CalAIM Behavioral Health Workgroup

December 1, 2023

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Housekeeping

- Members of the public will be able to comment at the end of the meeting.
- Workgroup members can participate in the “chat.”
- Workgroup members are encouraged to turn on their camera.
- Please mute yourself if you’re not speaking.
- Use the “raise hand” feature to make a comment during the discussion period.
- Live closed captioning is available – you can find the link in the Chat.

Agenda

10:00 – 10:05: Welcome and Overview

10:05 – 10:35: BH-CONNECT Overview and Updates

10:35 – 11:00: Discussion

11:00 – 11:15: Behavioral Health Documentation Redesign Program Overview and Updates

11:15 – 11:30: Discussion

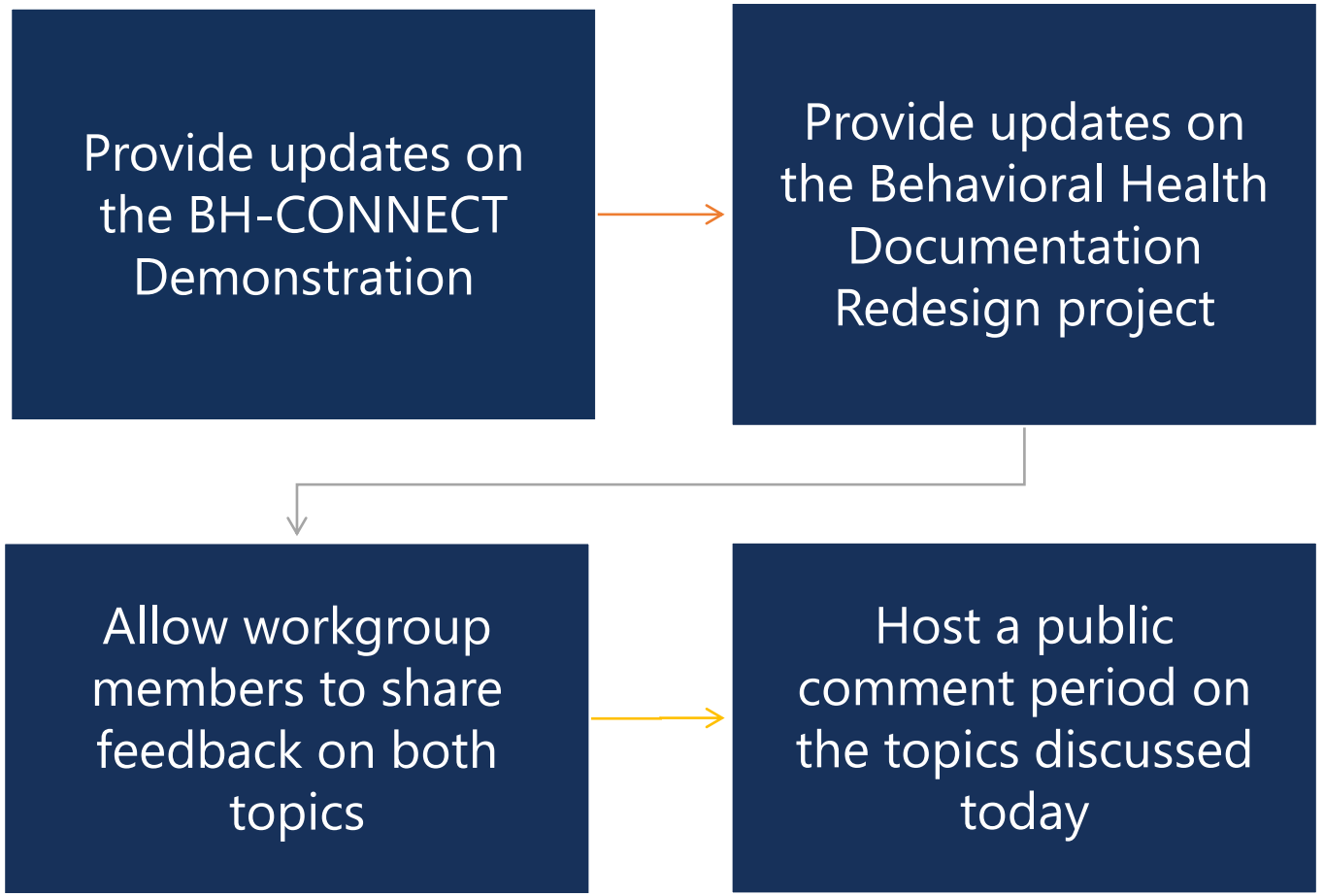
11:30 – 11:35: Wrap Up & Next Steps

11:35 – 12:00: Public Comment

Welcome & Introductions

- **Tyler Sadwith**, Deputy Director, Behavioral Health, DHCS
- **Paula Wilhelm**, Assistant Deputy Director, Behavioral Health, DHCS
- **Erika Cristo**, Assistant Deputy Director, Behavioral Health, DHCS
- **Ivan Bhardwaj**, Chief, Medi-Cal Behavioral Health - Policy Division, DHCS

