CalOES 988 Technical Advisory Board

CalHHS Update

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February 16, 2023

CalHHS
California Health & Human Services Agency

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Agenda

- Overview of CalHHS Crisis Care Continuum Plan and Findings
- CalHHS Requirements under AB 988
- Q & A / Discussion

Slide 2

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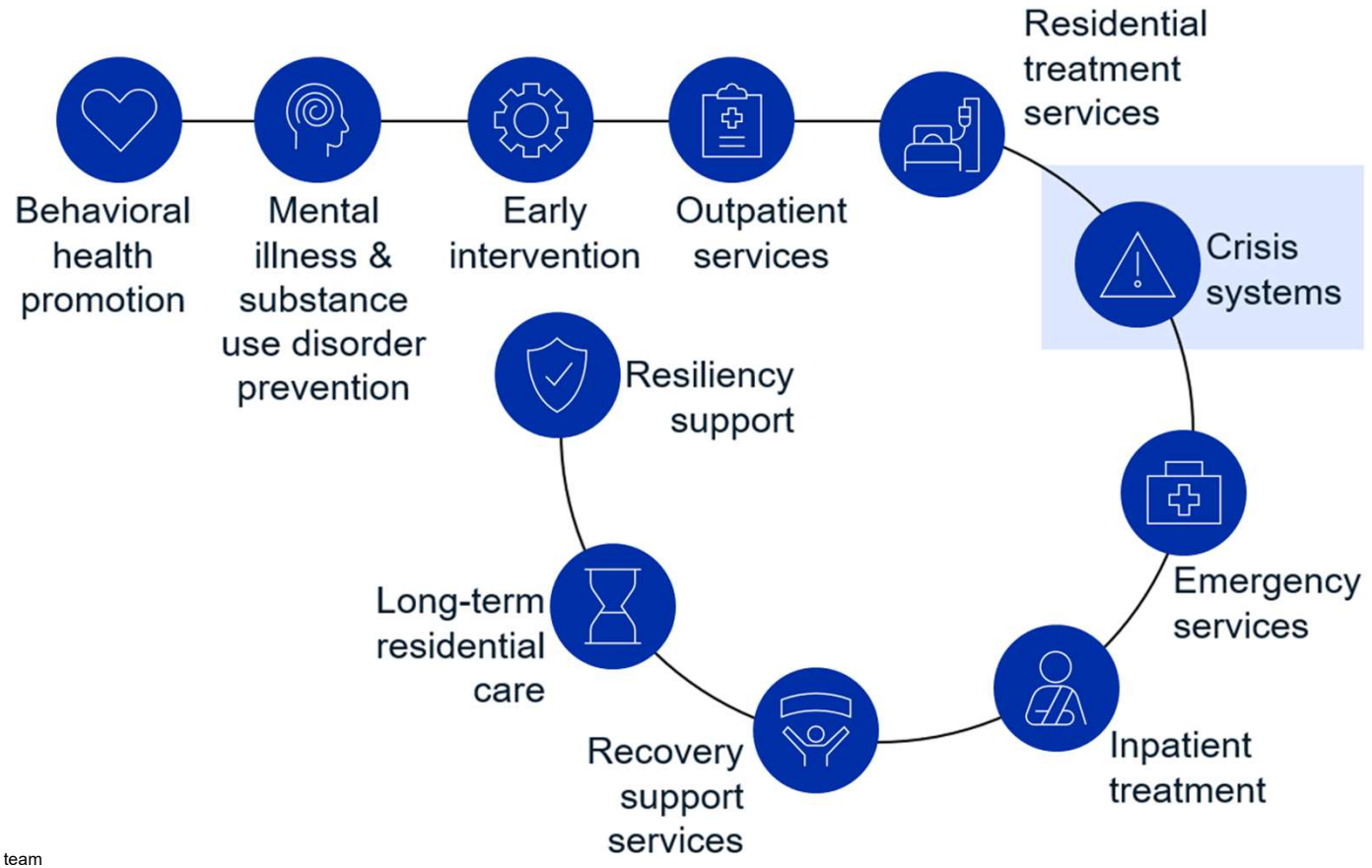
The Behavioral Health Continuum of Care

