every possible effort should be made to accommodate patients' accessibility needs. Language interpretation, including sign-language interpretation, and accessibly formatted materials should be made readily available[11].

Telehealth in Behavioral Health

As previously mentioned, the use of telehealth in psychiatry goes back to the 1960s. In 1969, remote psychiatric consultations for adults and children at a Logan International Airport Clinic were conducted by providers at Massachusetts's General Hospital. Telepsychiatry became more common in the 1970s-90s and became particularly common in Australia in the 1990s to overcome geographical distance. Research in the 1990s and 2000s indicated the effectiveness of these methods and led to practice guidelines from organizations such as the American Psychiatric Association (APA) and American Telemedicine Association (ATA)[13].

According the APA, telepsychiatry is equivalent to in-person care when it comes to patient satisfaction, treatment effectiveness, and diagnostic accuracy, and can save time, money, and other valuable resources. A growing body of evidence also demonstrates the effectiveness of telehealth for the delivery of psychotherapy, patient education and outreach, social support, and medication adherence. A systemic review of research on the effectiveness of telehealth for behavioral/mental health since 2000 found that it is cost-effective and adaptable, and is "the next logical step to delivering state-of-the-art care to mental patients alongside the conventional care, especially in under-developed communities and nations"[14].

Barriers to the implementation of telehealth for behavioral/mental health services have been identified as well, such as the cost of starting and maintaining telehealth services. The need for workforce training and technical assistance is also a common obstacle, as are regulatory and compliance-related barriers. On the client side, lack of technology and resources can be barriers to accessing telehealth services.[3] Perhaps the largest barrier however is reimbursement. Until recently, provider reimbursement from CMS has been highly limited.

The recent policy changes have created an opportunity to explore the potential of telehealth to bring behavioral health services to the home[15].

In conclusion, the implementation of telehealth as a delivery method for behavioral health services presents unique opportunities, advantages, and challenges. While telemedicine and telehealth have been advancing for decades, the COVID-19 public health emergency has led to an extremely rapid expansion in development and adoption. Telehealth can be an effective method of providing quality behavioral health services and has the potential to increase access to rural and remote communities. However, barriers to patient access needs to be considered and addressed.

Post-Survey Questionnaire

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, and behavioral health boards or commissions, etc.

References (foot notes?)

1 W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

2 SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For more information and reports, see www.SAMHSA.go

3 Institution for Mental Diseases (IMD) List:
https:/ www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx

4 Centers for Disease Control and Prevention, The Influence of Telehealth for Better Access Across Communities.

5 Center for Connected Health Policy, About Telehealth.

6 Business and Professions Code section 2290.5(a)(6).

7 World Health Organization, Telemedicine: Opportunities and Developments in Member States.

8 The Evolution of Telehealth: Where have we been and where are we going?

9 American Association of Medical Colleges, Telehealth Helps Close Health Care Disparity Gap in Rural Areas.

10 National Conference of State Legislatures, Increasing Access to Health Care Through Telehealth.

11 Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic.

12 American Academy of Family Physicians, Study Examines Telehealth, Rural Disparities in Pandemic.

13 American Psychiatric Association, History of Telepsychiatry.

14 Telemental Health Care, an Effective Alternative to Conventional Mental Care: A Systemic Review.

15 University of Michigan, The use of Telehealth Within behavioral Health Settings: Utilization, Opportunities, and Challenges.

VENTURA COUNTY BEHAVIORAL HEALTH ADVISORY BOARD
IDENTIFIED GAPS IN SERVICE - UPDATE
12/14/20

CLAUDIA ARMANN

1. More bilingual staff needed for STAR, and access to STAR services on Saturdays.
2. Need to reduce wait times between STAR evaluation and clinic appointments.
3. Need to streamline referral process within Logrando Bienestar. In the past, clients could contact coordinators directly to begin intake process. Now, referrals are sent through managers, adding an extra step.
4. Access to mental health services for those with developmental disabilities.

NANCY BORCHARD

1. Case management is seriously impacted with too many clients per case worker. Being connected usually just means checking in with doctor or nurse practitioner for a medical check every 3 months. No time allowed for talk therapy which is proven to be a key component to long term recovery. Are we spending money where it counts the most?
2. How timely, or if clients already enrolled receive services if having difficulty in between appointments. How soon can they be seen by someone who knows them?
3. Frequent changes in staff is extremely difficult for clients. Mental Health treatment is predicated on trust—same as medical treatment.
4. Review External Quality Review Organization (EQRO) Report as to recommendations for improvement. What are efforts to comply?

