TUOLUMNE COUNTY BEHAVIORAL HEALTH ADVISORY BOARD
REGULAR MEETING AGENDA

Time: Wednesday, November 2, 2022 @ 4:00 p.m. to 6:00 p.m.
Place: Tuolumne County Behavioral Health, Virtual Attendance Only

In order to protect public health and the safety of our Tuolumne County citizens, this Behavioral Health Advisory Board meeting will be physically closed to the public, however the public may participate and comment on any item via teleconference, U.S. Mail, email, or video conferencing through the Zoom platform at the following link:

Zoom (Video or Audio):
https://tuolumne-ca-gov.zoom.us/j/84265198165?pwd=TmpkTFg4MVEwK3ZPTm9RK0dQVFNGZz09
Meeting ID: 842 6519 8165 Passcode: 654248
Telephone (one tap mobile) +16694449171,,84265198165#,,,,*654248# US
Or Dial by your location +1 669 444 9171 US
Email: Email your comments to Attn: Pandora Armbruster at behavioralhealth@tuolumnecounty.ca.gov
U.S. Mail: Mail your comments to Attn: Behavioral Health Advisory Board, 2 S. Green St., Sonora CA 95370. Written comments must be received no later than 8:00 a.m. on the morning before the noticed meeting.

Important Public Notice: In accordance with Governor's Executive Order N-29-20, Accessibility Requirements, if you need swift special assistance during the meeting, please call (209) 533-6245. Under Executive Order N-25-20, members of the Tuolumne County Advisory Board may participate by teleconference.

AGENDA

BOARD OF SUPERVISOR'S REPRESENTATIVE
Jaron Brandon

ALTERNATE REPRESENTATIVE
Daniel Anaiah Kirk

CHAIRPERSON
Mary Anne Schmidt

VICE CHAIRPERSON
Sherry Bradley

SECRETARY
Heather Farris

OTHER MEMBERS
Cynthia Halman
Emily Valentine
Jenn Salazar
M. Elizabeth Marum
Marjorie Langdon
Maureen Woods
Susie DeMassey
Valerie Shuemake

I. **CALL TO ORDER** - 10 minutes

- Chair calls meeting to order.
- Announcement to attendees that the meeting is being recorded.
- Establish quorum with the introductions of Board Members
- Announce the October 5, 2022, Findings for AB 361
- Discussion and Action to determine whether the December 7, 2022, Behavioral Health Advisory Board Meeting will be either in-person or virtual. If virtual, make Findings for the December 2022 Meeting.

II. **INTRODUCTIONS** – 2 minutes

County staff, guests and any public attendees that wish to be identified

III. **REVIEW ORDER OF AGENDA ITEMS** – 2 minutes

IV. **CORRESPONDENCE** – 2 minutes

V. **APPROVAL OF MINUTES** – 5 minutes

October 5, 2022, Regular Meeting Minutes (Attachment 1)

VI. **PUBLIC COMMENT - 3 minutes per person**

Members of the public may be heard on any item, **not** on the Board's Agenda. A person addressing the Board will be limited to three minutes. Comments by members of the public on any item on the agenda will only be allowed during consideration of the item by the Board.

VII. **AD HOC COMMITTEE REPORTS & ACTION:**

A. BOARD MEMBERSHIP, RECRUITMENT, ORIENTATION & TRAINING – 10 minutes: Heather Farris

VIII. **REPORTS:**

A. BOARD MEMBER REPORTS/ANNOUNCEMENTS - 3 minutes per Board member: Members of the Advisory Board may share announcements and/or comment on matters, not on the agenda.
B. SUPERVISOR' S REPORT – 5 minutes: Jaron Brandon, Tuolumne County Board of Supervisors Representative
C. DIRECTOR'S REPORT – 10 minutes: Tami Mariscal, Behavioral Health Director
   - Q & A – 5 minutes
D. BEHAVIORAL HEALTH QUARTERLY STAFF REPORT:
   - External Quality Review Organization Report - 8 minutes: Lindsey Lujan, Agency Manager
   - Link to support material: Tuolumne MHP EQRO Final Report FY21-22
   - Q & A – 7 minutes
E. MENTAL HEALTH PLAN (MHP) CONTRACT:
   - State Performance Section 1 – 10 minutes: Lindsey Lujan, Agency Manager
   - Support material attached – Pages 1 thru 10
   - Q & A – 5 minutes

IX. **NEW BUSINESS AND ACTIONS:**

A. PROPOSAL OF GOALS FOR BHAB - 10 minutes: Mary Anne Schmidt
   - Support material attached
B. CREATION OF PUBLIC EVENTS AD HOC COMMITTEE FOR 2023 – 3 minutes: Mary Anne Schmidt
C. PROPOSAL OF TIME OF BHAB MEETINGS – 10 minutes: Mary Anne Schmidt
D. CALL A MEETING OF THE EXECUTIVE BOARD – 3 minutes: Mary Anne Schmidt

X. **SUGGESTIONS FOR NEXT MONTH'S AGENDA** - 2 minutes: Board Members, Behavioral Health Staff, Members of the Public

XI. **ADJOURNMENT**

Next Advisory Board Meeting is currently scheduled for December 7, 2022 @ 4 pm

This agenda can be made available in alternative formats upon request. Late agenda material can be reviewed at the Behavioral Health Department, 105 Hospital Road, Sonora, CA 95370.

