CCJBH Full Council Meeting Minutes

Friday, October 27, 2023
2:00-4:30 PM
MS Teams Meeting

I. Welcome & Introductions, Roll Call:

Councilmembers Present: Dr. Diana Toche (on behalf of Secretary Jeff Macomber), Christina Edens (on behalf of Stephanie Clendenin), Dr. Enrico Castillo, Dr. Tony Hobson, Anita Fisher, Sydney Armendariz (on behalf of Michelle Baass), Judge Stephen Manley, Tracey Whitney, Diana Becton, and Scott Svonkin.

Councilmembers Absent: Mack Jenkins,

Staff Members Present: Brenda Grealish, *Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH*), Elizabeth Vice, Kamilah Holloway, Jessica Camacho Duran, Emily Grichuhin, and Daria Quintero.

Dr. Toche welcomed Councilmembers and public participants on behalf of Secretary Macomber and communicated that the schedule is full for the meeting.

II. Bagley-Keen Update:

Ms. Grealish provided an update on the current status and future expectations regarding compliance with the Bagley-Keene Open Meeting Act considering recent legislative changes. She stated that Senate Bill (SB) 143, signed on September 13, 2023, reinstated certain meeting requirements that had been previously modified during the COVID-19 Public Health Emergency. Specifically, allowing Council meetings, including Full Council and Workgroup meetings, to be held virtually while temporarily suspending certain Bagley-Keene requirements. SB 143 is set to remain effective until December 31, 2023. Ms. Grealish then discussed SB 544, which is scheduled to take effect from January 1, 2024. While CCJBH was still reviewing SB 544, she assured that the Councilmembers, as well as public participants, that they would be kept informed of the modified Bagley-Keene requirements in future meetings.

III. Approval of July Meeting Minutes

Vote: Motion to adopt the July Full Council Meeting Minutes

Motion to approve the vote: Councilmember Scott J. Svonkin

Second: Councilmember Stephen Manley

No public comment on vote

Ayes: 7
Nays: 0
Abstains: 2
Not Available: 3

The July 2023 Full Council Meeting Minutes were approved.

IV. Department of Health Care Services (DHCS) Presentation on the California Advancing and Innovating Medi-Cal (CalAIM) Justice-Involved Initiative
Sydney Armendariz, Chief, Justice-Involved Reentry Services Branch, Department of Health Care Services

Ms. Armendariz oversees the DHCS Justice-Involved Reentry Services Branch, a which encompasses pre-release services, the Providing Access, and Transforming Health (PATH) capacity building funding program, and reentry services, including links to behavioral health and Enhanced Care Management (ECM) services. Ms. Armendariz also acknowledged Brian Hansen, Health Program Specialist with DHCS's Managed Care Quality and Monitoring Division, who plays a pivotal role in this initiative.

The presentation delved into California's ambitious transformation of its Medi-Cal system, known as CalAIM (California Advancing and Innovating Medi-Cal). This transformation is designed to ensure that Californians receive comprehensive health care that goes beyond traditional settings, addressing not only physical health, but also mental health needs and social determinants of health. Key aspects of CalAIM include:

- Expanded Benefits: Medi-Cal members now have access to new and improved benefits and services.
- Holistic Care: CalAIM aims to provide holistic care that goes beyond doctor's offices and hospitals to address both physical and mental health needs.
- Addressing Social Needs: The program focuses on addressing health-related social needs, such as housing support services, medically tailored meals, and better-integrated care for those with long-term health nee The presentation emphasized three primary goals of the CalAIM transformation:
    1. Whole-Person Care Approach: CalAIM adopts a whole-person care approach to address the social drivers of health.
    2. Improving Quality Outcomes: The program aims to improve quality outcomes and reduce health disparities through delivery system transformation and payment reform.
    3. Creating a Seamless System: CalAIM's goal is to create a consistent, efficient, and seamless medical system.

The CalAIM Justice-Involved Initiative, a significant part of the broader CalAIM transformation, was discussed in detail. Specifically, the federal Medicaid matching funds secured approval for California to authorize federal Medicaid matching funds for select Medi-Cal services for eligible justice-involved individuals. These individuals are in the 90-day period before release from incarceration in prisons, county jails, and youth correctional facilities. The Three Main Goals of the CalAIM Justice-Involved Initiative are:

1. Advancing Health Equity: Addressing poor health outcomes and disparities, particularly for individuals of color disproportionately impacted by incarceration.
2. Improving Health Outcomes: Providing targeted services during the pre-release period to establish a supportive reentry process and connect individuals to physical and behavioral health services upon release.
3. Setting a National Example: California aims to be a model for other states with pending justice-involved 1115 waivers.

