MENTAL HEALTH POLICY AND PRACTICE REFORM

A LOCAL, STATE, AND FEDERAL PERSPECTIVE

AARON J. BYZAK, MBA

OVERVIEW

MENTAL HEALTH POLICY AND PRACTICE REFORM

GOAL

The goal of this exercise was to develop a list of proposed policy and practice solutions to address unmet needs along the mental health continuum. This document was originally produced in 2018 and 2019.

PROPOSED CHANGES

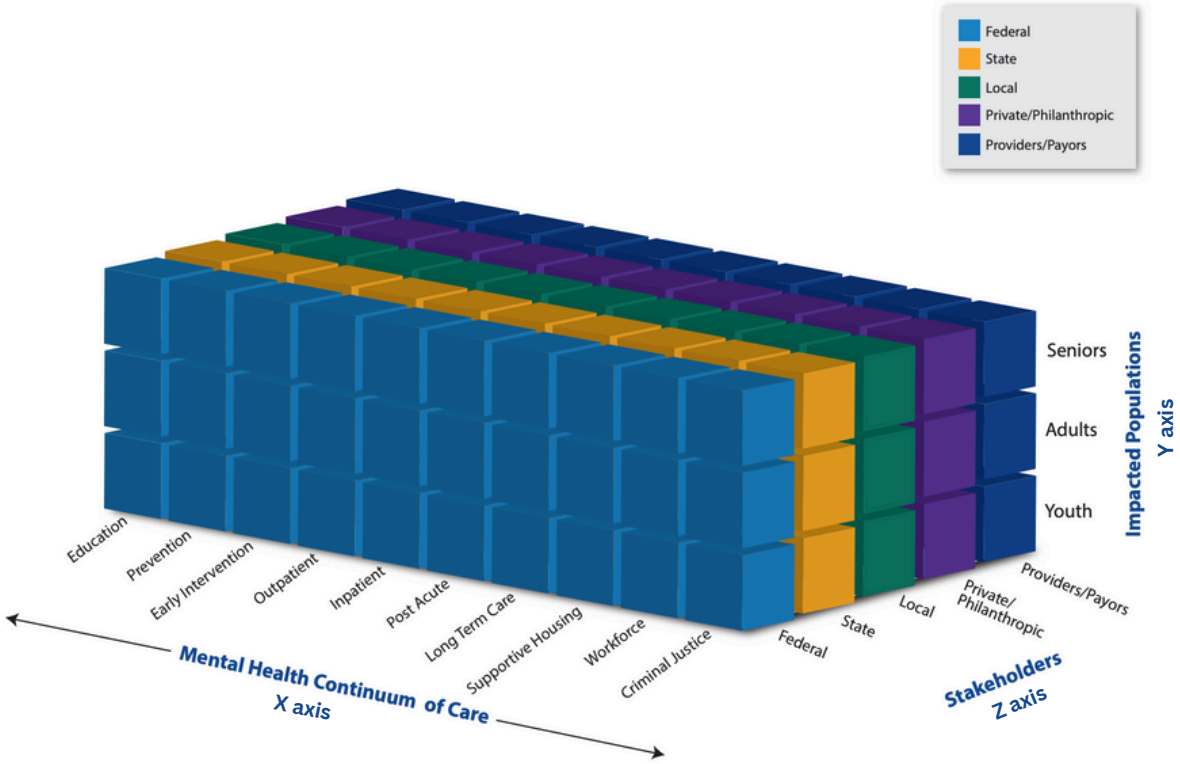
These proposed changes, which are listed on pages 4-6 of this document, were collected through one-on-one and small group discussions with more than 150 interested stakeholders over the course of 6 months. This list is not intended to be comprehensive, but is intended as a starting point for further discussion.

Ideally, this list may serve as a rallying point for additional reforms or suggested amendments to these proposals. These proposed reforms were written with simplicity in mind. This is not meant to suggest that the solutions are simple, but rather to attempt to explain complex issues in terms that are understandable to a wide array of audiences.

RUBRIC DESIGN

The rubric found on page 3 of this document was designed to:

- Illustrate the complex puzzle that is the mental health continuum of care
- Demonstrate the intersections of stakeholders and impacted populations at points along the continuum
- Create a mechanism for interested stakeholders to claim ownership of particular aspects of that continuum, and
- Serve as a collection point for future reform concepts.



RUBRIC ORIENTATION

Lengthwise along the bottom (X axis), you will find the various points along the mental health continuum of care — places where patients consume care; the depth (Z axis) shows the various interested stakeholders who have influence and responsibility for the care delivered; and the height (Y axis) shows the impacted patient populations, broken down by age groups. It is also important to consider the various subgroups of these populations, including, but not limited to, LGBTQ, veterans, and people of diverse racial, ethnic, and socioeconomic backgrounds.

POLICY AND PRACTICE CONCEPTS

Each of the 30 policy and practice concepts outlined in this document fits into one or more of the cubes within the rubric and has a one-page briefing sheet that includes a more detailed description of the problem the concept addresses, as well as potential supporters and opponents, and a simple cost to benefit chart.

This particular set of reforms is focused on local, state, and federal government activities.

AARON J. BYZAK, MBA

Aaron Byzak is the Chief Strategist and Lead Consultant at Galvanized Strategies, a strategic advisory firm focused on public affairs, healthcare policy, organizational leadership, and social-impact initiatives. Through his work, Aaron advises healthcare organizations, nonprofit institutions, public agencies, and executive leaders on navigating complex policy environments, strengthening public trust, and translating mission into results.

Over more than three decades, Aaron has worked at the intersection of healthcare delivery, public policy, and community engagement. He has held senior executive and advisory roles across hospital systems, healthcare districts, and nonprofit organizations, including interim leadership roles during periods of organizational transition. His experience spans strategy development, governance, government relations, communications, workforce development, and system-level reform.

Earlier in his career, Aaron led government and community affairs for a nationally recognized academic health system and advised elected officials at the state and county levels on health and human services policy. He also served as a surrogate speaker on healthcare reform and supported numerous strategic initiatives.

Aaron is the founder of Hazel's Army, a grassroots advocacy initiative that helped advance landmark assisted living reform in California. Before entering policy and executive leadership, he spent more than six years working as an EMT and Senior Field Training Officer on ambulances in San Diego County.

Aaron earned his MBA in Healthcare Management and Policy from the UC Irvine Paul Merage School of Business and holds a bachelor's degree in social science from Chapman University. He completed executive leadership programs at Cornell University and UCLA and was a Board-Certified Fellow of the American College of Healthcare Executives (FACHE) for 12 years.

He lives in Vista, California, with his family. Aaron is also a family member of individuals with lived behavioral health experience, giving him both professional and personal insight into the mental health system.

POLICY AND PRACTICE CONCEPTS

LOCAL

1. Create a multifaceted public relations campaign to improve awareness of behavioral health issues, reduce stigma, and promote the availability of services (funded by MHSA and local dollars).

2. Leverage local government and non-profit organization funding to expand behavioral health prevention messaging in collaboration with existing drug prevention efforts.

3. Create a local pilot program for psychiatric urgent cares and emergency rooms (youth, adults, seniors).

4. Increase County reimbursement to supplement Medicaid payments for inpatient behavioral health.

5. Conduct a research study to identify the appropriate number of inpatient, post acute, and long term care beds for the County and develop a master plan for meeting those goals.

6. Allocate local or private/philanthropic funding to subsidize select frequent utilizers to secure permanent supportive housing through ILF and BAC; attach funding availability with participation in County's ILF Association to ensure compliance with living standards.

7. Streamline the process for utilizing Laura's Law in San Diego County to afford family members the tools they need to meaningfully impact their relative's care.

8. Increase transparency for County spending under the Mental Health Services Act (MHSA) by requiring quarterly reporting on County website of MHSA spending (if not approved through state legislation).

9. Develop a Street Medicine pilot program in San Diego based on the USC model.

10. Using the Alzheimer's Project as a model, bring together relevant experts, researchers, clinicians, and philanthropic organizations as a convening panel to address the issue from multiple perspectives.

11. Conduct a study to assess the accuracy and efficacy of 5150 applications by law enforcement and consider possible alternatives.

STATE

12. Increase transparency for County spending under the Mental Health Services Act (MHSA) by requiring quarterly reporting on County website of MHSA spending.

13. Give local planning committees tools to expedite applications for outpatient CSUs and other services.

14. Conduct a study to assess necessary reimbursement rate for Medicaid inpatient and outpatient behavioral health services to promote the provision of services by health care providers.