If you require special assistance (i.e., auxiliary aids or services) in order to participate in this public meeting, please call (209) 533-6245 at least 48 hours prior to the start of the meeting to enable staff to make a reasonable accommodation to ensure accessibility to this public meeting.

Tuolumne County Behavioral Health Advisory Board (BHAB)
(Minutes of the meeting of October 5, 2022)
DRAFT

2022 BHAB Membership	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Jaron Brandon - BOS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Anaiah Kirk – BOS Alt	E	E	E	E	E	E	E	E	E	E		
Mary Anne Schmidt, Chairperson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Sherry Bradley, Vice-Chairperson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Heather Farris, Secretary	✓	✓	E	✓	✓	✓	✓	✓	✓	✓		
Cynthia Halman	✓	✓	E	✓	✓	✓	E	✓	✓	E		
Elizabeth Marum	✓	✓	✓	✓	E	✓	✓	✓	E	✓		
Emily Valentine	E	✓	✓	✓	E	✓	E	✓	A	A		
Jenn Salazar	✓	✓	✓	✓	✓	✓	✓	✓	E	✓		
Marjorie Langdon	A	✓	✓	E	✓	✓	E	✓	A	✓		
Maureen Woods	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Susie DeMassey	✓	E	✓	E	✓	E	✓	E	✓	✓		
Valerie Shuemake	E	✓	E	E	A	✓	✓	E	✓	E		

Present = ✓ Absent = A Excused = E **12 MHAB Members, 1 BOS Alternate**

Tuolumne County Staff in Attendance
Rebecca Espino, Director – Health & Human Services Agency
Tami Mariscal, Director – Behavioral Health Department
Brock Kolby, Deputy Director – Behavioral Health Department
Lindsey Lujan, Agency Manager – Behavioral Health Department
Jenn Guhl, MHSA Agency Manager – Behavioral Health Department
Pandora Armbruster, Administrative Assistant – Behavioral Health Department
Others in Attendance
Terri Alford – Mental Health Coordinator, Tuolumne County Superintendent of Schools

I. CALL TO ORDER

- Behavioral Health Advisory Board Chairperson, Mary Anne Schmidt, announced to attendees that the meeting was being recorded.

  The meeting was called to order at 4:02 pm. Eight of the twelve members were present and accounted for at the time of roll call to complete a quorum for the Board. Behavioral Health Advisory Board members introduced themselves as roll call was taken. Those present were Jaron Brandon, Mary Anne Schmidt, Sherry Bradley, Heather Farris, Jenn Salazar, Marjorie Langdon, Maureen Woods, and Susie DeMassey. Cynthia Halman, Elizabeth

Marum, Emily Valentine, and Valerie Shuemake were not in attendance at the time of roll call.

- The September 7, 2022, Findings Resolution for AB 361 indicating that the Behavioral Health Advisory Board would be meeting virtually only for the October 5, 2022, meeting was incorporated into the meeting record.
- A motion was made by Jaron Brandon and seconded by Marjorie Langdon to make the November 2, 2022, Behavioral Health Advisory Board meeting available for virtual attendance per AB 361 and through #2 of the associated Findings. The motion passed. (Ayes: 7 – Jaron Brandon, Mary Anne Schmidt, Sherry Bradley, Heather Farris, Marjorie Langdon, Maureen Woods, and Susie DeMassey. Nays: 1 – Jenn Salazar Abstentions: 0 Members Absent: 5 – Cynthia Halman, Elizabeth Marum, Emily Valentine, and Valerie Shuemake)

  As a result of this determination, the November 2, 2022, Behavioral Health Advisory Board meeting will be available through virtual attendance only, per the County Administrator's recommendation to allow in-person or virtual meetings, and not through a combination of both.

II. INTRODUCTIONS

Introductions were made by Tuolumne County staff in attendance, as follows: Rebecca Espino – Director, Health and Human Services Agency, Tami Mariscal – Director, Behavioral Health Department, Brock Kolby - Deputy Director, Behavioral Health Department, Lindsey Lujan - Agency Manager, Jenn Guhl – MHSA Agency Manager, and Pandora Armbruster – Administrative Assistant. Terri Alford – Mental Health Coordinator, Tuolumne County Superintendent of Schools was also present.

III. AGENDA REVIEW PERIOD

There were no suggested changes to the order of agenda items**.**

IV. CORRESPONDENCE

No correspondence was reported.

*** Elizabeth Marum arrived at the meeting.

V. APPROVAL OF MINUTES

Mary Anne Schmidt pointed out a correction to the members of the Application and Interview Committee Ad Hoc. Members should have been noted as Jaron Brandon and Mary Anne Schmidt.