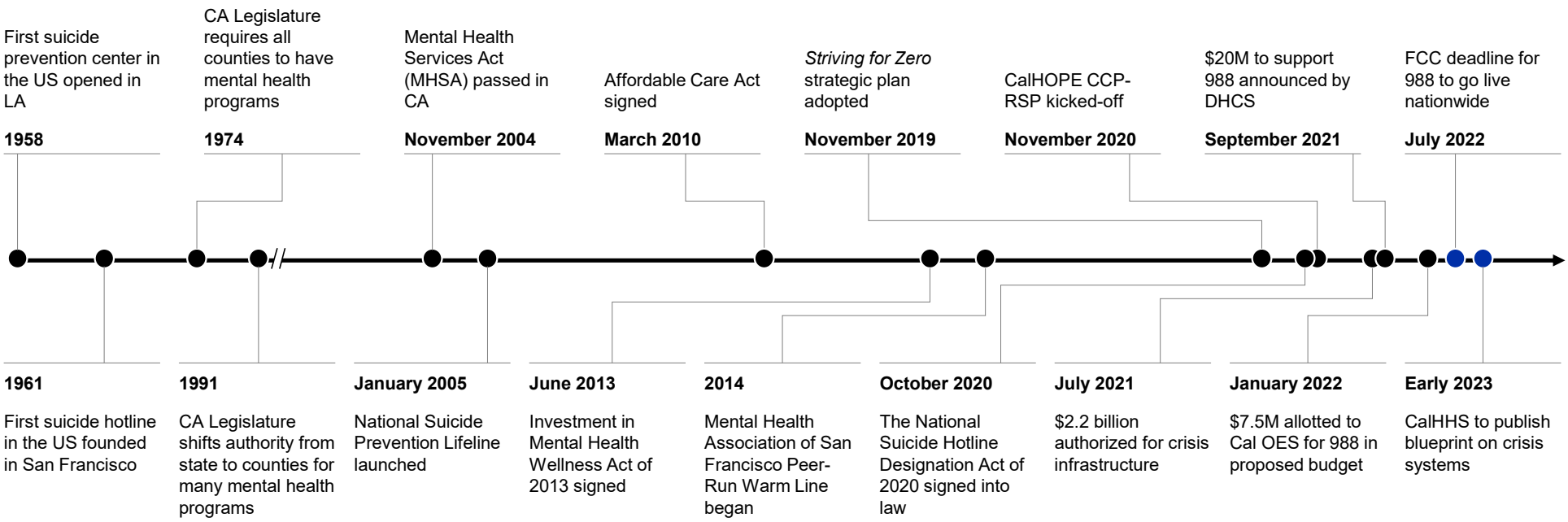


Source: Discussions with CalHHS team

Select Milestones in California's Crisis Care Continuum Development

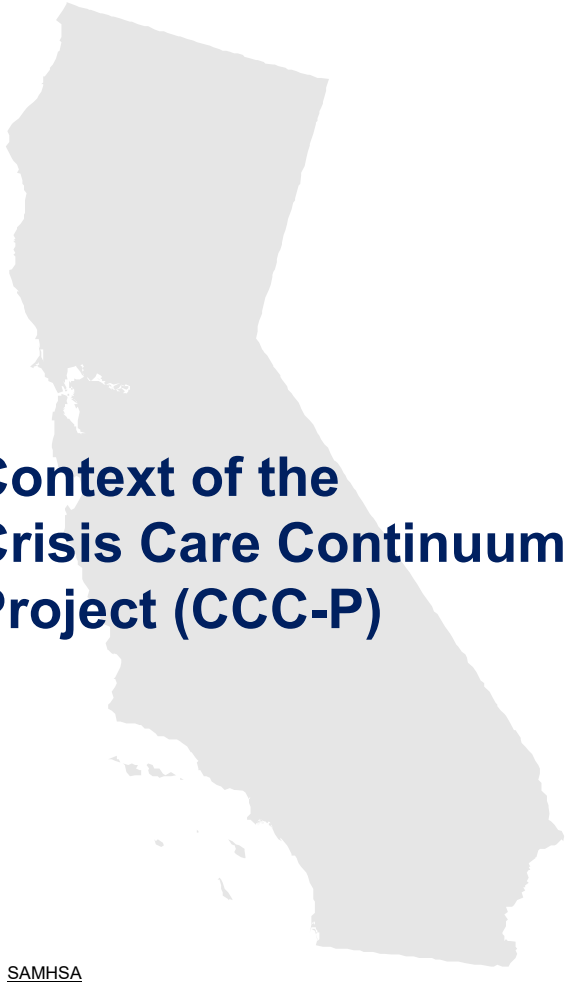
Developed Fall 2022

Forthcoming



Source: Suicide Prevention Lifeline, California State Treasurer, MHSOAC, SAMHSA , CalHOPE, DHCS, California Legislative Information, Cal OES, DHCS , CalHHS, FCC, healthcare.gov, DHCS, New York Times, National Library of Medicine, MHAOSF, LA County

Context of the Crisis Care Continuum Project (CCC-P)



More than **1 million individuals attempt suicide** each year nation-wide[1]

More than **4,000 individuals died by suicide in California** in 2020[2]

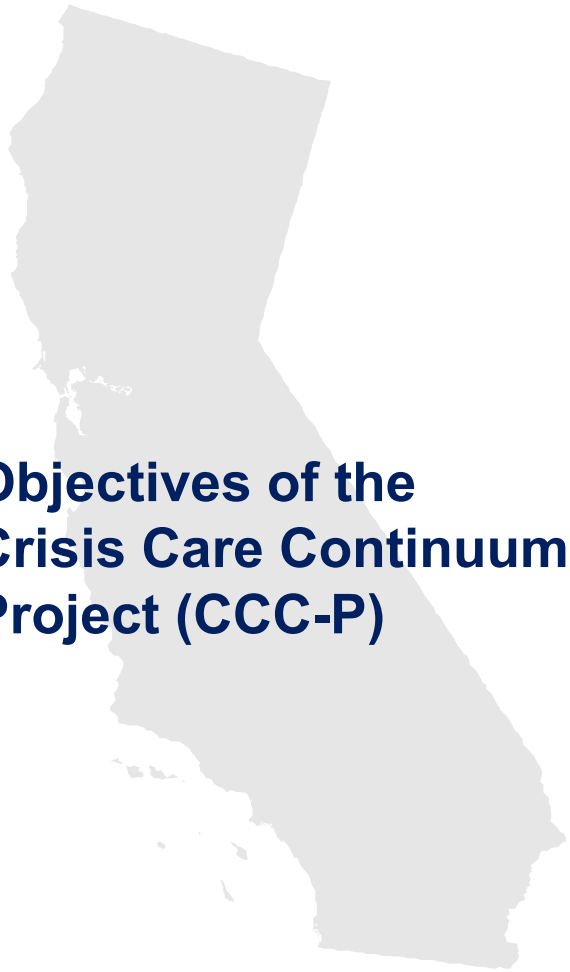
There are **existing challenges to accessing crisis care**, including capacity, coordination, and coverage

To address existing access challenges, **federal and state stakeholders are prioritizing crisis care:**

- **SAMHSA described a 5-year vision for 988**, following July 2022 launch as new 3-digit number to access National Suicide Prevention Line
- **California AB-988 passed Sept. 30th, 2022,** which requires CalHHS to develop a detailed implementation plan by end of 2023

1. SAMHSA
2. CDPH Data on Suicide and Self Harm

Source: CalHHS, SAMHSA, DHCS, AB-988



Objectives of the Crisis Care Continuum Project (CCC-P)

- Identify the **state-wide vision for full set of services** for individuals experiencing crisis
- Define state-wide **essential crisis services**
- Provide a **high-level view of resources required, or current investments** that could be used
- Outline a **governance model** to support implementation
- Identify a **roadmap** to reach major milestones

State Agencies and External Stakeholders Engaged

Completed November 2022

Plan is being developed with input from both internal (12+ state agencies) and external stakeholders (10+ external entities), in addition to Behavioral Health Task Force meetings that extend invitations to Task Force members and the general public

State agencies and departments

- California Department of Aging
- CDPH California Department of Public Health
- California Department of Corrections and Rehabilitation
- CDSS California Department of Social Services
- DHCS
- California Emergency Medical Services Authority
- Department of Managed Health Care
- MHSOAC Mental Health Services Oversight & Accountability Commission
- CalVET
- Cal OES Governor's Office of Emergency Services
- Office of the California Surgeon General
- Office of Youth and Community Restoration

External stakeholders

- Alliance for Children & Families
- cbhda County Behavioral Health Directors Association California
- cbha California Council of Community Behavioral Health Agencies
- California Hospital Association
- Didi Hirsch Mental Health Services
- The Education Coalition
- CASRA California Association of Social Rehabilitation Agencies
- Steinberg Institute
- NAMI National Alliance on Mental Illness
- CAADPE California Association of Alcohol and Drug Program Executives
- California Consortium for Urban Indian Health