JESSE FINKBEINER

1. Prevention – I believe that early prevention is the key to any successful undertaking. We must be able to educate young people as to mental health challenges, substance use pressure and amelioration of pain by way of chemical use and the dangers contains therein. Hence, more active school involvement, greater budget for more school therapists, counselors, etc. I also believe that we can insert (for lack of a better term) ourselves into the general curriculum so that young people have a greater understanding of their feelings, thoughts, identity, etc. and have a language/technology for effectively navigating not only the academic process, but more importantly their own internal process with respect to feelings, self-esteem, values building, and the things that truly matter in life.
2. I am not sure if this is already being done, but I think that every 6 months, an updated amalgamation of all services offered in Ventura County disseminated to all Ventura County residents in a number of different mediums (internet, paper by way of mail, etc.). This would not just be a list of services, but in-depth examinations of each including addresses, phone numbers, funding sources, programmatic descriptions with all pertinent information, etc. This way, consumers or potential consumers can always have updated lists of all services available to maximize effectiveness in navigating the already complex system. This could even have suggestions as to whom to call given specific situations that we could illuminate. This also seems like something that would not cost a lot of money.

3. Ongoing training of law enforcement as to how to work with, encounter, and better serve those with mental illness and substance use challenges. I like the roll out of the CIT training and the high response that it has garnered (something like 87% of all law enforcement have this training).
4. Additional CSU and IPU beds (this is obviously a hot topic and requires funding). In Riverside there are 24/7 Mental Health Urgent Care Centers that help in keeping ER rooms less full and helping to manage mental health crises and can provide an important bridge to adjunct services without over-burdening already burdened systems. In other words, this provides an entry way/transition/bridge into various aspects of the mental health services community, resources, etc. Forgive my ignorance if we have this already—have not seen anything like this on the East End of Ventura County.
5. Improvement of Veteran's Services—not even sure where to begin. In our clinic, we see suffering veterans frequently and it appears as if this is an underserviced, particularly sensitive, segment of our population who have been left feeling generally unsupported.
6. Greater collaboration and an invitation for members of any group to work together. I specify this as a gap because we can only, as a group and as subgroups, achieve maximum effectiveness if our common purpose remains the guiding light of our cause. It is easy to get bogged down in political structures, ego contests, minutia of language and particulars harming the greater objective, lack of focus on the larger objective, infighting, etc. In other words, how can we all become our best selves and keep our focus on the challenges without being coopted in the same kind of reactivity that permeates our focus. How can we pull together as a group and be of best service? I am not certain that we are there yet and believe that we need to refocus our efforts. I may be way off or going out on a limb by saying this, but maybe some time could be focused on team building, appreciation of different ideas, and working on one thing at a time to see it through to completion. Again, maybe I am naïve or too new to see the broader picture. However, it appears that there are some systemic, foundational communication skills that would be useful in helping to coordinate what we are doing, who is doing what, and how we can constructively come together to elicit the greatest good for all concerned.

JANIS GARDER

1. Substance Use Services (SUS)
   Men's Residential Facility
   Last year, Khepra House for men closed. Men are now sent to Tarzana Treatment Center/Hospital instead. I imagine the cost per person is higher. The women have Prototypes Residential Living for Women—the men do not have a residential living facility. Is there a plan for a new men's residential facility?

2. Mental Health Services
   IPU Beds, CSU Chairs
   Have these been implemented? In not, when?
   What is the current capacity at the IPU/CSU's?

MARY HAFFNER

1. CRISIS SERVICES – GAPS
   a. Ventura County does not have a facility that can directly accept adults experiencing a psychiatric emergency because it does not have the capacity to conduct medical screening, nor does it

conduct "field screening". Instead, individuals in psychiatric crisis are taken to hospital emergency departments where they can wait days before being evaluated and treated. Sometimes, individuals on a 5150 have to be released prior to evaluation or treatment because it takes longer than 72 hours to get help in an emergency department.

b. No in-the-field screening. Ambulance services should be able to perform a "field screening" of the person looking only for medical stability issues. If deemed medically stable, they could be brought directly to the CSU/PES. This is being done in other counties.