Heather Farris moved to approve the September 7, 2022, Behavioral Health Advisory Board Meeting Minutes with the noted correction. Sherry Bradley seconded. Motion passed.

(Ayes: 7 – Jaron Brandon, Mary Anne Schmidt, Sherry Bradley, Heather Farris, Jenn Salazar, Maureen Woods, and Susie DeMassey. Nays: 0 Abstentions: 2 – Elizabeth Marum and Marjorie Langdon. Members Absent: 3 – Cynthia Halman, Emily Valentine, and Valerie Shuemake.)

VI. PUBLIC COMMENT:

Members of the public may be heard on any item not on the Board's Agenda. A person addressing the Board will be limited to **three minutes**. Comments by members of the public on any item on the agenda will only be allowed during consideration of the item by the Board.

No public comments were received.

VII. NEW BUSINESS & ACTIONS

A. UPDATE ON BYLAWS – Supervisor Jaron Brandon, Tuolumne County Board of Supervisors

Supervisor Brandon updated the group on a recent meeting with Tami Mariscal, Behavioral Health Director, Chris Schmidt, County Counsel, Mary Anne Schmidt, Behavioral Health Advisory Board Chair, Pandora Armbruster, Administrative Support, and himself about the status of the draft BHAB Bylaws.

Director Mariscal shared that she had recently been informed by Chris Schmidt that his focus had been directed elsewhere due to pending litigation that recently came across his desk. He anticipated at least a four-week delay before being able to move them forward.

Jaron shared that the direction of the meeting was to focus on the key issues in the Bylaws that needed to be addressed. Mary Anne relayed that Chris Schmidt wanted to start over with a new template for the Bylaws. She sent him a template acquired from California Behavioral Health Board and Commissions (CALBHBC) to be utilized for that purpose.

B. DEVELOP PLAN FOR SITE VISITS – Mary Anne Schmidt, Behavioral Health Advisory Board Chair

As a result of recent conversations during BHAB meetings regarding the role of the BHAB to conduct site visits, Mary Anne created an Ad-Hoc Committee to develop a site visit plan for the next six months. Sherry Bradley was identified to take a lead role on this Ad Hoc Committee. Elizabeth Marum and Jenn Salazar declared their interest in also participating in this Ad Hoc.

C. ANNUAL REPORT TO THE BOARD OF SUPERVISORS – Mary Anne Schmidt, Behavioral Health Advisory Board Chair

Mary Anne informed the group that the Secretary, Heather Farris, would be keeping track of the Board's activities and accomplishments over the course of the next six months. In July of 2023, an Ad hoc Committee will be established to create a draft Annual Report. The draft will be reviewed at the August meeting for approval to be presented to the Board of Supervisors.

D. CALL A MEETING OF THE EXECUTIVE BOARD TO REVIEW BOARD GOALS IDENTIFIED AT THE BEHAVIORAL HEALTH ADVISORY BOARD RETREAT – Mary Anne Schmidt, Behavioral Health Advisory Board Chair

Mary Anne Schmidt will be calling a meeting of the Executive Committee (consisting of the Chair, Vice Chair and Secretary) to review and discuss the

goals identified at the future BHAB Retreat. This virtual meeting will be tentatively scheduled for Saturday, October 29, 2022, at 10:00 am. This public meeting will be posted and agendized. The BHAB would like to take their own minutes at this meeting.

The group discussed the logistics of this tentative Executive Committee Meeting, and the possibility of necessary County Staff support to manage meeting records and the virtual meeting platform. County Counsel will be consulted regarding this proposed committee meeting and any county permissions and Brown Act requirements that may need to be met.

VIII. AD HOC COMMITTEE REPORTS & ACTION

A. DATA NOTEBOOK - Sherry Bradley, Behavioral Health Advisory Board Vice-Chair

Sherry presented the remaining questions to members for their final feedback, review, and approval for submission of the 2022 Data Notebook to the California Behavioral Health Planning Council (CBHPC).

Heather Farris, Behavioral Health Advisory Board Secretary, made a motion to approve the 2022 Data Notebook for submission to CBHPC. Maureen Woods seconded the motion. Motion passed. (Ayes: 9 – Jaron Brandon, Mary Anne Schmidt, Sherry Bradley, Heather Farris, Elizabeth Marum, Jenn Salazar, Marjorie Langdon, Maureen Woods, and Susie DeMassey. Nays: 0 Abstentions: 0 Members Absent: 3 – Cynthia Halman, Emily Valentine, and Valerie Shuemake.)

B. BOARD MEMBER RECRUITMENT& MEMBERSHIP – Heather Farris, Ad hoc Chair

1. Update on the Orientation Plan for New Members – In the interest of time, this item was postponed until the November meeting.
2. Behavioral Health Advisory Board Members Application for Reappointment – Jenn Salazar

   A motion was made by Heather Farris and seconded by Marjorie Langdon to move Jenn Salazar's application forward to the Board of Supervisors for approval of reappointment to a new term. (Ayes: 9 – Jaron Brandon, Mary Anne Schmidt, Sherry Bradley, Heather Farris, Elizabeth Marum, Jenn Salazar, Marjorie Langdon, Maureen Woods, and Susie DeMassey. Nays: 0 Abstentions: 0 Members Absent: 3 – Cynthia Halman, Emily Valentine, and Valerie Shuemake.)

