Comment #1

The basic structure is sound with the work divided among work groups with a steering committee. As I stated when this concept was first presented and as others stated during this initial call, the exclusion of non governmental stakeholders from the steering committee is problematic to many stakeholders. If there is a valid need (not expressed during the call) to have only the government interests (but also likely to include some non stakeholders who serve on the MHSOAC or MH Planning Council as well as some private health plans) it seems like at a minimum the meetings should be open to stakeholders to receive the meeting materials (they are all public records) and to be able to listen to the meetings or sit in the audience. If there is no clear overriding interest in the exclusion of stakeholders, then the steering committee should be broadened to include a select small group of consumer, family member and provider organization representatives.

The grid is fairly comprehensive but the workgroups have a large and unedited set of topics from excerpted from other documents. They need extensive editing to group together under various subjects and to develop a process to address each topic while needing to set annual priorities and multi year time frames and benchmarks for addressing each issue given that the total scope of work would be impossible to do all at once. Inevitably there will have to be special subgroups formed for specific issues. In addition, many of these will require consultation from experts outside of DHCS.

Comment #2

I attended Part I of the Stakeholder call on Monday, and I would like to express my interest in being an active member on the Green (Integration) or Blue (Data) subcommittees.

I am a licensed clinical and developmental psychologist at Health Plan of San Mateo with experience in integrating behavioral health programs into primary care, specifically within safety net providers/FQHCs. I have rolled out depression and anxiety screening as well as developmental delay screening in primary care settings. Currently I work at Health Plan of San Mateo, a COHS, aiding in the rollout of the mild-moderate Medi-Cal benefit. This work requires collaboration with Behavioral Health and Recovery Services (BHRS), our County’s behavioral health carve out provider. So I have been both an administrator and a provider related to Behavioral Health. Additionally, I am a Certified Information Privacy Manager, with expertise in HIPAA and data security and general Personal Health Information (PHI) management.

Two things I am very interested in working on are network development and best practice strategies for expanding access to services. I noticed that loan repayment is an item on the grid. Whenever I hear discussions related to expanding access, the push always seems to allow providers to participate with fewer years of education and/or experience. Usually the debate is around MFTs. I do not doubt that sometimes the utilization of MFTs and other therapists with shorter graduate school commitments and practicum hours allow for general expansion. However, there are many psychologists and licensed clinical social workers who not only have the expertise but the experience to treat complex cases, including individuals with concurrent medical disorders. The problem is that the reimbursement is much too low. Additionally, the “practice desert” areas are places devoid of providers generally. MFTs,
LCSWs, MDs – all of these providers prefer to live and work in urban settings. Opening the gate for more kinds of providers doesn’t solve the problem, as the problem stems from the fact that people in general do not prefer to work in rural areas sans specific motivation.

This is where loan repayment should be a first-line strategy for network expansion. If DHCS is not interested in expanding rates for providers, loan repayment can provide the same effect. To use myself as an example, I am still six figures in debt from my doctorate program. This debt prohibited me in the past from carrying a Medicaid caseload, as I needed to align myself with a fairly well funded agency that could pay me. The program from the Public Health Service and Health Service Shortage Areas are always full, even though I would have considered that an option. The much bally-hooed Loan Repayment Program under the Obama Administration has such onerous rules that very few individuals will ever qualify. One only has to look to current news to see that many individuals are graduating with large amounts of debt and that this is a very real issue.

This problem of ultimately unsustainable educational costs will result in fewer individuals pursuing graduate degrees, which will add to the shortage, which will in turn push the quality requirements lower in order to create networks. Arguably, families needing the safety net can be complex and we need providers with experience and motivation to serve them. Solving this problem will also solve a problem for managed care. We are responsible for maintaining a comprehensive network, and yet there is a paucity of providers. But the Department of Managed Health Care and DHCS are clear in their mandates that it is our problem to solve. We would like to solve it, but usually the only thing that ultimately works is to give providers more money. Loan repayment is giving them more money and ultimately helps with their financial security, giving them more career options.

