Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Sacramento Creating Community Solutions Network Council
March 19, 2015

Jon Perez
SAMHSA Regional Administrator
DHHS Region IX
DHHS Organizational Chart

- The Executive Secretariat
  - Office of Health Reform (OHR)
- Secretary
  - Deputy Secretary
  - Chief of Staff
- Office of Intergovernmental and External Affairs (IEA)

- Office of the Assistant Secretary for Administration (ASA)
- Program Support Center (PSC)
- Office of the Assistant Secretary for Financial Resources (ASFR)
- Office of the Assistant Secretary for Health* (OASH)
- Office of the Assistant Secretary for Legislation (ASL)
- Office of the Assistant Secretary for Planning and Evaluation (ASPE)
- Office of the Assistant Secretary for Preparedness and Response* (ASPR)
- Office of the Assistant Secretary for Public Affairs (ASPA)

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)*
- Agency for Toxic Substances and Disease Registry* (ATSDR)
- Centers for Disease Control and Prevention* (CDC)

- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration* (FDA)
- Health Resources and Services Administration* (HRSA)
- Indian Health Service* (IHS)
- National Institutes of Health* (NIH)

- Substance Abuse & Mental Health Services Administration* (SAMHSA)

* Designates a component of the U.S. Public Health Service.

- Center for Faith-Based and Neighborhood Partnerships (CFBNP)
- Office for Civil Rights (OCR)
- Departmental Appeals Board (DAB)
- Office of the General Counsel (OGC)
- Office of Global Affairs* (OGA)
- Office of Inspector General (OIG)
- Office of Medicare Hearings and Appeals (OMHA)
- Office of the National Coordinator for Health Information Technology (ONC)
SAMHSA

- One of 11 DHHS Grant making agencies
- Approximately 550 employees
- 10 Regional Offices
- SAMHSA’s FY 2014 budget approximately $3.6 billion
Pacific Region

- Northern Mariana Islands
- Guam
- Marshall Islands
- Yap
- Palau
- Chuuk
- Pohnpei
- Kosrae
- Hawaii
- American Samoa

Pacific Ocean
Represent the Administrator in the Region
Behavioral Health: A National Priority

- SAMHSA’s Mission: Reduce the impact of substance abuse and mental illness on America’s communities

- Behavioral health is essential to health
- Prevention works
- Treatment is effective
- People recover
SAMHSA Core Functions

• Leadership and Voice
• Data/Surveillance
• Practice Improvement -- Technical Assistance, Quality Measures, Evaluation/Services Research
• Public Awareness and Education
• Grant-making
• Regulation and Standard Setting
SAMHSA OF THE FUTURE – FY 2015 AND BEYOND

SAMHSA’s Strategic Initiatives 2011 – 2014
1. Prevention
2. Trauma and Justice
3. Military Families
4. Recovery Support
5. Health Reform
6. Health Information Technology
7. Data, Outcomes & Quality
8. Public Awareness & Support

SAMHSA’s Strategic Initiatives 2015 – 2018
1. Prevention
2. Health Care and Health Systems Integration
3. Trauma and Justice
4. Recovery Support
5. Health Information Technology
6. Workforce

Business Operations  Data  Communications  Health Financing  Policy  Resource Investment  Staff Development

SAMHSA – A Life in the Community for Everyone
FY 2009 – FY 2015

FY 2009 - FY 2015 Total Program Level

* FY 2014 & FY 2015 totals include $1.5 M each year for extraordinary data and publication requests user fees
HHS/SAMHSA FY 2015 Budget Website
## SAMHSA Grant Funding, CA 2014-15

### California

#### Formula Funding

<table>
<thead>
<tr>
<th>Program</th>
<th>Funding (USD)</th>
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<tbody>
<tr>
<td>Substance Abuse Prevention and Treatment Block Grant</td>
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<tr>
<td>Community Mental Health Services Block Grant</td>
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<td>Projects for Assistance in Transition from Homelessness (PATH)</td>
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<td>Protection and Advocacy for Individuals with Mental Illness (PAIMI)</td>
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#### Discretionary Funding

