

California Behavioral Health Planning Council

Workforce and Employment Agenda

Wednesday, April 17th, 2019

Sheraton Fisherman's Wharf

2500 Mason Street, San Francisco, CA 94133

Marina 2 Room

1:30 pm to 5:00 pm

Conference Call-In: 1-877-951-3290 Participant Code: 8936702

TIME	TOPIC	TAB
1:30pm	Welcome and Introductions <i>Deborah Pitts, Chairperson</i>	
1:35pm	Approve January 2019 Meeting Minutes <i>Deborah Pitts and All</i>	Tab A
1:40am	Review and Approve Committee Work Plan <i>Deborah Pitts and All</i>	Tab B
1:45pm	Department of Rehabilitation Presentation <i>Kathi Mowers-Moore, Courtney Tracker, Rachel Pechter, & Theresa Comstock</i>	Tab C
2:55pm	Public Comment	
3:00pm	Break	
3:15pm	WET 5-Year Plan Development <i>C.J. Howard, OSHPD</i>	Tab D
3:45pm	WET Funding Legislation <i>Le Ondra Clark Harvey, CBHA</i>	Tab E
4:00pm	Discussion: Licensed Mental Health Professionals <i>Deborah Pitts and All</i>	Tab F
4:45pm	Next Steps / Planning for June 2019 Meeting	
4:55pm	Public Comment	
5:00pm	Adjourn	

The scheduled times on the agenda are estimates and subject to change.

Workforce and Employment Committee Members

Chairperson: Deborah Pitts **Chair-elect:** Dale Mueller

Members: Walter Shwe, Arden Tucker, Kimberly Wimberly, Vera Calloway, Karen Hart, Cheryl Treadwell, Steve Leoni, Lorraine Flores, Liz Oseguera, Kathi Mowers-Moore, Christine Costa, John Black, Celeste Hunter, Sokhear Sous

Staff: Justin Boese, Ashneek Nanua

If reasonable accommodations are required, please contact the CBHPC office at (916) 552-9560 not less than 5 working days prior to the meeting date.

**California Behavioral Health Planning Council
Workforce and Employment Committee**

Wednesday, April 17, 2019

Agenda Item: Review and approve meeting minutes from January 16, 2019

Enclosures: WE Committee Meeting Minutes January 16, 2019.

Background/Description:

Enclosed are meeting minutes from January 16, 2019. Committee members will have the opportunity to ask questions, request edits, and provide other feedback

Workforce and Employment Committee

Meeting Notes

Quarterly Meeting – January 16, 2019

1:30 am – 5:00 pm

Committee Members Present:

Deborah Pitts, Chair

Dale Mueller, Walter Shwe, Arden Tucker, Vera Calloway, Karen Hart, Steve Leoni, Lorraine Flores, Liz Oseguera, Kathi Mowers-Moore, John Black, Christine Costa, Celeste Hunter, Sokhear Sous

Council Staff Present:

Justin Boese, Jane Adcock, Ashneek Nanua

WET Steering Committee Members Present:

Le Ondra Clark-Harvey, Janet Frank, Amy Faulstich, Maxwell Davis, Olivia Loewy

Speakers Present:

Caryn Rizell, Anne Powell, John Madriz, Ross Lallian, Norlyn Asprec

Item 1: Approve October Meeting Minutes

Discussion

The meeting minutes from October 17, 2018 were approved with one edit to reflect that Celeste Hunter was in attendance. Motion to approve the minutes was made by Kathi Mowers-Moore, and seconded by Christine Costa. Karen Hart and Dale Mueller abstained.

Action

Justin Boese will update the October 17, 2018 minutes to reflect the requested edit.

Item 2: Review and Discuss Committee Work Plan

Discussion

At the October 2018 meeting, the committee reviewed the first part of the work plan. Following up on that work, Deborah Pitts reviewed objectives 2.1-2.4 of the work plan and asked members if they would like to keep it as written, eliminate, or edit the objectives. Dale Mueller requested edits for objective 2.1 and stated that she would like

to see “inventory” added to the objective. She used the following language: “Build Council’s understanding in order to provide and make available a current inventory...”

Kathi Mowers-Moore requested the inclusion of MHSA funded enterprises for objectives 2.3 and to include language that indicates going beyond and including other funding mechanisms.

Lorraine Flores mentioned the possibility of adding an age range due to youth needs differing from adult needs. Deborah Pitts recommended adding this to strategic goal instead and adding language that would be inclusive of age. Kathi Mowers-Moore suggested using the term “lifespan” and perhaps “pre-employment services.”

Vera Calloway discussed the need for career paths to open opportunities for people, especially if we want to increase the workforce. She said that they can’t all just be peer specialists. Deborah Pitts stated that mechanisms for employment and career advancement can be included in objective 2.3. Celeste Hunter seconded Vera Calloway’s point concerning the importance of consumer ability to advance in careers.

Christine Costa questioned the word “easy” in objective 2.0 and requested a change in language to “minimal barriers.”

Deborah Pitts reviewed the following edits:

- Adding age (lifespan) to a strategic goal statement, mentioning “work readiness” or “pre-employment services,” and eliminating the word of “easy” and replacing it with “minimal barriers.”
- Objective 2.1: Adding the language of “build an inventory and making it available to anyone who is interested.”
- Objective 2.3: Mention “MHSA funding or other funding sources” to refrain from limiting it to DoR funding.
- Objective 2.3: discuss exploring additional career pathways and options for advancement, including for peers.

Action

Justin Boese will edit the work plan to reflect the requested edits.

Item 3: CASRA Employment Initiative Support Letter

Discussion

Deborah Pitts facilitated discussion and summarized the letter to the California Association of Social Rehabilitation Agencies (CASRA) expressing support for their employment initiative. Arden Tucker read the CASRA letter out loud to Workforce committee members. Steve Leoni expressed questioned the language towards the end

of the second paragraph, and suggested that there be a better segue between paragraphs.

Kathi Mowers-Moore discussed a round-table summit that is being held with Department of Rehabilitation and CASRA on February 6. Kathi stated that she will craft language for the letter to reflect this and indicated that it may of value that the Department of Rehabilitation is engaged as a precursor.

Deborah Pitts suggested refraining from naming a specific mechanism for employment in order to keep it open. Lorraine Flores stated that Santa Clara County uses an IPS model which does not work for every individual. Deborah Pitts reviewed and indicated the need to look at employment beyond peer specialists (possibly at the end of the second paragraph of the letter) and to add language from Kathi.

Action

Justin Boese will make the requested edits to the support letter.

Item 4: Planning for Next Meeting

Deborah Pitts facilitated the conversation and stated that this meeting will most likely be the last one in which the committee discusses the development of the WET 5-Year Plan, since it will be taken to the full Council for approval. Steve Leoni suggested the continuation of WET plan discussion at the committee meetings, to follow up on the implementation of the plan. Deborah Pitts asked what other objectives or actions committee members would like to address at the next meeting.

Liz Oseguera brought up that the California Council of Community Behavioral Health Agencies (CBHA) has indicated that they would be working on a bill to address WET program funding, and suggested that they be invited to come speak on that. Le Ondra Clark Harvey from CBHA, who is a steering committee member and was on the conference line, confirmed that she would be happy to come to the meeting in April and speak about their legislative efforts.

Kathi Mowers-Moore offered to present on ongoing employment activities at the Department of Rehabilitation. She also said that she could possibly speak a little on MHSA funding, or may be able to get a partner who could speak on it more.

Public Comment

Janet Frank (UCLA) encouraged that the committee develop action plans to accomplish the objectives of the work plan. Amy Faulstich (CIBHS). suggested working with the county WET coordinator in the Bay Area to learn more about their work.

Item 5: WET 5-Year Plan Development

Discussion

Opportunity was given for individuals on the conference call to introduce themselves. Workforce Education and Training (WET) Steering Committee members on the phone and present in the room included Le Ondra Clark Harvey, Maxwell Davis, Janet Frank, Olivia Loewy, and Amy Faulstich.

The team from the Office of Statewide Health Planning and Development (OSHPD) introduced themselves: Anne Powell, Caryn Rizell, John Madriz, Norlyn Asprec and Ross Lallian.

Caryn reviewed the proposed 2020-2025 WET plan and stated that there will be time for Q&A after the presentation. In her review she described the WET plan as a blueprint to guide WET programming, and is designed to be flexible based on available funding. Caryn stated that OSHPD will develop programs to support the WET plan once the Planning Council approves the plan. The plan is to develop programs in partnership with stakeholders during fiscal year 2019-20, and implement programs in fiscal years 2020-21 through 2024-25.

John Madriz discussed the WET plan values, including:

- Develop a diverse licensed and non-licensed professional workforce.
- Promote wellness, recovery, and resilience and other positive mental health, substance use, and primary care outcomes.
- Use effective, innovative, community-identified, and evidence-based practices.
- Include the viewpoints and expertise of persons with lived experience as consumers, families, and caregivers in multiple healthcare settings.

After Norlyn Asprec quickly reviewed the WET plan goals and objectives, and then Caryn Rizell described the proposed framework for the 2020-2025 WET plan. The plan framework is organized into “Supporting Individuals” and “Supporting Systems.” The “Supporting Individuals” component includes a spectrum of programs that support a pipeline for public mental health workforce, from exposing students in K-12 to mental health careers, to scholarships, stipends, and loan repayment programs as people continue through education into careers in the public mental health system. These programs will be administered through the Regional Partnerships, with assistance from OSHPD, so that counties can leverage collective resources and capacity while addressing their unique local needs.

The second component of the plan framework, “Supporting Systems,” includes OSHPD-administered programs and activities, such as promoting peer personnel preparation, expanding capacity of psychiatric education programs, and continuing evaluation and research. Caryn then described a number of possible innovations for further

consideration, such as using the Health Workforce Pilot Projects Program to test changes in scope of practice for licensed clinicians.

Next, Ross Lallian presented on WET Statewide Program Evaluation. According to OSHPD's evaluation data, nearly all WET program grantees met or exceeded their goals. Some highlights included:

- Approximately 91% of stipend and Mental Health Loan Assumption Program (MHLAP) awardees completed their service commitments.
- Overall, 69% of WET program beneficiaries were non-white, and 24% spoke a non-English language.
- Over 22,000 students received exposure to, and promotion of, mental/behavioral health services and careers.

John Madriz shared some of the key themes from OSHPD's stakeholder engagement efforts. Some of those themes included:

- Well-defined career pathways that allow workers to progress with incremental training and accounting for work experience.
- Developing statewide standards and/or certifications for peer support specialists, community health/mental health workers, and case managers to promote the non-licensed workforce.
- Recruitment and retention strategies should focus on hard to serve communities, emphasizing grow-your-own strategies.

Anne Powell discussed the Educational Institution Capacity Survey that was conducted by University of California, San Francisco (UCSF). They found that most psychiatry, psychiatric mental health nurse practitioner, and MSW programs are currently at capacity and reject qualified applicants. However, Anne stated that because OSHPD was not satisfied with the response rate, they have asked UCSF to reopen the survey.

The OSHPD team then opened discussion and invited questions and feedback. Steve Leoni discussed the need for more attention to non-licensed providers. Caryn responded and referred to the pyramid image and pipeline to identify gaps in counties to determine the needs. Anne Powell stated that non-licensed social workers are included in the plan, but that it is difficult to find data on them. Steve suggested being upfront about the lack of data in that topic. Lorraine Flores also requested inclusion of more non-licensed, non-degreed peer positions, such as outreach workers, health educators, and others, in the plan.