The CalAIM Justice-Involved Initiative consists of the following components:

- Pre-Release Medical Application Processes: Counties and county jails are mandated to provide Medi-Cal applications to incarcerated individuals before their release.
- 90-Day Pre-Release Services: These services, part of an 1115 waiver, will go into effect with correctional facilities having a two-year window for implementation.
- Behavioral Health Links and ECM: Services to link individuals to medical behavioral health services and managed care services through ECM.
- Community Supports and Justice Reentry and Transition Providers: Ensuring access to community-based organizations (CBOs) and supportive services to address social needs post-release.

The presentation also covered the eligibility criteria, covered services, and PATH, a capacity funding program for pre-release services. Eligibility criteria include being part of Medicaid or the Children's Health Insurance Program eligibility groups, meeting income, immigration or citizenship, and household composition criteria. Covered services include reentry case management, clinical consultation, laboratory and radiology services, medications, medication administration, and more. Two primary care management models, the in-reach model, and the embedded model, were highlighted to ensure continuity of care. Additionally, readiness assessments for correctional facilities were mentioned as part of the preparation for implementing the 90-day pre-release services.

The PATH capacity-building program, authorized with $410 million in funding, supports collaborative planning and IT investments for pre-release and reentry planning services. ECM was discussed as a Medi-Cal benefit for individuals with complex needs, and community supports encompassed a wide range of services to address social needs during reentry. This was broken down into two distinct models:

In-Reach Model:

- Objective: To provide pre-release care management services to individuals in correctional facilities.
- How it Works: Community-based care management providers deliver these services, which can be conducted through telehealth or in-person.
- Post-Release**:** These community providers become the individuals' ECM provider once the individuals are enrolled into managed care after their release.

Embedded Model:

- Objective: To offer pre-release care management services within correctional facilities.
- How it Works: Care managers are directly employed or contracted by the correctional facilities to provide these services, typically done in person.
- Post-Release Transition: A warm handoff is required from the pre-release care manager to the post-release ECM provider, which can be conducted in-person or via telehealth.
- Warm Handoff Components: The process includes sharing the reentry care plan, establishing a trusted relationship, reviewing the care plan with the released individual, and addressing any unmet service needs.

The presentation also touched on the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration, aimed at strengthening community-based behavioral health services. It highlighted California's pioneering role in obtaining a waiver allowing expenditure authority in Institutions for Mental Disease (IMDs) for mental health care. The proposed approach for the BH-CONNECT Demonstration, including stakeholder feedback and public comment opportunities, was mentioned.

Q&A with Councilmember Advisors

Q: Mr. Svonkin inquired about the basis for the CalAIM PATH funding allocation, asking whether it was determined by the number of Medi-Cal participants per jurisdiction. He also questioned the method of funding allocation and whether jurisdictions and participating providers would be subject to regular evaluations. Furthermore, he was interested in understanding the criteria for these evaluations.

A: Ms. Armendariz explained that the PATH funding utilized a formula that took into consideration several factors: the average daily population at correctional facilities, the type of facility, and the overall county population. This formula aimed to distribute funds based on clear, objective measures. The funding was described more as an allocation rather than a grant, ensuring that all qualified entities received support for initiating pre-release services. The application process was designed to be simple, and only requires basic

information about the correctional facility and its population, along with contact details for those overseeing the funding and implementation of pre-release services.

As for the evaluation of these programs, she noted that DHCS is developing oversight and monitoring protocols in partnership with the Center for Medicare and Medicaid Services (CMS). Although specific evaluation criteria were not available at the time, she affirmed the expectation of regular monitoring to assess whether the pre-release service systems are functioning well and are effective. DHCS and CMS were collaborating closely to finalize the details of these evaluation protocols.

A: Mr. Hansen clarified that PATH funding is a one-time funding intended for infrastructure and the initial establishment of services. For the sustained provision of services, he noted that correctional facilities have access to what Medi-Cal funding, which is comprised of state and federal Medicaid contributions and is fully reimbursable to correctional facilities that provide these services. This funding also represents an ongoing source of financial support, as opposed to one-time or grant-based funding.