Sources: CalHHS

Summary of Findings for CCC-P

- Based on preliminary research and stakeholder discussions, CalHHS believes that California's current crisis care system **meets select measures of 988 readiness**[1], but includes geographic variation and opportunities to improve coordination across settings

- The Plan includes **three Strategic Pillars** for the future state crisis care system:
  i. Build towards **consistent access statewide**
  ii. Enhance **coordination across and outside of the crisis care continuum of care**
  iii. Design and deliver a **high quality and equitable system for ALL Californians**

- Initial implementation considerations to achieve these Strategic Pillars to be **executed over time with near-, medium-, and long-term milestones** over the next 5 years. The pillars will be measured against metrics that are not yet finalized

- **California has made significant investments in crisis care** over the last few years

- CalHHS **prioritizes inclusion and equity** and will examine best practices and evidence-based strategies to ensure the crisis care continuum meets the needs of diverse populations

1. Determined by the 988 Convening Playbook

Source: CalHHS; California AB-988 Mental health 988 Suicide and Crisis Lifeline bill, CalHHS analysis of state budget and funding sources, KFF Health Insurance Coverage of the Total Population 2021, Crisis resource need calculator – Ca , CalHOPE funding CalHHS budget highlights, Vibrant, SAMHSA

What did we learn?

CalHHS
California Health & Human Services Agency

Proposed Components of Future State Crisis Care Continuum

BH crisis systems strive to serve anyone, anywhere and anytime and fall along a continuum:

Preventing Crisis

Community-based preventive interventions for individuals at risk for suicide or mental health / substance use crises (e.g., Zero Suicide, harm reduction programs, warmlines, peer support, digital-self help, recovery support services, addressing stigma)

Responding to Crisis

Acute crisis response services, including hotlines, 911 / 988 coordination, mobile crisis teams, social service response, and co-response models

Stabilizing Crisis

Community-based crisis stabilization services, including in-home crisis stabilization, crisis receiving facilities, peer respite, crisis residential services, sobering centers and transitioning individuals to care

Preventing Crisis - Hotlines & Warmlines available to Californians

Completed November 2022

Scope	Warmlines	Hotlines
National	• **8+** major national warmlines, including the TeenLine • Largely operated by non-profits with private funding • Volume ranges from 10k – 75k+ conversations annually by line	• **5+** major national hotlines, including the **NSPL** which operates via **13 Lifeline Centers in CA** • Operated and funded by mix of non-profit, for-profit, and federal gov. entities • Volume ranges from 150k – 2.4M national crisis contacts / calls annually by line
State wide	• **2+** state-wide warmlines, including CalHOPE • Operated by gov / non-profit entities; funded by federal (e.g., CCP), state, and private sources • Annual call volume ranges from 20k – 60k by line	• **2+** statewide hotlines, including the Friendship Line (which operates as both a crisis line and a warmline) & the CA Youth Crisis Line • Operated by a non-profit organizations and funded by State of CA as well as private donors • Annual call volume ranges from 15k – 300k by line
County / local	• **6+** county / local warmlines • Operated by county governments and non-profits; funded through public (e.g., MHSA) and private sources • Annual call volume can be up to 100k+ in certain counties	• **75+** county / local crisis lines • Most lines run by counties and other operate as non-profits; some lines re-direct calls to lifeline centers • Annual call volume can be up to 55k+ in certain counties

Sources: Trans Lifeline, Teen Line, NBC News, CopLine, LBGT National Hotline, NAMI HelpLine, National Geographic, YouthLine, NAMI HelpLine, Samaritans, 988 Implementation Plan for California, Veteran's Crisis Line , The Trevor Project, American Association of Suicidology, NSPL, Vibrant, Crisis Text Line, NSPL, Suicide Prevention Resource Center, MHOSF, CalHOPE, CHHS Open Data, Institute on Aging, CalHOPE, State of California, CHHS Open Data, Institute on Aging, California Coalition for Youth, San Joaquin County, NAMI, Project Return Peer Support Network, NAMI Orange County, Northern Valley Peer Run Talk Line, NAMI Sonoma, NAMI San Diego, San Francisco Suicide Prevention, Del Norte Triplicate, Community Health Improvement Partners, State of California, California Senate

Responding to Crisis - Readiness for 988 within CA

Completed November 2022

The 13 CA Lifeline Centers largely meet 988 readiness metrics outlined in the NASMHPD self-assessment[1]

- CA Lifeline Centers have an in-state call answer rate[2] of ~85-90%, with some variation across counties[3]
- 12 of 13 Lifeline Centers operate 24/7/365; Yolo County to become 24/7/365 by July 2022 (launch of 988)[4]
- 2 of 13 Lifeline Centers offer text/chat capabilities through Lifeline[5]
  - Plan set for 80% chat/text in-state answer rate by 2023[5]
  - 7 Lifeline Centers offer text or chat locally[5]

Efforts underway within the CA Lifeline network to prepare for projected increases in call volume[6]

- Assessment of network volume, coverage, and gaps planned for 6 months following launch of 988
- Applications submitted from 3 additional California contact centers to join the Lifeline network
- Process initiated to select a unified training platform
- $20M from DHCS awarded for capacity & infrastructure
- $14.4M SAMHSA grant application submitted

Beyond the Lifeline Centers, open questions remain for how 988 will integrate into the broader network of hotlines & warmlines available to Californians[2]

1. NASMHPD 988 operational readiness self-assessment for states, territories, and tribes; performance against all criteria noted as "Criteria identified as priorities for July 2022" based on the State of California 988 Implementation Plan
2. The percentage of calls originating in California answered by a call center located in California
3. NASMPHD defines meeting self-assessment criteria as 90% in-state calla answer rate
4. NASMPHD defines meeting self-assessment criteria as 24/7 primary coverage for Lifeline calls
5. NASMPHD defines meeting self-assessment criteria as 1+ Lifeline contact center currently has chat / text capabilities, capacity to handle at least 50 percent of chats / texts by July 2022 and 80 percent of chats / texts by July 2023, and state- / territory-wide 24/7 primary coverage for chats / texts
6. Efforts listed in the section "Expand and Sustain Center Capacity to Maintain Target In-State/Territory Answer Rates for Current and Projected Call, Text, and Chat Volume" section in the State of California 988 Implementation Plan, or funding-related efforts listed in the "Overall Background and Context" section of the State of California 988 Implementation Plan

Source: 988 Implementation Plan for California, NASMHPD 988 operational readiness self-assessment for states, territories, and tribes