Janet Frank asked about career pathways and advancement for people who are already in the public mental health workforce. Caryn Rizell responded that the framework for "Supporting Individuals" is intended to provide financial support for those in the workforce already who wish to advance further through education or certification. Kathi Mowers-Moore expressed concern that vocational rehabilitation programs are completely absent in the WET plan. Kathi then asked if there was currently a budget

proposal to fund the plan, and questioned whether it was necessary to approve the plan at this time if there isn't.

Maxwell Davis voiced concern about implementation of the plan, given the lack of infrastructure for the plan's proposed programs. Maxwell also expressed concern about waiting until someone has finished a service obligation before awarding them, since that would cut out low-income students who have difficulty paying educational costs upfront. Caryn responded that OSHPD is looking at ways to provide more upfront support for students, including scholarships.

Theresa Comstock encouraged moving forward to get a plan and funding in place, and asked for clarification on how the plan can be updated in the future. Jane Adcock said that in the past, the Planning Council has approved the plan with the condition that OSHPD return with periodic updates on the implementation. Additionally, she expressed that the plan can be adjusted to address changing circumstances or needs.

Le Ondra Clark Harvey expressed gratitude for the plan, but requested that OSHPD continue to work with stakeholders to flesh out details for the programs. She also shared again that CBHA is currently looking for funding solutions.

Action

None.

The meeting adjourned at 5:00 pm.

**California Behavioral Health Planning Council
Workforce and Employment Committee**

Wednesday, April 17, 2019

Agenda Item: Review and Approve Committee Work Plan

Background/Description:

Enclosed is a draft of the Workforce and Employment Committee 2019 Work Plan, edited based on feedback gathered at the meeting on January 17, 2019. At the January meeting the committee members reviewed and revised Strategic Goal Objectives 2.1-2.4.

Enclosures:

Draft of WE Committee 2019 Work Plan.

California Behavioral Health Planning Council
Workforce and Employment Committee
Work Plan June 2018-July 2019

Committee Overview and Purpose

The efforts and activities of the Workforce and Employment Committee (WEC) will address both the workforce shortage and training in the public behavioral health system, including the future of funding, and the employment of individuals with psychiatric disabilities. Additionally, state law provides the Council with specific responsibilities in advising the Office of Statewide Health Planning and Development (OSHPD) on education and training policy development and also to provide oversight for the development of the Five-Year Education and Training Development Plan as well as review and approval authority of the final plan. The WEC will be the group to work closely with OSHPD staff to provide input, feedback and guidance and also to be the conduit for presenting information to the full Council membership as it relates to its responsibilities set in law.

There are a number of collateral partners involved in addressing the behavioral health workforce shortage in California. A number of them have been working with the Council in prior efforts and provide additional subject matter expertise. These individuals and organizations, collectively known as the WET Steering Committee, will continue to provide the WEC with expertise and are invited to participate in meetings, where appropriate.

Additionally, there are a number of other organizations and educational institutions, at the State level, who are engaged in efforts for the employment of individuals with disabilities, including psychiatric disabilities, with whom the WEC will maintain relationships to identify areas of commonality, opportunities for collaboration and blending of actions. They include but are not limited to:

- CA Council for the Employment of Persons with Disabilities
- State Rehabilitation Council
- Co-Op Programs within the Department of Rehabilitation
- California Workforce Development Board
- Labor Workforce Development Agency

Strategic Goal 1.0: Provide leadership and collaborate with other stakeholders to support the growth and quality of California's behavioral health workforce, reduce the workforce shortage and build sustained mechanism for ongoing workforce education and training to insure a recovery-oriented workforce.

Objective 1.1: Review and make recommendations to the full Council regarding approval of OSPHD WET Plan by:

- a. Engaging in regular dialogue and collaborating with the WET Steering Committee.
- b. Maintain an open line of communication with OSHPD via CBHPC Council staff, Justin Boese, in order to advise OSHPD on education and training policy development and provide oversight for education and training plan development.
- c. Participate in statewide OSHPD stakeholder engagement process.
- d. Build the Council's understanding of state-level workforce initiatives and their successes and challenges.

Objective 1.2: Build Council's understanding of workforce development 'best practices' for both entry-level preparation and continuing competency, including but not limited to the resources from the Annapolis Coalition on the Behavioral Health Workforce, WICHE Mental Health Program, as well as workforce development resources developed in California.

Objective 1.3: Build the Council's understanding of County specific workforce development initiatives and their successes and challenges.

Objective 1.4: Identify and inventory funding opportunities at the local, state and national levels for workforce development, scholarships, tuition support, etc.

Objective 1.5: Collaborate with Legislation Committee to support Peer Certification efforts.

Objective 1.6: Collaborate with Medicaid and Systems Committee to ensure that in the updated Medicaid waiver that occupational therapists and other Master's level, state licensed health providers with mental health practice education are identified as licensed mental health professionals (LMHPs) for Specialty Mental Health services.

Strategic Goal 2.0: Ensure through advocacy that any California mental health consumer who wants to work or be self-employed has minimal barriers and timely access to employment support services and pre-employment services across the lifespan to secure and retain a job or career of choice.

Objective 2.1: Expand Council’s knowledge in order to build and make available a current inventory of employment and education support services available to mental health consumers in each of California’s counties.

Objective 2.2: Build Council’s understanding of California Department of Rehabilitation’s mechanism to support employment and education for California’s mental health consumers, including but not limited to mental health cooperative programs.

Objective 2.3: Build Council’s understanding of employment services “best practices” and resources, including but not limited to: Individual Placement & Support (IPS) Model of supported employment; social enterprises; supported education; MHSA funding or other funding sources, and career pathways and advancement for consumers and peers.

Objective 2.4: Collaborate with CBHPC Legislative and Advocacy Committee to identify, monitor and take positions on legislation related to employment and education for California’s mental health consumers.

**California Behavioral Health Planning Council
Workforce and Employment Committee**

Wednesday, April 16, 2019

Agenda Item: Department of Rehabilitation Presentation

Background/Description:

This presentation on Department of Rehabilitation employment relationships will include an overview of the Department of Rehabilitation, innovative service models, Systems Integration and Collaboration, and opportunities.

Presenters:

- **Kathi Mowers-More**, Deputy Director, Department of Rehabilitation Vocational Rehabilitation Policy & Resources Division
- **Courtney Tacker**, Staff Services Manager I, Department of Rehabilitation Human Services Cooperative Programs Unit
- **Rachel Pechter**, MS, Occupational Therapist R/L, Occupational Therapy Training Program - San Francisco
- **Theresa Comstock**, Executive Director, CA Association of Local Behavioral Health Boards & Commissions

Enclosures:

1. **Employment, Independence, and Equality: Innovative Collaborations to Serve Consumers with Behavioral Health Disabilities.** PowerPoint slides for the presentation on April 17th, 2019.
2. **IPS Supported Employment: Practice and Principles.**
3. **IPS Supported Employment and State Vocational Rehabilitation: A Crosswalk.** <https://ipsworks.org/wp-content/uploads/2017/09/IPS-VR-Crosswalk-July-2017wfooter-margins.pdf>

Please contact Justin Boese at Justin.boese@cbhpc.dhcs.ca.gov for electronic copies of the materials.

DOR DEPARTMENT of REHABILITATION

Employment, Independence & Equality

Innovative Collaborations to Serve Consumers with Behavioral
Health Disabilities
April 17, 2019

Presentation Overview

- ❑ Department of Rehabilitation
- ❑ Innovative Service Models
- ❑ Systems Integration and Collaboration
- ❑ Opportunities

Overview

DEPARTMENT OF REHABILITATION

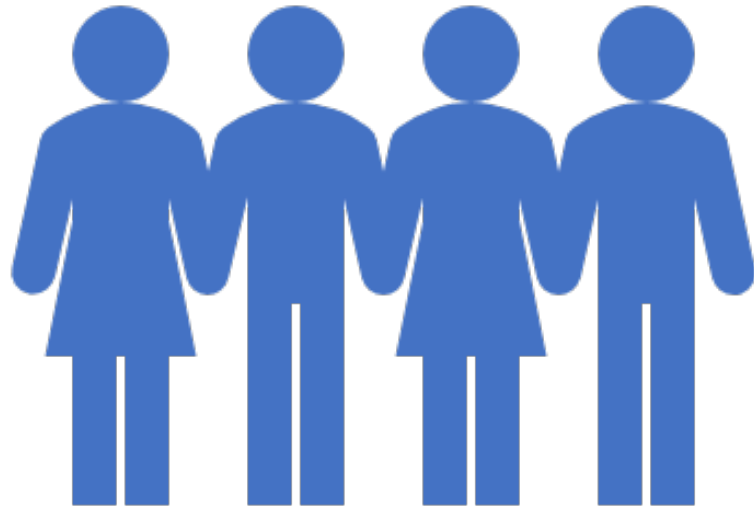
Department of Rehabilitation (DOR)

DOR Vision:

Employment, Independence and Equality for all Californians with Disabilities

DOR Mission:

The California Department of Rehabilitation (DOR) works in partnership with consumers and other stakeholders to provide services and advocacy resulting in employment, independent living and equality for individuals with disabilities



DOR Core Values

We believe in the talent and potential of individuals with disabilities. We invest in the future through creativity, ingenuity, and innovation. We ensure our decisions and actions are informed by interested individuals and groups. We pursue excellence through continuous improvement. We preserve the public's trust through compassionate and responsible provision of services.

Department of Rehabilitation

California operates the largest VR Program in the country.

Customized services to individuals with disabilities to prepare for, obtain, maintain and advance in employment, and to live independently in their communities

Consumer-Driven Plan (“Consumer Choice”) that is time-limited and goal-oriented

Consumer-centered team support

VR services may include:

- Eligibility and Vocational Assessment
- Counseling and guidance, and referral services
- Educational and vocational training and materials
- Tools and license for performance of an occupation
- Assistive Technology
- Transportation
- Job coaching services
- Job placement

Order of Selection (OOS)

DOR has been operating under an OOS since 1995.