15. Increase state Medicaid reimbursement rate for inpatient behavioral health.

16. Allow for state Medicaid reimbursement for intensive outpatient services and fund appropriately.

17. Allocate additional funding to the Health Professions Education Foundation (HPEF) to increase funding for scholarships and loan repayments for individuals pursuing college education and training for behavioral health careers. Specifically, backfill $10 million annually for the Mental Health Loan Assumption Program, which was previously funded out of MHSA dollars for state workforce education and training funds (program ended July 2017).

18. Have state apply for the Institutes for Mental Diseases (IMD) exclusion waiver through the Center for Medicare and Medicaid Services (CMS).

19. Allow MHSA dollars to be used for residential treatment programs.

20. Create a funding pool, possibly through HPEF, to support the development of medical career pathway programs and to facilitate connections between K-12, higher education, and industry organizations. Embed anti-stigma messaging into curriculum.

21. Grant provisional licensing to out-of-state health care providers if the state takes longer than X weeks to process their application for state licensure.

22. Develop a statewide program for addressing bullying in schools, including counseling services, recommendations on punishment, etc.

23. Allow providers possessing a post doctoral masters in psychopharmacology to prescribe medication in California.

STATE (CONT.)

24. Allow same day billing for behavioral health and physical health visits.

25. Allow paramedic units to transport to alternate destinations, including CSUs and other facilities that are appropriate for meeting the patient's needs.

26. Create a multifaceted state-wide public relations campaign to increase perception of risk of youth marijuana use.

27. Increase taxes on alcohol (beer) and utilize revenue for social service needs.

FEDERAL

28. Loosen the Institutes for Mental Diseases (IMD) exclusion restriction.

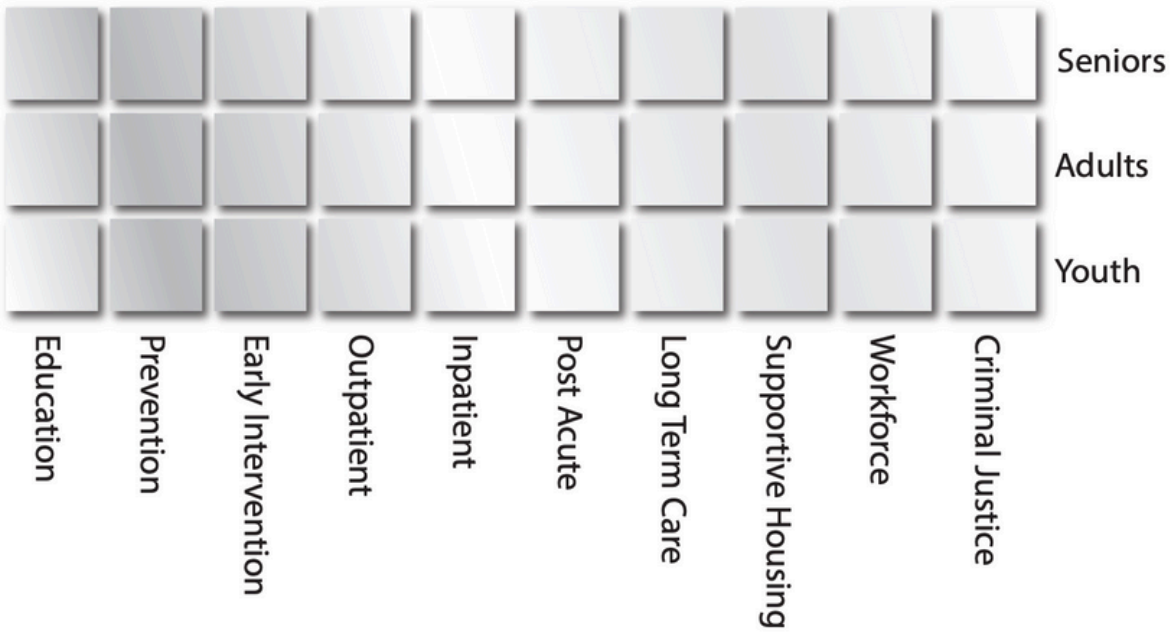
29. Make adjustments to the CMS Five Star rating system for Skilled Nursing Facilities (SNF) to eliminate or reduce disincentives for admitting patients being treated with psychotropic medications.

30. Lift the cap on Graduate Medical Education (GME) slots for primary care and psychiatry training.

SELECTED STAKEHOLDERS

Leaders and front-line stakeholders from the above organizations were consulted as part of this process. The presence of their logos is intended to demonstrate the breadth of outreach and is not intended to imply individual or collective endorsement of any of the policy and practice concepts listed.

LOCAL


Seniors
Adults
Youth
Education
Prevention
Early Intervention
Outpatient
Inpatient
Post Acute
Long Term Care
Supportive Housing
Workforce
Criminal Justice

CONCEPT

Create a multifaceted public relations campaign to improve awareness of behavioral health issues, reduce stigma, and promote the availability of services (funded by MHSA and local dollars).

PROBLEM

No best practice public relations campaign exists in California that addresses the three areas outlined above. While education and prevention programs would likely realize better ROI with focus on youth, it is imperative that all age groups be addressed as the nature of behavioral health illnesses may differ as one ages. San Diego County has the necessary resources and experience to create a best practice that can be shared with other regions.

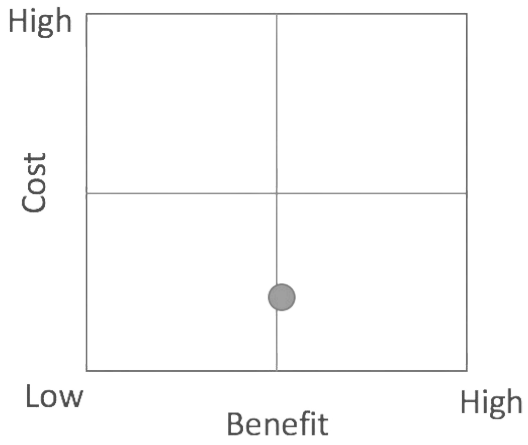
SUPPORTERS

All health providers, non-profits, advocacy groups, patients, family, etc.

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Leverage local government and non-profit organization funding to expand behavioral health prevention messaging in collaboration with existing drug prevention efforts.

PROBLEM

Current prevention messaging related to behavioral health conditions is sorely lacking; however, alcohol, tobacco, and other drug (ATOD) prevention messaging has been funded and highly successful when best practices have been utilized. ATOD prevention organizations are numerous (5,000 nationally) and are currently funded through a mix of federal and state dollars that are passed through County government to contracted prevention providers. Using this model and delivery system, increase funding to develop behavioral health prevention messaging in collaboration with existing drug prevention efforts.

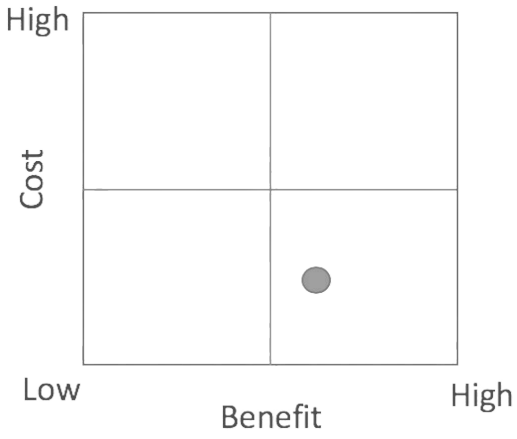
SUPPORTERS

Prevention advocates.

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Create a local pilot program for psychiatric urgent cares and emergency rooms (youth, adults, seniors).