C. INTERVIEW NEW CANDIDATES FOR THE BEHAVIORAL HEALTH ADVISORY BOARD – Jaron Brandon, Tuolumne County Board of Supervisor District 5, and Mary Anne Schmidt, BHAB Chair

Mary Anne Schmidt shared that she and Jaron Brandon interviewed recent candidate Alejandro Abarca and suggested that he attend upcoming Advisory Board meetings to meet other members and learn more about the meetings. Since that interview, Mary Anne received a call from Mr. Abarca withdrawing his application due to a conflict with the

timing of the monthly scheduled meetings. Mr. Abarca suggested that the time of the monthly meetings be changed to accommodate the public and working people.

There is another applicant, Kim Souza, whose application is currently pending. Mary Anne will speak with her to determine next steps and if appropriate schedule time to interview her with Supervisor Brandon.

IX. REPORTS

A. SUPERVISOR'S REPORT

Supervisor Brandon shared information on Board of Supervisors items regarding the approval of a Behavioral Health Department contract for acute tele-psychiatric services.

The Rural County Conference has been completed. Care Court is coming up. Tuolumne County is one of the counties that have opted into that.

The California State Association of Counties (CSAC) Conference is coming up. This is an important opportunity for counties to meet and discuss universal issues and legislation.

B. DIRECTOR'S REPORT

Tami Mariscal provided additional information on the department's participation in implementing the Care Court process. She described the process, participant requirements, implementation, and potential challenges (treatment, funding, housing) associated with implementation.

Mary Anne Schmidt interrupted the Director's Report to allow time for Dr. Brock Kolby's scheduled presentation on Mental Health Facilities.

***Susie DeMassey left the meeting at 5:30 pm.

The following items were tabled until next month's regularly scheduled meeting:

C. BEHAVIORAL HEALTH ADVISORY BOARD CHAIR REPORT

D. BOARD MEMBER REPORTS/ANNOUNCEMENTS

X. SUGGESTIONS FOR NEXT MONTH'S AGENDA

Tabled until November Meeting.

XI. PUBLIC SPEAKER

Dr. Brock Kolby- Deputy Director, Tuolumne County Behavioral Health, provided a PowerPoint Presentation on Mental Health Treatment Facilities.

A copy of his PowerPoint presentation will be provided within these minutes. (See attachment)

XII. ADJOURNMENT

The October 5, 2022, Behavioral Health Advisory Board meeting was adjourned at 6:10 pm.

The next Tuolumne County Behavioral Health Advisory Board meeting is scheduled for November 2, 2022, at 4:00 pm via videoconference through Zoom and teleconference only. Meeting information will be posted on the November 2022 Agenda.

TUOLUMNE CO. BEHAVIORAL HEALTH

RECOVERY PLACEMENTS

Dr. Brock Kolby, Ed.D.
Licensed Professional Clinical Counselor (LPCC)
October, 2022

AGENDA

When Placements are Needed,
History of Institutionalization and the LPS Act

Least Restrictive Environment

Mental Health Recovery Facilities

Substance Use Recovery Facilities

Costs, Funding, and Contracted Placements

Summary

Rationale for Treatment Facilities

- When a person with mental health or substance use treatment issue needs additional support to live in the community, then placement in a treatment facility may be needed.
- Placements provide a level of support that enables a person to succeed while they pursue their recovery goals.
- Placements may be short-term such as 1 month or less, or long-term such as a year or more.
- Placements are temporary in nature where treatment and supportive services are provided until a person can move into the community or into the least restrictive environment.
- Placements are not for purposes of legal reasons to “lock” people up two the community may find problematic or because of criminal justice reasons.

History of Institutionalization

- In the 20th century in Mental Health care in the United States, people were often locked up against their will and lost their civil rights due to their mental illnesses.
- People had little to no rights when locked up against their will. They were committed to large institutions where the psychiatrist or medical staff determined if they could leave or not.
- At times, this system was abused by family members who had financial reasons to lock up mentally ill relatives to take control of their houses, finances, or to hide a social problem. No system of appeal for this commitment was available for people for many years.
- People became aware that inhumane conditions existed in large institutions. Barbaric treatment were often used such as lobotomy, hydrotherapy, electroconvulsive therapy (ECT), and insulin shock therapy into the 1960's.
- The impersonal nature of institutions and dehumanizing aspect of institutional care were hallmarks of these approaches to mental health care.

Lanterman-Petris-Short Act (LPS)

- Consequently, human rights advocates came together in the 1960s to address the concerns of abuse and poor care for people with mental illnesses in these facilities.
- In 1967, the California legislature passed the Lanterman-Petris-Short Act to address these abuses and problems.
- The LPS Act was primarily designed to protect people's civil rights with appeal processes and protections for people.
- Hence, the "5150" code of this act came to represent an involuntary psychiatric hospitalization.