Opened wait list (CAT 3) on seven occasions since 2011

1998

1995

2011

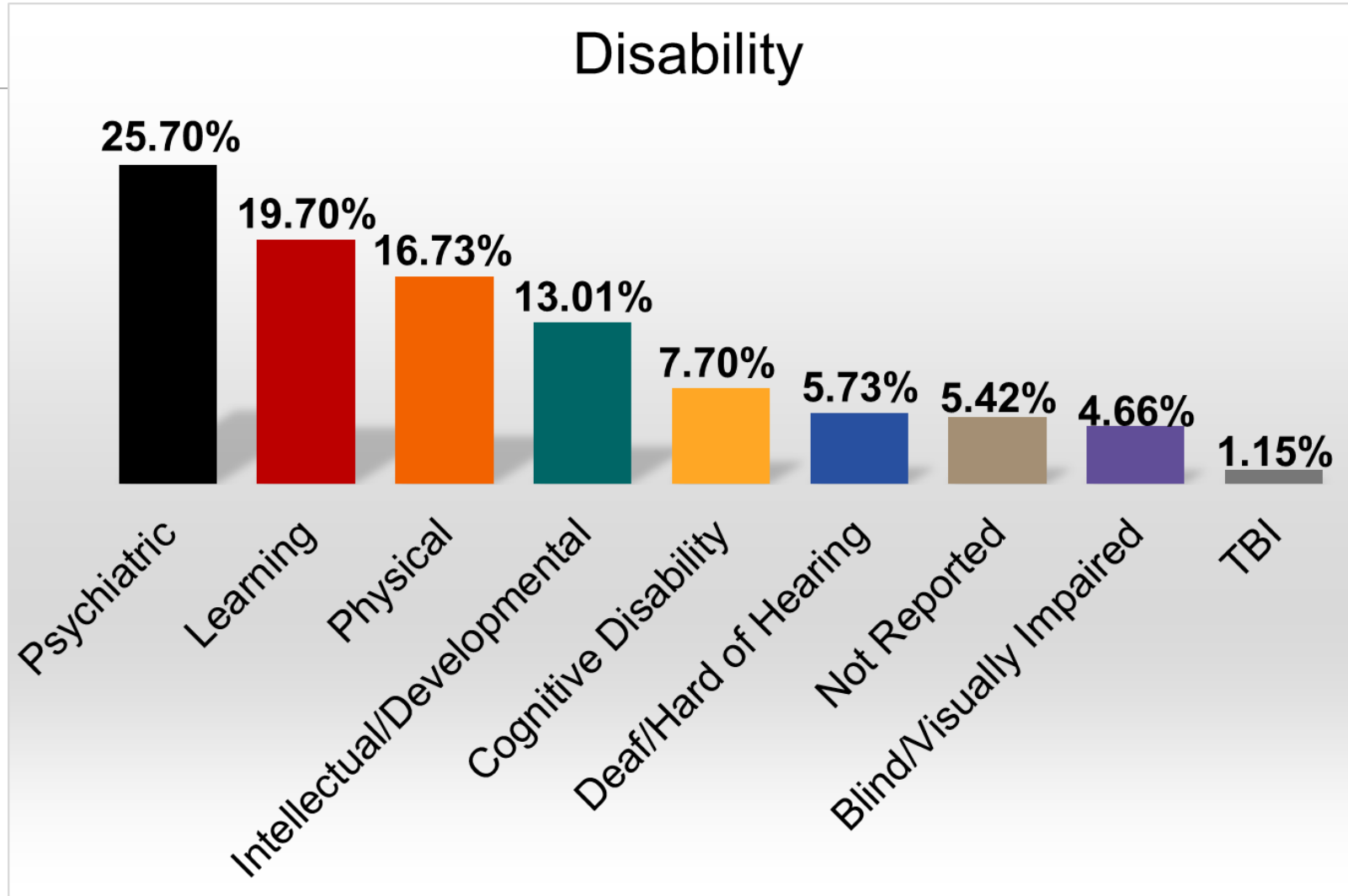
Two categories (I&II) remain open since 1998, most significantly disabled and significantly disabled

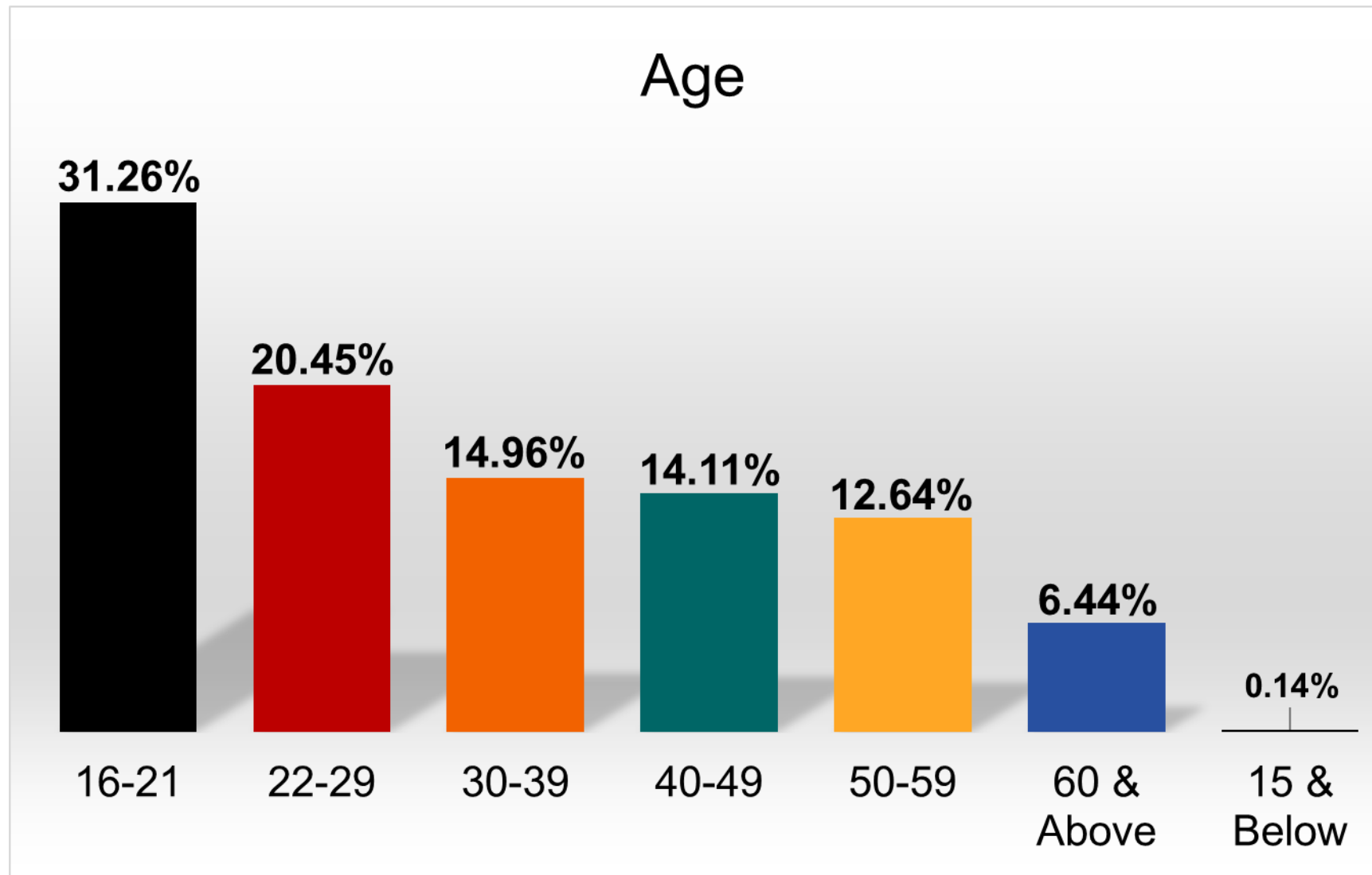
DOR Statistics

In state fiscal year 2017-2018, the Department of Rehabilitation (DOR) served **101,750** individuals with disabilities.

- Of the individuals served, **26,146** were individuals with a psychiatric disability (25.70% of DOR caseload).
- For fiscal year 2017-2018, **5,278** individuals with a psychiatric disability received vocational services through a DOR Cooperative Program with a county mental health agency

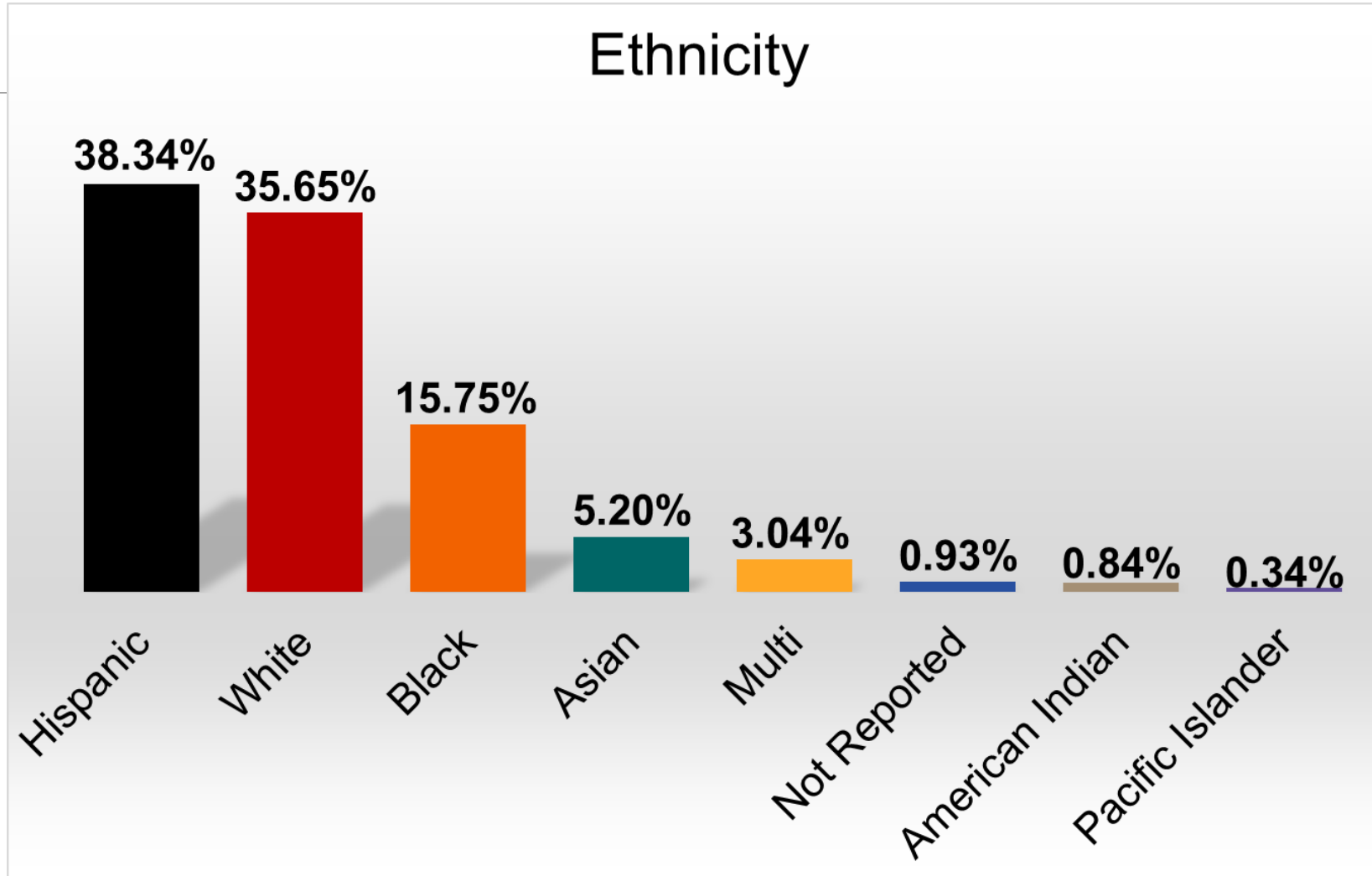
DOR Consumer Demographics





DOR Consumer Demographics

DOR Consumer Demographics



DOR Service Provision

- Individuals with a psychiatric disability may receive vocational rehabilitation program services through:
 - Community Rehabilitation Programs (CRPs)
 - Third-party cooperative agreements
 - DOR staff and other case service expenditures