PROBLEM

The current system of emergency care for psychiatric patients is insufficient to effectively address their needs. Utilization of existing LPS-designated emergency departments leads to ED overcrowding and boarding of behavioral health patients. Overcrowding negatively impacts patient care for both behavioral and physical health patients. Additionally, with reduced inpatient bed capacity across the state, the problem continues to grow. Far too many patients end up being admitted for inpatient care when they could likely be stabilized in under 24 hours if receiving appropriate care. (See Reference)

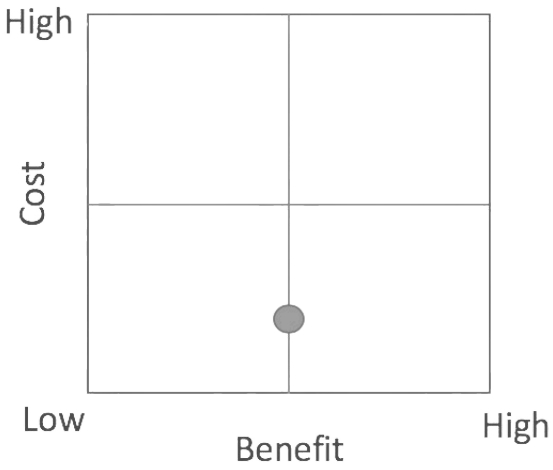
SUPPORTERS

Hospitals, EMS providers, law enforcement, patients, advocates

OPPONENTS

Some emergency physicians

COST TO BENEFIT



http://www.calhospital.org/sites/main/files/file-attachments/pes_model_mobile.pdf

CONCEPT

Increase County reimbursement to supplement Medicaid payments for inpatient behavioral health.

PROBLEM

The County of San Diego currently subsidizes Medicaid payments to elevate reimbursement rates for inpatient behavioral health services. While this is appreciated, unfortunately, the subsidies are insufficient.

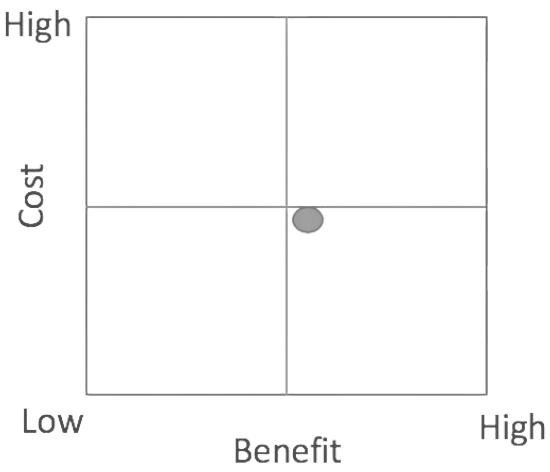
SUPPORTERS

Hospitals, patients, advocates

OPPONENTS

Budget advocates

COST TO BENEFIT



CONCEPT

Conduct a research study to identify the appropriate number of inpatient, post acute, and long term care beds for the County and develop a master plan for meeting those goals.

PROBLEM

The County of San Diego does not currently possess a behavioral health master plan for meeting the short, medium, and long-range needs of the community it is mandated to serve. Such a plan would include an analysis of demographic trends over time, consideration of the number of inpatient, post-acute, and long-term care beds required to meet population needs, and a strategic plan for building that capacity through public investment and public/private partnership.

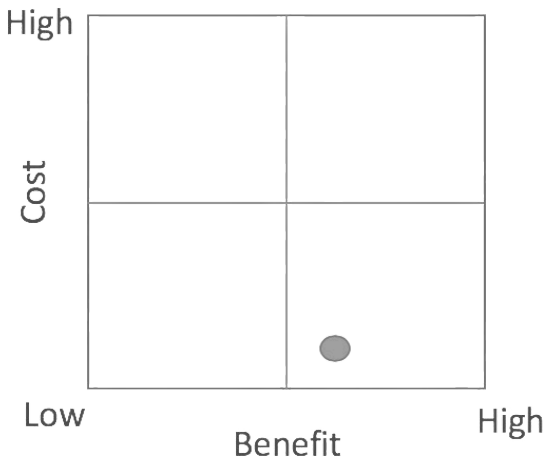
SUPPORTERS

Health care providers, patients, advocacy organizations

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Allocate local or private/philanthropic funding to subsidize select frequent utilizers to secure permanent supportive housing through ILF and BAC; attach funding availability with participation in County's ILF Association to ensure compliance with living standards.

PROBLEM

Many patient suffering from behavioral health illnesses are living on SSI/SSD payments of less than $1,000 per month. San Diego is one of the highest cost of living metropolitan areas in the United States. This leaves many vulnerable patients unable to afford housing. However, various living options exist in Independent Living Facilities (ILFs) and Board and Care (BAC) centers at a price that is slightly above SSI/SSD payments, or are available at lower costs but with questionable living accommodations. Simultaneously, the County of San Diego's Independent Living Association has had difficulty in recruiting members due, in part, to the standards expected for member ILFs.

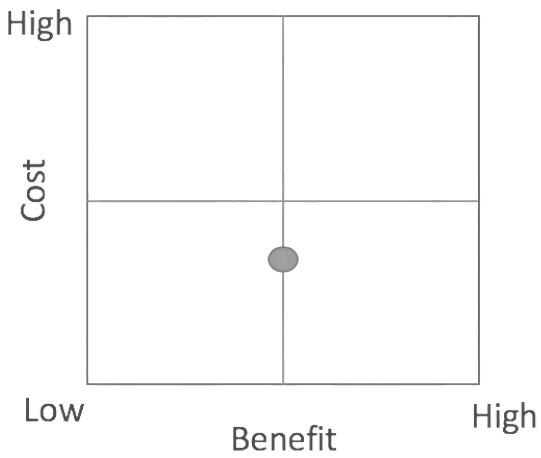
SUPPORTERS

Health care providers, patients, advocacy organizations

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Streamline the process for utilizing Laura's Law in San Diego County to afford family members the tools they need to meaningfully impact their relative's care.

PROBLEM

According to NAMI San Diego, "Laura's Law is a California state law that allows for court-ordered assisted outpatient treatment. To qualify for the program, the person must have a serious mental illness plus a recent history of psychiatric hospitalizations, jailings or acts, threats or attempts of serious violent behavior towards [self] or others. The law was named after Laura Wilcox, a mental health worker who was killed by a man who had refused psychiatric treatment." Unfortunately, bureaucratic barriers exist to the point where Laura's Law has only been successfully utilized in San Diego County a handful of times. Further streamlining of the process is needed.

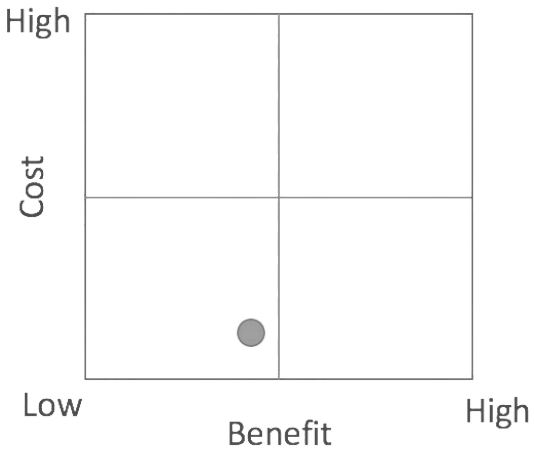
SUPPORTERS

Health care providers, advocacy organizations, families

OPPONENTS

Patient's rights advocates

COST TO BENEFIT



CONCEPT

Increase transparency for County spending under the Mental Health Services Act (MHSA) by requiring quarterly reporting on County website of MHSA spending (if not approved through state legislation).

PROBLEM

County spending under the MHSA has been less than transparent. This lack of transparency can result in a loss of public trust. As such, it can be difficult to track spending to ensure that it is being spent in a manner that is consistent with the intent of the MHSA and to the benefit of the people it is intended to serve. To remedy this, the County should require itself to report MHSA spending on a quarterly basis on a publicly available website, if not mandated by proposed state legislation.

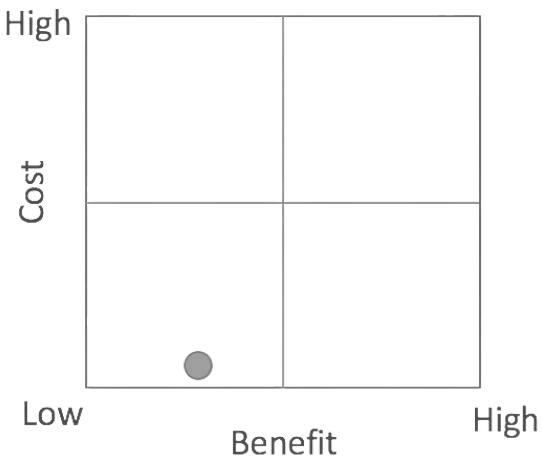
SUPPORTERS

Health care providers, advocacy organizations, watchdog groups

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Develop a Street Medicine pilot program in San Diego based on the USC model.

