NOTICE OF PUBLIC MEETING – County of Santa Cruz
IDEAL CRISIS SYSTEM (ICS) COMMITTEE of the
MENTAL HEALTH ADVISORY BOARD
FRIDAY, JULY 8, 2022 ♦ 3:30 PM-5:00 PM
HEALTH SERVICES AGENCY
1400 EMELINE AVENUE, BLDG K, ROOM 207, SANTA CRUZ, CA 95060
THE PUBLIC MAY JOIN THE MEETING BY CALLING (831) 454-2222, CONFERENCE ID 919 083 942#

ICS COMMITTEE MEMBERS:
Jeffrey Arlt, Chair, 5th District | Jennifer Wells-Kaupp, 5th District
Laura Chatham, 1st District | Michael Neidig, 3rd District | Serg Kagno, 4th District

IMPORTANT INFORMATON REGARDING PARTICIPATION IN THE
MENTAL HEALTH ADVISORY BOARD MEETING

The public may attend the meeting at the Health Services Agency, 1400 Emeline Avenue, Room 207, Santa Cruz. All individuals attending the meeting at the Health Services Agency will be required to use face coverings regardless of vaccination status. Individuals interested in joining virtually may click on this link: Click here to join the meeting or may participate by telephone by calling (831) 454-2222, Conference ID 919 083 942#. All participants are muted upon entry to prevent echoing and minimize any unintended disruption of background sounds. This meeting will be recorded and posted on the Mental Health Advisory Board website.

If you are a person with a special need, or if interpreting services (English/Spanish or sign language) are needed, please call 454-4611 (Hearing Impaired TDD/TTY: 711) at least 72 hours in advance of the meeting in order to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format.

Si usted es una persona con una discapacidad o necesita servicios de interpretación (inglés/español o Lenguaje de señas), por favor llame al (831) 454-4611 (Personas con Discapacidad Auditiva TDD/TTY: 711) con 72 horas de anticipación a la junta para hacer arreglos. Personas con discapacidades pueden pedir una copia de la agenda en una forma alternativa.

AGENDA

3:30 Roll Call
3:35 Public Comment
(No action or discussion will be undertaken *today* on any item raised during this Public Comment period except that Mental Health Board Members may briefly respond to statements made or questions posed. Limited to 3 minutes each)
3:45 Adoption of AB361 – Resolution Authorizing Teleconference Meetings
3:50 Approve May 13, 2022 and June 10, 2022 Minutes
3:55 Clarification of County Organized Health Systems (COHS)
4:00 Create Mission Statement and develop an implementation plan with behavioral health and stakeholders
4:25 Identify Town Hall Speakers on Ideal Crisis Systems
4:35 Create draft schedule for Town Hall presentations
4:40 Report Card Exercise Overview
4:45 New Business
5:00 Adjournment

NEXT ICS COMMITTEE MEETING IS ON:
AUGUST 12, 2022 ♦ 3:30 PM – 5:00 PM
HEALTH SERVICES AGENCY
1400 EMELINE AVENUE, BLDG K, ROOM 207, SANTA CRUZ, CA 95060
TELEPHONE CALL-IN NUMBER (831) 454-2222; CONFERENCE ID # - TO BE ANNOUNCED

Ideal Crisis System Committee Purpose

Committee Chair: Jeffrey Arlt
Date of Creation: 19-MAY-2022

Name of Committee: Ideal Crisis System Committee
Recurring PublicMeetings: Second Friday of the month 3:30-5:00

Maximum number of members in committee: 7 maximum
Committee members: Laura Chatham, Jenny Kaupp, Mike Neidig, Serg Kagno, Jeffrey Arlt

WIC 5604.2 Duty(s) or Annual Goals that committee will contribute toward:

1. (1) Review and evaluate the community's public mental health needs, services, facilities, and special problems in any facility within the county or jurisdiction where mental health evaluations or services are being provided, including, but not limited to, schools, emergency departments, and psychiatric facilities.
2. (3) Advise the governing body and the local mental health director as to any aspect of the local mental health program. Local mental health boards may request assistance from the local patients' rights advocates when reviewing and advising on mental health evaluations or services provided in public facilities with limited access.