Q: Mr. Svonkin then inquired whether it would be possible to share the distribution of funding across the state by county at a later time for review. He mentioned that there is a considerable push in various circles to redirect funding away from correctional facilities in favor of CBOs to perform some of this work. Additionally, he questioned whether all the funding was given directly to government agencies or if some was allocated to non-governmental organizations.

A: Ms. Armendariz indicated that there are no plans to publicly disclose on their website the amount of funding each county received. The funding was directed to eligible entities, which include county behavioral health agencies and correctional facilities. She clarified that county social services might have received funding through a different grant, not the current PATH round two. The decision on whether to structure contracts with CBOs or other vendors, and whether to pass any funding along to them, rests with the counties.

Q: Dr. Castillo brought up the complexities of release planning for incarcerated individuals, particularly when release dates are not definite, as is the case in places like the Los Angeles County Jail. He described the situation where the turnover in jails is high, and release dates are subject to change due to various factors, making release planning challenging. For instance, there might be an available slot in a residential treatment program aligned with a projected release date that is no longer available on the actual day of release. Dr. Castillo asked how DHCS has prepared for such uncertainties and what adjustments and advice they will offer to ECM and Community Support providers to assist this particular group of people.

A: Ms. Armendariz mentioned the release of their Policy and Operations Guide for Planning and Implementing the Justice-Involved Initiative. She explained that the policy guide addresses what they refer to as the "short term model" for individuals incarcerated in county jails and possibly youth correctional facilities. This model is designed to accommodate situations where release dates may change or when there is no scheduled release date, with individuals being released on an ongoing basis.

Key points of the short-term model include:

- General timeframes for when specific processes should occur during incarceration.
- Initiating Medi-Cal application processes as close to intake as possible.
- Conducting screenings shortly after intake.
- Providing as many services as possible while the person is still incarcerated.
- Ensuring that individuals are enrolled in Medi-Cal as quickly as possible, so they have access to medical services immediately upon release.

The guide specifically addresses these issues in section 8.2, aiming to create a seamless transition from incarceration to community reintegration, particularly in the context of healthcare services. Ms. Armendariz indicated that the DHCS will be monitoring the effectiveness of the short-term model and would be open to revising the policy based on what is observed to be working or not working as correctional facilities implement these services.

A: Mr. Hansen highlighted the challenge of providing services to individuals with very short stays in jails or youth detention facilities. For these individuals, DHCS' advice is to initiate services as quickly as possible given that their release dates can often be unpredictable or may occur suddenly.

In contrast, Mr. Hansen noted that release dates for individuals in prisons are more predictable even though they can occasionally change. He acknowledged that a smaller percentage of individuals in adult jails, youth detention facilities, and prisons have unknown release dates or may have their release or stay extended unexpectedly. To address this, DHCS is working on creating flexibility in the 90 days of pre-release services to accommodate these changes. This flexibility allows for services to be paused and then continued, as needed, ensuring that important post-release planning and appointments can be arranged effectively and that service providers can still be reimbursed.

Mr. Hansen conceded that the situation is not perfect and described it as "a little clunky," indicating that they are working within imperfect rules to fit the Medicaid payment structure. He concluded by stating that DHCS will continue to engage with stakeholders from jails and youth detention centers to optimize the operationalization of these services within the constraints of the existing rules.

Q: Judge Manley inquired about the provision of specialized treatment services within jails, specifically addressing Traumatic Brain Injury (TBI) and intellectual disabilities. He expressed concerns about the increasing number of individuals in jails who have TBI or cognitive issues that cannot be effectively treated through standard substance abuse or mental health treatment programs. He stressed the need for specialized treatment tailored to TBI or cognitive issues and asked whether such treatment will be available in the jail settings.

A: Mr. Hansen responded to Judge Manley's question about the availability of specialized treatment for TBI and intellectual disabilities within jails. He mentioned a service reimbursed by DHCS referred to as clinical consultation, which is intended to address such needs. However, he was unsure if actual treatment for TBI or intellectual disabilities would fall within this category and acknowledged the need to review whether such treatments could be included under clinical consultation services.

Regarding the general availability of these treatments in jails, Mr. Hansen admitted that he did not have an answer and that further investigation would be necessary. He suggested that he and Ms. Armendariz might need to inquire further about the specifics of such treatment provisions in jail settings.

Q: Judge Manley asked whether these individuals will simply be given a prescription that they must fill on their own or if they will be provided with the medication in hand when they leave the facility. This is an important detail, as the former scenario could lead to gaps in medication adherence due to barriers some individuals might face in filling prescriptions, such as lack of access to transportation or financial resources. The latter option would ensure that the individuals have the medication they need immediately upon release, which is crucial for continuity of care and preventing relapse or decompensation.