Potential Approaches for Streamlining Call Lines

Completed November 2022

Detail to follow

Core questions related to consolidation & streamlining to improve access and crisis care for residents	Potential approaches to consider[1]
How does the state support coordination across multiple warmlines, hotlines, and contact centers?	• Facilitate the sharing of resources & practices across call lines • Ensure front-end user interface comprehensively and clearly describes each line and capabilities
How does the state approach prioritization across multiple warmlines, hotlines, and contact centers to address demand across populations?	• Collapse call lines with overlapping capabilities • Consolidate call lines with complementary capabilities • Maintain lines with uniquely serving specific populations or specialty services

1. Based on guidance in the 988 Implementation Guidance Playbooks, SAMHSA National Guidelines for Crisis Care, and interviews with experts with experience from other geographies

Source: 988 Implementation Guidance Playbooks, SAMHSA National Guidelines for Crisis Care, expert interviews

Examples of how to facilitate the sharing of resources & practices

Completed November 2022

	Description	Case examples / efforts underway in CA
Common standards	Establishing common standard for conduct and operation for greater consistency and connection across call lines	The NSPL has common standards governing the 200+ Lifeline-affiliated centers CalHOPE is exploring building a federation of warmlines, including the development of common standards
Shared resource databases	Building out a shared database of community resources to be used by call lines across the state	Didi Hirsch is in the process of collating community resources to create a shared database for the 13 Lifeline Centers
Pooled workforce	Develop processes and procedures to shift supply of counselors across call lines to meet demand (e.g., interoperability)	NYC is working with NYC Well to pursue a pooled model as it currently operates 2 simultaneous hotlines

Source: 988 Implementation Guidance Playbooks, SAMHSA National Guidelines for Crisis Care, expert interviews, 988 Implementation Plan for California

Responding and Stabilizing Crisis - Availability & Sufficiency

From DHCS Behavioral Health Assessment Published Jan 2022

Number of Mobile Crisis Teams by county

Relative to projections from the Crisis Now Model

Number of Mobile Crisis Teams According to Crisis Now Calculator

- "Sufficient"[1] mobile crisis teams available
- Not enough mobile crisis teams available
- No mobile crisis teams available

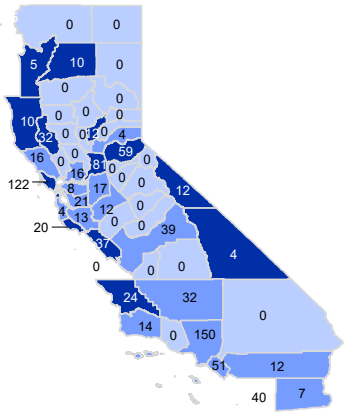
37 of 44 counties with mobile crisis teams have "sufficient"[1] intervention capacity

Number of Crisis Stabilization Units by county

Relative to projections from the Crisis Now Model

Number of CSU Slots According to Crisis Now Calculator

- "Sufficient"[1] CSU slots available
- Not enough CSU slots available
- No CSU slots available



16 of 33 counties with Crisis stabilization units have "sufficient"[1] crisis stabilization capacity

Presence of Crisis Residential Treatment Programs by county

Counties with Operational Crisis Residential Treatment Programs

- Yes
- Not yet, in planning
- No

9 of 28 counties with CRTPs reported sufficient[2] crisis residential treatment capacity

1. County-reported resource levels meet or exceed NASMHPD Crisis Resource Need Calculator recommended county level resource allocations (as reported by DHCS)
2. Counties that reported operating Crisis Residential Treatment Programs and did not report requiring additional residential treatment capacity

Sources: DHCS Assessing the Continuum of Care for Behavioral Health Services in California

Potential approaches to increase mobile crisis and crisis receiving & stabilization services capacity in the near-term and long-term

Completed November 2022

Detail to follow

	Increasing access and enhancing quality of care with existing workforce and infrastructure	Increasing the crisis care workforce and infrastructure within communities
Near term	• Applying evidenced-based solutions to increase access & enhance quality, e.g.: – Standardizing processes and protocols – Analyzing data to inform staffing & process decisions – Using telehealth innovations	• Exploring collaborations with first responders (e.g., EMS & local law enforcement) – Using existing first responder transportation systems – Strengthening co-response models
Long term	• Implementing a standardized performance management framework across the state – Collecting and tracking data on a state-wide level – Providing individualized support to communities based on performance	• Increasing the crisis workforce – Increasing the clinician workforce – Expanding opportunities for peer involvement • Building out crisis infrastructure – Building out mobile crisis infrastructure – Expanding physical crisis infrastructure

Source: 988 Implementation Guidance Playbooks, SAMHSA National Guidelines for Crisis Care, expert interviews

Evidence-Based Solutions to Increase Access & Enhance Quality

Completed November 2022

	Evidence-based approaches	Implementation references	Potential state-wide approaches
Standardizing processes and protocols	Standardize processes for assessments and intervention for medical conditions	Chickasaw Nation standardized processes for screening & suicide risk assessment	Establish standard processes that can be applied state-wide
	Structure protocols that enable the most credentialed clinicians have capacity for higher-acuity cases	connections Arizona: Connections supports team members to "work at the top of their license"	Offer trainings to providers on developing an organization-wide culture
Analyzing data to inform staffing & process decisions	Formally apply quality improvement technology	988 Convening Playbook: The 988 Playbook suggests LEAN & plan-do-check-act cycles	Offer trainings related to quality improvement technologies
	Use dashboard tracking tools to evaluate case-level and system-level outcomes	connections Arizona: Connections improved dashboard tracking tools as part of Lean Six Sigma approach to quality improvement	Provide grants to support the development of dashboards; require data tracking of providers
	Use data to estimate staffing needs and reflect working hours accordingly; promote working models that enable staffing flexibility	DCF Connecticut: CT supports providers in accessing staffing data and have flexibility to adjust staffing during peak times	Require data tracking of providers; offer staffing strategy consultations to individual organizations
Using telehealth innovations	Utilize telehealth in alignment with SAMHSA best practices		Provide grants to support telehealth infrastructure

Source: 988 Implementation Guidance Playbooks, SAMHSA National Guidelines for Crisis Care, expert interviews