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<td>Substance Abuse Prevention</td>
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<td>Substance Abuse Treatment</td>
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#### Total Funding

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<tr>
<td><strong>Total Mental Health Funds</strong></td>
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<td><strong>Total Substance Abuse Funds</strong></td>
<td><strong>$291,038,383</strong></td>
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<td><strong>Total Funds</strong></td>
<td><strong>$396,471,360</strong></td>
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Greater Sacramento Area (Davis to Placerville)  
Approximately $2.75 million

http://www.samhsa.gov/grants-awards-by-state/California
Health Reform
Bending the Cost Curve, Lowering Health Care Growth: Must Address Behavioral Health

- Expanded Coverage to Uninsured
- Prevention & Wellness
- Pay for Outcomes, Not Units
- Better Integrated Care
ACA and California (as of end 2014)

- 1,405,102 individuals selected a Marketplace plan
- 1,177,000 Californians enrolled in Medicaid and CHIP
- 2,582,102 Total new beneficiaries
  - expands mental health and substance use disorder benefits and federal parity protections for:
    - 7,559,245 Californians

http://www.hhs.gov/healthcare/facts/bystate/ca.html
• $1,065,683,056 in grants for research, planning, information technology development, and implementation of its Marketplace

http://www.hhs.gov/healthcare/facts/bystate/ca.html
Behavioral Health Impact on Physical Health
BH Impact on Physical Health

- MH problems **increase risk** for physical health problems & SUDs increase risk for chronic disease, sexually transmitted diseases, HIV/AIDS, and mental illness

- People with M/SUDs are nearly **2x as likely** as general population to die prematurely, often of preventable or treatable causes

- **Cost** of treating common diseases **higher** when a patient has untreated BH problems
  - Hypertension – 2x the cost
  - Coronary heart disease – 3x the cost
  - Diabetes – over 4x the cost

- M/SUDs rank among top 5 diagnoses **associated with 30-day readmission**; one in five of all Medicaid readmissions
  - 12.4 percent for MD
  - 9.3 percent for SUD

---

**Individual Costs of Diabetes Treatment for Patients Per Year**

- $0
- $50,000,000
- $100,000,000
- $150,000,000
- $200,000,000
- $250,000,000
- $300,000,000

- With behavioral health problems and diabetes
- With diabetes alone

---

**With behavioral health problems and diabetes**
Why is addiction treatment evaluated differently? Both require ongoing care.

Hypertension Treatment

Addiction Treatment

Comparison of Relapse Rates Between Drug Addiction and Other Chronic Illnesses

Percentage of Patients Who Relapse

- **Type 1 Diabetes**: 30 to 50%
- **Drug Addiction**: 40 to 60%
- **Hypertension**: 50 to 70%
- **Asthma**: 50 to 70%

ESSENTIAL HEALTH BENEFITS (EHB)

10 BENEFIT CATEGORIES

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care
Health Reform: Impact of the Affordable Care Act

- Focus on primary care & coordination w/ specialty care
- Emphasis on home & community-based services; less reliance on institutional & residential care (health homes)
- Priority on prevention of diseases & promoting wellness
- Focus on quality rather than quantity of care (HIT, accountable care organizations)
- Behavioral health is included – parity
Grant Opportunities
http://samhsa.gov/grants/grant-announcements
The **SAMHSA forecast (PDF | 290 KB)** provides information on SAMHSA’s upcoming Requests for Applications (RFAs). Prospective Applicants can learn more about SAMHSA’s plans for release of RFAs including brief program descriptions, eligibility information, award size, award number and proposed release date.