LEAST RESTRICTIVE ENVIRONMENT

1. A guiding principle of placement is always trying to help people live in the least restrictive environment for their treatment needs.
2. If a person is in a psychiatric hospital, when can they return to the community and their residence? The average stay in a psychiatric hospital is 5-7 days. It is a short-term intervention to stabilize a person on medication and provide a safe environment for them.
3. For people who are on LPS conservatorship, they may be in placement for the time needed for their mental health recovery. For locked facilities such as Mental Health Rehabilitation Centers (MHRC & IMD), they may receive treatment for an average of 3 months to 1 year, sometimes longer, until they can move to an unlocked board-and-care home.
4. Some people require longer-term care in a board-and-care home, a Residential Care Home for the Elderly (RCFE), permanent supportive housing, or other long-term residential living situations.

TYPES OF MENTAL HEALTH PLACEMENTS

- State Hospitalization (very rare, primarily forensic)
- Inpatient Psychiatric Hospitalization
- Mental Health Rehabilitation Centers (MHRC) and Institutes for Mental Disorders (IMD): locked longer-term residential treatment facilities and client must be on LPS conservatorship
- Board-and-Care homes (Adult Residential Facilities [ARF])
- Residential Care Home for the Elderly (RCFE)
- Supportive Living (e.g., in Tuolumne Co., Cabrini and Washington St. Houses)
- Independent Living in the Community

SUBSTANCE USE RECOVERY FACILITIES

- Residential Drug/Alcohol Treatment Facilities

  (usually 30-90 day programs)
  - Adults (co-ed)
  - Perinatal for women and/or their infants/children
  - Adolescent
- Clean and Sober Living Homes

COSTS OF PLACEMENT

- Costs vary greatly depending upon the treatment program provided
- Typically, placements that are more restrictive cost more than less restrictive ones
- The order of costs are from the highest costs at Acute Psychiatric Hospital, State Hospitalization, then IMD/MHRC, RCFE, residential drug/alcohol programs, board-and-care homes, and then last supportive living.
- For example, a psychiatric hospital may cost from $1,800 to $2,500/day.
- State Hospitalization is around $600/day.
- IMD/MHRC range from $300-$400/day on average, or as high for a special treatment program as $800/day.
- Residential drug/alcohol treatment varies from over $1,000/mo. to $3,000/mo. For adolescents, the cost is $7,000-$12,000/mo.
- Board-and-Care homes: paid in part by the client's SSI income at about $1000/mo., but then supplemental costs can be billed for additional services that raise the total costs to $3,000-$4,000/mo.

FUNDING FOR PLACEMENTS

- Residential placement costs are not a billable service under Medi-Cal insurance.
- Placements for LPS conserved clients are paid by Behavioral Health.
- Behavioral Health Realignment funds the costs of hospitalizations and placements for Medi-Cal beneficiaries.
- The Behavioral Health is responsible for these costs even if they exceed the amount of money given by the State under Realignment.
- At the most expensive placements, one child placement currently costs BH approximately $1/3 million per year.
- One adult placement, until recently, cost BH about $250,000/year.
- Consequently, placement costs must be managed to provide for adequate, highly needed care while still managing the fiscal costs.

Contracted Placements

Placement	Type of Facility	Maximum Contracted Amount / Fiscal Year
Davis Guest Home	Board and Care Home	$140,000
Mar-Ric Care Home	Board and Care Home	$125,000
Merced Behavioral	Institute for Mental Disorders	$300,000
Optimum Senior Care	Residential Care Facility for Elderly	$55,000
St. Francis Guest Home	Board and Care Home	$45,000
StarView Adolescent	Short Term Residential Treatment Program (children)	$500,000
Changing Echoes	Residential Drug Alcohol Facility	$25,000
California Psychiatric Transitions	Mental Health Rehabilitation Center	$300,000
Creative Alternatives	Short Term Residential Treatment Program (children)	$50,000
Crestwood	Mental Health Rehabilitation Center	$562,500
Ever Well	Residential Care Facility for Elderly	$150,000
Modesto Residential Living Center	Board and Care Home	$60,000
Summit View	Short Term Residential Treatment Program (children)	$50,000
Nirvana	Residential Drug Alcohol Facility	$55,000
Social Models Advocate, Inc.	Residential Drug Alcohol Facility Perinatal	$20,000
Adventist Health St Helena & Vallejo	Psychiatric Hospital	$300,000
Doctors Medical Center	Psychiatric Hospital	$300,000
Sierra Vista BHC	Psychiatric Hospital	$300,000

SUMMARY

In order to support clients in their mental health and substance use recovery, they may require a higher level-of-care facility to meet their treatment needs.

Ideally, treatment facilities are short-term in nature and follow the principle of Least Restrictive Environment.

For longer-term care needs, a small number of client may take advantage of residential placements to meet their needs.

For substance use recovery, client may enter into short-term residential treatment programs to learn how to achieve sobriety from the substances or alcohol use issues they struggle with.