Potential Actions to Consider Based on Current State

Completed November 2022

Transition point	Preliminary view of current state in CA	Potential actions[8]
A **Crisis prevention→ hotlines**	• Individual warmlines in CA (e.g., CalHOPE) initiate a warm handoff to a hotline if acute care is required[1] • Currently, there are no formalized standards governing handoffs[1]	• **Establish standards for protocols** for warm handoffs between warmlines and hotlines (building off work from CalHOPE) • **Provide training standards** for staff related to handoffs
B **Hotlines > Mobile crisis teams or co response models**	• Mobile crisis teams are largely run and initiated by county-run hotlines (rather than Lifeline centers)[2] • There is not utilization of location-tracking technology[3] • There are gaps in referrals from hotlines reported by Didi Hirsch[4]	• **Establish standards for protocols** for triage processes, safety considerations, and law enforcement engagement • **Incentivize formal partnerships** between the CA Lifeline Centers and county-operated mobile crisis teams • **Explore technological approaches** for location-tracking technology
C **Hotlines → 911/Emergency services**	• California is developing processes to transfer calls between 911 & 988 through the SAMHSA Gains Center Policy Academy[5] • County hotlines are already co-located with 911[6]	• **Establish standards for protocols** for warm handoffs between 911 & 988 (building off the SAMHSA Gains Center Policy Academy) • **Explore technological approaches** for interoperability between 911/988 (building off existing work from CalOES)
D **Mobile crisis teams or co response models→ crisis receiving & stabilization services**	• According to the DHCS, "stabilization services following an initial crisis are not generally available in CA" [7] • There is no current view of real-time vacancies for crisis receiving & stabilization services[3]	• **Establish standards for protocols** for assessment tools and voluntary & involuntary services • **Explore technological approaches** to generate a view of real-time vacancies for crisis receiving & stabilization services
E **Crisis receiving & stabilization services → short term crisis residential programs**	• Crisis receiving & stabilization services often serve people > 23 hours due to capacity constraints in other services according to DHCS[7]	• **Incentivize formal partnerships** between crisis receiving & stabilization services and short-term crisis residential programs • **Explore technological approaches** to generate a view of real-time vacancies for short-term crisis residential programs

1. DHCS; 2. CBHDA; 3. June 14 BHTF Meeting; 4. 988 Implementation Plan for California – 988 Planning Grant; 5. CalHHS; 6. SAMHSA Gains Center Policy Academy; 7. DHCS Assessing the Continuum of Care for Behavioral Health Services in California; 8. As identified in expert interviews; to be discussed/validated further with DHCS, CalHHS and other stakeholders

Essential Crisis Services Span the Continuum – Will Achieve Over Time

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

Preventing Crisis

1. **Peer-based warmlines**
2. **Community-based behavioral health services, such as:**
   - Community-based social services
   - School-based and school-linked services
   - Primary care clinics and FQHCs
   - Outpatient BH care (e.g., CCBHCs, urgent care clinics, transition clinics, bridge clinics)
   - Peer support
   - Harm reduction
   - Medication for Addiction Treatment (MAT)
   - Housing services
   - Employment services
3. **Digital apothecary (e.g., CYBHI digital platform, CalHOPE digital tool)**

Responding to Crisis

1. **Hotlines**
   - Operate 24/7/365
   - Answer all calls (or coordinate back-up)
   - Offer text / chat capabilities
   - Be staffed with clinicians overseeing clinical triage
2. **Mobile crisis services**
   - Operate 24/7/365
   - Staffed by multidisciplinary team meeting training, conduct, and capability standards
   - Respond where a person is
   - Include licensed and/or credentialed clinicians

Stabilizing Crisis

1. **Crisis receiving and stabilization services**
   - Operate 24/7/365 with multidisciplinary team or other suitable configuration depending on the model
   - Offer on-site services that last less than 24 hours
   - Accept all appropriate referrals
   - Design services for mental health and substance use crisis issues
   - Offer walk-in and first responder drop-off options
   - Employ capacity to assess & address physical health needs
2. **Peer respite**
3. **In-home crisis stabilization**

1. **Crisis residential treatment services**
   - Operate 24/7/365
2. **Post-crisis step-down services, such as (LT)**
   - Partial hospitalization
   - Supportive housing
3. **Sobering center**

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

Potential Metrics Corresponding to Essential Crisis Services

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

Preventing Crisis

1. Peer-based warmlines
- % of calls to peer-based warmline answered within 20 seconds

2. Community-based behavioral health services, such as:
- HEDIS measure (% of people connected with outpatient following a discharge)

3. Digital apothecary (e.g., CYBHI digital platform, CalHOPE digital tool)
- # of web visits and downloads of digital apothecary services

Responding to Crisis

1. Hotlines
- In-state call answer rate
- Time to answer
- Dropped call rate

2. Mobile crisis services
- Average in-person response time

Stabilizing Crisis

1. Crisis receiving and stabilization services
- % of referrals accepted

2. Peer respite
- Time to access peer respite
- Distance of peer respite from population base

3. In-home crisis stabilization
- Time to access in-home crisis stabilization staff

1. Crisis residential treatment services
- Time to access crisis residential treatment services
- Distance of crisis residential treatment services from population base

2. Post-crisis step-down services, such as (LT)
- % of patients with engagement provided w/in 30 days of discharge

3. Sobering centers
- Time to access crisis sobering centers
- Distance of sobering centers from population base

Sources: SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. NASHMPHD 988 Convening Playbooks, expert interviews

Several Options Exist for Local Implementation

Local implementation options for crisis service offerings:

Option	Description	Example
Full continuum of care	Fully integrated crisis care continuum for responding to and stabilizing crises (e.g., MCTs for crisis response, CSUs for stabilization)	San Francisco
Partial continuum, with focus on rapid crisis response	Deploy MCTs but use alternative approaches evidenced-based or community-defined approaches to deliver on the baseline service model[1] for stabilizing crises (e.g., in-home crisis stabilization, peer-respite	Santa Clara County
Partial continuum, with focus on crisis stabilizing services	Use alternative evidenced-based or community-defined approaches to deliver on the baseline service model for responding to crisis (e.g., co-response, virtual BH support); CSUs for stabilizing crises	Nevada County
Alternative continuum	Deliver all the components of the baseline service model using alternative, evidenced-based or community-defined approaches across the continuum (e.g., co-response, virtual BH support, in-home crisis stabilization, peer-respite)	N/A

Source: Expert interviews, DHCS, CalHHS

Options for scale of crisis service management:

Sub-county models

County-level models

Regional / county partnerships

Counties will be encouraged to do local implementation planning

Observations by Departments

Department	DHCS	Department of Managed Health Care	California Department of Corrections and Rehabilitation	CalVet California Department of Veterans Affairs	DDS
Summary of department observations and inputs	• **Growing crisis-related efforts** (e.g., CalHOPE, Friendship Line, FURS) • Draft **essential services are consistent with Medi-Cal coverage** • **Existing challenges remain** (e.g., coordination between hotlines and warmlines, counties, contact centers)	• Draft **essential crisis services are largely consistent with parity law**[6] • **Prevention-focused services** are covered less consistently through commercial plans	• Opportunity to improve training and clarify roles of **public safety partners** • Opportunity to facilitate **linkages to housing** through community partnerships • Beneficial to include **peers with lived experience in the justice system in crisis response**	• **Progress in ensuring access to BH resources for veterans** • Enhance understanding of veteran-specific issues among crisis providers working with veterans • **Beneficial to consider intersectionality** within the veteran community	• Individuals with I/DD may be at **increased risk of experiencing a mental health crisis** • First responders and BH providers have an **opportunity to enhance training with I/DD** • Potential to improve services through **training**, **strategic partnerships**, **advocates & individuals with lived experiences**
How inputs integrate into the CCC-P Blueprint	• Draft **essential crisis services** available by 2030 • **Insight on crisis related efforts and current coordination challenges are publicly available**	• Draft **essential crisis services** available by 2030 • Potential approaches to **ensuring insurance coverage** for crisis services	• Approach to **connect crisis services** to other systems • Approach to **tailor crisis services for system-involved individuals**	• Approach to **tailor crisis services for the veteran population**	• Approach to **tailor crisis services for the I/DD population**

1. Meetings on 8/25/22, 9/1/22, 9/8/22 and 9/21/22; 2. Meeting on 10/7/22; 3. Meeting on 9/16/22 with the Council on Criminal Justice and Behavioral Health (CCJBH); 4. Meeting on 10/4/22; 5. Fact Sheet developed by CalHHS in July 2022 synthesizing meeting with DDS 6. Parity law applies to fully-insured insurance products and not self-insured products

Source: Summaries of meetings with CA Departments on the Crisis Care Continuum Plan (CCC-P); inputs into CCC-P from CalHHS

Observations by Departments

Department	California Department of Public Health	EMSA	OES	CDSS California	California Department of Aging
Summary of department observations and inputs	• Potential for existing public health related **efforts in CA to be siloed** from one another • Opportunity to increase **social services** (e.g., food / housing supports) and other prevention efforts **to reduce the incidence of BH crises** • **Beneficial for the 988 workforce to reflect CA diversity** (e.g., language)	• **Variability in how PSAPs assign first responders** (e.g., EMS, law enforcement) to BH crises • **Growing efforts to integrate EMS into the crises care continuum** • **Opportunity to strengthen partnerships between EMS and county BH services**	• Current efforts to establish **911/988 interoperability** and **988 technology platforms** • Opportunity to develop **formalized processes to transfer misdirected calls** (e.g., public contacts 988 when 911 is needed) • **Beneficial to train** PSAPs to better understand which 988 crisis center **deploy mobile crisis**	• Opportunity to develop programs similar to The **Family Urgent Response System (FURS)** for other groups • Helpful to include **trauma-informed training for crisis care providers** • Opportunity to create forums where regions could **share various local innovations**	• **Training considerations** for crisis providers supporting older adults are evident • Opportunity to further utilize **The Friendship Line** • Opportunity to incorporate **access to care-giving and in-home services** as part of out-patient care
How inputs integrate into the CCC-P Blueprint	• **Approach to emphasize prevention** in the overall crisis care continuum • Approach to **equitable and appropriate care** for specific populations groups	• Approach to ensure **coordination within crisis systems** • Insight on **efforts in flight** and **current challenges**	• Approach to a **technology platform** • Approach on how to ensure **coordination** within crisis systems	• Approach to **tailor crisis services for individuals involved in the foster care system** • Insight on how **Family Urgent Response System (FURS) can be used as an innovation**	• Approach to **tailor crisis services** for older adults • Potential for **The Friendship Line to be a model for the state**

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Source: Summaries of meetings with CA Departments on the Crisis Care Continuum Plan (CCC-P); inputs into CCC-P from CalHHS

Summary of Findings - Lived Experience Listening Sessions

- Participants shared that often, care was unavailable until a person was in a state of crisis and emphasized the importance of “pre-crisis” preventive care.
- Crisis response can be a dehumanizing experience for vulnerable folks and their families. It can exacerbate the crisis and criminalize those needing help.
- Mental illness impacts whole families, and the role of supportive families and communities cannot be overstated. In addition to family members, other individuals and organizations also provide invaluable support and care.
- Self-advocacy and navigation through services is very challenging. It is difficult to know what services are available and who to ask for help.
- It is important to consider crisis care in the context of other impactful societal issues and inequities, such as economic forces, gentrification, trauma, racism, lack of housing, and food insecurities.
- Crisis care and law enforcement responses look different based on race, ethnicity, disability status, and class/neighborhood. It is difficult to find providers and support that align with individuals’ cultural, linguistic, and identity experiences and needs.

CalHHS is prioritizing embedding equity into crisis care service delivery

NOT EXHAUSTIVE

Synthesis of potential approach described in the 988 Convening Playbook for States, Territories, and Tribes

Understand the **historical trauma and cultural divide** that has created distrust in current systems

Assess crisis intervention outcomes and **how they vary** between groups within a region

Assess **social and economic conditions that impact health** and examine policies and systems that influence those social and economic conditions

Integrate health equity into crisis systems using proven tools and frameworks

Potential populations who may benefit from tailored services[1]

LGBTQ+ individuals	Youth, especially system-impacted youth
Older adults	Veterans
Deaf or hard of hearing	Individuals with intellectual / developmental disabilities
Diverse language needs	Immigrant populations
Racial & ethnically diverse populations	Tribes & native populations

1. 988 Convening Playbook States, Territories, and Tribes, , NASMHPD Addressing unique needs of diverse populations , Improving the Quality of Mental Health Care for Veterans , The Trevor project -Youth Risk Behavior Surveillance — United States, Suicide prevention resource center , Veteran and Military Mental Health Issues , National institute of mental health, Refers to Youth Involved with the Juvenile Justice System

California has made sizable investments in crisis prevention and response services, providing more than $1.6B* over the last few years

$1.4B

To add qualifying **community-based mobile crisis intervention services** as a Medi-Cal covered benefit, **this includes federal match**

$205M

Granted to support and expand **behavioral health mobile crisis and non-crisis services**

$43M

Granted **$13M to CalHOPE,** including the statewide **peer warmline,** base allocation and added **one-time $ 30M for 3 years** to support continued services.