PURPOSE of Committee: (Goals)

Using the report Roadmap to the Ideal Crisis System and other relevant reports:

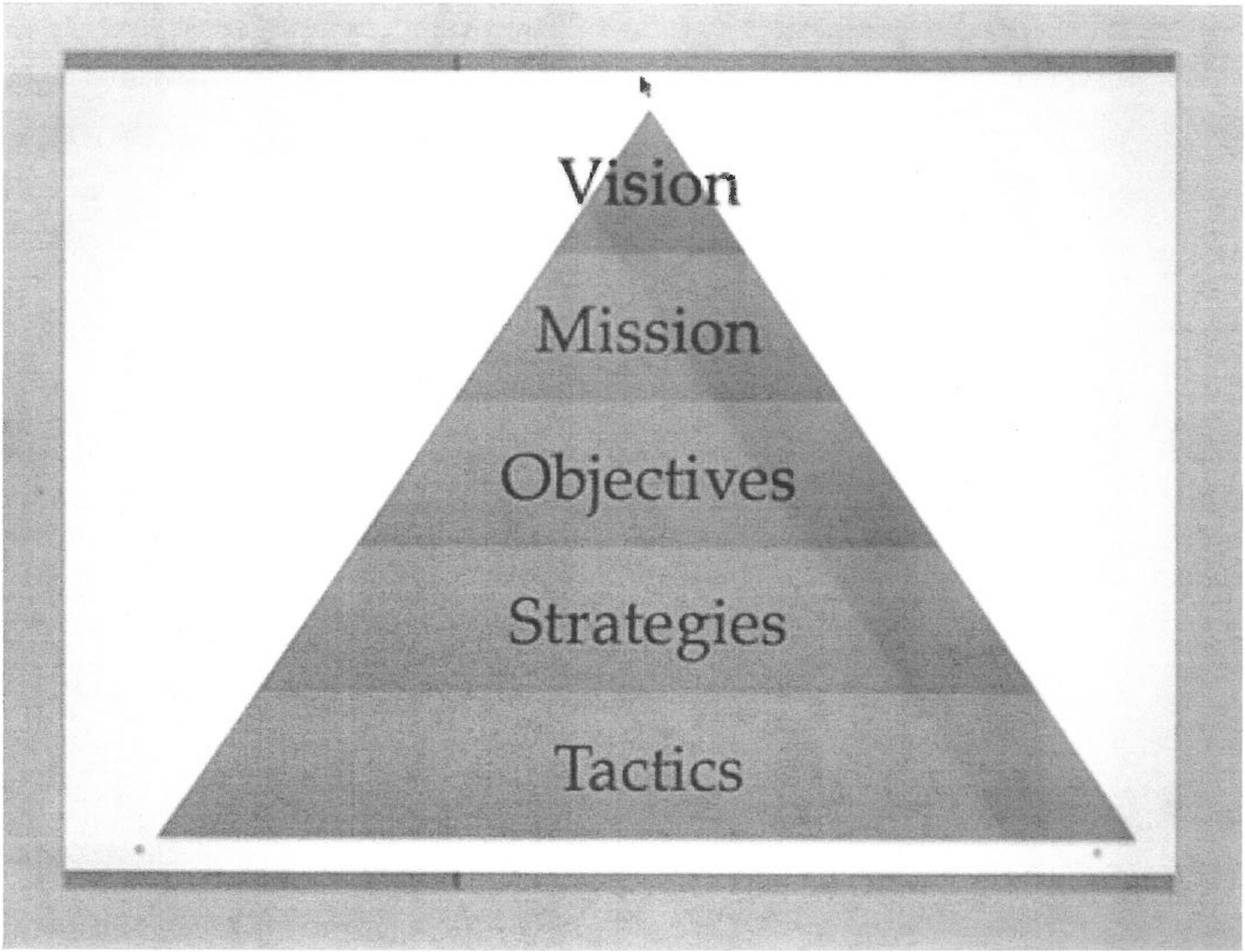
1. Create a vision and mission statement (Roadmap Exec summary page18)
    a. **Vision:** we envision every individual and family in Santa Cruz County with behavioral health needs receive the services they need where, when, as often, and for the duration and intensity necessary to achieve a stable and meaningful life
    b. **Mission:** (TBD) Evaluate, Collaborate, Recommend
2. Develop an implementation a plan with behavioral health and stakeholders