A: Ms. Armendariz clarified that that according to their waiver approval, individuals must be given their actual medications in hand upon release from jail.

A: Mr. Hansen acknowledges that providing actual medications in hand to individuals upon release from correctional facilities will be challenging. He assured that they are aware of these difficulties and will be offering technical assistance and support to the correctional facilities to help them meet this requirement.

Q: Judge Manley asked whether DHCS will issue guidance on the recommended number of cases per case manager for the ECM program, emphasizing the importance of manageable caseloads to ensure effective support and outreach to each client within the system. He notes from his experience that high caseloads can be a significant challenge for case managers and may impact the quality of care provided to individuals in need.

A: Mr. Hansen acknowledges that the ECM is designed for patients with the most intensive needs and that it is supposed to be a low caseload model. He notes that the rates provided to Managed Care Plans (MCPs) are developed with the assumption of a low caseload. However, he admits that he does not have a specific answer regarding any guidance on caseload numbers and offers to get back to Judge Manley with more information after consulting the team responsible for ECM.

A: Ms. Armendariz, adding to the conversation, noted that ECM is a service provided after release and is not part of the 90-day pre-release services. The responsibility for network capacity and setting capacity limits lies with the MCPs. Regarding pre-release care managers, their caseload is determined by the correctional facility where they are employed or with which they have a contract to provide services. The implication is that, while DHCS oversees the program, the specific details regarding caseloads for pre-release

care managers are managed at the level of the correctional facility and, for post-release services, by the MCPs themselves.

Q: Judge Manley then inquired if there will be monitoring of the plans' implementation in all areas and whether there is a structure established for this oversight, or if such a plan is in development.

A: Ms. Armendariz affirmed that for the ECM services offered by MCPs, there is a monitoring protocol already established. ECM services focus on various populations, including the justice-involved (JI) population, and there is ongoing oversight for these services.

A: Mr. Hansen added that, for pre-release services, additional information is forthcoming regarding the specifics of DHCS's monitoring and oversight of correctional facilities, county behavioral health agencies, and county social services departments. He confirmed that guidance for county social services departments is already in place and emphasized that monitoring will be comprehensive for both pre-release and ECM services.

Q: Ms. Fisher inquired about the mechanism for families to ascertain which correctional facilities have adopted the new services outlined in the presentation. She expressed the need for a system that informs families, possibly through social workers, about the services available to their incarcerated relatives and questioned if there would be an accessible list of participating facilities.

A: Ms. Armendariz confirmed that there is a plan to post a public list on their website indicating which correctional facilities are ready to implement the new services, as well as list the stage of readiness for each facility. Details on what specific information will be included and the frequency of updates are still being determined, but the intention is to make this information accessible on their website.

Q: Ms. Edens sought clarification on the consistency of the timing regarding the release of individuals from jail, specifically mentioning the population deemed incompetent to stand trial. She referenced the complexities of transitioning individuals from the Department of State Hospitals back to jails and the unpredictability of their release if they are not convicted or sentenced to prison. Ms. Edens inquired if there is flexibility within the 90-day period for jail in-reach services, wondering if the services could be provided intermittently, adding up to a total of 90 days over a potentially longer timeframe, rather than 90 consecutive days. She then asked for confirmation on whether her understanding of this flexibility is correct.

A: Ms. Armendariz confirmed that they are waiting for guidance from CMS on the feasibility of pausing and unpausing services and the specific timeframes that could be allowed for such actions.

Q: Ms. Edens inquired about the strategies for monitoring or maintaining the statewide average of 30 days of services under the IMD waiver and the 1115 Demonstration. She acknowledged the flexibility provided by the ability to extend services up to 60 days but expressed curiosity regarding how the average of 30 days would be consistently

maintained across the state and what expectations might be set for the IMDs in upholding this average.

A: Ms. Armendariz acknowledged a lack of specifics now and suggested that the matter was related to the BH-CONNECT services. Mr. Hansen elaborated that their team was not the one directly handling that issue and that another team was diligently working on it. They concurred to take the question back and seek a more detailed answer.