$20M

For a **one-time investment of State General Funds** to build 988 crisis center capacity for 988 implementation

$15M

Granted by SAMHSA to the **DHCS for communities to enhance contact center readiness**

$7.5M

Granted in **FY 2022-2023, with $6M ongoing**, to support equipment for transferring calls between the 988 National Suicide Prevention Lifeline and the 911 system

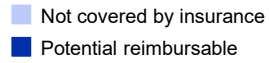
$4M

Provided per year by the **Mental Health Services Act** funding

*This includes federal reimbursement for Medi-Cal Mobile Crisis services

Source: California Budget Summary for FY 2022-2023

High level estimate of potential funding needs (based on publicly available data)



	Crisis services	Estimated need at maturity ($M) (Based on approximate years to maturity)	Approximate years to maturity	Methodology
Preventing crisis	Warmlines	~80	***N/A***	Used the FY 2022 – 2023 General Fund budget allocation for CalHOPE[2]
Responding to crisis	Hotlines	~262	***5 years***[6]	Multiplied estimated cost per contact ($79[3]) by the projected contact volume (3.3M[4] +17K for CalYouth hotlines) in CA at maturity (~5 years)
	Mobile crisis teams	~100	***3 years***[7]	
Stabilizing crisis	Crisis receiving & stabilization services	~1,100	***5 years***[7]	Used estimates from the Crisis Resource Needs[5] calculator for California
	Short-term crisis residential programs	~1,000	***5 years***[7]	
Total estimate of funding needs		***~$2.5B annually (of which $2.2B is potentially reimbursable)***		

Source: KFF Health Insurance Coverage of the Total Population 2021, Crisis resource need calculator – Ca , CALHope funding CalHHS budget highlights, Vibrant, SAMHSA

1. For services potentially covered by insurance (as indicated by existing Medi-Cal policies), applied the distribution of coverage by provider type as reported by KFF 2. 80M allocated to CalHope in the FY 2022 – 2023 General Fund 3. Based on Vibrant 4. Based on the Moderate Scenario 5-year projections from Vibrant (which was adopted by SAMHSA), extrapolated for the hotline network based on the assumption for crisis center diversions (~80%) and SAMHSA estimates for 911 call diversion under a moderate growth scenario; applied the distribution of national calls originating in California from August 2022 projections from Vibrant includes estimate for CalYouth Teen hotlines (Average annual calls at 17,000 multiplied by cost per contact estimation from vibrant @$79/contact) 5 The Crisis Now calculator provides potential annual behavioral

Continuity of Care

Completed November 2022

- Within the crisis care system, there are two potential challenges to continuity of care[1]:
  - Lack of access to services, either as a result of capacity constraints or lack of coordination
  - Gaps in insurance coverage & reimbursement
- To address gaps in insurance coverage & reimbursement, other states have considered[1]:
  - Standardizing crisis service billing across providers through engagement with departments such as DHCS, DMHC, and stakeholders
  - Standardizing commercial coverage and maintaining an adequate level of coverage for Medicaid populations, estimated to potentially save up to $5.9B[2] in healthcare costs that may result from lack of access to crisis care services

1. Based on insights from other state experience
2. According to the Crisis Resource Need Calculator, the potential annual behavioral health acute inpatient and crisis care system costs would be $5.9 billion lower in the Crisis Now model as compared to the ED/IP-only (emergency department and inpatient beds-only) scenario

Source: 988 Implementation Guidance Playbooks, SAMHSA National Guidelines for Crisis Care, DHCS, CalHHS, Crisis Resource Need Calculator, NASMHPD Sustainable Funding for Mental Health Crisis Services, expert interviews

Variation in Coverage – Overall Landscape

Completed November 2022

Health insurance coverage in CA

Payer type	% of population	# of in-person crisis episodes per month[1], 000s
Commercial health plans	54.4%	49k
Medi-Cal	23.7%	23k
Medicare	13.3%	10k
Military	1.1%	1k
Uninsured	7.5%	7k

Payer type	Existing coverage	Efforts in flight in CA
Commercial health plans	• California's Mental Health Parity Act, as amended in 2020, requires commercial health plans to[2]: – Cover the full spectrum of all medically necessary treatment in all settings – Not limit benefits or coverage to short-term or acute treatment. – Arrange coverage for out-of-network services if needed	• AB988 would require health care service plans and insurers to[5]: – Cover behavioral health crisis services provided by a 988 center or mobile crisis team – Charge the insured no more than the in-network cost-sharing amount (regardless of the provider)
Medi-Cal	• Medi-Cal covers crisis intervention / response, crisis stabilization, and crisis residential treatment services[3] – Crisis intervention not required to be mobile – Crisis stabilization must be provided on-site at 24-hr licensed or state facility • According to the DHCS Assessment[4]: – Current reimbursements do not cover full cost of mobile crisis services – Patients often exceed the permitted reimbursement time for CSUs	• Medi-Cal to expand coverage of mobile crisis services, effective Jan '23[6]: – Medi-Cal to provide mobile crisis intervention service for beneficiaries as mandatory Medi-Cal benefit – To meet qualifying requirement, mobile crisis teams must be: • Furnished by multidisciplinary mobile crisis team meeting training, conduct, and capability standards • Available 24 hrs / day – Funding for these services is from the 2021 American Rescue Plan Act

1. Calculated by assuming 230 in-person crisis episodes per 100k population (across ED/IP, MCT, CRF, and ST-CB)
2. National Health Law Program
3. KFF Health Insurance Coverage of the Total Population 2021 : Commercial health plans = Employer + Non-group, Medi-cal = Medicaid etc.
4. DHCS Assessing the Continuum of Care for Behavioral Health Services in California
5. AB988
6. National Health Law Program

Source: KFF Health Insurance Coverage of the Total Population 2019, National Health Law Program, DMHC, AB988, DHCS Assessing the Continuum of Care for Behavioral Health Services in California, CalHHS

Strategic Prioritization of Plan – Building Consistent Access Statewide

Strategic priorities

Potential considerations for implementation

1 Build towards consistent access statewide

- A **Availability:** Enhance system capacity across the care continuum
- B **Affordability:** Ensure continuity of care through coverage across all payors
- C **Appropriateness:** Ensure services meet the needs of diverse populations
- D **Awareness:** Educate communities on how to prevent, respond and stabilize crises

2 Enhance coordination across and outside the continuum

- A **Technology infrastructure:** Identify and develop technology infrastructure to enable system-wide interoperability
- B **Partnerships:** Ensure robust formal and informal partnerships across components of the crisis care continuum and related systems