PROBLEM

Our unsheltered homeless population is arguably the most vulnerable group in our society. Rates of mental illness, substance abuse, and physical illness are high among this population and are present as both causes and effects of their living situation. The University of Southern California (USC) is addressing this need through a program referred to as Street Medicine. The Street Medicine program brings primary care services to vulnerable populations through a coordinated effort of physicians, physician extenders (PA, NP), medical students, social workers, and volunteers armed with medical supplies.

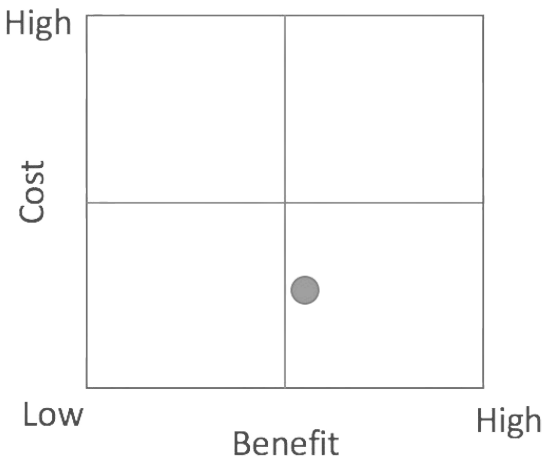
SUPPORTERS

Health care providers, social service agencies, academic institutions, advocacy organizations

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Using the Alzheimer's Project as a model, bring together relevant experts, researchers, clinicians, and philanthropic organizations as a convening panel to address the issue from multiple perspectives.

PROBLEM

Numerous groups convene to discuss a multitude of issues surrounding homelessness, behavioral health, alcohol and drug prevention, and more. However, none have been able to realize as much momentum and collaboration as the County's Alzheimer's Project. That project brought interested stakeholders from various perspectives together to discuss a better way forward and should be used as a model.

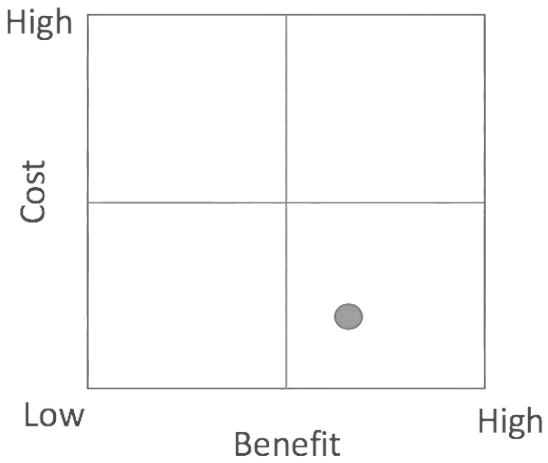
SUPPORTERS

Health care providers, social service agencies, academic institutions, advocacy organizations

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Conduct a study to assess the accuracy and efficacy of 5150 applications by law enforcement and consider possible alternatives.

PROBLEM

The 5150 application is a tool used by law enforcement to detain individuals who are suspected of being a danger to themselves and/or others so that further evaluation may be obtained. Patients held on this application are transported to Lanterman-Petris-Short (LPS) Act designated facilities—often at general acute care hospital emergency rooms—for evaluation. Unfortunately, at this time, alternate destinations are not available for such an evaluation. A large percentage of these patients are released from the hospital without needing inpatient care. Law enforcement officials have acknowledged that the 5150 may be applied too frequently due to a lack of better options.

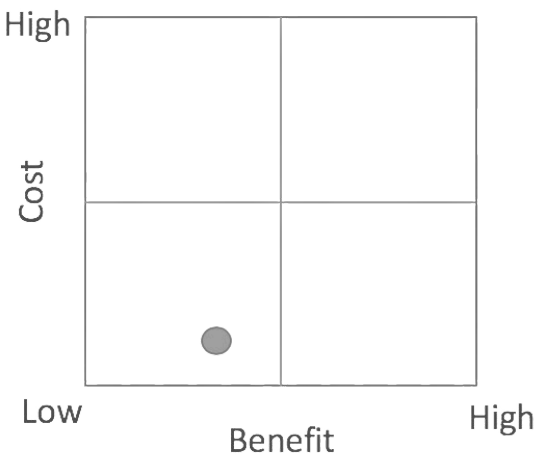
SUPPORTERS

Health care providers, patients, advocacy organizations, law enforcement

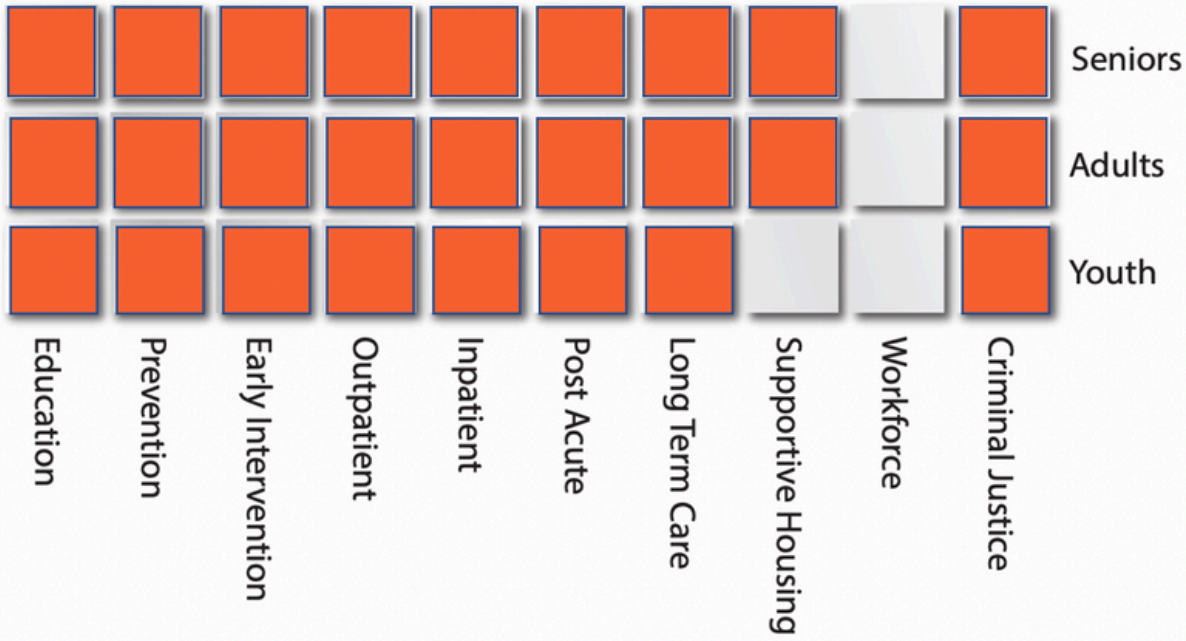
OPPONENTS

Unknown

COST TO BENEFIT



LOCAL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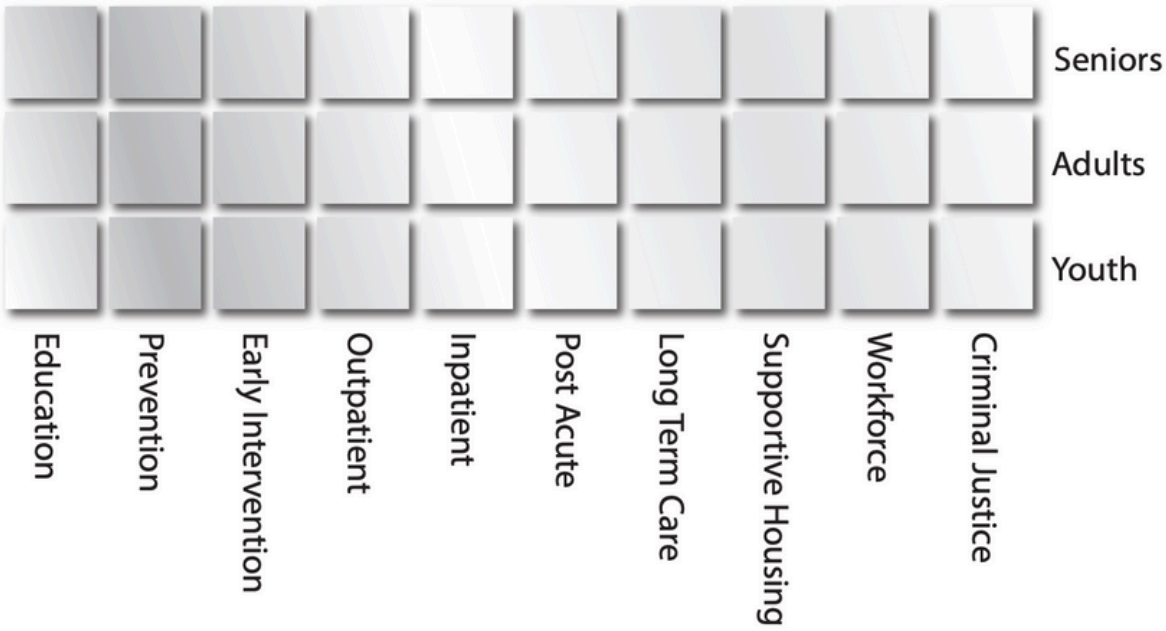
Long Term Care
Supportive Housing
Workforce
Criminal Justice

STATE


Seniors
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CONCEPT

Increase transparency for County spending under the Mental Health Services Act (MHSA) by requiring quarterly reporting on County website of MHSA spending.