Patient rights have been enacted into law under the LPS Act to protect clients from indefinite placement in a locked facility and to allow them a voice in determining their placement.

THANK YOU FOR YOUR TIME!

Exhibit A – Attachment 2
SCOPE OF SERVICES

1. Criteria for Beneficiaries to Access Specialty Mental Health Services

Effective January 1, 2022, the Contractor shall implement the criteria for access to SMHS (except for psychiatric inpatient hospital and psychiatric health facility services) established below, update the Contractor's policies and procedures as needed to ensure compliance with this policy effective January 1, 2022, and communicate these updates to providers as necessary.

In addition, the Contractor shall update beneficiary handbooks, manuals, and related materials to ensure the criteria for SMHS for individuals under 21 years of age and for adults is accurately reflected in all materials, including materials reflecting the responsibility of Medi-Cal managed care plans and the Fee for Service delivery system for covering non-specialty mental health services.(BHIN 21-073).

A. Pursuant to Welf. & Inst. Code section 14184.402(a) the following definitions of "medical necessity" or "medically necessary" apply:

1) For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5

2) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services needed to correct and ameliorate mental illness and conditions. Federal guidance from the Centers for Medicare & Medicaid Services makes it clear that services need not be curative or restorative to ameliorate a mental health condition. All mental health services that are not covered under Medi-Cal Fee For Service (FFS) or by Managed Care Plans as non-specialty mental health services as established in W&I Code section 14184.402(b) that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as EPSDT services and the Contractor shall cover them

Exhibit A – Attachment 2
SCOPE OF SERVICES

for beneficiaries who meet the criteria for access to the specialty mental health delivery system.

Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

B. Criteria for Adult Beneficiaries to Access the Specialty Mental Health Services Delivery System

For beneficiaries 21 years of age or older, the Contractor shall provide covered specialty mental health services for beneficiaries who meet both of the following criteria, (1) and (2) below:

1. The beneficiary has one or both of the following:
   a. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities
   b. A reasonable probability of significant deterioration in an important area of life functioning

AND

2. The beneficiary's condition as described in paragraph (1) is due to either of the following:
   a. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems
   b. A suspected mental disorder that has not yet been diagnosed

C. Criteria for Beneficiaries under Age 21 to Access the Specialty Mental Health Services Delivery System

For enrolled beneficiaries under 21 years of age, Contractor shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code. Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria:

Exhibit A – Attachment 2
SCOPE OF SERVICES

1) The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

OR

2) The beneficiary meets both of the following requirements in a and b below:
   a. The beneficiary has at least one of the following:
      i. A significant impairment
      ii. A reasonable probability of significant deterioration in an important area of life functioning
      iii. A reasonable probability of not progressing developmentally as appropriate
      iv. A need for specialty mental health services, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide

AND

   b. The beneficiary's condition as described in subparagraph (A) is due to one of the following:
      i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems
      ii. A suspected mental health disorder that has not yet been diagnosed
      iii. Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional

2. Provision of Services

A. The Contractor shall provide or arrange, and pay for, the following medically necessary covered specialty mental health services to beneficiaries who meet access criteria for receiving specialty mental

Exhibit A – Attachment 2
SCOPE OF SERVICES

health services. See Exhibit E, Attachment 2, Service Definitions, for detailed descriptions of the specialty mental health services listed below:

1) Mental health Services;

2) Medication Support Services;

3) Day Treatment Intensive;

4) Day Rehabilitation;

5) Crisis Intervention;

6) Crisis Stabilization;

7) Adult Residential Treatment Services;

8) Crisis Residential Treatment Services;

9) Psychiatric Health Facility Services;

10) Intensive Care Coordination (for beneficiaries under the age of 21);

11) Intensive Home Based Services (for beneficiaries under the age of 21);

12) Therapeutic Behavioral Services (for beneficiaries under the age of 21);

13) Therapeutic Foster Care (for beneficiaries under the age of 21);

14) Psychiatric Inpatient Hospital Services;

15) Targeted Case Management; and

16) For beneficiaries under the age of 21, the Contractor shall provide all medically necessary specialty mental health services required pursuant to Section 1396d(r) of Title 42 of the United States Code (Welf. & Inst. Code 14184.402 (d)).

Exhibit A – Attachment 2
SCOPE OF SERVICES

B. Medi-Cal Managed Care Plan beneficiaries receive mental health disorder benefits in every classification - inpatient, outpatient, prescription drug and emergency - that the beneficiaries receive medical/surgical benefits, in compliance with 42 C.F.R. 438.910(b)(2). The Contractor is only required to provide inpatient and outpatient specialty mental health services, as provided for in this Contract and as required pursuant to section 1396d(r) of Title 42 of the United States Code, as prescription drug and emergency benefits are provided through other delivery systems.

C. Services shall be provided, in accordance with the State Plan, to beneficiaries, who meet criteria to access SMHS, documented in accordance with state and federal requirements.