<table>
<thead>
<tr>
<th>RFA Number</th>
<th>Title</th>
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<th>Due Date</th>
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<tbody>
<tr>
<td>SM-14-001</td>
<td>Planning Grants for Expansion of the Comprehensive Community Mental Health Services for Children and their Families (System of Care Expansion Planning Grants)</td>
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<td>SM-14-003</td>
<td>Planning and Developing Infrastructure to Improve the Mental Health and Wellness of Children, Youth and Families in American Indian/Alaska Natives (AI/AN) Communities (Circles of Care VI)</td>
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<td>SM-14-004</td>
<td>Cooperative Agreements for Linking Actions for Unmet Needs in Children’s Health (Project LAUNCH)</td>
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<td>Statewide Family Network Program (Statewide Family Network Program)</td>
<td>CMHS</td>
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<td>SM-14-008</td>
<td>PPHE–2014 Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention (PPHE–2014) (State/Tribal Youth Suicide Prevention Cooperative Agreements)</td>
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<td>SM-14-010</td>
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NOW IS THE TIME –
FY 2014 $115 M CONTINUED IN FY 2015

- $55 M – Project AWARE to improve MH awareness, increase referrals to BH services and support systems
  - $40 M for Project AWARE state grants
  - $15 M for Mental Health First Aid
- $20 M – Healthy Transitions to support youth ages 16 to 25 w/ MH and/or SA problems, and their families
- $40 M – BH Workforce activities:
  - $35 M jointly administered w/ HRSA to expand the Mental and Behavioral Health Education and Training (MBHET) Grant Program
  - $5 M for expansion of Minority Fellowship Program - Youth
EVIDENCE-BASED PRACTICES THROUGH BLOCK GRANTS

• Substance Abuse Prevention and Treatment Block Grant (SABG) – $1.8 B
  – Maintains FY 2014 level (+ $ 110 M over FY 2013)

• Community Mental Health Services Block Grant (MHBG) – $ 484 M
  – Maintains FY 2014 level (+ $ 47 M over FY 2013)
  – Continues new FY 2014 5 percent set aside
    • For “evidence-based MH prevention and treatment practices to address the needs of individuals with early SMI, including psychotic disorders,” regardless of age at onset
STRENGTHENING AND INTEGRATING CARE

• Primary Care and Addiction Services Integration (PCASI) – + $20 M
  – Allow addiction treatment providers to offer an array of physical health and addiction treatment services
  – Modeled after Primary/Behavioral Health Care Integration (PBHCI) program

• HIV/AIDS Continuum of Care
  – $24 M of existing resources
  – Links Minority Aids Initiative, PBHCI, and PCASI
  – Builds on FY 2014 pilot
• **Now Is the Time** – $130 M (+ $15.0 M)
  - $115 M continued from FY 2014
  - Science of Changing Social Norms (+ $4 M)
  - Peer Professionals (+ $10 M)
  - Workforce Data (+ $1.0 M)
BUILDING THE WORKFORCE

• $56 M in *Now Is the Time* (+ $ 11 M)
  – In collaboration with HRSA
  – Adds commitment to BH workforce data
  – Maintains most of FY 2014 increase to Minority Fellowship Program
  – Adds commitment to peer/paraprofessional workforce
REACHING AMERICANS IN COMMON HEALTHCARE SETTINGS

- Grants for Adult Trauma Screening and Brief Intervention (GATSBI) – + $2.9 M
  - Repeat request from FY 2014
  - To advance the knowledge base to address trauma for women in primary care, OB/GYN, and emergency departments of hospitals and urgent care settings
  - Will be developed by SAMHSA in consultation with ACF, CDC, NIAAA, NIDA, NIMH, and VA
• State Grants within Strategic Prevention Framework Program (SPF Rx) – + $10 M
  – Enhance, implement and evaluate state strategies to prevent prescription drug abuse/misuse
  – Improve collaboration on risks of overprescribing and use of Prescription Drug Monitoring Programs (PDMPs) between states public health and behavioral health authorities, and pharmaceutical and medical communities
  – Coordinated with new CDC program
PREVENTING SUICIDE