PROBLEM

County spending under the MHSA has been less than transparent. This lack of transparency can result in a loss of public trust. As such, it can be difficult to track spending to ensure that it is being spent in a manner that is consistent with the intent of the MHSA and to the benefit of the people it is intended to serve. To remedy this, Counties should be required to report MHSA spending on a quarterly basis on a publicly available website.

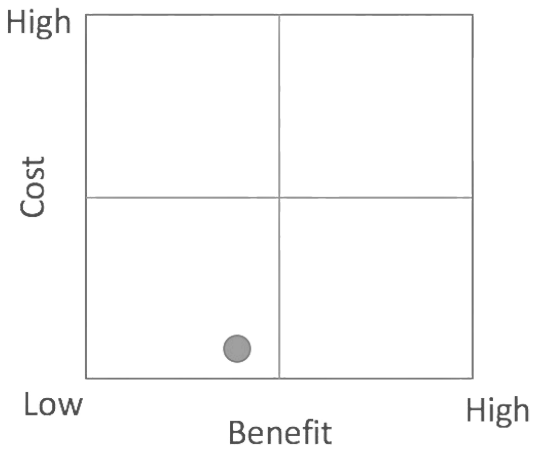
SUPPORTERS

Health providers, non-profits, advocacy groups, patients, family, etc.

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Give local planning committees tools to expedite applications for CSUs and other outpatient services.

PROBLEM

The phenomenon known as Not in My Back Yard, also referred to as NIMBYism, is one in which local planning groups face tremendous backlash from the local community when considering approval of plans for outpatient behavioral health programs, among other projects. This has resulted in a dearth of such facilities leading to a disproportionate number of patients requiring inpatient care, or often winding up in jail. Local planning committees should be given the tools necessary to expedite and approve such applications.

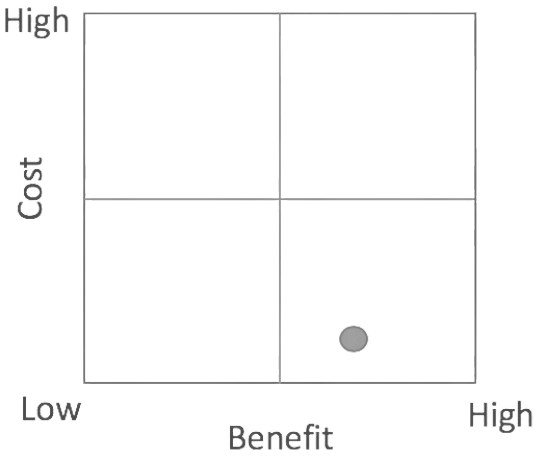
SUPPORTERS

Outpatient behavioral health providers

OPPONENTS

Community groups, homeowners associations

COST TO BENEFIT



CONCEPT

Conduct a study to assess the necessary reimbursement rate for Medicaid inpatient and outpatient behavioral health services to promote the provision of services by health care providers.

PROBLEM

It is widely known that reimbursement rates under Medicaid are insufficient and cause health care providers to suffer financial losses while treating publicly funded patients with behavioral health needs. While providers have consistently asked for an increase in such reimbursement, and the state has continually rejected such increases at the legislative and executive branches, it is important to understand the gap that exists between current reimbursement rates and necessary reimbursement rates to ensure that providers are adequately reimbursed for their services.

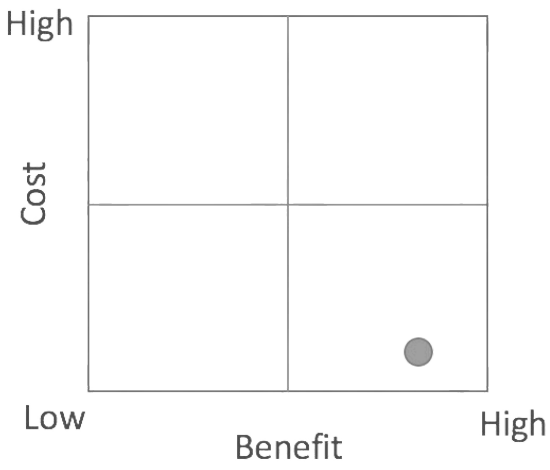
SUPPORTERS

Inpatient and outpatient behavioral health providers, patients, advocacy groups

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Increase state Medicaid reimbursement rate for inpatient behavioral health.

PROBLEM

It is widely known that reimbursement rates under Medicaid are insufficient and cause health care providers to suffer financial losses while treating public funded patients with behavioral health needs. It is important to close the gap that exists between current reimbursement rates and necessary reimbursement rates to ensure that providers are adequately reimbursed for their services.

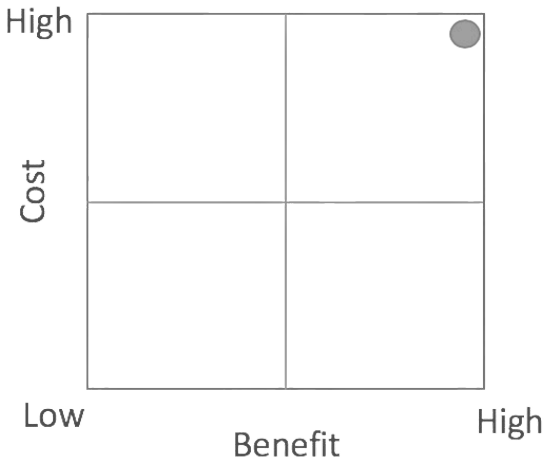
SUPPORTERS

Hospitals, advocacy organizations, patients

OPPONENTS

Budget restraint advocates

COST TO BENEFIT



CONCEPT

Allow for state Medicaid reimbursement for intensive outpatient services and fund it appropriately.

PROBLEM

Currently, Medicaid does not provide reimbursement for intensive outpatient services such as counseling and therapy. This dramatically limits the ability of socioeconomically disadvantaged patients to receive the outpatient care they need and increases the likelihood of them requiring inpatient care, a less effective and more costly way to deliver services.

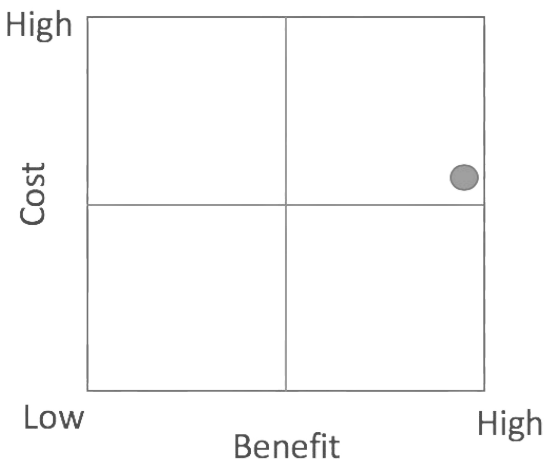
SUPPORTERS

Inpatient and outpatient behavioral health providers, patients, advocacy groups

OPPONENTS

Budget restraint advocates

COST TO BENEFIT



CONCEPT

Have the state apply for the Institutes for Mental Diseases (IMD) exclusion waiver through the Center for Medicare and Medicaid Services (CMS).

PROBLEM

CMS's long standing IMD exclusion has greatly limited the ability of inpatient behavioral health providers with more than 16 beds to be reimbursed through the Medicaid program. It has also discouraged the opening of larger stand-alone inpatient behavioral health hospitals. The recent announcement by Secretary Azar opens the door for states to apply for waivers to this exclusion. This has the potential to dramatically impact care in San Diego as it may allow the San Diego County Psychiatric Hospital to receive Medicaid reimbursement, a long standing complaint from the County of San Diego.