HOW will committee accomplish its purpose (goals):

1. *Research Meetings with [list individuals, agencies or organizations]*
2. *Listening Sessions with [list organizations]*
3. *Identify successful programs or practices by reviewing [List Documents or on-line resources to Review])*

SCHEDULE OF TASKS with target dates for completion
Example Response:
1. Begin [Date]
2. Submit Draft Report to Executive Committee [Date]
3. Report to [Mental/Behavioral health Board/Commission] [Date]

APPROVED BY: [Executive Committee or Chair]
DATE:
COMMENTS:


Vision
Mission
Objectives
Strategies
Tactics

Teach for America

- **Vision**: One day, all children in this nation will have the opportunity to attain an excellent education.
- **Mission:** Our mission is to enlist, develop, and mobilize as many as possible of our nation's most promising future leaders to grow and strengthen the movement for educational equity and excellence.

- We recruit remarkable and diverse individuals to become teachers in low-income communities. They commit to teach for two years and are hired by our partner public schools across the country. During these two years they are called corps members.

- We train and support corps members in the practices of great teachers and leaders. With hard work, perseverance, and strong partnerships with their students, students' families, and communities, corps members can dramatically increase the opportunities available to their students in school and in life.
- Corps members don't just teach their students, they learn from them. At the end of two years, they use those lessons to choose their path forward.

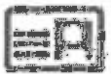
Section II: Crisis Continuum: Basic Array Of Capacities And Services

An ideal behavioral health crisis system has comprehensive array of service capacities, a continuum of service components and adequate multi-disciplinary staffing to meet the needs of all segments of the population.

OVERALL DESIGN ELEMENTS

ELEMENTS OF THE CONTINUUM
(see inset below)

POPULATION CAPACITIES



STAFFING CAPACITY

SERVICE COMPONENTS

Elements Of The Continuum

Crisis Center or Crisis Hub

Intensive Community-based Continuing Crisis Intervention

Call Centers and Crisis Lines

23-hour Evaluation and Extended Observation

Deployed Crisis-trained Police and First Responders

Residential Crisis Program Continuum

Medical Triage and Screening

Role of Hospitals in Crisis Services

Mobile Crisis

Transportation and Transport

Behavioral Health Urgent Care

Section II: Crisis Continuum: Basic Array Of Capacities And Services

Section II: Key Takeaways

- **The system has welcoming and safe access for all populations, all levels of acuity and for those who are both voluntary and involuntary.**
- **Family members and other natural supports, first responders and community service providers are priority customers and partners.**
- **Crisis response begins as early as possible, well before 911 (or 988) and continues until stability is regained.**
- **There is capacity for sharing information, managing flow and keeping track of people through the continuum.**
- **There is a service continuum for all ages and people of all cultural backgrounds.**
- **All services respond to the expectation of comorbidity and complexity.**
- **Welcome all individuals with active substance use in all settings in the continuum.**
- **Medical screening is widely available and is not burdensome.**
- **There is a full continuum of crisis components, including a crisis call center, mobile crisis, walk-in urgent care, secure crisis center, 23-hour observation, residential crisis services, hospitalization and intensive crisis outpatient services.**
- **Telehealth is provided for needed services not available in the local community.**
- **Program components are adequately staffed by multidisciplinary teams, including peer support providers.**
- **There is clinical/medical supervision, consultation and leadership available commensurate with provisions for emergency medical care.**

TABLE 6: REPORT CARD

Introduction and Purpose of the Report Card

This instrument is designed to provide a process to assist communities working on enhancing their crisis system to assess their current status on each of the elements of an "ideal crisis system," and to help prioritize next steps.