Community Rehabilitation Programs (CRP)

An agency, organization, or institution, that provides vocational rehabilitation services on a fee-for-service basis in any of the following core service categories:

- Assessment Services (i.e. Vocational Assessment)
- Training Services (i.e. Personal, Vocational, Social Adjustment)
- Employment Services

DOR currently has 245 of CRPS, of which there are 28 CRPs that specifically serve individuals with psychiatric disabilities

Mental Health Cooperative Programs



A partnership between DOR and local county mental health agencies through a contractual agreement

Provides vocational services to mutual consumers of the county mental health agency and DOR

Leverages federal funding through match resources to fund vocational services



Currently 24 cooperative programs with local county mental health agencies

30 associated case service contracts with private non-profit Community Rehabilitation Programs (CRPs)

DOR Budget

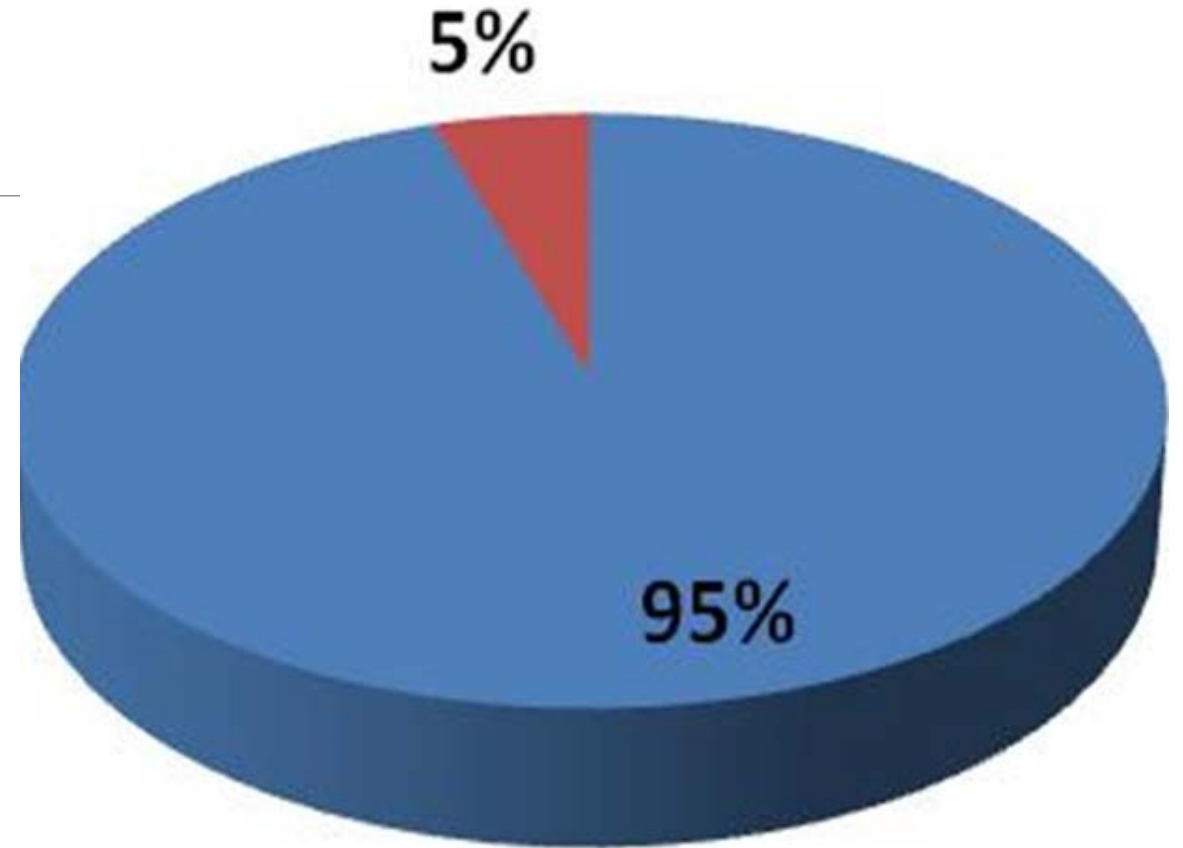
DOR Program Allocations

VR - 95% of DOR's Budget

IL - 5% of DOR's Budget

The budget includes:

- ✓ *Staffing*
- ✓ *Services to consumers*
- ✓ *Operating Expenses*
- ✓ *Local Assistance*



- Vocational Rehabilitation
- Independent Living

DOR Funding Sources

Federal Funds	\$390,209,000 – 82%
General Fund	\$ 72,475,000 – 15%
Reimbursements	\$ 10,080,000 – 2%
Vending Stand Fund	\$ 3,361,000 – 1%
Traumatic Brain Injury	\$ -6,000 – 0%
<u>Total DOR Budget Authority</u>	<u>\$ 476,119,000 – 100%</u>

Certified Expenditure Match (\$ 20,725,000)

Total Positions: 1,882 (92 Temp Help)

Certified Expenditure Match



211 Cooperative agreements (public entities) with school districts, state and community colleges, county mental health programs.



Provide over \$28 million in cash/certified time



Match stabilizes Order of Selection



Over 23,000 consumers served

Innovative Service Models

Innovative Service Models

Individuals with psychiatric disabilities are the largest population served by the Department of Rehabilitation (DOR). The department is looking at innovative strategies to best serve individuals with psychiatric disabilities.

This presentation will provide you with an overview of innovative service models currently being implemented in California.

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Individual Placement & Support (IPS) Model

Individual Placement & Support (IPS) Model

Evidence-based practice that helps people with mental illness identify and acquire competitive jobs of their choice in the community with rapid job-search and placement services.

IPS Core Principles

Zero exclusion: Eligibility is based on consumer choice

IPS services are integrated with mental health treatment

Competitive employment is the goal

Rapid job search- Job search starts soon (within 1 month) after consumers express interest in working

IPS Core Principles Continued

Employment specialists develop relationships with employers based on their consumers' work preferences.

Personalized benefits counseling is important

Follow along supports are continuous

Consumer preferences are important

DOR IPS Pilot

Background:

2015- DOR Director Joe Xavier and other executive staff attended a presentation on IPS

DOR elected to develop an IPS pilot within an existing MH cooperative program

Pros:

- Funding already exists within the cooperative program's budget authority
- Collaborative relationship already exists
- Funding would continue whether a decision was made to continue the model after the end of the pilot
- Some outcome measures already in place through the cooperative program

DOR IPS Pilot Continued

Implemented within the Special Service for Groups/Occupational Therapy Training Program (OTTP) case service contract, as part of the San Francisco County MH cooperative program

1 year pilot began September 2016 serving Transition Age Youth

County mental health provided MHSA funding to pay for IPS training for contract staff

Clients referred to the IPS program as soon as they identify a desire to work.

- Goal:
 - Begin employment services 30 days from referral
 - Vocational Specialist meets with employer on behalf of the client within 30 days

DOR IPS Pilot Continued

Summary of Pilot Outcomes:

	IPS	Non-IPS
Number of clients in the program	13	30
Percentage of clients who obtain at least one job while in program	77%	54%
Average hourly wage	\$13.30	\$12.88
Time it takes to make first face-to-face contact with employer from referral to program	82 days	92 days
Time it takes for clients to get first job from referral to program	109 days	188.5 days

DOR IPS Pilot: Lessons Learned

Collaboration with DOR counselor is key to success.

Need IPS champions in leadership.

Important to examine agency philosophy.

IPS works! After completion of pilot, OTTP began using the IPS model throughout its employment program.

Identified Strengths

Rapid job search identified as an essential component for Transition Age Youth

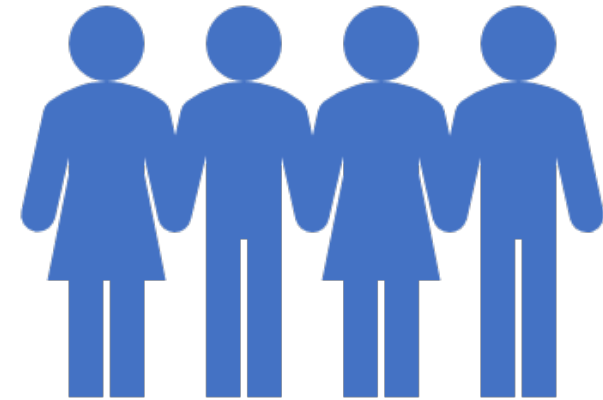
Integration of the Vocational Specialist within the mental health team

High engagement of clients referred to the program

Clients participated in several job starts

Individualized benefits counseling for all clients

Increased levels of motivation, self-confidence, and work skills



Challenges

Successful employment outcome is defined differently between IPS and DOR

Funding has not been identified at this time for time-unlimited follow along supports

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Butte County Department of Behavioral Health Program

Butte County Department of Behavioral Health Program

Overview:

Pre-vocational training program funded by MHSA funds

Butte County contracts with three service providers that provide training opportunities for employment:

- Jesus Center- Volunteer opportunities (homeless shelter, cafeteria, snack bar)
- Dreamcatchers- paid employment opportunities in the community (children's consignment store, janitorial positions, warehouse/retail and office)
- Caminar- Social enterprise projects designed and established for clients receiving services from Butte County DBH (Sensible Cyclery and Pro-Touch)
- All positions are nine months in duration

Butte County Department of Behavioral Health Program Continued

Overview Continued:

Consumers may be referred to DOR at anytime during their participation in the pre-vocational training program

Clients referred to DOR are done so through the Butte County DBH cooperative program

Clients may elect to return to the pre-vocational training program after a six month break to allow other clients the opportunity to participate

DOR and Butte County DBH hold weekly case staffing meetings to discuss client progress

Identified Strengths

Clients participate in job interviews with an opportunity to receive feedback that assists in increasing interview skills

Operates within a safe environment that can provide practical feedback to advance clients to community employment (i.e. monthly meeting to discuss client progress)

Clients gain the skills necessary to go out in the community and obtain employment (rarely need Short-term support once placed in CIE)

Given the opportunity to succeed in a rural environment

Opportunity for benefits counseling (i.e. hands on budgeting experience)



Challenges

Rural communities are small and it's important to ensure employers have a positive experience

Re-educating the mental health system about the importance of employment

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Supported Employment Demonstration (SED) Study

Supported Employment Demonstration (SED) Study

Conducted by Westat under contract with the Social Security Administration

6 year study

Purpose: To assess the impact of evidence-based services on employment

Two treatment groups, 1 control group

- Full-service treatment
- Basic-service treatment
- Usual services

Supported Employment Demonstration (SED) Study Continued...

Participant enrollment began in December 2017

3000 participants nationwide

30 community mental health agencies across the

country 1 participant site in California- Penny Lane

- Projected to serve 80 participants
 - 40 participants in full-service treatment
 - 40 participants in basic service treatment

Primary outcome of interest: Employment

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Additional Innovative Service Model Components

Behavioral Health Roundtable

Objective: Collectively determine goals and next steps to design, develop, and implement collaborative strategies and service models to assist individuals with behavioral health disabilities to decrease poverty, increase health stability, and achieve sustainable competitive integrated employment.