c. Ventura County does not have a streamlined medical clearance process. Like other counties, Ventura County could institute a process whereby no specific lab tests are required (similar to Alameda County) to facilitate transfer to a CSU/PES and to prevent hospital boarding.

d. An individual should be accepted by the CSU/PES without regard to their psychiatric diagnosis or history or whether they have medical insurance or access to a psychiatric hospital bed.

e. A severe shortage of inpatient psychiatric beds. The county should conduct a needs assessment to determine how many inpatient psychiatric beds will be required to serve the subgroup of approximately 1-3% of the county's adult population with a serious mental illness who are often brought into hospital emergency departments or the CSU in psychiatric crisis, including those under a 5150. Many individuals who enter the hospital emergency department in psychiatric emergency are sent out of the county to other facilities, away from family support.

f. Inadequate and/or inappropriate staffing at Hillmont IPU. While at Hillmont, individuals with serious mental illness should be provided best practice treatment with a goal of wellness and function. Staffing should reflect an understanding that it is foreseeable that some untreated individuals, while psychotic, can exhibit hostile or violent behaviors. Individuals with serious mental illness should not be arrested while at Hillmont for conduct that is foreseeable given their state of psychosis.

g. A shortage of appropriate step-down facilities. It would be helpful if the county could analyze the data it has to determine the number and types of step-down facilities required to serve individuals exiting both Hillmont IPU and the out-of-county placements. Currently, individuals who do not require acute inpatient care at Hillmont IPU cannot leave the IPU and are occupying beds because there is no place for them to go; there are not enough step-down options, creating a logjam in emergency departments. These step-down facilities should be commensurate with the level of need and consistent with a goal toward long-term stabilization and treatment so individuals can regain function.

2. <u>ENGAGEMENT AND SUPPORT – GAPS</u>

a. ACT level case management for people with serious mental illness who require this level of engagement and support.

b. Insufficient warm hand-offs and no tracking mechanism or benchmarks to determine whether these warm hand-offs and supports are working. Individuals with serious mental illness require follow-up to prevent falling through the cracks and cycling through homelessness, incarcerations, 5150s, emergency rooms, and hospitalizations. Keep families and loved ones in the communication loop to help stem the cycling.

c. Collaboration with family members who may have relevant and important information about their loved one with a serious mental illness and who want to be involved in their care should be happening.

3. KEEPING PEOPLE WITH SERIOUS MENTAL ILLNESS OUT OF JAIL – GAPS
   a. The county does not have an Intercept Model pre-arrest and pre-trial Diversion Program. The county has a diversion program but, it is missing critical components, including housing and support upon exiting the program. Other counties have implemented, or are in the process of implementing, effective Intercept Model pre-arrest and pre-trial diversion programs.

4. HOUSING – GAPS
   a. Insufficient housing options for individuals enrolled in and exiting the current diversion program.
   b. Insufficient housing options for individuals in, and exiting, the Assist (Laura's Law) program.
   c. Insufficient housing options for individuals with serious mental illness exiting jails.
   d. The county needs more housing overall, with case management, for people with serious mental illnesses.

5. JAILS – GAPS
   a. People with serious mental illness in our jails deteriorate and decompensate because they are not receiving best practice treatment for their illness in a therapeutic setting. There are very limited slots for the JBCR program for individuals deemed IST.

6. CONSERVATORSHIP – GAPS
   a. There is no service or help for families trying to conserve their loved ones.
      For their long-term health, some individuals with serious mental illness will require conservatorship. If they are not conserved, many of these individuals will end up homeless or incarcerated.
   b. If a conservator directs authorization to provide involuntary medication to someone with a serious mental illness, including long-acting antipsychotic injections, VCBH and Hillmont IPU should articulate protocol regarding these directives. It appears that the county will not do this. This county is missing a clear understanding of the roles of both VCBH and Hillmont IPU regarding this conservatorship issue.

7. GOALS – GAPS
   a. The county has not identified the costs associated with untreated serious mental illness. Because there is a percentage of people with serious mental illness who interface with numerous county agencies and departments, it would serve the county, from both a healthcare and fiscal perspective, to create a comprehensive plan to provide treatment and supports for this population so that they do not inefficiently utilize numerous resources. Investment on the front end for their care and treatment can result in better health outcomes and less cost and resource utilization.
   b. No goals have been articulated for the services we provide for individuals with serious mental illness. Goals regarding promptness and efficacy of treatment, long-term function, recidivism rates, housing, and diversion from jails should be specific.
   c. The county should articulate a commitment to early and effective treatment with the goal of helping them to attain the highest function possible.