Scoring the Report Card

All items are scored on a 1 – 5 scale. The scale reflects a complete continuum ranging from non-existent/not started in our community through fully implemented and functioning well.

Anchors

These may be useful in assigning a score on individual items:

1. Not started and/or not on our radar and/or if interest does exist in moving on this, barriers seen as too overwhelming to make it worthwhile to put any energy into moving forward.
2. At least some awareness of this as a desirable goal within our system, and/or initial efforts to explore implementation, but no actual movement or specific plans yet.
3. Active steps that are beginning the process toward implementation; early stages of implementation.
4. Active steps being taken toward full implementation, but still incomplete, with intent to implement further.
5. Implemented in our system in a manner that is functioning well.

Tips on Scoring and Using This Report Card

Keep in mind this is not an exact science; Not all items will fit neatly with the specific anchors suggested above. In general, **if you find yourself between two scores (which will happen commonly) choose the lower score.** This may prompt you to set the higher score as a short or intermediate term goal.

Also remember that there is neither a "perfect score" for the instrument as a whole or a "right answer" for individual items. The goal is to ensure that stakeholders are aware of each of the specific aspects or ingredients of an ideal crisis system and have a common language and a process by which to discuss and assess where their community is at with regard to each of these. Hopefully, this can be used to assist in goal setting (short-, medium- and long-term) and prioritization.

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in "Ideal Behavioral Health Crisis System." Completed means that all indicators are met and are matched to population need.

Community/Region:
Size of Population:
Adult/Child/Both
Date Completed:

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION I: ACCOUNTABILITY AND FINANCE			
1A	Accountable entity identified and established.		
1.	Behavioral health crisis system coordinator identified.		
1C	Community behavioral health crisis system collaborative meets.		
1D	All services are accountable for system values.		
1E	Multiple payers contribute to financing services and capacity in the continuum.		
1F	Accountable entity coordinates financing.		
1.	Financing is adequate for population need.		
1H	Everyone is eligible, regardless of insurance.		
1I	The crisis continuum meets standards for capacity and geographic access for the population.		
1J	Quality metrics are established and measured for each service and the crisis continuum as a whole.		
1K	Data is collected and used collaboratively for customer oriented continuous improvement.		
1L	Provider contracts include incentives for performance in line with values and metrics.		
1M	System metrics include attention to how clients flow through the continuum timely/successfully.		
1N	The crisis system has data and capability to keep track of client progress through the continuum.		
1O	Satisfaction of primary customers (clients/families) and secondary customers (first responders/referents) measured/improved.		
1P	Consistent level of care determination and utilization management criteria throughout the system.		
1Q	All services in the crisis system function as safety-net support partners for behavioral health system programs.		
1R	Standards define how the crisis systems works collaboratively with other community systems (e.g., criminal justice, housing, intellectual and developmental disabilities (I/DD), child protection).		
1S	Standards define how community systems work collaboratively with the behavioral health crisis system.		
	Section I Total:	/ 95 (total points possible)	

1 = just getting started | 2 = making initial progress | 3 = about halfway there
4 = substantial progress | 5 = nearly completed or completed

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in "Ideal Behavioral Health Crisis System." Completed means that all indicators are met and are matched to population need.