So this is my feedback about the grid: I would like to see more items around network development and strategies for filling in gaps for desperately needed services, such as health psychology consultation. Research shows that behavioral interventions around chronic issues like diabetes result in better outcomes. And yet these are services that remain out of reach for individuals receiving services through Medi-Cal. Ultimately such things are cost saving measures and if we are rethinking behavioral health services generally, then let us move towards what we know works -- and make the best use of professionals who are already available.

Comment #3

As requested during the Behavioral Health Forum Kick-off (Part I) on March 24, 2014, we are submitting our feedback on the Behavioral Health Forum Issue Grid for your consideration. We hope this is helpful and look forward to the next Forum meeting!

Streamlining & formatting suggestions

- Consider consolidating Blue issues into systems development (1, 4, 6, 7, 8, 14, 15), specific research questions (9, 10, 11, 12, 13).
- Consider moving Blue 2 and 16 out of the data workgroup, possibly sending to Red or Green.
- Blue 5 might be too vague to do much with. Consider deleting it unless it can be elaborated upon.
- Consider eliminating duplicative issues. Here are some examples (there may be others):
  - Delete Green 9, which is covered by Green 15.
  - Delete Green 13, which is identical to Green 18.
  - Consider consolidating Green 21, 25, 28, and the MOU portions of 29 and 30 into a single MOU issue.
Green 8 and 10 both call for peer certification. Consider consolidating the wording in 10 into the list in Green 8.

Move the portions of Green 8, Red 2, and all of Red 18 into Purple 22, which can serve as the single home for the state certification issue.

Delete Red 33, which is covered in Red 17 (joint MH-SUD certification).

The use of an abbreviated sub-committee name in the left column, as occurs for purple section (“SUD-PL”, though we’re not sure what PL stands for!) is useful, and saves readers from having to refer to the legend at the bottom. Consider replacing “Blue” with “Data”, Green with “Coord / Integ”, red with “Delivery Systems.”

**Content Suggestions**

- Blue 1: To clarify, add to the third bullet “e.g. NQF and HEDIS measures.”
- Blue 3: While only clarification of MEDS access is mentioned here, the same could be said of many other important data systems including CalOMS, CSI, etc. We recommend expanding this issue to include DHCS data systems relevant to performance and outcome monitoring more generally.
- Blue 13: Add HIV screening to the bullet point on Hep-C screening. The data source would be the same (NSSATS covers both).
- Green 8: Consider adding a bullet that calls for a more thorough assessment of the SUD workforce size, composition, and professional capacity.
- Red 17: Consider adding sober living, other recovery services.
- Purple 24: To clarify this further, consider adding “Consider eliminating the DMC carve-out to facilitate integration of SUD services into settings other than specialty care.”

**Other feedback**

- We had difficulties with the webinar during the first BH Forum call, so we had audio access only. Hopefully the technology will be more cooperative for future calls!

**Comment #4**

I apologize in advance for the informal format of my comments, but I did want to meet your deadline set for today. I will comment first on the information contained in the forum itself, then the PowerPoint, and finally on the “Stakeholder Issues Grid”

**Forum Format:**

Dr. Baylor was noticeably absent from this and other stakeholder meetings. Her attendance would have demonstrated the department’s commitment this work.

The forum format results in more of a “show and tell” from DHCS. There should be a means for more interaction. Maybe a webinar?

Nowhere in the forum or in the accompanying documents were children’s issues addressed. The entitlement, definitions, services, functional impairments, and providers are vastly different in the children’s behavioral health system compared to that of the adults.

**PowerPoint:**

Slide 6: We have been asking DHCS to identify an individual or individuals who can respond to issues specifically related to children/youth. There are no positions on this organizational chart.
that fill that gap. Please provide us with a list of who we should approach on which issues specific to children and youth for both EPSDT SMHS and youth alcohol and drug services.