JERRY HARRIS

1. Sufficient number of CSU slots to address the community need (15 in the east county and 15 in the west county).
2. Elimination of the use of community hospital emergency rooms to evaluate, treat and medically clear people who are experiencing mental health emergencies.
3. Additional inpatient psychiatric hospital beds to address the needs of the county's population.
4. Additional supportive housing facilities to address the needs of mental health clients discharged from inpatient psychiatric hospitals.
5. Additional supportive housing facilities to address the needs of mental health clients released from jails.
6. Drastically reducing the number of people with mental health issues that end up incarcerated as opposed to receiving needed services.
7. Additional community services and supports for people with mental health issues and individuals with substance use disorders.

SUPERVISOR LINDA PARKS

1. More psychiatric beds.
2. More supportive housing.
3. Streamline access to crisis services.
4. Decriminalize mental illness.
5. Increase outreach to Transitional Age Youth (TAY) to avoid severe mental illness.
6. Focus on healing, recovery and job placement.

MICHAEL RODRIGUEZ

1. Significantly increase IPU capacity, including increasing the number of IPU beds and increased / improved programming.
2. Significantly increase CRT beds/facilities.
3. Establish inpatient alcohol treatment programs.
4. Significantly increase supportive housing.
5. Establish and/or significantly increase dual diagnosis treatment (mental illness and drug/alcohol).

BHAB ADULT SERVICES COMMITTEE INPUT (VIA NANCY BORCHARD / GANE BROOKING)

1. Availability, county wide, of timely services in order to avoid issues of not sick enough to qualify for services until a major episode happens. Explore alternatives.
2. No inpatient facility for older adults who are in mental health crisis and are also frail medically. Typically sent out of County. Does Ventura County need to pay for such placement?
3. Review Needs Assessment Study done by MHSA in 2018-19. Have recommendations been followed?
4. Consider special needs of Transitional Age Youth (TAY) and discuss with them what they see. How to access services is one area that they see as important especially in the STARR Program.

BHAB TRANSITIONAL AGE YOUTH COMMITTEE INPUT (VIA DR. MARGARET CORTESE)

1. Carole Shelton - The crisis response for those with intellectual/developmental disabilities with psychiatric disorders. Who handles the crisis? Is it law enforcement? Is it VCBH? De-escalation is needed to address aggression which may happen when they are having a psychiatric manifestation. When law enforcement needs to arrive and that may make things worse. Decrease the chances of law enforcement involvement which could result in arrest and needing to put hands on these vulnerable youth. Other counties have collaboration between their behavioral health and regional centers that allows for this de-escalation.
2. Cathy Nye - Between behavioral health and those students that really do not benefit from traditional cognitive behavioral therapies because of their intellectual disabilities (ID). How to move behavioral health to support students with ID.
3. Mary Haffner - Concur with Ms. Shelton. Already submitted a list of gaps to the BHAB, however agree that is another gap.
4. Elizabeth Stone - Appealed to members/guests in the TAY group to speak to their perception of gaps.
5. Margaret Cortese - Past meetings with TAY present pointed to homelessness.
6. Elizabeth Stone - De-escalation in a crisis situation goes beyond any one group; no one wants to be in a situation with coercion.
7. Margaret Cortese - Training in de-escalation for first responders, especially in dangerous situations. Review of crisis intervention training aimed at de-escalation.