Q: Ms. Whitney, following Judge Manley's inquiry, spoke to the critical issue of transportation needs for individuals immediately after their release from jail. She emphasized the vulnerability of these individuals at the time of release and asked whether there were provisions for transportation services to either a placement facility, a family member's home, or to another safe location. Ms. Whitney highlighted the importance of preventing the undesirable outcome of newly released individuals ending up in places like Skid Row and stressed that appropriate transportation could significantly impact their immediate future. She sought clarification on whether such transportation assistance is included in the services offered.

A: Ms. Armendariz stated that once a person is released, they qualify for the full set of Medi-Cal services, which includes a non-emergency medical transportation benefit that might cover the transportation needs to which Ms. Whitney referred. However, Ms. Armendariz was unable to confirm this definitively, indicating uncertainty about whether it would be covered in every case, but suggested that there could be qualification for such services through Medi-Cal.

A: Mr. Hansen then explained that while correctional facility staff often do an excellent job with the reentry planning for inmates, there has historically been a gap once individuals are released, with no system in place to support them. This can result in negative outcomes like recidivism, overdose, or mental health crises.

To address this issue, the initiative includes a new system where individuals who receive pre-release services are enrolled into an MCP on the day of their release, in contrast to the current situation where there can be a delay of one to two months while they are in a fee-for-service Medi-Cal system.

Mr. Hansen also emphasized that the program will automatically enroll these individuals into a MCP using an algorithm. This immediate enrollment is intended to ensure access to managed care services right from the day of release, with coordination between pre-release reentry plans and MCPs. For those at risk of homelessness, there should be access to Community Support services, such as housing navigation or recuperative care, which would include transportation.

However, Mr. Hansen clarified that not every individual in the program will receive transportation to a personal destination like a family member's home post-release. There will be a connection to medically related transportation and services, suggesting that transportation will be provided if it's related to medical needs or services post-release.

A: Ms. Armendariz concluded that pre-release case managers and ECM managers are responsible for coordinating the reentry care plan, which includes arranging referrals and transportation to community and social services as part of a warm handoff meeting. This means that as individuals are released, these case managers should have already planned for their immediate transportation needs, whether that is to housing, health care appointments, or other essential services, as part of their overall reentry strategy. She confirmed that transportation could be part of the ECM benefit when individuals are released.

Q: Dr. Hobson confirmed with Ms. Armendariz that when she referred to MCPs, she was talking about Medi-Cal MCPs. He then connected his comments to a previous point made by Judge Manley regarding caseload sizes. Dr. Hobson noted that the level of care coordination required for individuals transitioning from correctional facilities to the community resembles that of a Full-Service Partnership (FSP) program, which involves intense coordination of services to meet clients' comprehensive needs, including addressing social determinants of health.

He pointed out that, while the DHCS is very specific and directive about network adequacy requirements for county behavioral health plans, he does not understand why similar prescriptive measures concerning the ratio of providers to patients are not applied to MCPs. Dr. Hobson suggests a call for more stringent guidelines or regulations regarding MCPs' capacity to handle their beneficiaries, especially those with complex needs coming out of correctional settings.

A: Ms. Armendariz clarified that the matter is under the purview of a different division within DHCS, specifically the Managed Care division. She expressed a willingness to convey Dr. Hobson's feedback to that division for consideration.

Q: Dr. Hobson recognized the challenges that county behavioral health directors had faced in engaging with MCPs over the past decade. He suggested that more prescriptive provider-to-patient ratios might provide leverage in discussions with MCPs. Following this, he transitioned the conversation towards the issue of private insurance, especially in relation to children in juvenile correctional facilities who might be covered under their parents' insurance. Dr. Hobson questioned whether it would be possible for such private insurance plans to reimburse the efforts made in the care and reentry planning of these individuals. He was aware that this was a complex issue but wanted to bring it up for consideration.

***** PUBLIC COMMENT *****

Q: A question was posed concerning the potential for securing additional PATH funding. Highlighting that the third installment of PATH funding, directed specifically at correctional facilities, did not present an opportunity for community organizations or county bodies to seek financial support for the purpose of enhancing infrastructure or to perform preliminary activities to augment the roster of providers that deliver post-release ECM and GI (General Infrastructure) services. The commenter was interested in learning if there would be forthcoming opportunities through PATH or other initiatives like CalAIM to obtain funds for such developmental or expansion efforts, or if decisions regarding this were pending.