• National Strategy for Suicide Prevention (NSSP) Implementation – + $2.0 M
  – Assist states in establishing and expanding evidence-based suicide prevention efforts
  – Address middle age population – most # deaths
  – Improve follow-up after suicide attempts
  – Goals
    • Reduce # of deaths by suicide
    • Reduce # of suicide attempts

• Tribal Behavioral Health Grants – $5 M
  – Continued from FY 2014
BUILDING PARTNERSHIPS
EXPANDING PRACTICES THAT WORK

• Building BH Coalitions (BBHC) –
  – $3.0 M of existing resources
  – Jointly administered by Center for Mental Health Services (CMHS) and Center for Substance Abuse Prevention (CSAP)
  – Working to address shared risk and protective factors for substance abuse and mental illness
  – Building resilience and emotional health
Contact Information

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Regional Administrator, HHS IX
Substance Abuse and Mental Health Services Administration
90 Seventh Street, 8th Floor
San Francisco, CA 94103
415 437 7600
jon.perez@samhsa.hhs.gov
California Reducing Disparities Project Overview & Update

Office of Health Equity’s Presentation to Sacramento’s Creating Community Solutions Network Council
March 19, 2015

Tamu Nolfo, PhD
Office of Health Equity
California Department of Public Health
California Reducing Disparities Project (CRDP)

In response to former U.S. Surgeon General David Satcher’s call for national action to reduce mental health disparities, the former Department of Mental Health (DMH), with Health Directors Association (UMHDA) and the California Mental Health Planning Council (CMHPC), created a statewide policy initiative to identify solutions for historically unaddressed problems. In addition, California reducing disparities project (CRDP), which focuses on five populations:

- African Americans
- Asians and Pacific Islanders (API)
- Latinos
- Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ)
- Native Americans

The CRDP Phases

The CRDP seeks to move away from “business as usual” and provide a truly community-focused approach to reducing disparities. The CRDP project requires multiple planning phases:

- **Phase I**: Focuses on developing strategies to transform the public mental health system and identifying community-based promising practices in each of the five target populations. Throughout the process, California will present this work on the national stage so that other states can learn from our efforts.

Stakeholder Generated Reports

List of CRDP Population Reports and CRDP Draft Strategic Plan.
CRDP OVERVIEW

- Community Mobilizing/Grassroots Partnership
- Community-Defined Evidence (CDE): Definition

- This is a key statewide policy initiative to improve:
  - Access to care
  - Quality of care
  - Positive mental health outcomes for racial, ethnic, and cultural communities
SEMINAL DOCUMENTS

- Mental Health: Culture, Race, and Ethnicity
  A Supplement to Mental Health: A Report of the Surgeon General

- Achieving the Promise: Transforming Mental Health Care in America, Executive Summary – The President’s New Freedom Commission on Mental Health
**BACKGROUND**

2007

- Legislature approves $1.5 million (annually) of state-administrative Mental Health Services Act (MHSA) dollars to support the development of a California Reducing Disparities Project (CRDP) Strategic Plan for the state.

- Mental Health Services Oversight and Accountability Commission (MHSOAC) provides policy direction for statewide projects including ethnic and cultural specific programs and interventions.

- MHSOAC identifies CRDP as 1 of 5 Prevention and Early Intervention (PEI) statewide projects.
BACKGROUND (CONT.)

2010

- Former Department of Mental Health (DMH) executed 7 contracts: 5 to form Strategic Planning Workgroups (SPWs) for 5 communities – African American (AA); Asian/Pacific Islanders (API), Lesbian Gay Bisexual Transgender, Queer/Questioning (LGBTQ); Latino; and Native American (NA) – and the California MHSA Multicultural Coalition (CMMC) and Facilitator/Writer

2012

- AB 100 eliminates DMH FY 12-13

- AB 1467 Omnibus Health Trailer Bill creates the Office of Health Equity

- Governor’s Final Budget Summary FY 12-13 (page 363) allocates the CRDP to CDPH along with $15 million and Legislative intent totaling $60 million for Phase II implementation and evaluation
MHSA FUNDING COMPOSITION CHART