VENTURA COUNTY BEHAVIORAL HEALTH ADVISORY BOARD
IDENTIFIED GAPS IN SERVICE
12/14/20

SUBMISSION NUMBER	GAP IN SERVICE ITEM	SUBMISSION FREQUENCY
1	Case Management Workload	1
2	Timeliness in Service Delivery	3
3	Impact of Frequent Staff Changes on the Ability to Establish Therapeutic Relationships	1
4	Review EQRO Recommendations	1
5	Increase Focus on Prevention (MH and SUD)	1
6	List of Services Offered to be Sent from VCBH to Community (every 6 months)	1
7	Continue Education for Law Enforcement Following CIT	1
8	Additional CSU Chairs/Slots	5
9	Additional Psychiatric Inpatient Beds	7
10	Improved Veterans' Services	1
11	Create Ongoing Collaborative and Coordination Between Public and Private Agencies	1
12	Additional Substance Use Disorders (SUD) Residential Facilities	1
13	Additional CSU Chairs with Ability to Medically Screen Clients and Receive Clients Directly from Law Enforcement	1
14	Need to Conduct In-Field Medical Screening	1
15	Streamline Medical Screening Process	2
16	Need to Evaluate Staffing Ratios at Hillmont IPU	1
17	Reduce/Eliminate Arrest of Clients at Hillmont IPU	1
18	Critical Need for Step-Down Facilities	1
19	ACT Level Case Management for Clients Requiring a Higher-Level Engagement and Support	1
20	Insufficient Warm Hand-Offs and Tracking to Determine Effectiveness of Hand-Offs and Supports	1
21	Increased Collaboration with Family Members to Identify Relevant and Important Information About Clients	1
22	Keep People with Serious Mental Illness Out of Jail	5
23	Insufficient Housing Options for Clients in Diversion Programs	3
24	Insufficient Housing Options for Clients in the Assist Program	3
25	Insufficient Housing Options for Clients Released from Jail	3
26	Insufficient Supportive Housing Options for Mental Health Clients Discharged from Psychiatric Hospitals	2
27	Additional Community Services and Supports for People with Mental Illness Issues and Individuals with Substance Use Disorders	1
28	Increase Overall Housing Options and Case Management for People with Mental Illness	1
29	Clients in Jails Deteriorate and Decompensate in Jail Due to Lack of Best Practice Treatment	1
30	Lack of Support for Families Whose Loved Ones Need to be Conserved	1

VENTURA COUNTY BEHAVIORAL HEALTH ADVISORY BOARD
IDENTIFIED GAPS IN SERVICE
12/14/20

SUBMISSION NUMBER	GAP IN SERVICE ITEM	SUBMISSION FREQUENCY
31	When a Conservator Directs Authorization to Provide Involuntary Medication for Someone with Serious Mental Illness, VCBH and Hillmont IPU Should Articulate Protocols Regarding These Authorizations	1
32	The County Needs to Identify the Cost Associated with Untreated Mental Illness	1
33	There are No Established Goals for Services/Outcomes for People with Mental Illness	1
34	The County Should Articulate a Strong Commitment to Early and Effective Treatment in Order to Strive for the Highest Level of Functioning Possible	2
35	Eliminate the Use of Community Hospital Emergency Rooms to Evaluate, Treat and Medically Clear People Who Are Experiencing Mental Health Emergencies	1
36	Reduce the Number of People with Mental Illness that are Incarcerated	1
37	Streamline Access to Crisis Services	2
38	Consider the Unique Needs of TAY and Increase Outreach to TAY to Avoid Sever Mental Illness	1
39	Focus on Healing, Recovery and Job Placement	1
40	Increase the Availability of Timely Services County-wide	2
41	In-County Psychiatric Inpatient Beds for Older Adults who are in Mental Health Crisis and Frail Medically	1
42	More bilingual staff needed for STAR, and access to STAR services on Saturdays.	1
43	Need to reduce wait times between STAR evaluation and clinic appointments.	1
44	Need to streamline referral process within Logrando Bienestar. In the past, clients could contact coordinators directly to begin intake process. Now, referrals are sent through managers, adding an extra step.	1
45	Access to mental health services for those with developmental disabilities.	1
46	Significantly increase IPU capacity, including increasing the number of IPU beds and increased / improved programming.	1
47	Significantly increase CRT beds/facilities.	1
48	Establish inpatient alcohol treatment programs.	1
49	Significantly increase supportive housing.	1
50	Establish and/or significantly increase dual diagnosis treatment (mental illness and drug/alcohol).	1
51	Increase collaboration between VCBH and law enforcement to assist with de-escalation during a crisis response for those with intellectual/developmental disabilities with psychiatric disorders.	2
52	Increase VCBH support to students with intellectual disabilities (ID) who may not benefit from traditional cognitive behavioral therapies.	1
53	Past meetings with TAY present pointed to homelessness.	1
54	De-escalation when a crisis situation goes beyond any one group; no one wants to be in a situation with coercion.	1
55	Training in de-escalation for first responders, especially in dangerous situations. Review of crisis intervention training aimed at de-escalation.	1