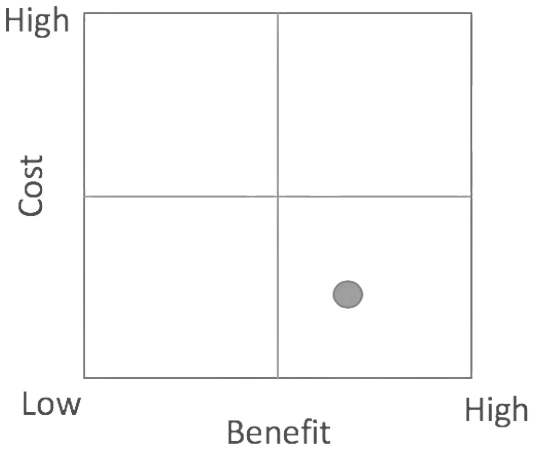
SUPPORTERS

Inpatient and outpatient behavioral health providers, patients, and some advocacy groups

OPPONENTS

Some advocacy groups

COST TO BENEFIT



CONCEPT

Allocate additional funding to the Health Professions Education Foundation (HPEF) to increase funding for scholarships and loan repayments for individuals pursuing college education and training for behavioral health careers. Specifically, backfill $10 million annually for the Mental Health Loan Assumption Program, which was previously funded out of MHSA dollars for state workforce education and training funds (program ended July 2017).

PROBLEM

While the state of California has the HPEF, it has not and is not making a sufficient financial investment in the program to produce enough behavioral health providers to meet demand, especially in medically underserved regions.

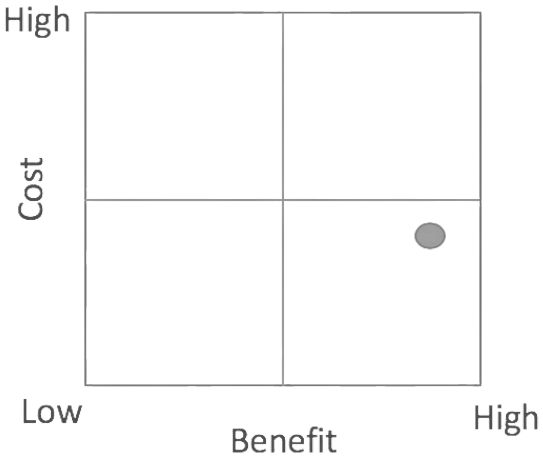
SUPPORTERS

Inpatient and outpatient behavioral health providers, patients, advocacy groups, educational institutions, prospective providers/students

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Allow MHSA dollars to be used for residential treatment programs.

PROBLEM

Currently, it is argued that the MHSA does not allow for funding of residential treatment programs. Residential treatment programs are non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with the individual treatment plan. Residential treatment services are provided in a continuum as per the five levels of American Society of Addiction Medicine (ASAM) residential treatment.

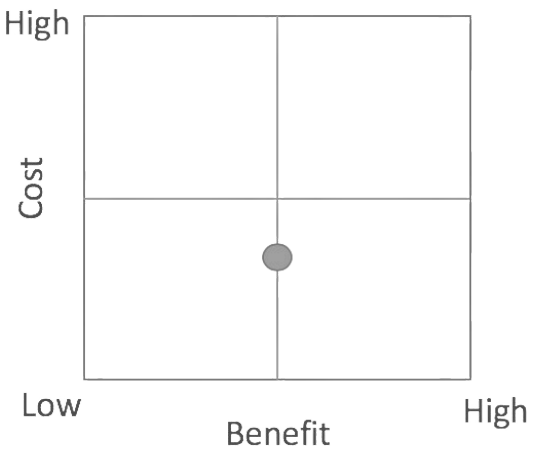
SUPPORTERS

Residential treatment providers, patients, advocacy groups.

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Create a funding pool, possibly through HPEF, to support the development of medical career pathway programs and to facilitate connections between K-12, higher education, and industry organizations. Embed anti-stigma messaging into curriculum.

PROBLEM

Medical career pathway programs prepare high school students for careers in health care; however, many lack the financial and curriculum support necessary to do that effectively and lack the connections to college/training facilities and industry partners to ensure continuity of the pathway from program entry to career. Dedicated funding and coordination through HPEF could help remedy this and make great strides towards developing the behavioral health (and physical health) workforce of tomorrow.

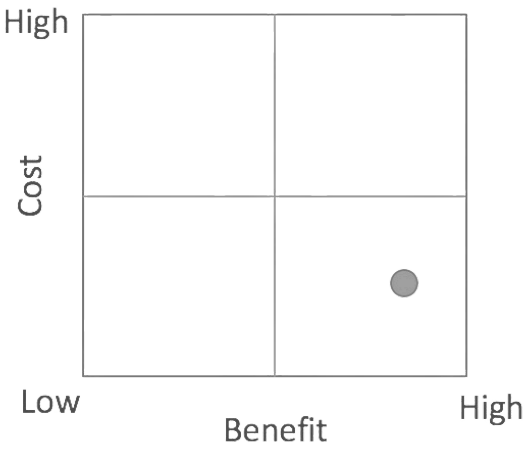
SUPPORTERS

Inpatient and outpatient behavioral health providers, patients, advocacy groups, educational institutions, prospective providers/students

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Grant provisional licensing to out-of-state health care providers if the state takes longer than X weeks to process their application for state licensure.

PROBLEM

The State of California takes too long to process the licensing applications of out-of-state health care providers who want to work in California. This has the effect of limiting the number of providers delivering care in California while also discouraging those in other states who may want to move to the state. Bureaucratic sluggishness shouldn't stand in the way of otherwise qualified applicants from other states willing to provide care in California.

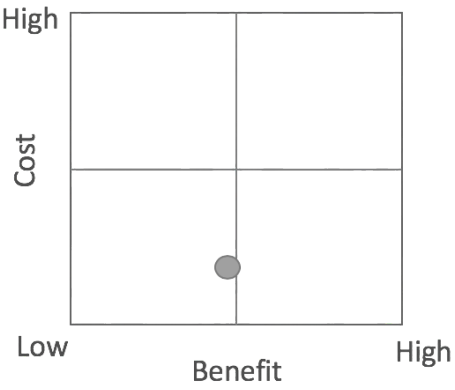
SUPPORTERS

Inpatient and outpatient behavioral health providers, patients, advocacy groups

OPPONENTS

Some provider associations

COST TO BENEFIT



CONCEPT

Develop a statewide program for addressing bullying in schools, including counseling services, recommendations on punishment, etc.

PROBLEM

Bullying continues to be a problem in schools and has been exacerbated in the internet era with a dramatic increase in cyberbullying. Many local educational institutions lack best practice information about ways to prevent and address bullying. A state standard in this arena may also include recommendations on the availability of counseling services, recommendations of effective punishments (or other methods to discourage bullying), etc.

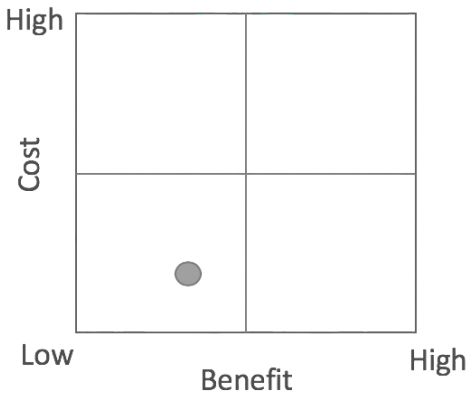
SUPPORTERS

School districts, educational leaders, teachers, advocacy groups

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Allow providers possessing a post-doctoral master's in psychopharmacology to prescribe medication in California.

PROBLEM

The State of California currently doesn't allow for providers such as psychologists who possess a postdoctoral master's in pharmacology to prescribe medication in this state. However, 5 other states currently do, including New Mexico (2002), Louisiana (2004), Illinois (2014), Iowa (2016), and Idaho (2017). By allowing psychologists who possess this additional education to prescribe certain medications, the state could increase the number of providers with prescribing authority and thus increase the capacity to help patients with certain behavioral health needs.