Outcomes:

Participation in the Behavioral Health Workgroup

Participation in the Southern CA Behavioral Health Roundtable

CASRA Concept Paper

Provides a framework of strategies to support employment success

Identifies vital principals to helping individuals with behavioral health disabilities move out poverty and improve their quality of life

Seeks allies among policy makers, providers, consumers, and family members

Employment Support Quadrants- Identified supports and resources by individual needs

CASRA Concept Paper Continued

Three Recommendations:

- 1) Convene a statewide summit on Supported Education and Supported Employment
- 2) Support the formation of local taskforces to identify resources and develop programs, policies and practices that support employment and career development
- 3) Seek funding for to re-establish the technical assistance program originally offered through the DOR/DMH cooperative program

Systems Integration & Collaboration

Systems Integration & Collaboration

- Opportunity to work collaboratively towards common goals
- Find a path forward to innovative services for consumers with behavioral health disabilities
 - No additional funding
 - Alignment of resources from a sequencing perspective
 - Interdisciplinary team approach
 - Leveraging of existing funds



How can we best work together to serve individuals with behavioral health disabilities?

Opportunities

Opportunities

Participation in the Behavioral Health Workgroup

Interested individuals can sign up to be a member of the workgroup by contacting Cindy Chiu, Assistant Deputy Director, DOR: cindy.chiu@dor.ca.gov

Participation in the Southern CA Behavioral Health Roundtable

Individuals interested in participating can contact Courtney Tacker, SSMI: Courtney.tacker@dor.ca.gov. Requesting no more than 1-2 representatives per group as this is intended to be a small roundtable to discussion

Resources

IPS Supported Employment and State Vocational Rehabilitation: A Crosswalk

<https://ipsworks.org/wp-content/uploads/2017/09/IPS-VR-Crosswalk-July-2017wfooter-margins.pdf>

February 6, 2019 Behavioral and Mental Health Roundtable #1

<https://www.dor.ca.gov/Home/BMHRoundtable>

IPS Supported Employment Practice & Principles

Overview of IPS Supported Employment

IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations of supported employment exist, IPS (Individual Placement and Support) refers to the evidence-based practice of supported employment. Mainstream education and technical training are included as ways to advance career paths.

Characteristics of IPS Supported Employment

- * It is an evidence-based practice
- * Practitioners focus on each person's strengths
- * Work promotes recovery and wellness
- * Practitioners work in collaboration with state vocational rehabilitation counselors
- * IPS uses a multidisciplinary team approach
- * Services are individualized and last as long as the person needs and wants them
- * The IPS approach changes the way mental health services are delivered

Practice Principles of IPS Supported Employment

1. Focus on Competitive Employment: *Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.*
2. Eligibility Based on Client Choice: *People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.*
3. Integration of Rehabilitation and Mental Health Services: *IPS programs are closely integrated with mental health treatment teams.*
4. Attention to Worker Preferences: *Services are based on each person's preferences and choices, rather than providers' judgments.*
5. Personalized Benefits Counseling: *Employment specialists help people obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements.*
6. Rapid Job Search: *IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.*
7. Systematic Job Development: *Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.*
8. Time-Unlimited and Individualized Support: *Job supports are individualized and continue for as long as each worker wants and needs the support.*

IPS Supported Employment and State Vocational Rehabilitation: A Crosswalk

Individual Placement and Support (IPS) supported employment is an evidence-based practice that helps people with mental health conditions work in competitive jobs related to their preferences. Vocational Rehabilitation (VR) is a state/federal program that assists eligible individuals with disabilities in obtaining and maintaining competitive integrated employment related to each person’s strengths, resources, priorities, concerns, abilities, capacities, interests, and informed choice. Individuals who have access to both IPS and VR benefit from the expertise and resources of both systems. This document describes commonalities between the IPS practice principles and the VR system.

IPS Supported Employment	Vocational Rehabilitation
<p>1. <i>Competitive employment is the goal</i></p> <ul style="list-style-type: none"> • Minimum wage or higher. Wage and benefits are the same as others in similar jobs • Integrated job settings • Positions that are open to qualified candidates, regardless of disability status 	<p><i>Competitive Integrated employment</i></p> <ul style="list-style-type: none"> • Minimum wage or higher and same as others in similar jobs • Integrated job settings • Opportunities for advancement • Same benefits as others in similar jobs
<p>2. <i>IPS services are integrated with mental health treatment services</i></p> <ul style="list-style-type: none"> • Mental health practitioners & IPS specialists meet weekly • IPS specialists collaborate with VR counselors, family/friends (with person’s permission) 	<p><i>Identification of needed service providers and supports</i></p> <ul style="list-style-type: none"> • VR counselors help identify comprehensive support services for people holding competitive jobs • VR counselors help remove barriers that prevent person from working
<p>3. <i>Eligibility is based on client choice</i></p> <ul style="list-style-type: none"> • IPS developed for people with mental health conditions (including co-occurring substance use disorders) • Desire to work helps people overcome barriers to employment • Practitioners assume that people will benefit from IPS services 	<p><i>Eligibility determination</i></p> <ul style="list-style-type: none"> • Person must have documented disability/impairment that presents barriers/impediment to secure, retain, or advance in employment • VR counselor presumes that an applicant can benefit in terms of an employment outcome from the provision of VR services
<p>4. <i>Individual preferences are honored</i></p> <ul style="list-style-type: none"> • Services are based on person’s preferences, skills, & experiences • IPS specialist records job history, education, goals, supports, etc. in career profile (guides work plan) 	<p><i>Comprehensive assessment</i></p> <ul style="list-style-type: none"> • VR counselor encourages & facilitates exploration of the (eligible) person’s strengths, resources, capabilities, priorities, concerns, abilities, interests, & informed choice

<ul style="list-style-type: none"> • Preferences help determine type of job sought, education/ training programs, team supports, & decisions about disclosing personal information at work. 	
<p>5. <i>Rapid job search: Contact with employers begins soon after a person expresses interest in working</i></p>	<p><i>Timely Individualized Plan for Employment (IPE) development within 90 days</i></p>
<ul style="list-style-type: none"> • Pre-vocational training & skill assessments rarely utilized. • Person meets with hiring manager about employment within 30 days of IPS program entry 	<ul style="list-style-type: none"> • Workforce Innovation & Opportunity Act of 2014 (WIOA) requires development of Individualized Plan for Employment (IPE) within 90 days of an eligibility determination
<p>6. <i>IPS specialist builds relationships with employers</i></p>	<p><i>VR counselor assists IPS team with building employer relationships</i></p>
<ul style="list-style-type: none"> • IPS specialist facilitates multiple, in-person meetings with hiring managers/owners to learn about business needs • Visits are based on jobseekers' work preferences 	<ul style="list-style-type: none"> • Shares job leads, coordinate visits to employers, organize joint presentations to employers, coordinate activities to gain access to large companies, & coordinate development of job search plans for shared IPS individuals • A designated business relations position (in many states) focuses on building relationships with employers in the community
<p>7. <i>Individualized job supports</i></p>	<p><i>VR counselor arranges for extended services</i></p>
<ul style="list-style-type: none"> • Individualized follow-along supports for work/school • Continued for as long as the worker/student wants & needs • Provided by IPS specialist, treatment team, family, friends, & work colleagues 	<ul style="list-style-type: none"> • Ongoing supports must be identified, as a part of supported employment Individualized Plan for Employment • Extended services provided by an entity other than VR program • Post-Employment Services may be provided within five years of case closure when job problems may result in job loss
<p>8. <i>Personalized benefits counseling is provided</i></p>	<p><i>Personalized benefits counseling is provided</i></p>
<ul style="list-style-type: none"> • IPS specialist helps program participants access information from benefits planner about Social Security, Medicaid, etc., to make informed employment decisions 	<ul style="list-style-type: none"> • VR counselors may refer eligible person for work incentives planning to help them understand how earnings may impact benefits

**California Behavioral Health Planning Council
Workforce and Employment Committee**

Wednesday, January 16, 2019

Agenda Item: WET 5-Year Plan Development

Background/Description:

The Office of Statewide Health Planning and Development (OSHPD) presented the 2020-2025 Workforce Education and Training (WET) Five-Year Plan to the Planning Council at the January 2019 quarterly meeting. The Planning Council reviewed and approved the plan. C.J. Howard, Deputy Director of the Healthcare Workforce Development Division, will provide an update on OSHPD's activities since the January approval of the Five-Year Plan.

**California Behavioral Health Planning Council
Workforce and Employment Committee**

Wednesday, January 16, 2019

Agenda Item: WET Funding Legislation

Background/Description:

The California Council of Community Behavioral Health Agencies (CBHA), the California Behavioral Health Planning Council (CBHPC) and the California Association of Marriage and Family Therapists (CAMFT) are co-sponsoring legislation to fund the Workforce Education and Training (WET) Five-Year Plan. This includes SB 539, authored by Senator Caballero, and an additional budget request for \$70 million in State General Funds.

Enclosures:

1. SB 539: Workforce Education and Training Funding
2. SB 539 Fact Sheet
3. WET FAQ 2019

Please contact Justin Boese at Justin.boese@cbhpc.dhcs.ca.gov for electronic copies of the materials.

Introduced by Senator CaballeroFebruary 21, 2019

An act to amend Sections 5890 and 5892 of the Welfare and Institutions Code, relating to mental health, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 539, as introduced, Caballero. Mental Health Services Act: workforce education and training funds.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, imposes a 1% tax on that portion of a taxpayer's taxable annual income that exceeds \$1,000,000 and requires that the revenue from that tax be deposited in the Mental Health Services Fund to fund various county mental health programs. The MHSA requires the Office of Statewide Health Planning and Development (OSHPD), in coordination with the California Behavioral Health Planning Council, to identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a 5-year education and training development plan. Existing law requires OSHPD to include in the 5-year plan, among other things, expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages and curriculum to train and retrain staff to provide services in accordance with the provisions and principles of the MHSA. The MHSA permits amendment by the Legislature by a $\frac{2}{3}$ vote of each house if the amendment is consistent with, and furthers the intent of, the MHSA.

This bill would amend the MHSA by requiring the Controller, in any fiscal year in which the Department of Finance estimates that the revenues to be deposited into the Mental Health Services Fund for the fiscal year will exceed the revenues deposited into the fund in the prior fiscal year, to, no later than the last day of each month and before any transfer or expenditure from the fund for any other purpose for the following month, set aside in the fund an amount that is equal to 25% of $\frac{1}{12}$ of the estimated amount of increased revenue. The bill would require, at the end of each fiscal year, the Controller to transfer 25% of the amount reported by the Department of Finance to be the actual increased revenue amount from the fund to the Mental Health Services Workforce Education and Training Account, which the bill would establish as an account in the fund and continuously appropriate money to the Office of Statewide Health Planning and Development to implement its 5-year education and training development plan.

The MHSA authorizes a county's allocation of MHSA funds for community supports and services to include funds for technological needs and capital facilities, human resource needs, and a prudent reserve, and limits the total allocation for those specified purposes to 20% of the average amount of funds allocated to that county for the previous 5 years.

The bill would amend the MHSA by authorizing a county to transfer funds allocated for community supports and services to the Mental Health Services Workforce Education and Training Account if included in the county's plan, and exempting that transfer of funds from the 20% limitation described above.