VENTURA COUNTY BEHAVIORAL HEALTH

A Department of Ventura County Health Care Agency

Sevet Johnson, PsyD
Director

Jason Cooper, MD
Medical Director

MEMORANDUM

DATE: **December 14, 2020**

TO: **Behavioral Health Advisory Board**

FROM: **Contracts Administration**

SUBJECT: **Board of Supervisors Approved November Agreements/Board Items**

Board of Supervisors Approved Agreements – November 10, 2020

1. **Fiscal Year (FY) 2020-21 Netsmart Technologies, Inc. (Netsmart) Agreement.**

This item recommended approval for the Ventura County Behavioral Health (VCBH) Director or designee to sign the agreement for CareManager subscription and services with Netsmart, in the amount of $387,200, effective November 10, 2020 through November 10, 2023. This Agreement is funded with Proposition 63 Mental Health Services Act (MHSA) funding.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) oversees programs funded by the MHSA with the mission of collaborating with non-MHSA service providers to catalyze transformational changes across service systems so everyone needing mental health care has access to and receives effective and culturally competent care. The MHSA Innovations category of funding seeks to improve the quality of mental health services, including measurable outcomes involving reductions in hospitalization, incarceration and homelessness recidivism, which are developed within communities via an inclusive and representative process, especially utilizing unserved, underserved and inappropriately served individuals.

VCBH submitted a Full Service Partnership (FSP) Data Exchange Work Plan to the MHSOAC, which was approved by the MHSOAC on June 25, 2020. Through this plan, VCBH will work with the Ventura County Health Care Agency, Human Services Agency and Sheriff's Office to develop a network of legally sanctioned, shared data streams focused on the most at-risk individuals in our FSP programs. Having access to shared data across service systems will improve the quality of care that VCBH FSP clients receive, with VCBH care managers more likely to know if any of the 1,500-2,000 FSP clients are incarcerated, hospitalized or eligible for or in need of homeless services.

To execute the FSP Data Exchange Work Plan, VCBH intends to contract with Netsmart for software services related to management of specific client population groups, with integration of data from outside systems. Using Netsmart's CareManager software, an interface will be configured for receiving data streams pertaining to FSP clients from (1) Cerner Millennium HealthCare, (2) Manifest MedEx Health Information Exchange, (3) Ventura County Integrated Justice Information System (VCJIS), (4) Homeless Management Information System (HMIS), and (5) Netsmart myAvatar. These data connections will permit VCBH to gain near real-time visibility into some of the major life experiences that FSP clients encounter, and with this visibility, enhance the quality of care these clients receive. Because Netsmart is the vendor of the VCBH Electronic Health Record, myAvatar, there are internal linkages and interfaces built into the application framework, which allows seamless and proprietary integration with other Netsmart modules, such as CareManager. Keeping the technical architecture under the same vendor minimizes the cost of ongoing maintenance and system updates. For the term of the three-year agreement with Netsmart, VCBH will incur: (1) one-time implementation and professional services charges that total $255,000, (2) recurring CareManager subscription charges of $41,400 per year, and (3) travel charges at a not to exceed amount of $8,000 for the duration of the agreement.

VCBH recommended approval for the VCBH Director or designee to sign the agreement for CareManager subscription and services with Netsmart.

2. **FY 2020-21 Casa Pacifica Centers for Children and Families (Casa Pacifica) Agreement and Three Aspiranet Agreements. FY 2019-20 Casa Pacifica Amendment.**

This item recommended approval for the VCBH Director or designee to sign the: (1) agreement with Casa Pacifica for residential/campus treatment services, in the amount of $4,958,498, effective July 1, 2020 through June 30, 2021, (2) agreement with Aspiranet for collaborative education services, in the amount of $1,586,487, effective July 1, 2020 through June 30, 2021, (3) agreement with Aspiranet for early and periodic screening, diagnostic and treatment (EPSDT) intensive services foster care services, in the amount of $918,240, effective July 1, 2020 through June 30, 2021, (4) agreement with Aspiranet for intensive care coordination/intensive home-based mental health services, in the amount of $1,516,580, effective July 1, 2020 through June 30, 2021, and (5) thirteenth amendment with Casa Pacifica for residential/campus treatment services, reallocating $200,000 from the short term residential treatment program (STRTP) to the non-public school (NPS) services program and with no change to the maximum contract amount of $5,658,498, effective July 1, 2019 through June 30, 2020. These agreements are funded with Short Doyle/Medi-Cal Federal Financial Participation (SD/MC FFP), 2011 Realignment, Special Education Local Plan Area, and other County Resources funding.