CRDP is less than 1% of all MHSA funding
CRDP VISION

“service delivery defined by multicultural communities for multicultural communities”

- Identification of strategies developed across targeted communities to improve outcomes and reduce disparities

- Implementation of selected community-identified strategies

- Culturally and linguistically competent Community Participatory Evaluation of community-defined evidence (CDE) for racial, ethnic, and cultural communities

- Replication of approaches to reduce mental health disparities
CRDP PHASE I STRUCTURE

Strategic Planning Workgroups (SPWs)

- African American SPW Contract #1
- Asian / Pacific Islander SPW Contract #2
- LGBTQ SPW Contract #3
- Latino SPW Contract #4
- Native American SPW Contract #5

CA MHSA Multicultural Coalition

- Establish, Convene, Sustain a Statewide Multicultural Coalition
- Establish Emerging Community Leader Mentorships
- Collaboration and Support of the Five SPWs
- Implementation of CA Reducing Disparities Strategic Plan
- Assessment of MHSA Implementation

#6

CRDP Facilitator/Writer

Collaborate with the five SPWs and the CA MHSA Multicultural Coalition to complete an analysis and produce a comprehensive statewide Reducing Disparities Strategic Plan

#7
SPW DELIVERABLES

- Established, convened, and sustained a cultural-specific SPW
- Asked respective community what works
- Developed Reducing Disparities Population Reports
- Contributed to the development of the CRDP draft Strategic Plan on Reducing Mental Health Disparities
CRDP SUPPORT TEAM

- Facilitator/Writer (California Pan-Ethnic Health Network) works collaboratively with the 5 SPW Project Managers to ensure the final strategic plan is inclusive of the work completed by the SPWs.

- Mental Health Association in California (MHAC) has responsibility to organize and mobilize the CA MHSA Multicultural Coalition (CMMC).
CRDP SPW AND SUPPORT TEAM

Activity Outcomes

- Engaged respective communities throughout the state
- Convened focus groups in rural, urban, and geographic regional areas
- Conducted key informant and cultural broker interviews to identify community strengths
- Developed community needs assessments
- Participated on mental health committees to educate, update, and garner input/feedback
- Conducted community forums prior to, and after, dissemination of the reports
CRDP POPULATION REPORTS
LINKAGE FROM CRDP PHASE I TO CRDP PHASE II

CRDP Phase I

• SPWs engaged communities
• Identified promising programs and practices
• Identified strategies to reduce disparities
• Developed Population Reports
• Contributed to the Draft CRDP Strategic Plan

CRDP Phase II

• Roadmap to transform the public mental health system into one that meets the needs of all Californians
• Implement the Strategic Plan
• Blueprint for the $60 million dollar roll out for CRDP Phase II components
COMMUNITY RECOMMENDED ACTIONS

Systems Level
- Workforce development
- Capacity building

Community Level
- Community involvement/engagement
- Community leadership

Provider Level
- Linguistic access
- Robust community engagement/cultural brokering
CRDP STRATEGIC PLAN

Four Over Arching Themes

• Address and incorporate cultural and linguistic competence at all levels
• Implement Capacity Building at all levels
• Improve data collection standards
• Address social and environmental determinants of health

5 Goals

• Goal 1. Increase Access
• Goal 2. Improve the Quality of Services
• Goal 3. Build on Community Strengths to Increase the Capacity of and Empower Unserved/Underserved/Inappropriately Served
• Goal 4. Develop, Fund, and Demonstrate the Effectiveness of Population-Specific and Tailored Programs.
• Goal 5. Develop and Institutionalize Local and Statewide Infrastructure to Support the Reduction of Mental Health Disparities.
CRDP Phase II Update
CRDP PHASE II OPEN PROCUREMENT

On March 5, 2015, the California Department of Public Health, Office of Health Equity (CDPH OHE) released Draft Pre-Solicitations for the California Reducing Disparities Project (CRDP) Statewide Evaluation Team, Technical Assistance Provider, Capacity Building Pilot Projects and Implementation Pilot Projects.