A: Ms. Armendariz acknowledged the question, informing that currently there are no plans for future PATH funding rounds beyond the third one. She mentioned she is willing to relay the feedback to the department's leadership, but clarified there were no definite plans for more PATH funding. Mr. Hansen added to the conversation, specifying that the justice-involved initiative for pre-release services is indeed directed to correctional facilities and behavioral health agencies. Furthermore, Mr. Hansen pointed out that there is approximately $1.8 billion in PATH funding allocated for various initiatives. He further elaborated that there are different, distinct categories of PATH funding dedicated to ECM provider capacity development, among other things. He acknowledged not being completely familiar with all aspects of this funding, but noted his belief is that these opportunities are continuing and that multiple rounds of funding are available. Mr. Hansen indicated that for ECM providers dealing with post-release scenarios, there are still available PATH opportunities.

Q: An individual with a stated association with Pure Voices in San Diego raised several inquiries about compassionate release and continuity of care for inmates. The first question addressed was whether those being released from the California Department of Corrections and Rehabilitation (CDCR) and California Correctional Health Care Services (CCHCS) are eligible for any benefits, especially if they are on compassionate release. There was concern about the absence of benefits for those who, although not deceased, lack medical benefits upon release, with a specific reference to those only eligible for hospice benefits.

The second query concerned ensuring ADA compliance for individuals' environments post-release from CDCR. The person sought to understand the mechanisms for a warm handoff that would guarantee ADA-compliant living conditions upon release and addressed the lack of such compliant housing or treatment facilities in California. Additionally, there was a question regarding the potential for funding to be used for securing housing that meets ADA standards or for reserving a spot in a skilled nursing facility to prevent an individual qualifying for compassionate release from having to die in prison.

A: Mr. Hansen acknowledged the complexity of the issues surrounding pre-release services and ADA compliance in the context of compassionate release. He noted that, while pre-release services might play a role prior to an individual's release, the nuances of ensuring ADA-compliant environments post-release, and the intricacies related to nursing facility admissions, were complex matters with no simple solutions. Mr. Hansen then addressed a concern that a significant number of individuals being released from incarceration face temporary housing situations before securing a permanent residence. He explained that outside of compassionate release, the Community Supports initiative provides options like home modifications for ADA compliance for individuals returning to their own homes. Furthermore, for those without a home to return to, he detailed that there are alternatives, such as recuperative care, short-term placements, and medical housing accessible through Medi-Cal Managed Care Plans, ensuring that these facilities would comply with ADA standards.

Q: The participant expressed appreciation for the comprehensive presentation, which brought clarity to the extensive changes and next steps involved. The active engagement in gathering input from counties and the community was particularly praised. However, a blind spot was identified in the presentation regarding the involvement of MCPs in post-release ECM. The suggestion was made to consider inviting representatives from MCPs or the relevant division at the DHCS to address their role in ECM post-release. This recommendation aimed to bridge a gap in understanding, or at least to shed light on an area that had not been fully explored in the discussion, ensuring a more complete picture of the ECM process post-release.

A: Ms. Grealish mentioned that there would be updates later in the meeting, during the project updates section, that might touch upon some of the aspects mentioned, specifically regarding what the Council is doing to track and enhance connections to ECM. She expressed appreciation for the suggestion and the consideration behind it.

Q: A chat participant raised a question about funding allocations, specifically asking why counties aren't directly provided with funds. Additionally, they queried about the service provision strategies for rural communities.

A: Ms. Grealish clarified that counties indeed receive funding. She suggested that perhaps this was not made clear earlier. She explained that counties then contract with providers within their communities to deliver services.

Q: A participant commented on the “pause and unpause” function discussed earlier in the context of medication-assisted treatment (MAT). They expressed concern that halting necessary medication in an attempt to ration out the 90 days of payment might be counterproductive to the treatment process.

A: Ms. Armendariz clarified that the “pause” function does not imply the cessation of medical services or treatments. She emphasized that the correctional facility is responsible for ensuring the continuity of necessary medical treatments. The “pause” refers specifically to the reimbursement process during the 90-day period before an inmate's release. If an individual becomes ineligible for pre-release services, the reimbursement to the correctional facility is paused until they are eligible again. This means that while the funding may be on hold, the treatment should not be interrupted.