Power Point Slide 14: We are concerned that the “DHCS – Partners Behavioral Health Services Steering Committee” is staffed entirely of representatives from government agencies. We request, as we did on the call, that representatives from providers, legal advocates, youth, adult consumers, and family members be added to this committee.

Slide 15: While this proposed committee could be helpful to some members of these stakeholder groups, it appears to disregard the skills and level of involvement of many youth, consumers, and family members. Youth, consumers and family members should be involved similarly to other stakeholders and treated as equal partners, not segregated to a separate committee.

Slide 18: The coordination of care committee should be separated into two parallel committees: one focusing on the adult system of care, and one on the children’s system of care.

Slide 19: Evaluation and Outcomes. There are currently a great number of on-going efforts to develop and utilize meaningful measures for performance and outcomes evaluation across state departments, with several active projects existing in DHCS. Please confirm that these efforts will be integrated, or at the very least, inform each other.

Blue (data system issues): Please incorporate components already discussed and addressed through the EPSDT Performance Outcome System, and Katie A ACO.

Blue 7: This information has been gathered by similar projects. Please learn from those efforts rather than starting over.

Blue: Also add a requirement that costs of items under consideration or recommended are identified. Costs would include individual forms, training, data bases, staff time to complete the measures, scoring and interpretation of measures, and reporting of findings.

Blue: Add a requirement to ensure state wideness in all recommendations.

Blue: Add a requirement to ensure meaningful stakeholder involvement in all phases of the proposed system.

Green (coordinated system) and Red (strengthen delivery systems): Add elements which would enable private/contracted providers to receive information regarding changes in requirements directly from DHCS, similar to the relationship CMHDA and CSAC have with the state.

Comment #5

We would like to add a comment to “Blue 5”

-Improve care and quality using health information technology-

Comment>

As we are moving rapidly towards consumer/patient centric care delivery models, consumer point of use mobile technologies which are dependent on consumers’ technical and interpretation skills, and their health literacy levels need to be assessed along with the traditional clinical assessment during their first
clinic visit. This ensures successful deployment of device and accurate data being captured for treatment outcome evaluation.

**Reference> page 4 diagram**


**Comment #6**

Blue 6: Add Language

Establish a baseline expectation of no longer than every 3 years for regular modification/updates of data systems in order to ensure that needed changes can be made*

*this request based on being told, “we can add that data element because it’s too expensive/time consuming/difficult to change our system.”

Blue 14: Add Language

Make data readily available to qualified outside researchers in order to improve and broaden data analysis and interpretation

The phrase “multiple services in the same day are reimbursable” (Green7) is mentioned several times in the document, but phrased differently each time, sometimes as a strong recommendation, other times as something DHCS might like to consider. I’d advocate for strong recommendation.

Green 10: Add Language

DHCS should then take steps to submit a State Plan Amendment to define the scope of work of the specialists, in accordance with the CMS rule change which allows preventive services to be provided by non-medical personnel.

SUD PL 22: Add Language

Any background checks should not automatically disqualify individuals who were imprisoned for drug-related and alcohol-related offenses, and such individuals should be recognized as having valuable experience to offer.

Red 11: Add Language

Add: Stronger monitoring and oversight by DHCS of the HIV Set-Aside expenditures.

Add: Consider reevaluating how the HIV Set-Aside funds are distributed by considering other models for making the most effective use of the dollars (such as retaining some funds at the DHCS level to fund a full time position to provide technical assistance and oversight.)
Comment #7

I am sending this email on behalf of Californians for Safety and Justice. Please excuse our slight delay in getting this to you. We have limited our comments to a few areas of intersection with the criminal justice system that we believe may need to be further defined in the issue grid. Specifically, we propose adding and/or amending the following:

Additional issue for the Blue group: Determine how behavioral health data collection, evaluation, and information sharing can be integrated with CDCR and county jail providers.

Green 11: Amend to include timely information exchange with CDCR and county jail behavioral health providers.