Workgroup Meeting Objectives



BH-CONNECT

DHCS

Updates on BH-CONNECT Section 1115 Demonstration Request

DHCS

BH-CONNECT Section 1115 Demonstration Submission Updates

- **Public Comment Period.** From August 1, 2023 to August 31, 2023, DHCS held a public comment period on the proposed BH-CONNECT application. During the 30-day comment period, DHCS received 98 public comments
- **Response to Public Comment.** DHCS addressed stakeholder feedback received during the public comment period and revised the final application in advance of submission to CMS.
- **Submission to CMS.** DHCS submitted the BH-CONNECT application for CMS review on October 20, 2023.
- **Demonstration Go-Live.** The BH-CONNECT demonstration will be implemented on a phased timeline to ensure ample time for successful implementation. Pending CMS approval, DHCS anticipates the first components of BH-CONNECT will go-live as soon as January 1, 2025.
- **Ongoing Stakeholder Engagement.** DHCS is committed to engaging with stakeholders on an ongoing basis throughout the design and implementation of BH-CONNECT.

Find the BH-CONNECT Section 1115 demonstration application and public hearing materials posted on https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

Application Changes Following Public Comment

In August 2023, DHCS received 98 comments on the BH-CONNECT application. DHCS included responses to public comments in the application that was submitted to CMS.

- **Activity Stipends.** Many commenters made recommendations on the age criteria for Activity Stipends and on activities that should be covered. Others made recommendations on how to distribute and oversee Activity Stipends. **DHCS updated the application language to remove the age limitation and will consider making Activity Stipends available for children ages 0-2.**
- **Workforce Initiative.** Many commenters expressed support of DHCS' investments in California's behavioral health workforce through the workforce initiative. Multiple commenters shared recommendations for the design and implementation of the initiative. **DHCS revised the application language to make more explicit the workforce initiative's focus on expanding access to EBPs and will continue to engage stakeholders on the design of the initiative.**
- **Transitional Rent Services.** Many commenters supported the proposal to cover transitional rent services for up to six months for eligible members. Some commenters recommended updates to the eligibility criteria. **DHCS updated the application to clarify that "correctional facilities" include state prisons, county jails, and youth correctional facilities. DHCS also updated its modifications to the HUD definition of homelessness to make it easier for Medi-Cal members to access transitional rent.**

Continued Partnership with Stakeholders

DHCS will continue to engage with stakeholders on areas highlighted in public comments that didn't require immediate changes to the Section 1115 application. For example:

- **Cross-Sector Incentive Program.** Several commenters supported the establishment of the cross-sector incentive program. Multiple commenters suggested expanding the cross-sector incentive program to include county probation departments. **Based on initial implementation experience, DHCS may amend BH-CONNECT in the future to potentially expand this program to juvenile justice, the Department of Developmental Disabilities, and/or the Department of Education. DHCS will work closely with stakeholders on this.**
- **Statewide Incentive Program and Incentive Program for Opt-In Counties.** Commenters supported the concept and goals behind the incentive programs but asked for more detail on specific measures and implementation. Others suggested additional measures and data sources to inform the program. **DHCS is committed to working closely with stakeholders to develop the measures for the statewide and opt-in incentive programs.**
- **BH-CONNECT Features Not Included in Section 1115 Request.** DHCS received many comments on features of BH-CONNECT that do not require Section 1115 demonstration authorities, including features for children and youth, Centers of Excellence, and new EBPs such as Assertive Community Treatment (ACT), Forensic ACT, Coordinated Specialty Care for First Episode Psychosis (CSC for FEP), Supported Employment, Clubhouse Services and Community Health Worker (CHW) Services. **DHCS is committed to working with stakeholders on an ongoing basis on the design and implementation of these features.**

Deep Dive: Select BH-CONNECT Features

Assertive Community Treatment

Overview: Assertive Community Treatment

As part of BH-CONNECT, DHCS intends to cover Assertive Community Treatment (ACT) as a Medi-Cal service. All counties will have the option to implement ACT. Counties that opt-in to receive FFP for care provided during short-term stays in IMDs will be required to provide ACT to members for whom it is clinically appropriate.