V. CCJBH Business Meeting

Brenda Grealish, *Executive Officer, Council on Criminal Justice and Behavioral Health (CCJBH*)

A. Vote to Adopt the 2022 Annual Legislative Report and Delegate Post-Vote Editing Authority

As Required by Penal Code Section 6044(h)(1), CCJBH shall provide a report to the State Legislature on the Council's activities during the preceding year, including recommendations for improving the cost effectiveness of behavioral health and criminal justice programs. CCJBH staff completed the draft report, and the Council was respectfully asked to consider two votes, as follows:

1. Adopt the 2022 Annual CCJBH Legislative Report and Recommendations.

Vote: Motion to adopt the 2022 Annual Legislative Report

Motion to approve the vote: Mr. Svonkin

Second: Judge Manley

NO PUBLIC COMMENT ON VOTE

Ayes: 9
Nays: 0
Abstains: 1
Not Available: 2

Motion passed to adopt the 2022 CCJBH Annual Legislative Report.

2. Delegate authority to the CCJBH Executive Officer to make non-substantive updates to the report during the final review process.

Vote: Motion to delegate authority to the CCJBH Executive Officer to make non-substantive updates to the report during the final review process.

Motion to approve the vote: Mr. Svonkin

Second: Judge Manley

NO PUBLIC COMMENT ON VOTE

Ayes: 10
Nays: 0
Abstains:
Not Available: 2

Motion passed to delegate authority to the CCJBH Executive Officer to make non-substantive updates to the report during the final review process.

B. CCJBH Project Updates

1. Annual 2023 CCJBH Legislative Report

- Drafting of the CCJBH 2023 Report is underway.
- Routing for approval will begin in November.
- Once approved, Councilmembers will review and vote to adopt the final report, which is due to the Legislature by December 31, 2023.

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2. CalAIM CCJBH developed the following materials to support justice system partners in navigating the DHCS California Advancing and CalAIM initiative.

- An informational factsheet with high-level information on the CalAIM initiatives relevant to the justice-involved population with behavioral health needs.
- A CalAIM 101 Overview, which CCJBH developed and recorded in partnership with DHCS, to outline the CalAIM initiatives. The PowerPoint presentation is also available.
- A CalAIM ECM informational flyer, which CCJBH developed in collaboration with DHCS and other system partners to guide justice system partners on the process to make an ECM assessment referral for the justice-involved population, many of whom have behavioral health needs.
- A list of ECM Referral processes for each Medi-Cal Managed Care Plan, by county.

3. Juvenile Justice Compendium and Tool Kit

- The Lived Experience Advisory Board and System Representative Advisory Board continue to meet to provide input on the compendium and implementation toolkit.
- The draft Evidence-Based and Promising Practices Compendium Tableau has been posted to the CCJBH website and is being tested for usability with three county probation departments.
- The RAND Corporation is currently working on the Implementation Toolkit, which will provide detailed information on how an organization could implement the programs and practices featured in the compendium. The initial draft of the Toolkit is expected to be completed in December 2023.

4. Pre-Trial Diversion Training and Technical Assistance

- CCJBH contracted with the Council of State Governments (CSG) Justice Center for subject matter expert specialty consultation services and technical assistance to counties to enhance, sustain, and/or expand local capacity to successfully implement mental health diversion.
- CSG also facilitated 12 collaboration meetings to assess what is working (or not) within local diversion systems and examine impacts of COVID-19 on diversion efforts.
- The information captured from these efforts has been summarized into a final report that provides recommendations to support efforts to expand diversion best practices statewide.
- Once final, CCJBH will disseminate the report via the CCJBH listserv and posting to the CCJBH website. Note: the draft findings and recommendations for this report may be found in the meeting materials from the February 2023 Diversion and Reentry Workgroup on the CCJBH website.

5. CDCR-DHCS Medi-Cal Utilization Project

The Medi-Cal Utilization Project (MCUP), which examines individuals released in FY 2019-20, is currently being routed for review. As with prior reports, the report will:

- Present updated Medi-Cal enrollment and Managed Care Plan selection rates.
- Examine mental health and substance use disorder services penetration and engagement rates stratified by identified behavioral health need at the time of release.
- CCJBH staff are beginning to analyze data for individuals released in FYs 2020-21 and 2021-22.
- Once final, CCJBH will disseminate the report via the CCJBH listserv and posting to the CCJBH website.

6. Public Health Meets Public Safety UC Berkeley Contract

- The Interagency Agreement (IA) with UC Berkeley ended on August 30, 2023.
- The Contract Goals included:
    - Determining key indicators for the treatment domain for the Public Health Meets Public Safety (PH/PS) Data Visualizations.
    - Identifying public data sources to populate treatment domain indicators; and
    - Developing data visualizations for treatment domain.
- CCJBH is working to incorporate the new data into the PH/PS Data Visualization.
- CCJBH is also in the process of establishing a new IA with UC Berkeley's Possibility Lab to continue building out the PH/PS Framework, as per the Councilmember vote at the July 2023 Full Council Meeting.