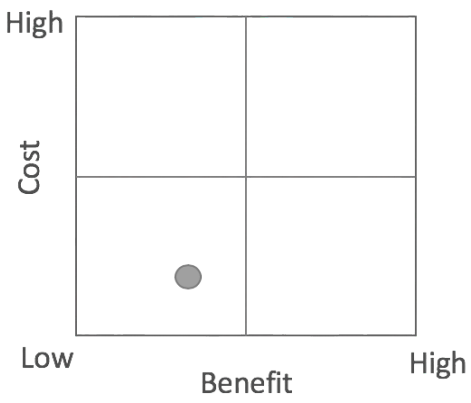
SUPPORTERS

Unknown

OPPONENTS

California Medical Association (CMA), California Nurses Association (CNA)

COST TO BENEFIT



CONCEPT

Allow billing for same day behavioral health and physical health visits.

PROBLEM

With certain exceptions, same-day billing is largely not allowed in the State of California. That is, patients needing both behavioral and physical health appointments are unable to receive both appointments on the same day because providers, such as community clinics that are focused on integrating physical and behavioral health under one roof, can not bill for both visits on the same calendar day. This disrupts the continuity of care and disproportionately impacts those who come from challenging socioeconomic backgrounds, as it requires them to travel or take time off work on multiple days to receive the care they need.

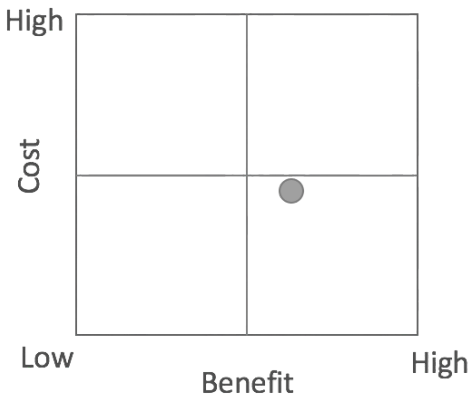
SUPPORTERS

Inpatient and outpatient behavioral health providers, patients, advocacy groups

OPPONENTS

Uknown

COST TO BENEFIT



CONCEPT

Allow Emergency Medical Services (EMS) units to transport to alternate destinations, including CSUs and other facilities that are appropriate for meeting the patient's needs.

PROBLEM

Under California law, EMS units staffed by EMTs and paramedics are limited to transporting patients to emergency departments at acute medical centers. As a result, many patients who may otherwise be effectively treated at a more appropriate level of care are transported to chaotic, noisy emergency rooms. By allowing EMS units to transport non-emergent patients to alternate and appropriate destinations, patients can receive care that is aligned with their needs while also saving the state the high costs associated with hospital stays.

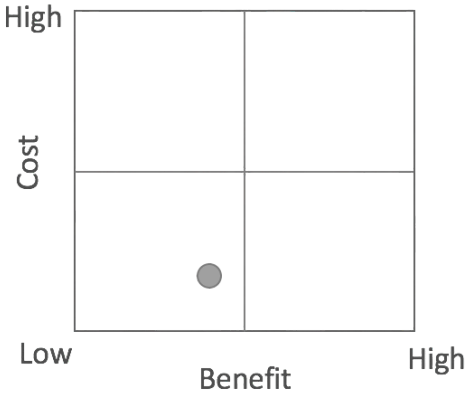
SUPPORTERS

California Hospital Association, California Emergency Nurses Association, California Paramedic Foundation

OPPONENTS

California Nurses Association, CalACEP (American College of Emergency Physicians)

COST TO BENEFIT



CONCEPT

Create a multifaceted public relations campaign to increase the perception of risk of youth marijuana use.

PROBLEM

With the legalization of marijuana, access and promotion have increased dramatically. There is strong evidence that adolescent marijuana use negatively impacts mental health (and use rates are higher in legalized states). Utilize success of CA Tobacco Control Program as model to implement statewide media campaigns and funding for local programs to prevent youth use.

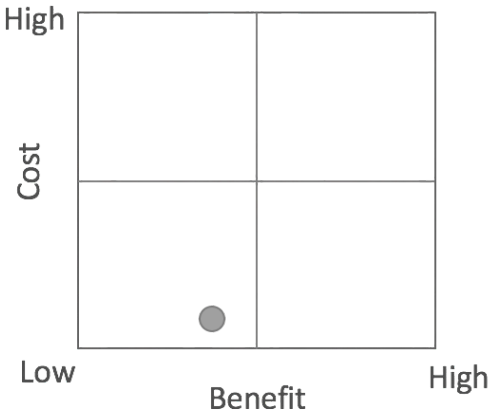
SUPPORTERS

Prevention advocates, schools

OPPONENTS

Marijuana industry

COST TO BENEFIT



CONCEPT

Increase taxes on alcohol (beer) and utilize the revenue for social services needs.

PROBLEM

California's excise tax on distilled spirits is $3.30/gallon, yet only $.20/gallon for beer and wine. Alcohol remains the most abused substance and is related to DUI, violence, sexual assault, etc.

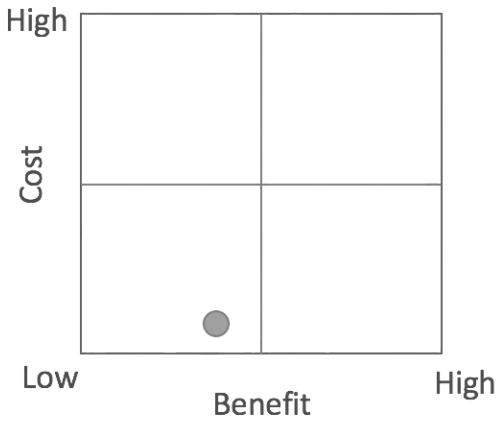
SUPPORTERS

Prevention advocates

OPPONENTS

Business (hospitality, brewers, etc.)

COST TO BENEFIT



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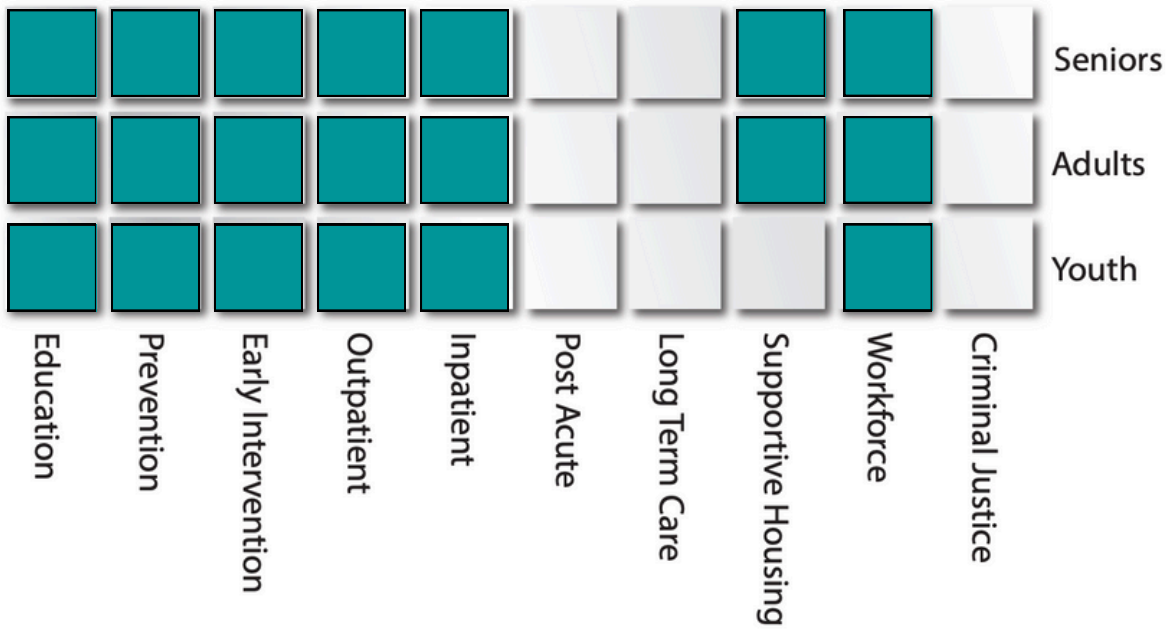
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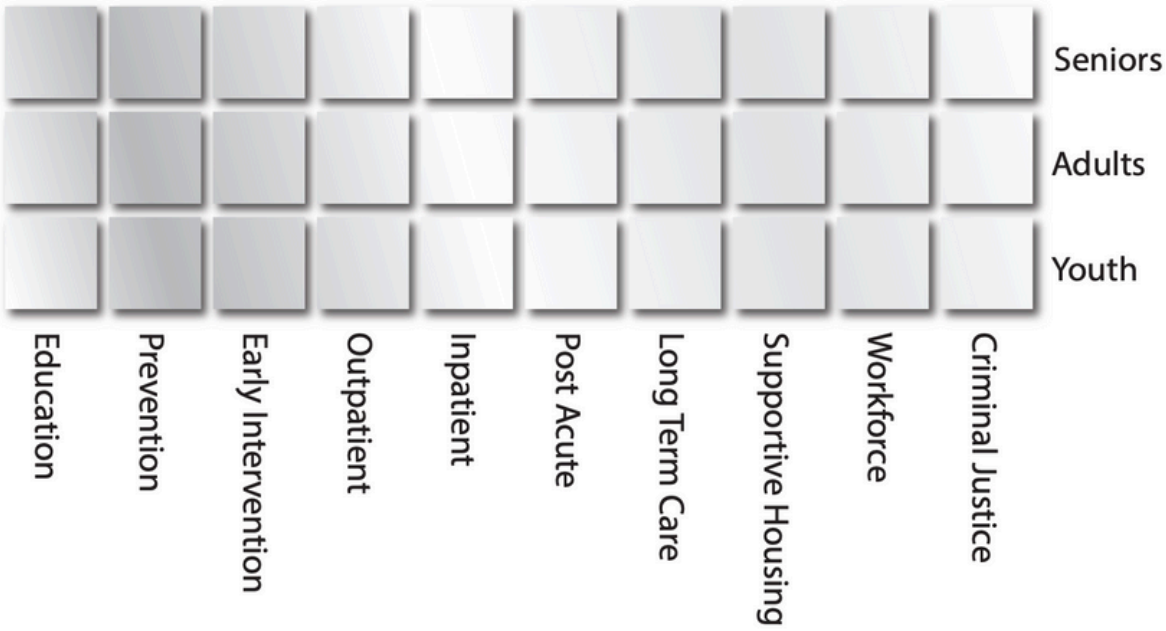
Early Intervention
Outpatient
Inpatient
Post Acute
Long Term Care
Supportive Housing
Workforce
Criminal Justice