The Draft Pre-Solicitations can be found on the CRDP Phase II webpage at

http://www.cdph.ca.gov/programs/Pages/OHECaliforniaReducingDisparitiesProjectPhaseII.aspx

The purpose of the draft release is to solicit public feedback about the program and solicitation designs prior to release of the official solicitations. CDPH is not accepting applications at this time.
CRDP PHASE II OPEN PROCUREMENT

We invite feedback on all sections of the Draft Pre-Solicitations, but are particularly interested in receiving feedback on the following areas:

- Program evaluation guidelines and evaluation plan components
- Minimum and desired qualifications for Proposers or Applicants
- Scoring criteria

Your feedback would be most useful if your comments address specific parts of the solicitations and you explain how your suggested change would improve CRDP.

We need to obtain your written feedback by close of business March 25, 2015.
CRDP PHASE II OPEN PROCUREMENT

Though we are asking stakeholders for their feedback to improve solicitations for CRDP Phase II, CDPH OHE must work to ensure all potential proposers have a level playing field and that the department operates in a manner that is transparent to the public.

In order to make sure all input is properly considered, it is essential that interested stakeholders submit their input in writing using the designated email for each solicitation. Please note that there is a different email set up for each solicitation.

The emails are as follows:

Statewide Evaluation Team Draft Pre-Solicitation
Email Comments To: CRDPevaluation@cdph.ca.gov

Technical Assistance Provider Draft Pre-Solicitations
Email Comments To: CRDPta@cdph.ca.gov

Capacity Building Pilot Projects Draft Pre-Solicitations
Email Comments To: CRDPPilot@cdph.ca.gov

Implementation Pilot Projects Draft Pre-Solicitations
Email Comments To: CRDPPilot@cdph.ca.gov
CRDP PHASE II OPEN PROCUREMENT

CDPH OHE will not be able to take personal meetings or respond to telephone inquiries regarding the solicitations to ensure a level playing field, full transparency, and the integrity of the solicitations.

If you would like to be sent an OHE email announcement, please subscribe at OHE@cdph.ca.gov.
FOR MORE INFORMATION

CRDP Website
http://www.cdph.ca.gov/programs/Pages/OHECaliforniaReducingDisparitiesProject.aspx

CRDP Fact Sheet

OHE Contact Information/Added to E Blast
OHE@cdph.ca.gov

“service delivery defined by multicultural communities for multicultural communities”
OVERVIEW AND OUTCOMES FROM THE SACRAMENTO DAY OF DIALOGUE

MORE THAN 300 PEOPLE ATTENDED THE ALL-DAY EVENT

- 30% OF PARTICIPANTS WERE UNDER THE AGE OF 25
- 48% OF PARTICIPANTS REPORTED HAVING A DIRECT PERSONAL EXPERIENCE WITH MENTAL HEALTH
- 64% OF PARTICIPANTS IDENTIFIED AS A RACE/ETHNICITY OTHER THAN CAUCASIAN

WHO ATTENDED THE SACRAMENTO CREATING COMMUNITY SOLUTIONS MEETING?
KEY TOPICS FOR YOUTH AGES 12-17:

- **EDUCATION AND TRAINING IN THE SCHOOLS:**
  - More clinically trained professionals
  - Training for teachers on what to look for
  - Integrate mental health into curriculum
  - Workforce training and transition support

- **ACTIVITIES TO SUPPORT MENTAL HEALTH NEEDS OF YOUTH:**
  - Peer support groups and safe places to explore mental health issues
  - After school activities with positive youth development, role models, and drop in programs
  - Social media campaigns discussing mental health issues

KEY TOPICS FOR YOUTH AGES 18-24:

- **WORKFORCE AND TRAINING:**
  - Career counseling, job placement, internships
  - Mentoring and peer support programs
  - Entry level jobs opportunities and internships

- **ACCESS TO SERVICES:**
  - Address access to services and health insurance
  - Ability to navigate services as an adult; better hand-offs between child and adult systems
  - Need for mobile crisis services; address issues of homelessness
WHAT STOOD OUT?