ACT provides a **person-centered, comprehensive approach to care** for individuals living with serious mental illness (SMI).

There is a **robust evidence base for ACT**. ACT is one of the most comprehensive community-based and cost-effective treatment options to reduce the need for institutional care and support individuals living with SMI who are at risk for criminal justice system involvement and for homelessness.

California is in the minority of states that do not fully cover and reimburse ACT through Medicaid. As of 2018, 33 states offer ACT as a Medicaid service.

DHCS does not have comprehensive data on how or where full-fidelity ACT programs may be operating in California today. Some counties may incorporate ACT within their Full Service Partnership (FSP) programs, but there is no statewide inventory of where this may occur or how it is being done.

Components of ACT can be funded via Medi-Cal SMHS, MHSA FSP programs and other local funding. However, full fidelity ACT cannot currently be billed as a bundled service under Medi-Cal. By covering ACT as a Medi-Cal service, **DHCS intends to optimize FFP for ACT services** and help ensure ACT is available to members for whom it is clinically appropriate.

Overview: ACT Workgroup

Between April and November 2023, DHCS convened a small workgroup of subject matter experts to discuss key considerations for implementing ACT in Medi-Cal. The workgroup shared their experience and expertise with ACT to support DHCS' goal of designing a service that meets the needs of Medi-Cal members while retaining fidelity to the evidence-based model.

Members

- Workgroup members brought perspectives on ACT implementation statewide and in other states, and included representatives from:
  - County Behavioral Health Agencies: Nevada County, Solano County, Alameda County, San Diego County
  - Experts at Academic Institutions: UCLA, UCSF
  - Advocacy Groups: County Behavioral Health Directors Association (CBHDA), National Health Law Program (NHeLP)

Discussion Topics

- Over the course of 10 meetings, workgroup members met to discuss key issues related to ACT service design and implementation, including:
  - Service Components
  - Fidelity Models and Team Structure
  - Eligibility Criteria
  - Reimbursement Strategies
  - Training and Technical Assistance
  - Accountability, Oversight, and Monitoring

Key Considerations: ACT Service Design (1 of 2)

- **Service Components.** The workgroup discussed how other states currently cover ACT under Medicaid, and reviewed how ACT service components align with existing Medi-Cal SMHS. Consistent with the approach approved in other states, **DHCS intends to cover the full range of Medicaid-coverable ACT components.**

- **Fidelity Model and Team Structure.** The workgroup discussed the benefits and drawbacks of each of the three leading fidelity models for ACT: the Dartmouth Assertive Community Treatment Scale (DACTS), the Tool for Measurement of Assertive Community Treatment (TMACT), and the "Functional" or "Flexible" ACT model, which is primarily used in Europe. TMACT and Flexible ACT build on the original DACTS model but provide greater flexibility for different ACT team sizes and settings, particularly rural areas. **DHCS is considering using the TMACT fidelity model to allow for multiple team sizes while still aligning with the evidence-based model.**

- **Flexibility in Rural Areas.** Workgroup members emphasized the need for programmatic and regulatory flexibility to support implementation of ACT in relatively rural counties. In addition to multiple team sizes, DHCS could consider additional flexibilities, such as lower baseline fidelity score requirements or waivers for certain key team members, specifically for rural areas. **DHCS will continue working with stakeholders to develop solutions for ensuring evidence-based ACT services are available in more rural areas.**

Key Considerations: ACT Service Design (2 of 2)

- **Eligibility Criteria.** The workgroup reviewed how other states define eligibility for ACT, and discussed how to ensure the state is not overly prescriptive in its eligibility criteria. At the same time, it will be important to focus ACT on the population for whom the evidence suggests it can be most beneficial (a subset of individuals with significant behavioral health needs). **The eligibility criteria for ACT will be designed to build off the eligibility criteria recommended in SAMHSA's toolkit (similar to approaches in other states).**

- **Reimbursement Model.** The workgroup discussed reimbursement strategies used in other states and the benefits and drawbacks of different rate structures, including 15-minute, daily, and weekly or monthly rates. Workgroup members largely agreed that a weekly or monthly rate for ACT may reduce administrative burden and documentation time and support teams in providing the full range of services and supports that are needed on an individualized basis. **DHCS is considering a bundled reimbursement rate for ACT that captures the full cost of delivering the evidence-based service.**

- **Certification and Implementation Planning.** The workgroup discussed if ACT teams should be "certified" to be reimbursed for ACT service delivery and discussed potential barriers in scaling ACT services across the state. **DHCS will continue working with stakeholders to develop a plan to ramp up full-fidelity ACT statewide, including policies for bringing along existing ACT teams, and FSP program teams that may want to transition to provide high-fidelity ACT.**

Key Considerations: Role of a Center of Excellence in ACT Implementation

As part of BH-CONNECT, DHCS plans to establish one or more Centers of Excellence (COEs) to support high- fidelity implementation of evidence-based practices across the state, including COEs for ACT, Coordinated Specialty Care for First Episode Psychosis, Supported Employment, and evidence-based practices for children and youth.