Community/Region:
Size of Population:
Adult/Child/Both:
Date Completed:

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION II: CRISIS CONTINUUM: BASIC ARRAY OF CAPACITY AND SERVICES			
2A	Safe, welcoming, values-based services throughout the continuum.		
2B	Services address the continuum of crisis experience from pre-crisis to post-crisis.		
2C	Spaces and security practices are safe, warm, welcoming, therapeutic.		
2D	Families and collaterals are partners/customers.		
2E	First responders are priority customers		
2F	The service continuum responds to all ages		
2G	Continuum of capacity for people with co-occurring needs: mental health/substance use disorder (MH/SUD), behavioral health/ intellectual and developmental disabilities (BH/IDD), behavioral health/physical health (BH/PH), domestic violence (DV), homeless, criminal justice (CJ).		
2H	Cultural/linguistic/immigrant capacity.		
2I	Continuum of services described operationally.		
2J	Capacity for seamless flow and continuity of care.		
2K	Client information sharing thru the continuum.		
2L	Clients are kept track of through the continuum.		
2M	Family/collateral outreach and engagement.		
2N	Outreach/consultation with community providers.		
2O	Telehealth utilized effectively throughout the continuum.		
2P	Crisis hub secure access and urgent care center(s).		
2Q	Crisis call/text/chat center (911/non-911).		
2R	Crisis-trained first responders deployed.		
2S	Available, low barrier, medical screening/triage.		
2T	Mobile crisis for all ages, to homes, schools, etc.		
2U	23-hour observation.		
2V	Residential crisis services: high and low medical.		
2W	Peer respite/Living Rooms.		

2X	Detox and sobering support center capacities
2Y	Psychiatrically capable emergency room services
2Z	Psychiatric inpatient capacity: all ages, both general units and specialized units
2AA	Continuity of crisis intervention: home and office
2BB	Emergency and non-emergency transport
2CC	Adequately staffed multidisciplinary teams in all settings
2DD	Clinical, nursing, medical leadership
2EE	Access to specialty consultation
2FF	Peer support throughout the continuum
	Section II Totals / 150 (total points possible)

1 = just getting started | 2 = making initial progress | 3 = about halfway there
4 = substantial progress | 5 = nearly completed or completed

Medi-Cal Managed Care

Medi-Cal Managed Care provides high quality, accessible, and cost-effective health care through managed care delivery systems.

Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care.

Today, approximately 10.8 million Medi-Cal beneficiaries in all 58 California counties receive their health care through six main models of managed care (/services/Documents/MMCD/MMCDModelFactSheet.pdf): Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), Imperial, and San Benito. Medi-Cal providers who wish to provide services to managed care enrollees must participate in the managed care plan's provider network.

Hot Topics

Housing and Homelessness Incentive Program (/services/Pages/Housing-and-Homelessness-Incentive-Program.aspx)

Managed Care Plan County Model Change Information (/services/Pages/County-Model-Change-Information.aspx)

Managed Care Plan (MCP) Procurement – County Letter of Support

Contact Information

Medi-Cal Managed Care (/services/Pages/ManagedCareContactInfo.aspx)

Resources & Information

Medi-Cal Managed Care Quality Awards (/services/Pages/QualityAwards.aspx)

Aid Code Chart (PDF) (/services/Documents/MMCD/AidCodeChartv.1.9

(/services/Documents/MMCD/Letter-of-Support-4-13-21.pdf)

County Managed Care Transition to Local Plan: Letter of Intent Instructions (/services/Documents/MMCD/County-Managed-Care-Transition.pdf)

COVID-19 Updates (/)

Developmental Center Closures: Transitioning Medi-Cal Eligible Beneficiaries to Managed Care (PDF) (/services/Documents/MMCD/DCClosuresSept20

Managed Care Organization (MCO) Tax Approval (/services/medi-cal/Documents/CAMCOTaxlett51716.pdf)

Directed Payments (/services/Pages/DirectedPymts.aspx)

Dual Eligibles Coordinated Care Demonstration (/Pages/DualsDemonstration.aspx)

Health Homes Program (/services/Pages/HealthHomesProgram.aspx)

DHCS Comments to CMS Proposed Managed Care Rule (2019) (/services/Documents/CA-DHCS-Comment-Letter-CMS-2408-P-011419.pdf)

DHCS Comments to CMS Proposed Managed Care Rule (2015) (/services/Documents/MMCD/ManagedCareRegu

Palliative Care and SB 1004 (/provgovpart/Pages/Palliative-Care-and-SB-1004.aspx)

Student Behavioral Health Incentive Program (SBHIP) (/sbhip)