3 Design and deliver a high quality and equitable system for ALL

- A **Measurement strategy:** Develop a data strategy that is inclusive of populations and geographies
- B **Quality & equity strategy:** Develop a quality-of-care strategy, including an equity-focused measurement framework

Source: CalHHS

Required areas for CalHHS 988 Policy Advisory Group

	Required recommendation areas (per AB 988)	Relevant material in the CCC-P
1	SAMHSA **requirements and national best practices guidelines for operational and clinical standards**, including training requirements and policies for transferring callers	Synthesized national best practice guidelines and compared to current state in California at a high and somewhat superficial level
2	Maintenance of an **active agreement with the administrator of the National Suicide Prevention** for participation within the network	None
3	Compliance with **state technology requirements** or guidelines for the operation of 988	Synthesized national best practice guidelines and began benchmarking to current state
4	**State governance structure** to support the implementation and administration of crisis services accessed through 988	Documented observed practices from a few states – but not specially California other than what is directed in AB 988
5	**988 infrastructure, staffing, and training standards** that will support statewide access to crisis counselors	None
6	**Access to crisis receiving and stabilization services** and triage and response to warm handoffs from 911 and 988 call centers	Documented essential crisis services but only superficially based on available public data sources. Much more is needed to get accurate data.
7	**Resources and policy changes** to address statewide and regional population needs for behavioral health crisis services	Conducted high-level cost estimations, synthesized current sources funding, but there are multiple unanswered questions on resources needed and no work was done on policy changes

Required areas for CalHHS 988 Policy Advisory Group

	Required recommendation areas (per AB 988)	Relevant material in the CCC-P
8	Statewide and regional **public communications strategy** informed by National Suicide Prevention Lifeline and SAMHSA	Documented key considerations and national best practices – nothing done specific to CA
9	Statewide **provision of mobile crisis team services** that… are offered 24/7/365, can respond to individuals in crisis in a timely manner, [and] are able to respond to clearly articulated suicidal or behavioral health contacts made or routed to 988	None – would have to work with DHCS to monitor how counties are expanding these teams as part of current and future funding investments
10	**Quantifiable goals** for the provision of **statewide and regional BH services**	Identified potential metrics but did no assessment of how possible or practical or costly it would be to implement
11	**Process for establishing outcome measures, benchmarks, and improvement targets** for 988 [crisis] centers	Gathered observed practices from other states but did not apply to CA existing system – would need substantial stakeholder input and analysis
12	Findings from **comprehensive assessment of the behavioral health crisis services system** that takes into account infrastructure projects that are planned and funded	Just used DHCS existing BH Needs Assessment. A lot of work is needed b/c the data is in so many places and needs to be cross referenced for accuracy, need provider surveys
13	Procedures for **determining annual budget for purpose** of establishing the rate of the 988 surcharge and how revenue will be dispersed [sic] to fund the 988 system	None
14	Strategies to **support the BH crisis service system** is adequately funded, including mechanisms for reimbursement	Gathered key considerations for commercial coverage but nothing specific on how to ensure mechanisms for reimbursement

988 State Advisory Group Potential Next Steps

	AB-988 required areas for CalHHS and 988 state advisory group recommendations	Next steps
1	SAMHSA **requirements and national best practices guidelines for operational and clinical standards**, including training requirements and policies for transferring callers	Determine where additional details are needed for the comparison of California's current state to the national best practice guidelines and convene the appropriate stakeholders to finalize the information
2	Maintenance of an **active agreement with the administrator of the National Suicide Prevention** for participation within the network	N/A
3	Compliance with **state technology requirements** or guidelines for the operation of 988	Finalize benchmarking of state technology requirements against current state
4	**State governance structure** to support the implementation and administration of crisis services accessed through 988	Determine state governance structure per what is discussed in AB-988
5	**988 infrastructure, staffing, and training standards** that will support statewide access to crisis counselors	Develop high-level training standards and staffing targets for 988 and confirm hypothesis with stakeholders
6	**Access to crisis receiving and stabilization services** and triage and response to warm handoffs from 911 and 988 call centers	Determine additional data needed on access to essential crisis services
7	**Resources and policy changes** to address statewide and regional population needs for behavioral health crisis services	Landscape assessment of current statewide and regional policies regarding coverage, rates, service definitions, and others needed to facilitate access, quality, and quality of crisis services

Source: California AB-988, Discussions with CalHHS, Cal HHS draft blueprint

988 State Advisory Group Potential Next Steps

	AB-988 required areas for CalHHS and 988 state advisory group recommendations[1]	Next steps
8	Statewide and regional **public communications strategy** informed by National Suicide Prevention Lifeline and SAMHSA	Use documented key considerations and national best practices to determine California's guiding principles for a public communications strategy
9	Statewide **provision of mobile crisis team services** that are offered 24/7/365, can respond to individuals in crisis in a timely manner, [and] are able to respond to clearly articulated suicidal or behavioral health contacts made or routed to 988	Meet with the DHCS to monitor how counties are expanding these teams as part of current and future funding investments
10	**Quantifiable goals** for the provision of **statewide and regional BH services**	Confirm potential metrics with stakeholders
11	**Process for establishing outcome measures, benchmarks, and improvement targets** for 988 [crisis] centers	Apply gathered observed practices from other states to existing California system
12	Findings from **comprehensive assessment of the behavioral health crisis services system** that takes into account infrastructure projects that are planned and funded	Determine what additional findings are needed in addition to existing DHCS BH Needs Assessment
13	Procedures for **determining annual budget for purpose** of establishing the rate of the 988 surcharge and how revenue will be dispersed [sic] to fund the 988 system	Develop high-level hypothesis on the budgeting process
14	Strategies to **support the BH crisis service system** is adequately funded, including mechanisms for reimbursement	Determine high-level guiding principles based on the key considerations for commercial coverage found in the blueprint

1. As noted in AB-988

Source: California AB-988, Discussions with CalHHS, CalHHS draft blueprint

CalHHS Next Steps

- **Publish and disseminate the Plan** in early 2023
- **Convene 988 Policy Advisory Group** in Summer 2023 and **begin developing required recommendations** for 5-Year Implementation Plan
- **Leverage Plan** to address CalHHS responsibilities as part of AB-988, including development of 5-Year Implementation Plan
- **Continue to support** CalOES as member of Technical Advisory Board
- **Budget Proposal** and **Clean-Up TBL**

Questions and Discussion

For additional information regarding Crisis Care Continuum - Plan:

CalHHS Crisis Care Continuum – Plan webpage

CalHHS
California Health & Human Services Agency