Each year, VCBH contracts with a variety of contractors for the provision of various Medi-Cal mental health services to assist in meeting the needs of the various target populations served by VCBH. The agreements listed above are summarized in Board Letter Summary of Contracts. The proposed FY 2020-21 agreements were renewed based on successful performance and carry a term of July 1, 2020 through June 30, 2021.

Contractor performance is reviewed throughout the fiscal year to ensure compliance with the agreement goals and outcomes. These contractors have complied with the terms and conditions of the agreements and performed satisfactorily in the delivery of the agreed upon services. When necessary, technical assistance has been provided to resolve any contractual issues. VCBH is satisfied with the performance of these contractors and anticipates that services provided under the renewed agreements will continue to meet or exceed expectations for service delivery in the next term. Ongoing monitoring will continue to be conducted throughout the coming fiscal year to review contractor compliance and ensure the provision of appropriate high-quality program services.

Casa Pacifica provided residential/campus EPSDT services in FY 2019-2020 through the following four programs: (1) STRTP, a program that provides services to traumatized foster and probation youth with high acuity levels who are either Ventura County or out-of-county EPSDT Medi-Cal beneficiaries, (2) NPS, a private school certified by the California Department of Education to provide mental health related services to special education students, (3) Therapeutic Behavioral Services (TBS), a county-wide program providing a one-to-one planned cognitive behavioral intervention for youth at home, school, or within other community settings, and (4) Parent Child Interactive Therapy (PCIT), an evidence-based intervention for children and their caregiver(s) to decrease behavioral problems, improve parenting skills and enhance the quality of the parent-child relationship. The common goals of these programs are to transition children to lower levels of care and prevent further progression of mental health symptomology, deterioration, and functioning. The FY 2019-20 thirteenth amendment to the agreement with Casa Pacifica reallocated $200,000 from the STRTP to the NPS program and modified Medi-Cal mental health provisional unit rates and units of service. This reallocation was needed because the STRTP program census was lower than projected and the NPS program costs to provide the services were higher than projected. Aside from the proposed reallocation, there was no change to the contract maximum or other substantive changes.

VCBH recommended approval for the VCBH Director or designee to sign the: (1) FY 2020-2021 Casa Pacifica and Aspiranet agreements for mental health treatment services and (2) FY 2019-20 Casa Pacifica agreement for mental health services.

Ventura County Behavioral Health

Board Letter Summary of Contracts for November 2020

Board Date	Contractor	Amount	Term	Description
11/10/2020	Netsmart Technologies, Inc. (Netsmart)	$387,200	11/10/2020 to 11/10/2023	The Mental Health Services Oversight and Accountability Commission (MHSOAC) oversees programs funded by the Mental Health Services Act (MHSA). MHSA's mission is to work with non-MHSA service providers to catalyze transformational changes across service systems to provide mental health services recipients with efficient and culturally competent care. Ventura County Behavioral Health (VCBH) submitted a Full Service Partnership (FSP) Data Exchange Work Plan to the MHSOAC, which they approved on June 25, 2020. Through this plan, VCBH will work with the Ventura County Health Care Agency, Human Services Agency and Sheriff's Office to develop a network of legally sanctioned shared data streams focused on the most at-risk individuals in our FSP program. This collaboration will enable enhanced data collection and sharing to improve the quality of care to FSP clients and reduce hospitalization, incarceration and homelessness recidivism rates. VCBH will contract with Netsmart, the vendor of VCBH's electronic health record, which has internal linkages and interfaces built into the application framework and allows seamless, proprietary integration with other Netsmart modules, such as CareManager. This minimizes the cost of ongoing maintenance, including system updates. With the three-year agreement with Netsmart, VCBH will incur (1) one-time implementation and professional services charges totaling $225,000, (2) recurring CareManager subscription charges of $41,400 per year, and (3) travel charges not to exceed $8,000 for the duration of the agreement.
11/10/2020	Casa Pacifica Centers for Children and Families (Casa Pacifica)	$4,958,498	7/1/2020 to 6/30/2021	Casa Pacifica will provide residential/campus Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services in FY 2020-21 through the following three programs: (1) Short-Term Residential Therapeutic Program (STRTP), (2) Non-Public School (NPS), and (3) Therapeutic Behavioral Services (TBS). The common goals of these programs are to transition children to lower levels of care and prevent further progression of mental health symptomology, deterioration, and functioning. The unduplicated client counts in FY 2019-2020 for the three programs were (1) STRTP - 56, (2) NPS - 51 and (3) TBS - 173. The agreement is reduced $700,000 from the prior fiscal year due to the conclusion of the PCIT program ($500,000) and reduction to the STRTP budget ($200,000). This agreement is funded with Short-Doyle/Medi-Cal (SD/MC) Federal Financial Participation (FFP) and 2011 Realignment funding.