D. The Contractor shall provide or arrange and pay for all medically necessary covered specialty mental health services in a sufficient amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary covered specialty mental health service solely because of diagnosis, type of illness, or condition of the beneficiary. The Contractor may deny services based on Welfare and Institutions Code sections 14184.402, subdivisions (a), (c), and (d), 14059.5; and departmental guidance and regulation. (42 C.F.R. § 438.210(a)(2) and (3).)

E. The Contractor shall make all medically necessary covered specialty mental health services available in accordance with Cal. Code-Regs., tit. 9, sections1810.345, 1810.350 and 1810.405, and 42 Code of Federal Regulations part 438.210.

F. The Contractor shall provide second opinions from a network provider, or arrange for the beneficiary to obtain a second opinion outside the network, at no cost to the beneficiary. (42 C.F.R § 438.206(b).) At the request of a beneficiary when the Contractor or its network provider has determined that the beneficiary is not entitled to specialty mental health services due to not meeting the criteria for access to SMHS, the contractor shall provide for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (Cal. Code Regs., tit. 9, § 1810.405(e).)

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G. The Contractor shall provide a beneficiary's choice of the person providing services to the extent feasible in accordance with Cal. Code-Regs., tit. 9, section 1830.225 and 42 Code of Federal Regulations part 438.3(l).

3. Requirements for Day Treatment Intensive and Day Rehabilitation

A. The Contractor shall require providers to request prior authorization for day treatment intensive and day rehabilitation services, in accordance with Information Notice 22-016 and any subsequent departmental notices.

B. The Contractor shall require that providers of day treatment intensive and day rehabilitation meet the requirements of Cal. Code Regs., tit. 9, §§ 1840.318, 1840.328, 1840.330, 1840.350 and 1840.352.

C. The Contractor shall require that providers include, at a minimum, the following day treatment intensive and day rehabilitation service components:

1) Therapeutic milieu. This component must include process groups and skill-building groups. Specific activities shall be performed by identified staff and take place during the scheduled hours of operation of the program. The goal of the therapeutic milieu is to teach, model, and reinforce constructive interactions by involving beneficiaries in the overall program. For example, beneficiaries are provided with opportunities to lead community meetings and to provide feedback to peers. The program includes behavior management interventions that focus on teaching self-management skills that children and adults and older adults may use to control their own lives, to deal effectively with present and future problems, and to function well with minimal or no additional therapeutic intervention. Activities include, but are not limited to, staff feedback to beneficiaries on strategies for symptom reduction, increasing adaptive behaviors, and reducing subjective distress.

2) Process groups. These groups, facilitated by staff, shall assist each beneficiary to develop necessary skills to deal with their problems and issues. The group process shall utilize peer interaction and feedback in developing problem-solving strategies

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to resolve behavioral and emotional problems. Day rehabilitation may include psychotherapy instead of process groups, or in addition to process groups.

3) Skill-building groups. In these groups, staff shall help beneficiaries identify barriers related to their psychiatric and psychological experiences. Through the course of group interaction, beneficiaries identify skills that address symptoms and increase adaptive behaviors.

4) Adjunctive therapies. These are therapies in which both staff and beneficiaries participate. These therapies may utilize self-expression, such as art, recreation, dance, or music as the therapeutic intervention. Participants do not need to have any level of skill in the area of self-expression, but rather be able utilize the modality to develop or enhance skills directed toward achieving beneficiary plan goals. Adjunctive therapies assist the beneficiary in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Adjunctive therapies provided as a component of day rehabilitation or day treatment intensive are used in conjunction with other mental health services in order to improve the outcome of those services consistent with the beneficiary's needs.

D. Day treatment intensive shall additionally include:

1) Psychotherapy. Psychotherapy means the use of psychological methods within a professional relationship to assist the beneficiary or beneficiaries to achieve a better psychosocial adaptation, to acquire a greater human realization of psychosocial potential and adaptation, to modify internal and external conditions that affect individual, groups, or communities in respect to behavior, emotions and thinking, in respect to their intrapersonal and interpersonal processes. Psychotherapy shall be provided by licensed, registered, or waivered staff practicing within their scope of practice. Psychotherapy does not include physiological interventions, including medication intervention.

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2) Mental Health Crisis Protocol. The Contractor shall ensure that there is an established protocol for responding to beneficiaries experiencing a mental health crisis. The protocol shall assure the availability of appropriately trained and qualified staff and include agreed upon procedures for addressing crisis situations. The protocol may include referrals for crisis intervention, crisis stabilization, or other specialty mental health services necessary to address the beneficiary's urgent or emergency psychiatric condition (crisis services). If the protocol includes referrals, the day treatment intensive or day rehabilitation program staff shall have the capacity to handle the crisis until the beneficiary is linked to an outside crisis service.

3) Written Weekly Schedule. The Contractor shall ensure that a weekly detailed schedule is available to beneficiaries and as appropriate to their families, caregivers or significant support persons and identifies when and where the service components of the program will be provided and by whom. The written weekly schedule will specify the program staff, their qualifications, and the scope of their services.