DHCS anticipates that the COE for ACT will be critical in supporting training, technical assistance, fidelity monitoring, and other implementation activities. Core responsibilities may include:

- **Training** providers and county mental health plans to stand up ACT teams and deliver ACT services.
- **Ongoing technical assistance** for providers and county behavioral health delivery systems of new and existing ACT teams to support fidelity implementation.
- **Conducting fidelity reviews** and **certification** for ACT teams.
- **Data collection** and outcomes reporting about providers, status of fidelity reviews, outcomes, and member access to/utilization of ACT.
- Establishing **learning communities** for providers and opt-in counties.
- Other activities to **support ramp-up and scaling**, such as developing “train-the-trainer” models, helping existing ACT teams across the state meet DHCS requirements, and doing outreach and engagement.

Discussion Questions

Please share any feedback you have about DHCS' early thinking on the approach to covering ACT under Medicaid for members living with significant behavioral health needs.

- What learnings can workgroup members share about their experiences implementing ACT in California or in other states?
- What potential barriers should DHCS anticipate in the design and implementation of ACT?
- How can a Center of Excellence best support counties and provider organizations in implementing ACT with fidelity?

Coordinated Specialty Care for First Episode Psychosis

Overview: Coordinated Specialty Care

Every year, approximately 100,000 adolescents and young adults in the U.S. experience their first episode of psychosis (FEP).

- **Role of Coordinated Specialty Care.** Coordinated Specialty Care (CSC) is the leading, team-based approach for serving young adults following a first episode of psychosis. Like ACT, it is a team-based, multidisciplinary behavioral health practice.
- **Evidence Base for CSC.** Previous research on CSC for FEP found that individuals who received CSC were much less likely to develop a serious mental illness later in life compared to those who received typical care. Other benefits to providing CSC for FEP include improved psychopathology and overall quality of life.
- **SAMHSA Community Mental Health Services Block Grant (MHBG) Funding.** Federal law requires SAMHSA to set aside 10 percent of the MHBG allocation for each state to support evidence-based programs for FEP. California allocates 11 percent of its MHBG allocation to support FEP.
- **National Landscape.** Almost every state has a CSC program and many use Medicaid – in addition to SAMHSA block grant funding – to finance components of the service. However, **no state currently has a State Plan Amendment (SPA)** to cover CSC for FEP as a bundled service – only New York has indicated it plans to submit a SPA for its bundled case rate.

State Landscape: CSC for FEP in California

Many counties In California already implement programs to support members experiencing their first psychotic episode. BH-CONNECT intends to build upon work already underway in California to expand access to evidence-based treatment for first episode psychosis.

- **Mental Health Services Oversight & Accountability Commission.** In addition to MHSOAC INN, AB 1315 established the Early Psychosis Intervention Plus (EPI Plus) Program. This consisted of a competitive selection process to expand the provision of high-quality, evidence-based early psychosis and mood disorder services. UC Davis was selected as a lead TA provider to support grantees in reaching full fidelity to the CSC model over four years. In 2020, MHSOAC awarded five EPI Plus Program grants totaling $10M. In 2021, two additional grants were awarded.

- **Role of UC Davis.** UC Davis currently supports implementation of CSC for FEP programs across California and nationwide, spearheading several initiatives to provide training and technical assistance to county behavioral health departments. The California Early Psychosis Intervention Program (EPI-CAL) is a learning health care network and training and technical assistance center for California's early psychosis programs. DHCS is actively participating in convenings hosted by UC Davis to discuss the California landscape for CSC for FEP and key barriers and opportunities in implementation.

  - In FY 2022-23, DHCS allocated $24M directly to counties for FEP set-aside. DHCS is committing $25M for a contract expansion to further support and expand EPI-CAL from April 1, 2022 through June 30, 2025.