11/10/2020	Aspiranet	$1,586,487	7/1/2020 to 6/30/2021	Aspiranet provides intensive social/emotional and/or behavioral supports through the Collaborative Education Services (COEDS) program with the goal of assisting children to overcome psychological and social challenges that impact their ability to succeed in school. These services are offered to students who have already been receiving Educationally Related Social Emotional Services (ERSES) through the Individualized Education Program (IEP) process. Services are intensive and can be short term or long term depending on the students' needs and are provided in the home or community. The unduplicated client count in FY 2019-20 was 92. The proposed FY 2020-21 agreement with Aspiranet for COEDS services is for a one-year term (July 1, 2020 through June 30, 2021). This agreement is funded by SD/MC FFP, 2011 Realignment, and Special Education Local Plan Area funding.
11/10/2020	Aspiranet	$918,240	7/1/2020 to 6/30/2021	Aspiranet provides EPSDT/Intensive Services Foster Care (ISFC) specialty mental health care services. Services are targeted at children younger than 21 years of age who are EPSDT Medi-Cal beneficiaries. Aspiranet has been contracted to provide mental health, case management and crisis intervention units of service. Many of the children/youth whom Aspiranet is serving have complex trauma histories which make them vulnerable to mental health challenges, circumstances and/or conditions that require a more timely response. In these cases, more intensive services such as crisis intervention are required. The unduplicated client count in FY 2019-20 was 138. This agreement is funded by SD/MC FFP, 2011 Realignment, and other County resource funding.
11/10/2020	Aspiranet	$1,516,580	7/1/2020 to 6/30/2021	Aspiranet provides Intensive Care Coordination/Intensive Home-Based Mental Health Services (ICC/IHBS) services for EPSDT specialty mental health care services. Services are targeted at children younger than 21 years of age who are EPSDT Medi-Cal beneficiaries. Aspiranet has been contracted to provide mental health, case management, and crisis intervention units of service. Many of the children/youth whom Aspiranet is serving have complex trauma histories which make them vulnerable to mental health challenges, circumstances and/or conditions that require a more timely response. In these cases, more intensive services such as crisis intervention are required. The unduplicated client count in FY 2019-20 was 136. This agreement is funded by SD/MC FFP and 2011 Realignment funding.

11/10/2020	Casa Pacifica	$5,658,498	7/1/2019 to 6/30/2020	Casa Pacifica provided residential/campus EPSDT services in FY 2019-20 through the following four programs: (1) STRTP, a program that provides services to traumatized foster and probation youth with high acuity levels who are either Ventura County or out-of-county EPSDT Medi-Cal beneficiaries, (2) NPS, a private school certified by the California Department of Education to provide mental health related services to special education students, (3) TBS, a county-wide program providing a one-to-one planned cognitive behavioral intervention for youth at home, school, or within other community settings, and (4) Parent Child Interactive Therapy (PCIT), an evidence-based intervention for children and their caregiver(s) to decrease behavioral problems, improve parenting skills and enhance the quality of the parent-child relationship. The common goals of these programs are to transition children to lower levels of care and prevent further progression of mental health symptomology, deterioration, and functioning. The FY 2019-20 thirteenth amendment reallocated $200,000 from the STRTP to the NPS program and modified Medi-Cal mental health provisional unit rates and units of service. This reallocation was needed because the STRTP program census was lower than projected and the NPS program costs to provide the services were higher than projected. Aside from the proposed reallocation, there was no change to the contract maximum or other substantive changes. This agreement is funded with SD/MC FFP and 2011 Realignment.