FEDERAL


Seniors
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CONCEPT

Loosen the Institutes for Mental Diseases (IMD) exclusion restriction.

PROBLEM

"The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. The exclusion is one of the very few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21, and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services." (Reference Below)

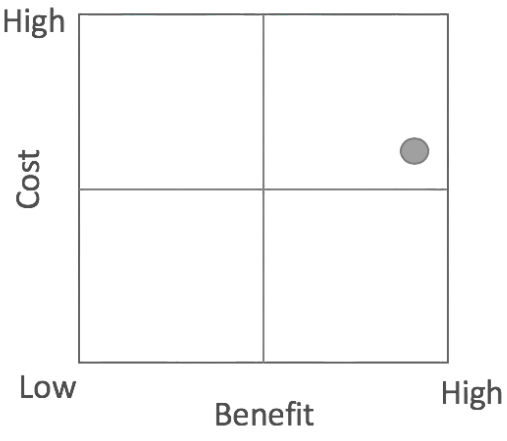
SUPPORTERS

Inpatient providers, some advocates

OPPONENTS

Some advocates

COST TO BENEFIT



CONCEPT

Make adjustments to CMS Five Star rating system for Skilled Nursing Facilities (SNF) to eliminate or reduce disincentives for admitting patients being treated with psychotropic medications.

PROBLEM

Current SNF rating system penalizes facilities for admitting patients on psychotropic medications; intended to prevent chemical restraint but has unanticipated consequence of discouraging new admissions and/or reduction in medications; results in more senior behavioral health patients held in inpatient units unnecessarily or repeated decompensation of patients.

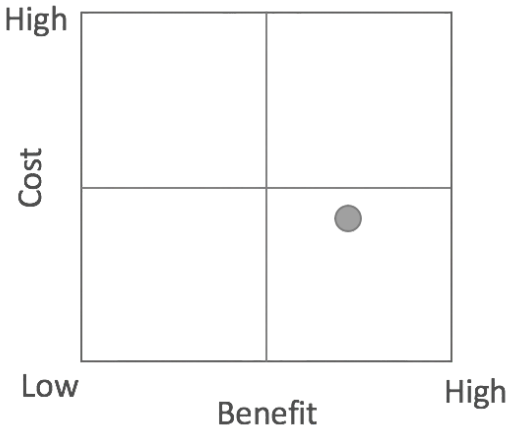
SUPPORTERS

Various health provider associations, advocates, patients

OPPONENTS

Unknown

COST TO BENEFIT



CONCEPT

Lift the cap on Graduate Medical Education (GME) slots for primary care and psychiatry training.

PROBLEM

There is currently a shortfall of primary care physicians and psychiatrists across the United States. Resident physicians who graduate from medical school typically spend additional years training in a particular area of specialty. Unfortunately, for many years, the number of Graduate Medical Education (GME) residency slots have not kept pace with demand. To address this, the federal government should increase the number of GME residency slots in these impacted areas.

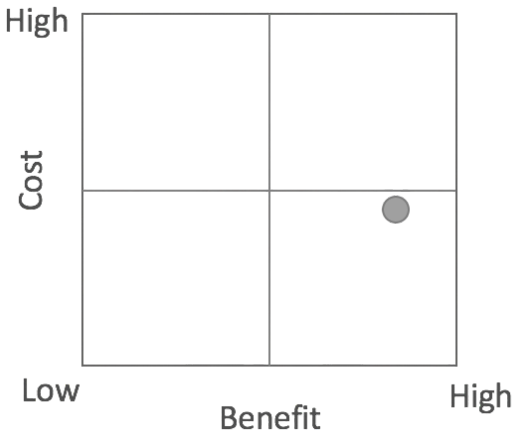
SUPPORTERS

Various health providers associations, advocates, patients, academic health centers, teaching hospitals, Association of American Medical Colleges (AAMC), America's Essential Hospital (AEH)

OPPONENTS

Budget advocates

COST TO BENEFIT



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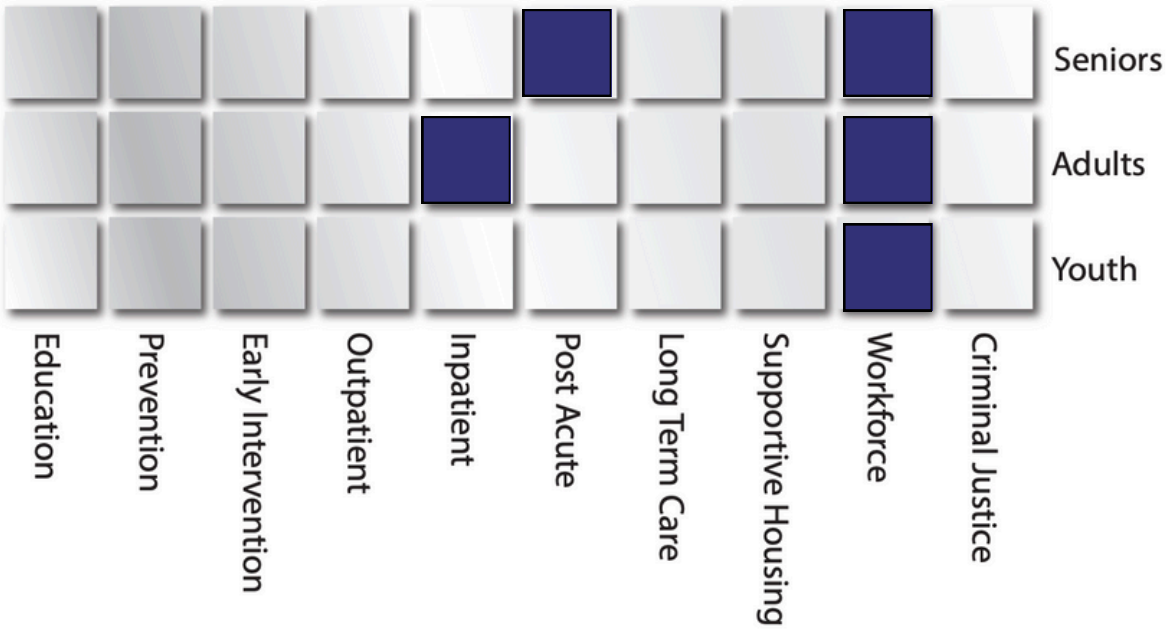
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