For Individuals

Provider Information Network (PIN) (/services/Pages/MgdCareProvInfoNet.aspx)

Managed Care Boilerplate Contracts (/provgovpart/Pages/MMCDBoilerplateContracts

Managed Care County Map (PDF) (/services/Documents/MMCD-Cnty-Map.pdf)

Managed Care Models Fact Sheet (PDF) (/services/Documents/MMCD/MMCDModelFactS

Managed Care Monitoring (/services/Pages/ManagedCareMonitoring.aspx)

Managed Care Advisory Group (MCAG) (/services/Pages/ManagedCareAdvisoryGroup.asp

Medi-Cal Managed Care Performance Dashboard (/services/Pages/MngdCarePerformDashboard.as

Medi-Cal Managed Care Request for Proposal #20-10029 (/provgovpart/rfa_rfp/Pages/CSBmcodmcpHOME

Staying Healthy Assessment (SHA) (/formsandpubs/forms/pages/stayinghealthy.asp

CalAIM Section 1115 Demonstration & 1915(b) Waiver (/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx)

MIPPA - Medicare Improvements for Patients and Providers Act of 2008 (/services/Pages/MIPPA.aspx)

Health Plan Accreditation Status – January 2021 (/services/Documents/MCQMD/Compliance%20U CAP/Health-Plan-Accreditation-Status-January-2021.pdf)

Health Plan Accreditation Status-July 2020 (/services/Documents/MCQMD/Compliance%20U CAP/HealthPlanAccreditationStatus-July2020.pdf)

Publications & Reports

Quality Improvement & Performance Measurement Reports

Continuity of Care (/services/Pages/ContinuityOfCare.aspx)

Health Plan Directory (/individuals/Pages/MMCDHealthPlanDir.aspx)

Office of the Ombudsman (/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx)

Medical Exemption Request Documentation (/services/Pages/MERDoc.aspx)

For Health Plans

All Plan, Policy & Duals Plan Letters (/formsandpubs/Pages/MgdCarePlanPolicyLtrs.as

Auto Assignment Incentive Program (/provgovpart/Pages/MgdCareAAIncentive.aspx)

Claims & Encounter Data Reporting (/dataandstats/data/Pages/MMCDClmsEncDataR

Managed Care Enrollment Reports (https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report)

SB 97 Medi-Cal Ombudsman Reports (/services/Pages/SB97.aspx)

Financial Reports (/dataandstats/reports/Pages/MMCDFinancialRep

(/dataandstats/reports/Pages/MMCDQualPerfMs

Last modified date: 2/9/2022 2:14 PM

Non-Discrimination Policy and Language Access (/Pages/Language_Access.aspx)

Access Health Care Language Assistance Services (SB 223) (/Pages/Health_Care_Language_Assistance_Services.aspx)

العربية (/Pages/Language_Access.aspx#arabic) | Հայերեն (/Pages/Language_Access.aspx#armenian) | ខ្មែរ (/Pages/Language_Access.aspx#cambodian) | 繁體中文 (/Pages/Language_Access.aspx#chinese) | فارسی (/Pages/Language_Access.aspx#farsi) | हिंदी (/Pages/Language_Access.aspx#hindi) | Hmoob (/Pages/Language_Access.aspx#hmong) | 日本語 (/Pages/Language_Access.aspx#japanese) | 한국어 (/Pages/Language_Access.aspx#korean)