Additional issues for the Red Group: 1. Develop a streamlined pre-release enrollment process for CDCR inmates; 2. Ensure that benefit exclusions (including interpretations of medical necessity) do not prevent appropriate coverage of court-ordered behavioral health treatment.

Comment #8

Thank you for your email. ACHSA, which represents over 85 nonprofit community mental health and child welfare agencies in Los Angeles County, would like to share the following feedback regarding the issue grid:

1) We would like to see added something focused on maintaining the State’s current mental health carve out, which we believe best serves the mental health needs of Californians with serious mental illness.

2) We believe there should be a separate subcommittee focused specifically on all of the fiscal related issues, which are currently scattered in several places in the document. These include: 1) Explore new approaches to purchasing MH/SUD services (Green 3); 2) Develop longer term fiscal models… (Green 6); and 3) Establish effective policy and processes for purchasing services (Green 7). Given the importance of these issues, and their obviously inter-connected nature, we believe that they should be discussed together in a separate fiscal subcommittee.

Comment #9

What an amazing list of things to do. I'm sure some of them are already at least partly in place now that would be interesting to know.

Several issues in SUD-PL 14 are not currently accepted standard of care. Use of residential programs should be determined by placement criteria, not sure why all SUD clients would need residential.

Also there is no need to pit social model vs medical model in the 21st century. Psychosocial and medical care should both be available at any level of care when needed.

Of course I see there is overlap and some redundancy, I assume that is OK at this point.

Thanks for sending it for review.
Comment #10

Thanks for the opportunity to comment on this well-constructed grid.

I probably missed it but I think under either integration or strengthening, there ought to be something about:

- Standardize benefits and levels of service across Counties and Plans to permit clear and precise MOUs and to strengthen all providers’ and members’ ability to seamlessly transition between the Plans and the County Mental Health and SUD services.

Comment #11

Regarding Day Treatment (see red):

RED-17-Develop a joint certification for MH and SUD service providers and sites. Create a special workgroup to review and recommend a set of organizational certification standards for outpatient, day treatment, and residential programs.

I am concerned that this workgroup may not represent the interests of current day treatment providers, so I am recommending this be added.

That is, counties appear to want to replace the day treatment modality with the Intensive outpatient modality. This makes them more money but it is destroying a workable model with an ungainly one. The reasons against this have already been sent but here are my comments again:

Day Care Habilitative (DCH) is a different modality from Intensive outpatient (IOP). It is the step between residential and outpatient. We currently have a perinatal program that has both (hybrid DCH-IOP). Both modalities provide childcare and transportation but here are the key differences:

- DCH = Services are billed per person, per day unit. It is a comprehensive unit of service that includes a treatment team (drug therapy, health education, mental health counseling, parent-child interaction/observation, parenting classes, case management, etc.). A minimum of 3 hours a day, 3 days a week (we do 4.5 hours a day, 4 days a week). Charting is per week and only the drug therapist must be registered or certified as an AOD counselor. Group size is not limited to 4-10 as it includes a therapeutic community component. Cost = approx. $75 per day unit. It is also strongly recommended that there be no restriction on size because a lot of this work is milieu work, which is another recommendation that has also been recently proposed.

- IOP = Services are billed per activity, a minimum of 2 x 90-minute groups a day (only one billed to DMC unless it is a different modality, at which time ADP form 7700 is used), 2-3 days a week. All staff who bill must be registered/certified as an AOD counselor and each service is charted. Each client is assigned a “primary counselor” and the team concept is replaced by individual caseloads. Groups size is 4-10 so the program becomes weighed down by the need for more AOD staff at the expense of other specializations (e.g. MH, case mgmt, health ed.). Cost = 2 groups, maybe an individual, per day (e.g. $60-$120 per day). Charting also becomes a very heavy administrative cost because each service is charted (vs. per week), which further takes away from service capacity (e.g. case management, home visits).