E. Staffing Requirements. Staffing ratios shall be consistent with the requirements in Cal. Code Regs., tit. 9, section 1840.350, for day treatment intensive, and Cal. Code Regs., tit. 9 section 1840.352 for day rehabilitation. For day treatment intensive, staff shall include at least one staff person whose scope of practice includes psychotherapy.

a. Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic program (e.g., time for travel, documentation, and caregiver contacts).

b. The Contractor shall require that at least one staff person be present and available to the group in the therapeutic milieu for all scheduled hours of operation.

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c. The Contractor shall require day treatment intensive and day rehabilitation programs to maintain documentation that enables the Contractor and the Department to audit the program if it uses day treatment intensive or day rehabilitation staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). The Contractor shall require that there is documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

F. The Contractor shall ensure that the provider receives Medi-Cal reimbursement only if the beneficiary is present for at least 50 percent of scheduled hours of operation for that day. In cases where absences are frequent, it is the responsibility of the Contractor to ensure that the provider re-evaluates the beneficiary's need for the day rehabilitation or day treatment intensive program and takes appropriate action.

G. Documentation Standards. The Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation requirements in BHIN 22-019.

H. The Contractor shall ensure that day treatment intensive and day rehabilitation have at least one contact per month with a family member, caregiver or other significant support person identified by an adult beneficiary, or one contact per month with the legally responsible adult for a beneficiary who is a minor. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). Adult beneficiaries may decline this service component. The contacts should focus on the role of the support person in supporting the beneficiary's community reintegration. The Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.

I. Written Program Description. The Contractor shall ensure there is a written program description for day treatment intensive and day rehabilitation. The written program description must describe the specific activities of each service and reflects each of the required components of the services as described in this section. The Contractor shall review the

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written program description for compliance with this section with prior to the date the provider begins delivering day treatment intensive or day rehabilitation.

J. Continuous Hours of Operation. The Contractor shall ensure that the provider applies the following when claiming for day treatment intensive and day rehabilitation services:

a. A half day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

b. A full-day shall be billed for each day in which the beneficiary receives face-to-face services in a program with services available more than four hours per day.

c. Although the beneficiary must receive face to face services on any full-day or half-day claimed, all service activities during that day are not required to be face-to-face with the beneficiary.

d. The requirement for continuous hours of operation does not preclude short breaks (for example, a school recess period) between activities. A lunch or dinner may also be appropriate depending on the program's schedule. The Contractor shall not conduct these breaks toward the total hours of operation of the day program for purposes of determining minimum hours of service.

4. Therapeutic Behavioral Services

Therapeutic Behavioral Services (TBS) are specialty mental health services covered as Early and Periodic Screening, Diagnostic and Treatment (EPSDT). (Cal. Code Regs., tit. 9, § 1810.215.) TBS are intensive, one-to-one services designed to help beneficiaries and their parents/caregivers manage specific behaviors using short-term measurable goals based on the beneficiary's needs. TBS is described in the Department of Mental Health Information Notice 08-38.

Tuolumne County Behavioral Health Advisory Board

Annual Goals November 2022-July 2023

Goal #1: Fulfill the mandated responsibilities and core purposes of the Tuolumne County Behavioral Health Advisory Board.

A. Review and evaluate the community's mental health needs, services, facilities, and special problems [5604.2 (a)(1)] Welfare & Institutions Code (WIC).

B. Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council (CMHPC) [5604.2 (a)(7)] WIC.

C. Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process [5604.2 (a)(4)] WIC.

D. Review any county agreement entered pursuant to Section 5650 of the Welfare & Institutions Code (WIC).

E. Submit an annual report to the Board of Supervisors on the needs and performance of the county's Behavioral Health system [WIC 5604.2 (a) (5)].

F. Review and make recommendations on applicants for the appointment of a local director of behavioral health services. The board shall be included in the selection process prior to the vote of the governing body.

G. Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council (CMHPC) [WIC 5604.2 (a)(7)].

H. Assess the impact of the realignment of services from the state to the county on services delivered to clients and the local community [WIC 5604.2 (b)].

I. Conduct a public hearing on the county's Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan and Annual Update at the close of the 30-day comment period required by the subdivision [WIC 5848(a)].

Goal #2: Maintain an active, involved Behavioral Health Advisory Board.

J. Achieve full BHAB membership that reflects the diversity of the client populations served in the county. (See WIC 5604).

K. Maintain a high attendance and participation at all Behavioral Health Advisory Board meetings, including all committees and/or workgroups.

L. Maintain representation on appropriate local, regional, and state boards, committees, councils, etc., and regular reporting to the Behavioral Health Board.

M. Complete 100% of scheduled site visits.

N. Provide mentorship and training opportunities to Behavioral Health Board Members.

O. Conduct an annual retreat in April to set yearly goals.

P. Activate the Executive Committee as a standing committee.

Q. Design a budget.

R. Design Behavioral Health Advisory Board website pages with county staff.

S. Streamline board meetings.

T. Develop a self-evaluation tool for the Behavioral Health Advisory Board.

U. Update the Behavioral Health Advisory Board notebook to a concise and electronic version.