The bill would additionally appropriate \$70,000,000 from the General Fund to OSHPD for the purpose of funding the 5-year education and training development plan.

Vote: $\frac{2}{3}$. Appropriation: yes. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 5890 of the Welfare and Institutions Code
2 is amended to read:
3 5890. (a) The Mental Health Services Fund is hereby created
4 in the State Treasury. The fund shall be administered by the state.
5 Notwithstanding Section 13340 of the Government Code, all
6 moneys in the fund are, except as provided in subdivision (d) of

1 Section 5892, continuously appropriated, without regard to fiscal
2 years, for the purpose of funding the following programs and other
3 related activities as designated by other provisions of this division:

4 (1) Part 3 (commencing with Section 5800), the Adult and Older
5 Adult Mental Health System of Care Act.

6 (2) *Part 3.1 (commencing with Section 5820), Human Resources,*
7 *Education, and Training Programs.*

8 —

9 (3) Part 3.2 (commencing with Section 5830),

10 ~~Programs~~ *Programs*

11 —

12 (4) Part 3.6 (commencing with Section 5840), Prevention and
13 Early Intervention Programs.

14 —

15 (5) Part 3.9 (commencing with Section 5849.1), No Place Like
16 Home Program.

17 —

18 (6) Part 4 (commencing with Section 5850), the Children’s
19 Mental Health Services Act.

20 (b) The establishment of this fund and any other provisions of
21 the act establishing it or the programs funded shall not be construed
22 to modify the obligation of health care service plans and disability
23 insurance policies to provide coverage for mental health services,
24 including those services required under Section 1374.72 of the
25 Health and Safety Code and Section 10144.5 of the Insurance
26 Code, related to mental health parity. This act shall not be
27 construed to modify the oversight duties of the Department of
28 Managed Health Care or the duties of the Department of Insurance
29 with respect to enforcing these obligations of plans and insurance
30 policies.

31 (c) This act shall not be construed to modify or reduce the
32 existing authority or responsibility of the State Department of
33 Health Care Services.

34 (d) The State Department of Health Care Services shall seek
35 approval of all applicable federal Medicaid approvals to maximize
36 the availability of federal funds and eligibility of participating
37 children, adults, and seniors for medically necessary care.

38 (e) Share of costs for services pursuant to Part 3 (commencing
39 with Section 5800) and Part 4 (commencing with ~~*Section~~
40 ~~5850) of this division~~*, 5850), shall be determined in accordance
with the

1 Uniform Method of Determining Ability to Pay applicable to other
2 publicly funded mental health services, unless this Uniform Method
3 is replaced by another method of determining copayments, in which
4 ~~ease case~~, the new method applicable to other mental health
5 services shall be applicable to services pursuant to Part 3
6(commencing with Section 5800) and Part 4 (commencing with
7~~Section* 5850) of this division.*5850).~~

8 (f) (1) The Supportive Housing Program Subaccount is hereby
9 created in the Mental Health Services Fund. Notwithstanding
10 Section 13340 of the Government Code, all moneys in the
11 subaccount are reserved and continuously appropriated, without
12 regard to fiscal years, to the California Health Facilities Financing
13 Authority to provide funds to meet its financial obligations pursuant
14 to any service contracts entered into pursuant to Section 5849.35.
15 Notwithstanding any other law, including any other provision of
16 this section, no later than the last day of each month, the Controller
17 shall, before any transfer or expenditure from the fund for any
18 other purpose for the following month, transfer from the Mental
19 Health Services Fund to the Supportive Housing Program
20 Subaccount an amount that has been certified by the California
21 Health Facilities Financing Authority pursuant to paragraph (3)
22 of subdivision (a) of Section 5849.35, but not to exceed an
23 aggregate amount of one hundred forty million dollars
24 (\$140,000,000) per year. If in any month the amounts in the Mental
25 Health Services Fund are insufficient to fully transfer to the
26 subaccount or the amounts in the subaccount are insufficient to
27 fully pay the amount certified by the California Health Facilities
28 Financing Authority, the shortfall shall be carried over to the next
29 month, to be transferred by the Controller with any transfer
30 required by the preceding sentence. Moneys in the Supportive
31 Housing Program Subaccount shall not be loaned to the General
32 Fund pursuant to Section 16310 or 16381 of the Government Code.

33 (2) Prior to the issuance of any bonds pursuant to Section 15463
34 of the Government Code, the Legislature may appropriate for
35 transfer funds in the Mental Health Services Fund to the Supportive
36 Housing Program Subaccount in an amount up to one hundred
37 forty million dollars (\$140,000,000) per year. Any amount
38 appropriated for transfer pursuant to this paragraph and deposited
39 in the No Place Like Home Fund shall reduce the authorized but
40 unissued amount of bonds that the California Health Facilities

1 Financing Authority may issue pursuant to Section 15463 of the
2 Government Code by a corresponding amount. Notwithstanding
3 Section 13340 of the Government Code, all moneys in the
4 subaccount transferred pursuant to this paragraph are reserved and
5 continuously appropriated, without regard to fiscal years, for
6 transfer to the No Place Like Home Fund, to be used for purposes
7 of Part 3.9 (commencing with Section 5849.1). The Controller
8 shall, before any transfer or expenditure from the fund for any
9 other purpose for the ~~*following month*~~ *month*, but after any
10 transfer from the fund for purposes of paragraph (1), transfer
11 moneys appropriated from the Mental Health Services Fund to
12 the subaccount pursuant to this paragraph in equal amounts over
13 the following 12-month period, beginning no later than 90 days
14 after the effective date of the appropriation by the Legislature. If
15 in any month the amounts in the Mental Health Services Fund
16 are insufficient to fully transfer to the subaccount or the amounts
17 in the subaccount are insufficient to fully pay the amount
18 appropriated for transfer pursuant to this paragraph, the shortfall
19 shall be carried over to the next month.

20 (3) The sum of any transfers described in paragraphs (1) and
21 (2) shall not exceed an aggregate of one hundred forty million
22 dollars (\$140,000,000) per year.

23 (4) Paragraph (2) shall become inoperative once any bonds
24 authorized pursuant to Section 15463 of the Government Code are
25 issued.

26 (g) (1) *The Mental Health Services Workforce Education and*
27 *Training Account is hereby created in the Mental Health Services*
28 *Fund. Notwithstanding Section 13340 of the Government Code,*
29 *all moneys in the account are hereby continuously appropriated,*
30 *without regard to fiscal years, to the Office of Statewide Health*
31 *Planning and Development for the purpose of funding the five-year*
32 *education and training development plan developed pursuant to*
33 *Part 3.1 (commencing with Section 5820).*

34 (2) *The account shall consist of the following:*

35 (A) *Funds transferred pursuant to paragraph (3).*

36 (B) *Funds transferred from a county pursuant to paragraph (3)*
37 *of subdivision (b) of Section 5892.*

38 (C) *Any other federal, state, or private funds received for the*
39 *purposes specified in paragraph (1).*

1 (3) Notwithstanding any other law, in any fiscal year in which
2 the Department of Finance estimates that the revenues to be
3 deposited into the Mental Health Services Fund for the fiscal year
4 will exceed the revenues deposited into the fund in the prior fiscal
5 year, no later than the last day of each month, the Controller shall,
6 before any transfer or expenditure from the fund for any other
7 purpose for the following month, reserve in the fund an amount
8 that is equal to 25 percent of one-twelfth of the estimated amount
9 of increased revenue for the fiscal year. At the end of the fiscal
10 year, the Department of Finance shall report to the Controller the
11 actual amount of revenues deposited into the fund in the fiscal
12 year that exceeded the revenues deposited into the fund in the prior
13 fiscal year, and the Controller shall transfer 25 percent of the
14 amount reported by the Department of Finance from the fund to
15 the Mental Health Services Workforce Education and Training
16 Account. This paragraph shall not apply in a fiscal year in which
17 the balance of the Mental Health Services Workforce Education
18 and Training Account exceeds three hundred million dollars
19 (\$300,000,000) or in which the Director of Statewide Health
20 Planning and Development makes a determination that additional
21 funds are not needed in the following fiscal year in order to
22 implement the five-year education and training development plan
23 developed pursuant to Part 3.1 (commencing with Section 5820).

24 SEC. 2. Section 5892 of the Welfare and Institutions Code is
25 amended to read:

26 5892. (a) In order to promote efficient implementation of this
27 act, the county shall use funds distributed from the Mental Health
28 Services Fund as follows:

29 (1) In the 2005–06, 2006–07, and 2007–08 fiscal years, 10
30 percent shall be placed in a trust fund to be expended for education
31 and training programs pursuant to Part 3.1 (commencing with
32 Section 5820).

33 (2) In the 2005–06, 2006–07, and 2007–08 fiscal years, 10
34 percent for capital facilities and technological needs shall be
35 distributed to counties in accordance with a formula developed in
36 consultation with the County Behavioral Health Directors
37 Association of California to implement plans developed pursuant
38 to Section 5847.

39 (3) Twenty percent of funds distributed to the counties pursuant
40 to subdivision (c) of Section 5891 shall be used for prevention and

1 early intervention programs in accordance with Part 3.6
2 (commencing with Section 5840).

3 (4) The expenditure for prevention and early intervention may
4 be increased in any county in which the department determines
5 that the increase will decrease the need and cost for additional
6 services to persons with severe mental illness in that county by an
7 amount at least commensurate with the proposed increase.

8 (5) The balance of funds shall be distributed to county mental
9 health programs for services to persons with severe mental illnesses
10 pursuant to Part 4 (commencing with Section 5850) for the
11 children’s system of care and Part 3 (commencing with Section
12 5800) for the adult and older adult system of care. These services
13 may include housing assistance, as defined in Section 5892.5, to
14 the target population specified in Section 5600.3.

15 (6) Five percent of the total funding for each county mental
16 health program for Part 3 (commencing with Section 5800), Part
17 3.6 (commencing with Section 5840), and Part 4 (commencing
18 with Section 5850), shall be utilized for innovative programs in
19 accordance with Sections 5830, 5847, and 5848.

20 (b) (1) In any fiscal year after the 2007–08 fiscal year, programs
21 for services pursuant to Part 3 (commencing with Section 5800)
22 and Part 4 (commencing with Section 5850) may include funds
23 for technological needs and capital facilities, human resource
24 needs, and a prudent reserve to ensure services do not have to be
25 significantly reduced in years in which revenues are below the
26 average of previous years. The total allocation for purposes
27 authorized by this subdivision shall not exceed 20 percent of the
28 average amount of funds allocated to that county for the previous
29 five fiscal years pursuant to this section.

30 (2) A county shall calculate an amount it establishes as the
31 prudent reserve for its Local Mental Health Services Fund, not to
32 exceed 33 percent of the average community services and support
33 revenue received for the fund in the preceding five years. The
34 county shall reassess the maximum amount of this reserve every
35 five years and certify the reassessment as part of the three-year
36 program and expenditure plan required pursuant to Section 5847.