We are certified to provide both DCH and ODF (outpatient drug free, which includes IOP). DCH and IOP are qualitatively different. If just the name is changing, that is one thing. But if the billing structure of
DCH changes to the expanded ODF, like we have now, it is incredibly cumbersome, it has totally bastardized our DCH program, and has repeatedly been found to be ineffective in our County – our DCH program has been sustainable for over two decades whereas ALL County perinatal IOP clinics have closed over the last two decades. However, we have been forced by the County to add this IOP component (I am not sure why they keep pushing this modality over DCH other than it brings them more money, at the expense of the treatment functionality of our perinatal services, and because they were not certified by ADP to do DCH per se).

Hence, another concern I have is that if the only voice DHCS listens to are County representatives, then DHCS will be misinformed (as evidenced by their promotion of IOP [the expanded ODF version] in place of DCH). Please keep the non-County providers in mind as they are often on the ground, doing the actual work. For example, CAADPE is a body that represents non-County providers.

**Comment #12**

As per your request, the grid comments are attached. *(considerable detail and work went into this feedback)*

**Blue Subcommittee (Data)**

Blue 1-

Overarching concern: Because SUD professionals providing services in California are poorly regulated (no license, varying standards for certification, licensed and untrained providers from other professions) it is critical that any outcome measurements be indexed to the quality of the treatment given. Regardless of the treatment setting, it is important to consider the level of skill, experience, and education present in the performance of counseling, which is the preponderance of the input of treatment.

Data collection regarding the workforce, which is de facto capacity, is outdated, nonexistent, or not California-specific. Data about the size and capabilities of the workforce is urgently needed. Data about the workforce needs to be added here.

Blue 7 - Same as Blue 1

Blue 9-

Need to compare enrollment data between all sets of insured. What is the rate of enrollment outside of the Affordable Care Act and between Covered California and the Medicaid expansion population. If there are different rates for mental health and substance use disorder patients, what is the difference and what factors contribute to the difference.

Blue 10-

Again, compare rates to different types of insurance and explore factors that generate differences.

Blue 11-

Why compare only to existing Medi-Cal use? The access and provision of care should be compared to private insurance as well. If there are gaps, recommendations to close them need to be made in this process.
Blue 13-

Bullet 1 - Cost savings for treatment impact numerous systems in California. Foster care, emergency room costs, incarceration and domestic violence should also be evaluated.

Bullet 6 - Consider studying these variances between carriers. Is the lack of access to MH/SUD services more prevalent under one or more plans? Also, consider comparing severity when assessing crossovers between the two systems. At what level of care is the natural consequence of loss of employment (and benefits) prompting a change in insurance status? At what severity level are patients "too costly" to insure?

Blue 14-

Bullet 5 - Consider the use of pilot projects to “think outside the box.” For instance, a pilot project where certified counselors are reimbursed for private practice where SUDs can be treated at lower levels of severity could yield cost saving results. Wherever possible, the “new system” should borrow from the private insurance market. If SUD patients at Kaiser are screened early and given care at low severity rates, this should be the goal for this system as well. There needs to be inventive thinking about how to replicate cost saving measures.

Bullet 6 - Again, the comparison of county success or failure rates needs to be evaluated according to the level of competency of the workforce.

Green Subcommittee (Coordination/Integration)

Green 8-

Bullet 2 - There needs to be discussion about whether the state needs to be the certifying agency, or whether it needs to strengthen its ability to regulate the private entities who do and verify the credentials they award.

Bullet 2.5 – The majority of states (including the vast majority of populous states) offer a license for the SUD profession. At the very least, any workforce development discussion should include this topic. This committee should be tasked with performing a Sunrise Review Regulatory Request for this profession. One was done by UCLA more than 15 years ago and is in critical need of updating.