MEDI-CAL MANAGED CARE PROGRAM FACT SHEET - Managed Care Models

County Organized Health Systems (COHS)	Geographic Managed Care (GMC)	Two-Plan
Model Description: In a COHS Model county, the Medi-Cal managed care health plan is run by the county. In a COHS county, there is only one managed care plan serving the Medi-Cal population. Required Steps: The county Board of Supervisors (BOS) may establish, by ordinance, a commission to negotiate a COHS contract with DHCS. The commission serves as an independent oversight entity for the delivery of Medi-Cal managed care services in that county. COHS contracts may be on a non-bid basis and exempt from Chp. 2 of Part 2 of the Public Contract Code. Legal References: Article 2.8, Chp. 7, Part 3, Div. 9 of the Welfare & Institutions Code	Model Description: In a GMC Model DHCS contracts with multiple Knox-Keene Act licensed commercial health plans within a single county. The GMC Model serves clearly defined geographic areas. Required Steps: In a GMC Model county, interested health plans are required to participate in DHCS' procurement process. Such a procurement process would be open to all eligible organizations that can meet qualification requirements. This process may result in one or more health plan contracting with DHCS. Legal References: Assembly Bill 336, Chapter 95, Statutes of 1991 and Senate Bill 485, Chapter 722, Statutes of 1992 Article 2.91, Chp. 7, Part 3, Div. of the Welfare & Institutions Code California Code of Regulations, Title 22, Sections 53900-53928	Model Description: In a Two-Plan Model county, there is a county organized plan called the Local Initiative (a prepaid health plan) and a commercial plan. The Local Initiative plan is a Knox-Keene Act licensed, county sponsored managed care plan that serves one or more counties. DHCS contracts with both plans for the delivery of Medi-Cal managed care services in the county. Required Steps: In the Two-Plan Model counties, interested counties must establish a Local Initiative by county ordinance. Interested commercial plans must compete for a contract through DHCS' procurement process. Legal References: Prepaid Plans, Chp. 8, Part 3, Div. 9 of the Welfare & Institutions Code California Code of Regulations, Title 22, Section 53800 et. Seq.

MEDI-CAL MANAGED CARE PROGRAM FACT SHEET - Managed Care Models

Regional	Imperial	San Benito
Model Description: Rural counties that have not elected to participate as a COHS model or as the Local Initiative of a Two-Plan model can offer Medi-Cal managed care through the Regional Model. The Regional Model developed for the rural expansion and consists of two commercial health plans, that are Knox-Keene Act licensed, wanting to serve two or more contiguous counties in the designated Expansion Region. Required Steps: Commercial Plans interested in participating as a Regional Model plan must participate in a procurement process. Such a procurement process would be open to all eligible organizations that can meet qualification requirements, including commercial businesses, nonprofit organizations, State or public universities (including auxiliary organizations) and other entities that are currently operating a managed care health plan. Legal References:	Model Description: The Imperial Model originated out of the Regional Model to serve rural expansion needs. Similarly, in an Imperial Model county, there are two Knox-Keene Act licensed commercial plans that contract with DHCS to serve one or more counties. Required Steps: Commercial Plans interested in participating as an Imperial Model plan must participate in a procurement process. Such a procurement process would be open to all eligible organizations that can meet qualification requirements, including commercial businesses, nonprofit organizations, State or public universities (including auxiliary organizations) and other entities that are currently operating a managed care health plan. Legal References: Assembly Bill 1467, Chapter 23, Statutes of 2012 Sections 14087.48 and 14087.98 of the Welfare & Institutions Code	Model Description: The San Benito Model also originated out of the Regional Model to serve rural expansion needs. In the San Benito Model county, there is one Knox-Keene Act licensed commercial plan that contracts with DHCS. Beneficiaries can choose the managed care plan or regular (fee-for-service) Medi-Cal. Required Steps: Commercial Plans interested in participating as an Imperial Model plan must participate in a procurement process. Request for Application (RFA). Such a procurement process would be open to all eligible organizations that can meet qualification requirements, including commercial businesses, nonprofit organizations, State or public universities (including auxiliary organizations) and other entities that are currently operating a managed care health plan. Legal References: Assembly Bill 1467, Chapter 23, Statutes of 2012

MEDI-CAL MANAGED CARE PROGRAM FACT SHEET - Managed Care Models

Regional	Imperial	San Benito
Assembly Bill 1467, Chapter 23, Statutes of 2012 Sections 14087.48 and 14087.98 of the Welfare & Institutions Code		Sections 14087.48 and 14087.98 of the Welfare & Institutions Code