Youth ages 14-24 identified Peer Support as the highest rated specialized mental health need

4 of the TOP 5 themes for services for TAY include employment related services

KEY TOPICS FOR THE COMMUNITY OVERALL:

- **Address the treatment gap and access/affordability of mental health services**
  - Create new avenues for early identification and referral
  - Provide a clearer map about how to navigate services
  - Identify the gap in resources for specific types of services
  - Develop a linkage with the Affordable Care Act, Covered California, health insurers, and mental health providers

- **Identifying the need for mental health services**
  - Early identification is critical with half of mental illness before age 14 and 3/4 before age 24. Establish clear protocols for identification in primary care settings, schools, and other service providers.
  - Providing clearer guidance about when to seek help for individuals, families, schools, and providers
  - Create an interactive educational tool: “When would you say something?”
KEY TOPICS FOR THE COMMUNITY OVERALL:

- Concerns about safety and problems with untreated illnesses
  - Educating the public about mental health facts
  - Teaching Mental Health First Aid on a broader basis

- Discrimination for persons diagnosed with a mental illness continues to be a problem
  - Change the reaction to mental health and mental illness so that it is recognized and normalized and that people feel comfortable seeking treatment
  - Acknowledge the barriers and taboos in cultural communities that prevent individuals and families from seeking help
  - Review social media efforts to date and provide recommendations and program ideas to implement new ideas especially for youth

SACRAMENTO MENTAL HEALTH ACTION PLAN
BREAKING THROUGH BARRIERS ON MENTAL HEALTH

JULY 2013
Overarching Strategies to be Addressed by Each Action Team:

**Strategy 1**
- Capitalize on the momentum from the dialogue to build leadership and support for mental health

**Strategy 2**
- Continue the mental health conversations through use of media and materials from the day of dialogue in community centers, schools and nonprofit organizations.

**Strategy 8**
- Ensure all services meet standards for cultural and language competencies

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**Action Team A – Identifying Early Signs of Mental Health Issues through Schools and Community Programs**

- **Strategy 3** - Create a broad-based effort to identify the early signs and symptoms of mental health problems through schools and related community programs.
- **Address Strategies 1, 2 & 8**

**Action Team B – Connecting Youth to Health-Focused Social Media Campaigns**

- **Strategy 4** - Develop a youth-based social media campaign to encourage youth to get involved in addressing mental health issues.
- **Address Strategies 1, 2 & 8**
**ACTION TEAMS & STRATEGIES**

- **Action Team C - Integrating Behavioral Health and Primary Health Care**
  - **Strategy 5** - Integrate behavioral and mental health more directly into primary health care services at health care clinics, schools, and in colleges.
  - **Address Strategies 1, 2 & 8**

- **Action Team D - Support for Transition-Age-Youth to Navigate Systems and Gain Employment**
  - **Strategy 6** - Establish reliable and up-to-date systems to navigate access to mental and behavioral services
  - **Strategy 7** - Develop a more focused system of care for transition age youth, ages 18-24, and ensure greater linkage to the employment and training system.
  - **Address Strategies 1, 2 & 8**

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**ACTION TEAMS & STRATEGIES**

**Council Advisory Group**

- **Strategy 8**
  - Ensure all services meet standards for cultural and language competencies
  - Coordinate, Advocate, and Advise on the “Big Picture”
WANT TO KNOW MORE?

Check out
- The Action Team Work plans
- The Action Team Posters
- The Sierra Health Foundation’s Center for Health Program Management at http://www.shfcenter.org/sacramento-creating-community-solutions

Talk to
- Action Team Members
- Council Members
- Action Team Facilitators
- Project Staff & Leadership