7. CCJBH Lived Experience Projects (LEP)

- The CCJBH State contract with the California State University, Sacramento (CSUS), and Regional Lived Experience Projects ended on June 30, 2023, culminating in a final presentation to Councilmembers that month.
- The Medi-Cal Utilization Listening Session Summary Report, which summarizes information gathered from individuals with lived experience on their health and behavioral health services experiences/preferences, is the final deliverable under the CSUS LEP contract. Once finalized, the report will be published on the CCJBH website and disseminated via the CCJBH listserv.
- Per the Councilmember votes at the April 2023 Full Council Meeting, CCJBH staff are developing requests for proposals to secure new State and Local-Level LEP contracts.

8. Justice Involved (JI) Peer Support Specialty

- CCJBH believes that the use Justice Involved Peer Support (JIPS) Specialists can be of significant benefit to individuals who are justice-involved and have a mental health and/or SUD. JIPS Specialists are individuals who have lived experience with behavioral health conditions and are, or have been, involved with the justice system.
- CCJBH staff continues to track CalMHSA's Medi-Cal Peer Certification process.
- Similarly, CCJBH staff continue to track HCAI's Community Health Worker certification process.**9. Words to Deeds**
- In July 2023, the Council voted to allocate $166,668 from CCJBH's annual budget to further the efforts of Words to Deeds (W2D).

- CCJBH is partnering with the Mental Health Services Oversight & Accountability Commission (MHSOAC) to collaborate on W2D to maximize resources for the justice-involved population.
- Efforts will include continuing the annual W2D conference/workshop, as well as developing/providing additional relevant technical assistance related to current initiatives.

10. Housing & Homelessness

- CCJBH continues to work with CDCR's Division of Adult Parole Operations, Division of Adult Programs, and Office of Research to support the Secretary's participation as an appointed member of the California Interagency Council on Homelessness by providing quarterly reports on the progress of CDCR's commitments specified in Cal ICH's Action Plan for Preventing and Ending Homelessness in California.
- CCJBH continues to track the efforts of:
  - The U.S. Interagency Council on Homelessness;
  - California Interagency Council on Homelessness;
  - Housing and Community Development; and
  - Other State Agencies that operate related housing programs (e.g., Board of State and Community Corrections, CA Department of Social Services, DHCS).

11. Legislation

- The California Legislature will reconvene on January 3, 2024.
- In FY 2022-23, CCJBH tracked a total of 143 bills:
  - 38 bills tracked were 2-year bills.
  - 52 bills tracked were Chaptered and/or Enrolled by the end of September 2023.
    - 15 Bills were Vetoed and 37 have been signed into law.
    - 53 Bills - died in committee.
  - For a complete list of the bills tracked by CCJBH for the 2023 Session of the Legislature, please visit our website at CCJBH Legislation Update

Q&A with Councilmember Advisors

Q: Dr. Hobson expressed satisfaction that the "Words to Deeds" initiative would persist and noted the collaboration with MHSOAC. He inquired whether this entails representation at the upcoming Forensic Mental Health Conference (FHAC).

A: Ms. Grealish responded by saying she doesn't think the representation will be part of the FHAC this year, suggesting that due to strategic reasons, it will be separate.

Q: Dr. Castillo inquired about the possibility of UC Berkeley's Possibility Lab presenting their work at one of the meetings. Dr. Castillo asked for the thoughts of others on the suggestion.

A: Ms. Grealish acknowledged the suggestion to invite UC Berkeley's Possibility Lab to present and mentioned that it would be considered during the Council's planning process. She informed the attendees that a survey would be sent out to Councilmembers seeking ideas for the 2024 planning, as the December meeting, where the annual planning is conducted, was approaching.

Ms. Grealish indicated that, while UC Berkeley's Possibility Lab isn't under contract yet, she would determine how best to include their work in the planning as it relates to the Council's activities.

VI. Upcoming Meetings (via Teleconference)

The next Juvenile Justice Workgroup will be Friday, November 17, 2023, from 12:45 – 2:45 PM and focus on student behavioral health. The next Diversion/Reentry Workgroup will be Friday, November 17, 2023, from 3:00 – 5:00 PM and focus on employment for the justice-involved population. The next Full Council Meeting will be Friday, December 8, 2023, from 2:00-4:30 PM and the topic is TBD.

VII. Adjourn