37 (3) *A county may transfer funds allocated for programs for*
38 *services pursuant to Part 3 (commencing with Section 5800) and*
39 *Part 4 (commencing with Section 5850) to the Mental Health*
40 *Services Workforce Education and Training Account, as*

1 *established pursuant to subdivision (g) of Section 5890, if included*
2 *in the county's plan pursuant to Section 5847. The 20-percent*
3 *limitation specified in paragraph (1) shall not apply to any transfer*
4 *of funds made pursuant to this paragraph.*

5 (c) The allocations pursuant to subdivisions (a) and (b) shall
6 include funding for annual planning costs pursuant to Section 5848.
7 The total of these costs shall not exceed 5 percent of the total of
8 annual revenues received for the fund. The planning costs shall
9 include funds for county mental health programs to pay for the
10 costs of consumers, family members, and other stakeholders to
11 participate in the planning process and for the planning and
12 implementation required for private provider contracts to be
13 significantly expanded to provide additional services pursuant to
14 Part 3 (commencing with Section 5800) and Part 4 (commencing
15 with Section 5850).

16 (d) Prior to making the allocations pursuant to subdivisions (a),
17 (b), and (c), funds shall be reserved for the costs for the State
18 Department of Health Care Services, the California Behavioral
19 Health Planning Council, the Office of Statewide Health Planning
20 and Development, the Mental Health Services Oversight and
21 Accountability Commission, the State Department of Public Health,
22 and any other state agency to implement all duties pursuant to the
23 programs set forth in this section. These costs shall not exceed 5
24 percent of the total of annual revenues received for the fund. The
25 administrative costs shall include funds to assist consumers and
26 family members to ensure the appropriate state and county agencies
27 give full consideration to concerns about quality, structure of
28 service delivery, or access to services. The amounts allocated for
29 administration shall include amounts sufficient to ensure adequate
30 research and evaluation regarding the effectiveness of services
31 being provided and achievement of the outcome measures set forth
32 in Part 3 (commencing with Section 5800), Part 3.6 (commencing
33 with Section 5840), and Part 4 (commencing with Section 5850).
34 The amount of funds available for the purposes of this subdivision
35 in any fiscal year is subject to appropriation in the annual Budget
36 Act.

37 (e) In the 2004–05 fiscal year, funds shall be allocated as
38 follows:

39 (1) Forty-five percent for education and training pursuant to
40 Part 3.1 (commencing with Section 5820).

1 (2) Forty-five percent for capital facilities and technology needs
2 in the manner specified by paragraph (2) of subdivision (a).

3 (3) Five percent for local planning in the manner specified in
4 subdivision (c).

5 (4) Five percent for state implementation in the manner specified
6 in subdivision (d).

7 (f) Each county shall place all funds received from the State
8 Mental Health Services Fund in a local Mental Health Services
9 Fund. The Local Mental Health Services Fund balance shall be
10 invested consistent with other county funds and the interest earned
11 on the investments shall be transferred into the fund. The earnings
12 on investment of these funds shall be available for distribution
13 from the fund in future fiscal years.

14 (g) All expenditures for county mental health programs shall
15 be consistent with a currently approved plan or update pursuant
16 to Section 5847.

17 (h) (1) Other than funds placed in a reserve in accordance with
18 an approved plan, any funds allocated to a county that have not
19 been spent for their authorized purpose within three years, and the
20 interest accruing on those funds, shall revert to the state to be
21 deposited into the Reversion Account, hereby established in the
22 fund, and available for other counties in future years, provided,
23 however, that funds, including interest accrued on those funds, for
24 capital facilities, technological needs, or education and training
25 may be retained for up to 10 years before reverting to the Reversion
26 Account.

27 (2) If a county receives approval from the Mental Health
28 Services Oversight and Accountability Commission of a plan for
29 innovative programs, pursuant to subdivision (e) of Section 5830,
30 the county's funds identified in that plan for innovative programs
31 shall not revert to the state pursuant to paragraph (1) until three
32 years after the date of the approval.

33 (3) Notwithstanding paragraph (1), any funds allocated to a
34 county with a population of less than 200,000 that have not been
35 spent for their authorized purpose within five years shall revert to
36 the state as described in paragraph (1).

37 (4) Notwithstanding paragraphs (1) and (2), if a county with a
38 population of less than 200,000 receives approval from the Mental
39 Health Services Oversight and Accountability Commission of a
40 plan for innovative programs, pursuant to subdivision (e) of Section

1 5830, the county’s funds identified in that plan for innovative
2 programs shall not revert to the state pursuant to paragraph (1)
3 until five years after the date of the approval.

4 (i) If there are revenues available in the fund after the Mental
5 Health Services Oversight and Accountability Commission has
6 determined there are prudent reserves and no unmet needs for any
7 of the programs funded pursuant to this section, including all
8 purposes of the Prevention and Early Intervention Program, the
9 commission shall develop a plan for expenditures of these revenues
10 to further the purposes of this act and the Legislature may
11 appropriate these funds for any purpose consistent with the
12 commission’s adopted plan that furthers the purposes of this act.

13 SEC. 3. The Legislature hereby appropriates seventy million
14 dollars (\$70,000,000) from the General Fund to the Office of
15 Statewide Health Planning and Development for the purpose of
16 funding the five-year education and training development plan
17 developed pursuant to Part 3.1 (commencing with Section 5820).



SB 539 (Caballero)

Workforce Education and Training Trust Fund BACKGROUND:

In November 2004, California approved Proposition 63, the Mental Health Services Act (MHSA), to improve the lives of adults with serious and persistent mental illness, and children with serious emotional disturbances. Funding comes from a 1% tax on income over one million dollars. The MHSA specifies the use of the funds in a number of key areas including Workforce, Education, and Training (WET).

The MHSA included funding, for 10 years, to address the shortage and promote workforce development strategies to establish the necessary infrastructure for a well-trained, culturally and linguistically responsive workforce. The Office of Statewide Health Planning and Development (OSHPD) is statutorily mandated to create a Five-Year Education and Training Development Plan (Five-Year Plan) to guide the state's effort to grow the behavioral healthcare workforce. However, funding for the plans ended in June of 2018. While implementation of the previous Five-Year Plans provided additional resources and attention, neither the Economic Downturn nor the expansion of Medi-Cal were anticipated by the authors of Proposition 63. Thus, the known workforce shortage has grown more critical. Access to services by California's diverse population is essential to early identification and the reduction of years spent living with untreated mental illness.

Workforce development, which includes recruiting, training and retaining behavioral health staff, is a top priority for the California Council of Community Behavioral Health Agencies (CBHA), the California Behavioral Health Planning Council (CBHPC), the California Association of Marriage and Family Therapists (CAMFT) and other allied behavioral health organizations. Without ongoing incentives for students to pursue careers in the behavioral health professions, and infrastructure to support integrated healthcare provider teams, the crisis in the behavioral health workforce will continue to exist. **SB 539 ADDRESSES THE WORKFORCE SHORTAGE BY FUNDING OSHPD'S 5-YEAR PLAN:**

To address the lack of funding for the Five-Year Plan, the CBHA, CBHPC and the California Association of Marriage and Family Therapists (CAMFT) are proposing the **creation of a trust fund (WET-TF) dedicated to funding the workforce efforts outlined in the Five-Year Plan.** Examples of those efforts include funding for loan repayment programs/stipends for behavioral health clinicians, increasing capacity at universities to train and supervise behavioral health professionals, and regional partnerships where counties can pursue specific strategies to address their communities' needs. SB 539 proposes the following funding sources for the WET-TF:

- *MHSA growth funds:*
In years where the revenues deposited into the MHS Fund exceed revenues from the prior fiscal year, 25% of those growth funds would be transferred into the WET-TF. **This proposal would earmark 25% of growth funds to be deposited into the WET-TF.**
- *County transfer of funds:*
Many counties experience significant workforce shortages and choose to make investments into workforce development and retention pursuant to existing rules, under the MHSA, which allows a transfer of a limited amount of funding under Part 3 and Part 4. **This proposal would allow a county to earmark unspent funds for deposit into the WET-TF and exempt such transfers from the current 20% limitation.**

For more information please contact:

Le Ondra Clark Harvey, Ph.D.
lclarkharvey@cccba.org

(916) 557-1166



California Association of Marriage and Family Therapists



Workforce Education and Training FAQ

In November 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), which imposes a one percent tax on personal income in excess of \$1 million to support prevention, early intervention, and services in the public mental health system (PMHS). The MHSA included a component for Workforce Education and Training (WET) programs, which are referenced in Welfare and Institutions Code 5820-5822. The WET program aims to address the shortage of mental health practitioners in the public mental health system (PMHS) via programs that fund Stipends, Mental Health Loan Assumption, Education Capacity, Consumer and Family Member Employment, Regional Partnerships, Recruitment (Career Awareness) and Retention, and Evaluation. The MHSA requires the Office of Statewide Health Planning and Development (OSHPD) to develop ongoing five-year education and training development plans, which must be approved by the California Behavioral Health Planning Council (CBHPC).

When and why did the WET funding end? The MHSA directed a portion of MHSA revenues to be set aside in the early years for WET. A total of \$444.5 million was available to be spent over a 10-year span: \$210 million was allocated to counties for local WET program implementation and \$234.5 million for WET programs administered by the state. The WET funding became available in April 2008 and ended on **June 30, 2018**.

Is there still a need for WET programs? Absolutely. California's mental health system, particularly the public mental health system, continues to be understaffed, creating large gaps in service which negatively impacts access. The mental health workforce is shrinking as the need for services continues to increase. A recent study done by the Healthforce Center at UCSF estimated that by 2028, California will have 50% fewer psychiatrists than will be needed, and 28% fewer psychologists, LMFTs, LPCCs and LCSWs combined than will be needed. There are also lingering disparities in mental health service access based on geographic location, age, language and race/ethnicity. We don't just need a larger workforce, we need a workforce that is more diverse, well trained, and evenly distributed.

Why is there still a need for WET programs? There are many factors that have led to the ongoing mental health workforce shortage, including significant challenges that could not be anticipated by the authors of Proposition 63, such as the expansion of Medi-Cal in 2014 and the severe economic downturn (2007-2010). The implementation of the Affordable Care Act greatly increased the number of people who are now eligible for mental health services, including public mental health services, which in turn has created a large increase in demand. Furthermore, much of the existing workforce is aging; currently 45% of psychiatrists and 37% of psychologists are over 60 years of age. The number of psychiatrists is expected to decrease by 34% between 2016 and 2028.

What happens if WET funding isn't renewed? If WET funding isn't renewed, the PMHS workforce will face astronomical workforce challenges resulting in significantly increased lack of access/service gaps. The number of people with unmet mental health needs will rise, impacting the lives of the 1 in 6 Californians who have been diagnosed with a mental illness, and many



California Association of Marriage and Family Therapists



others who have not been diagnosed. Untreated mental illness touches every segment of our society and is costly both to government as well as the human toll.

What are some of the successes of the WET program?

Though evaluation of the 2014-2019 plan is still ongoing, so far the program evaluation findings indicate that nearly all WET program grantees have met or exceeded their goals. Some of the program highlights from 2014-2019 thus far include:

- **Education Capacity:** Training at least an additional **135** Clinical Psychiatrists and **138** Psychiatric Mental Health Nurse Practitioners (PMHNP) in the PMHS.
- **Recruitment and Career Awareness Program:** Encourages individuals to pursue careers as mental health professionals, exposing more than **26,000** students to mental health careers and providing **90** students with internships in the PMHS.
- **Stipends:** More than **950** stipends of up to \$21,000 to mental health professionals in exchange for working in the public mental health system (PMHS) for 12 months.
- **Loan Assumption:** Supported **8,237** mental health professionals by providing up to \$10,000 in loan repayment in exchange for working 12 months in the PMHS.
- **Peer Personnel Preparation:** Supported the training and job placement of more than **1,300** individuals with lived experience within the PMHS.
- **Consumer and Family Member:** Supported training sessions for individuals with lived experience and PMHS employers throughout the state.
- **Regional Partnerships:** Supported regional coordination of numerous strategic initiatives designed to increase the capacity of the PMHS
- Overall, **69%** of WET Program beneficiaries were non-white (including Latinos), and **24%** spoke a non-English language, contributing to the diversity of the workforce.