The lack of access to licensed professionals who are specialists in SUD treatment is a gaping hole in California’s treatment system. This committee needs to evaluate how licensure of SUD counselors in other states impacts SUD access and treatment outcomes. Massachusetts has an interesting study delineating this issue. Other states with previous experience with “universal healthcare” also have valuable data to suggest that access to care from licensed professionals is essential.

Bullet 6 – Add scholarships to offset certification and testing fees. Also add language that specifies that loan forgiveness be extended to all levels of education and include SUD students.

Bullet 9 – Cross training is an inappropriate term. Cardiovascular doctors are not “cross trained” to treat orthopedic cases. A knowledge of and ability to refer between MH and SUD is desirable. The idea that someone can be cross trained to be competent in actually providing services is dangerous and short sighted. If a lack of SUD treatment providers is the problem, it needs to be addressed.
Bullet 10- Marriage Family Therapists and Certified SUD counselors need to be included for billing purposes only within their scopes of practice and area of specialty. Marriage Family Therapists receive very little education (15 hours) and no experience requirement for the treatment of SUD. They are also not tested for competency in this area.

Green 9-

The issue of WHO can sign off on evaluations for MH and SUD needs to be delineated. SUD counselors needing signing from other licensed professionals with less education and experience and education in the area of SU disorders needs to be reviewed. Better coordination is needed.

Green 10-

The term peer specialist needs to denote “mental health peer specialists.” The term peer specialist for SUD is an antiquated term used in the infancy of the professional development for this area of specialization.

Green 30 –

Any “menu” of services developed should include a designation as to what type of program or individual could competently provide each menu item.

There is no bullet about utilization or access to care. There must be an evaluation of what care is being used and at what severity level. If managed care is “managing” SUD patients out of care due to severity and cost, this needs to be documented.

Green 40 –

Add access to private practitioners for SUD treatment.

Green 42-

Treatment needs to be “unhitched” from programs. There is a need to access SUD treatment in the same settings that MH care is available. A person shouldn’t have to go to a treatment center as his or her only means to receive counseling for SUDs.

Red Subcommittee (Strengthen Delivery Systems)

Red 2-

Bullet 6-

Certification was better placed in the Green category as that is where professional issues and workforce development needs are addressed. The language in this bullet is better however. It should replace the single agency language in Green 8, bullet 2. Either way, it should NOT be the responsibility of two committees.

Red 2-

Bullet 16 – A standardized contract seems extremely vague. Each type and level of SUD care has different needs and should have different components. Need to specify this in this bullet.
Red 5-

Bullet 8-Same as Bullet 16.

Red 6-

Bullet 2 – Increasing capacity does not occur via creating an umbrella organization. The bed limitation needs to be the focus of this bullet.

Red 18-

Although a meaningful topic, a single agency for counselor certification needs to be with the Green committee. Remove this bullet. Consumers and stakeholders would have a difficult time reporting to three committees about this subject. There will be many crosscutting issues. This will be one of them, but it does not need to be in three committees.

Red 21 –

This item needs to be moved to the discussion about private practice and licensure. This category is, for all intents and purposes, private practice with no competency requirements and little consumer safeguards. It needs to be eliminated and replaced with licensure.

Red 25 –

This item is antiquated. There is no “switching” between treatment approaches. Each needs to be valued. Each needs to have quality parameters and an ability to be reimbursed. Clinical and social approaches are seen in various levels in a blended fashion throughout California. This bullet needs to be removed. It doesn’t make sense in today’s treatment environment.

Red 31-

Bullet 1 -Accountability measures must be aligned to treatment populations. Programs providing services to difficult and severe cases must not be penalized for “lack of clinical success.”

Bullet 2- A pilot project for reimbursement for private practice for certified SUD counselors would be an excellent example of this.

Purple 3-

Improving the competency and ethical component of those directly delivering the services needs to be inserted here.

Purple 13 –

Same as purple 3.

Purple 14-

Add access to private practitioners to this list.

Purple 22 and 23 –

These items need to be moved to Green subcommittee. All counselor professional certification and licensure issues need to be grouped together.