Will there be another 5-year plan?

Yes. Welfare and Institutions Code section 5820 states that OSHPD shall develop a subsequent plan every 5 years. This means that OSHPD had to develop a new Five-Year Plan even though there is no funding currently available for the program. They worked closely with the California Behavioral Health Planning Council to develop a new, flexible, and innovative plan for 2020-2025, utilizing a rigorous stakeholder engagement process to identify strategies, programs and policies that will address California’s workforce needs. This plan was approved by the Planning Council in January 2019.

However, an unfunded plan will be severely limited in its ability to respond to California’s PMHS workforce shortage needs. Proven and effective programs such as stipends, residencies, and pipeline and retention activities all require funds in order to operate. Additionally, OSHPD will be hampered in its ability to fulfill its duties such as evaluating the mental health workforce, assessing workforce needs, and developing future plans.

How much does the WET program cost?

The original WET funding was a total of \$444.5 million. Of that total, \$210 million was provided directly to counties to administer local WET efforts, and \$234.5 million was kept at the state level to administer statewide programs. The amounts allocated from this budget for statewide programs each fiscal year varied, but the



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combined amount for ten years of county and statewide programs allowed for an average of \$44.5 million per year.

The new plan for 2020-2025 effectively combines the county and statewide programs by administering many of the WET programs through Regional Partnerships, which will provide flexibility to allow local jurisdictions to meet their unique needs while also standardizing PMHS workforce education and training programs across the state. A proposed budget for the 2020-2025 Five-Year Plan is under development and will be available in early February 2019.

What needs to be done?

Looking forward to the 2020-2025 Five-Year Plan, it is clear that there is a persistent and dire need for continued efforts to address the mental health workforce shortage. Allowing the funded WET activities to cease would greatly exacerbate staffing shortages and could undo some of the vital progress that has been made by the WET program. We need a long-term funding solution to continue the WET program until the workforce shortage no longer presents an obstacle to Californians who need crucial mental health care services.

Resources:

Mental Health Services Act (as of January 04, 2018). Retrieved from: <http://mhsoac.ca.gov/document/2018-01/mental-health-services-act-revised-january-04-2018>

OSHPD Workforce Education and Training Five-Year Plan 2014 – 2019. Retrieved from: <https://oshpd.ca.gov/ml/v1/resources/document?rs:path=/Loan-Repayments-Scholarships-Grants/Documents/WET/WET-Five-Year-Plan-2014-2019.pdf>

Healthforce Center at UCSF. *California's Current and Future Behavioral Health Workforce*. 2018. Retrieved from: <https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California%E2%80%99s%20Current%20and%20Future%20Behavioral%20Health%20Workforce.pdf>

**California Behavioral Health Planning Council
Workforce and Employment Committee**

Wednesday, January 16, 2019

Agenda Item: Discussion: Expansion of “Licensed Mental Health Professionals”

Background/Description:

In order to receive Federal Financial Participation (FFP) for provider payments for Medi-Cal Specialty Mental Health Services, services must be provided under the direction of a “licensed mental health professional” (LMHP), which includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, registered nurses, licensed vocational nurses, and licensed psychiatric technicians.

Many other mental health professionals, including physician’s assistants, pharmacists, occupational therapists, and those in the category of “other qualified providers,” are excluded from the definition of LMHP, and therefore cannot direct services, and must provide services under the direction/supervision of an LMHP.

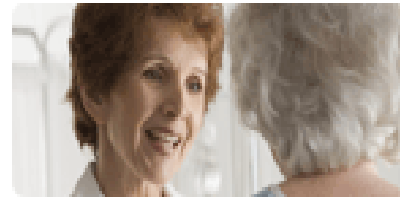
This discussion will explore the possibility of expanding the definition of LMHP to professions it does not currently include.

Enclosures:

1. CA Code of Regulations (CCR) § 1840.314. Claiming for Service Functions – General.
2. CCR § 1810.223. Licensed Mental Health Professional.
3. DHCS Medi-Cal Specialty Mental Health Services 101 (excerpt)
For the full document, please contact Justin Boese at justin.boese@cbhpc.dhcs.ca.gov
or access at: https://www.cibhs.org/sites/main/files/file-attachments/medi-cal_smhs_101_training_feb_03_2017.pdf



Department of
Health Care Services



MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES 101

Welcome



California Institute for Behavioral Health Solutions

Established in 1994 as the California Institute for Mental Health (CiMH)

- Consultation, Training & Implementation Support
- Statewide: Contractor to DHCS; Fiscal Leadership Institute, Care Coordination Learning Collaborative; Pathways to Mental Health/Katie A; Evidence-Based Practices Symposium; Drug Medi-Cal Waiver Support
- Regional: Regional Partnerships/Workforce Development Projects in the Greater Bay Area and Central Region (OSHPD); Peer Leadership Institute
- Counties/CBOs: Implementation of Evidence-based Practices; customized implementation, training and TA



Learning Objectives

- Understand the core elements of the Medi-Cal Specialty Mental Health Services (SMHS)
- Understand the requirements that providers must meet in order to become a SMHS provider





SMHS Providers

Provider Types

- **County Owned and Operated Providers**
 - County staff provide services
- **Organizational Providers**
 - Community based organizations operate SMHS programs including administrative and direct care services
- **Individual Providers**
 - County MHP contracts with individual licensed providers to provide services only





SMHS Providers (cont.)

Organizational Provider Requirements

- Contract with county Mental Health Plan(s) for specific SMHS
- Medi-Cal provider certification and tri-annual re-certification
- Minimum certification requirements are provided by DHCS based on the need to comply with federal law. County mental health plans can include additional requirements to meet local requirements



SMHS Providers (cont.)

- For organizational providers, the term “Provider” applies to those facilities delivering mental health services. A Provider **must** have a Legal Entity identification number and must also have an NPI number, if the provider will be billing Medi-Cal
- “Legal Entity” applies to a corporation, individual, or county that directly owns a facility offering public mental health services. Many Providers in California are owned by a corporation or individual (entity) that owns more than one provider





SMHS Providers (cont.)

- The NPI is a 10-digit numeric identifier which is assigned to a service facility location and is assigned to each provider number along with the county code, which is used for claiming in the Short-Doyle/Medi-Cal System. NPI information can be found at:
<https://nppes.cms.hhs.gov/NPPES/Welcome.do>
- Many counties may use the same provider, but each county will have its own provider number for that provider



SMHS Providers (cont.)

- Once a Provider File is established, a site certification must be conducted
- A “Head of Service”, fire clearance, and program description must be in place prior to the provision of services
- The Program Statement submitted to CDSS for licensure may be used and submitted to meet the program description requirement
- The Fire Clearance submitted to CDSS for licensure may be used and submitted to meet the Fire Clearance requirement
- For county owned and operated providers, DHCS will perform the site certification
- For county contract organizational providers, the county Mental Health Plan will perform the site certification
- The site certification must be performed within 6 months of the activation date



SMHS Providers (cont.)

Organizational Provider Certification Elements

- Head of Service
- License
- Beneficiary Informing Materials (i.e., Required Posted Notices, Brochures, and Problem Resolution Process)
- Physical Plant Review/tour (i.e., clean, sanitary, and in good repair)

* CCR, Title 9, Section 1810.435 (c) (3)





SMHS Providers (cont.)

- Policies and Procedures (i.e., general operating procedures; disaster/evacuation; unusual occurrence reporting; confidentiality/HIPAA, service delivery (assessment, intake, discharge), maintenance, and referral to a psychiatrist)
- Additional requirements specific to type(s) of services being certified (i.e., Medication Support, Day Treatment, and Crisis Stabilization)



SMHS Providers (cont.)

- Once the initial site certification is done, site re-certifications are required every 3 years thereafter
- A new site certification may be required depending on the action being requested. For example, a new site certification is required for an address change in order to certify the new location



SMHS – Direct Service Providers

- **Physicians ****
- **Licensed/Waivered Psychologists ****
- **Licensed/Registered/Waivered Clinical Social Workers ****
- **Licensed/Registered/Waivered Professional Clinical Counselor ****
- **Licensed/Registered/Waivered Marriage and Family Therapist ****
- **Registered Nurse ****
- **Certified Nurse Specialist**
- **Nurse Practitioner**

** = Can be head of service (CCR, Title 9, Section 622 through 630)



SMHS - Direct Service Providers (cont.)

- **Licensed Vocational Nurse ****
- **Licensed Psychiatric Technician ****
- **Mental Health Rehabilitation Specialist ****
- **Physician Assistant**
- **Pharmacist**
- **Occupational Therapist**
- **Other Qualified Provider**

** = Can be head of service (See CCR, Title 9, Section 622 through 630)





SMHS - Direct Service Providers (cont.)

Waivered / Registered Professional

- An individual who has a waiver of psychologist licensure issued by DHCS or has registered with the corresponding state licensing authority for psychologists, marriage and family therapists, clinical social workers, or professional clinical counselors, to obtain supervised clinical hours for psychologist, marriage and family therapist, clinical social worker, or professional clinical counselor licensure



SMHS - Direct Service Providers (cont.)

Mental Health Rehabilitation Specialist (MHRS)

- An individual who meets one of the following requirements:
 - Has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment
 - Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis
 - Up to two years of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting
- A MHRS may function as the “Head of Service”



SMHS - Direct Service Providers (cont.)

Other Qualified Provider

- An individual at least 18 years of age with a high school diploma (or equivalent) determined to be qualified to provide the service by the MHP

May provide the following services under the direction of a licensed, registered, or waived LPHA:

- Mental Health Services (including contributing to Assessment, but excluding Therapy)
- Day Rehabilitation or Day Treatment Intensive Services,
- Crisis Intervention Services
- Targeted Case Management
- ICC, IHBS, TFC



SMHS - Direct Service Providers (cont.)

Graduate Students / Interns

- An individual participating in a field internship/trainee placement while enrolled in an accredited and relevant graduate program
 - No minimum experience required for graduate students
 - Works “Under the Direction” of a licensed, registered, or waived staff. If under the direction of a waived staff, the waived staff must be supervised by a LPHA
 - Can complete the following “under the direction” of the LPHA:
 - Comprehensive assessments including Mental Status Exams (MSE) and diagnosis, complete client plans, conduct individual and group therapy
 - Write progress notes
 - Claim for any service within the scope of practice of the discipline of his/her graduate program
-



SMHS - Direct Service Providers (cont.)

- Can complete the following “under the direction” of the LPHA:
 - Comprehensive assessments including Mental Status Exams (MSE) and diagnosis, complete client plans, conduct individual and group therapy
 - Write progress notes
 - Claim for any service within the scope of practice of the discipline of his/her graduate program