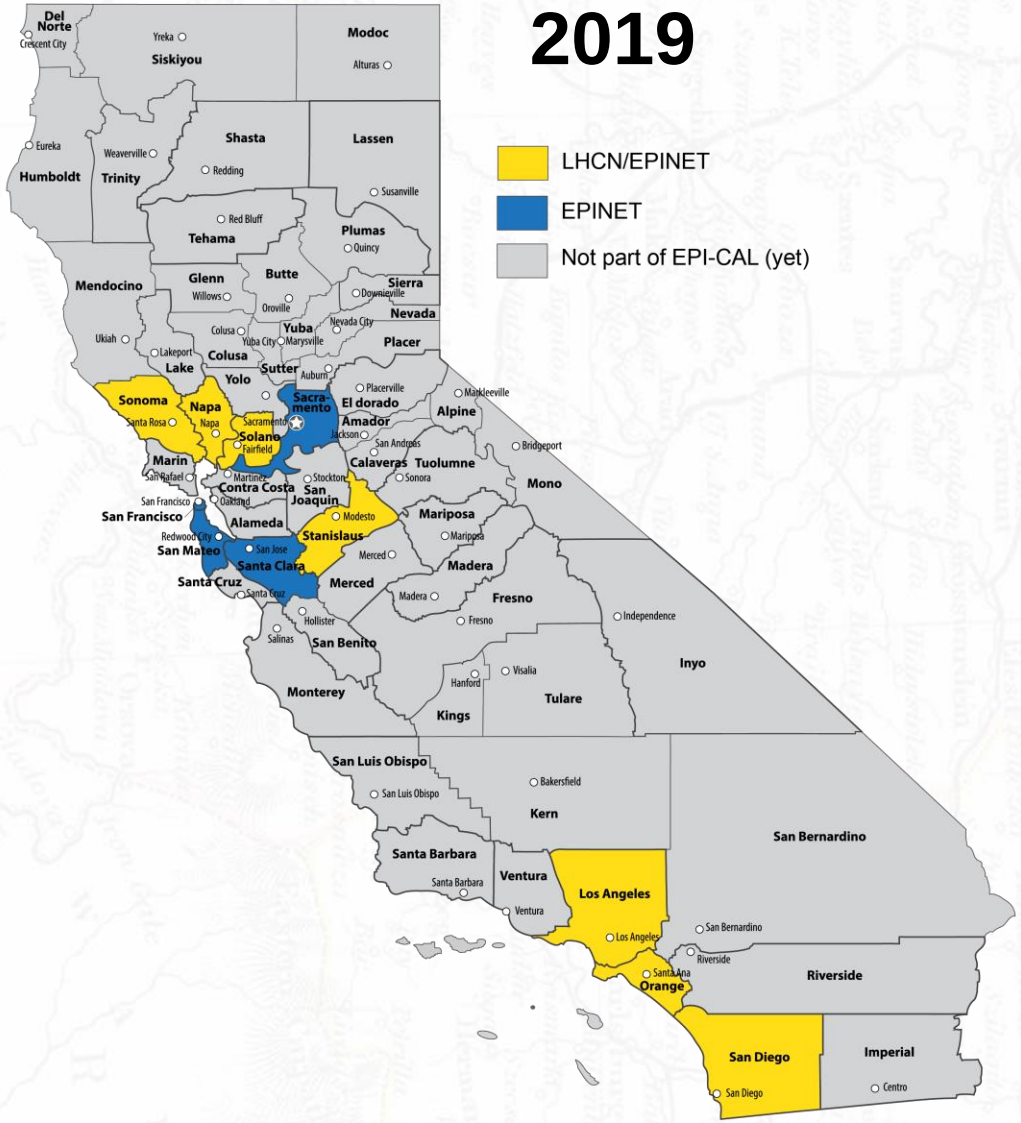
State Landscape: CSC for FEP in California (continued)

- **Children and Youth Behavioral Health Initiative (CYBHI).** CYBHI includes $429 million in grants to organizations seeking to scale evidence-based and/or community-defined evidence practices (EBPs/CDEPs) that improve youth behavioral based on robust evidence for effectiveness, impact on racial equity, and sustainability.
  - Through extensive community engagement and close collaboration with MHSOAC, DHCS selected EBPs and CDEPs to consider for scaling throughout the state. The initiative includes 100+ practices and programs across the continuum of care that are applicable in a variety of clinical, home, and community-based settings.
  - Six rounds of CYBHI EBP/CDEP grants were released.
  - Fifth round ($80M) focused on Early intervention programs and practices – RFA submission was November 17, 2023
    - CSC for FEP was explicitly called out.
    - Commitment to follow CSC model to fidelity.

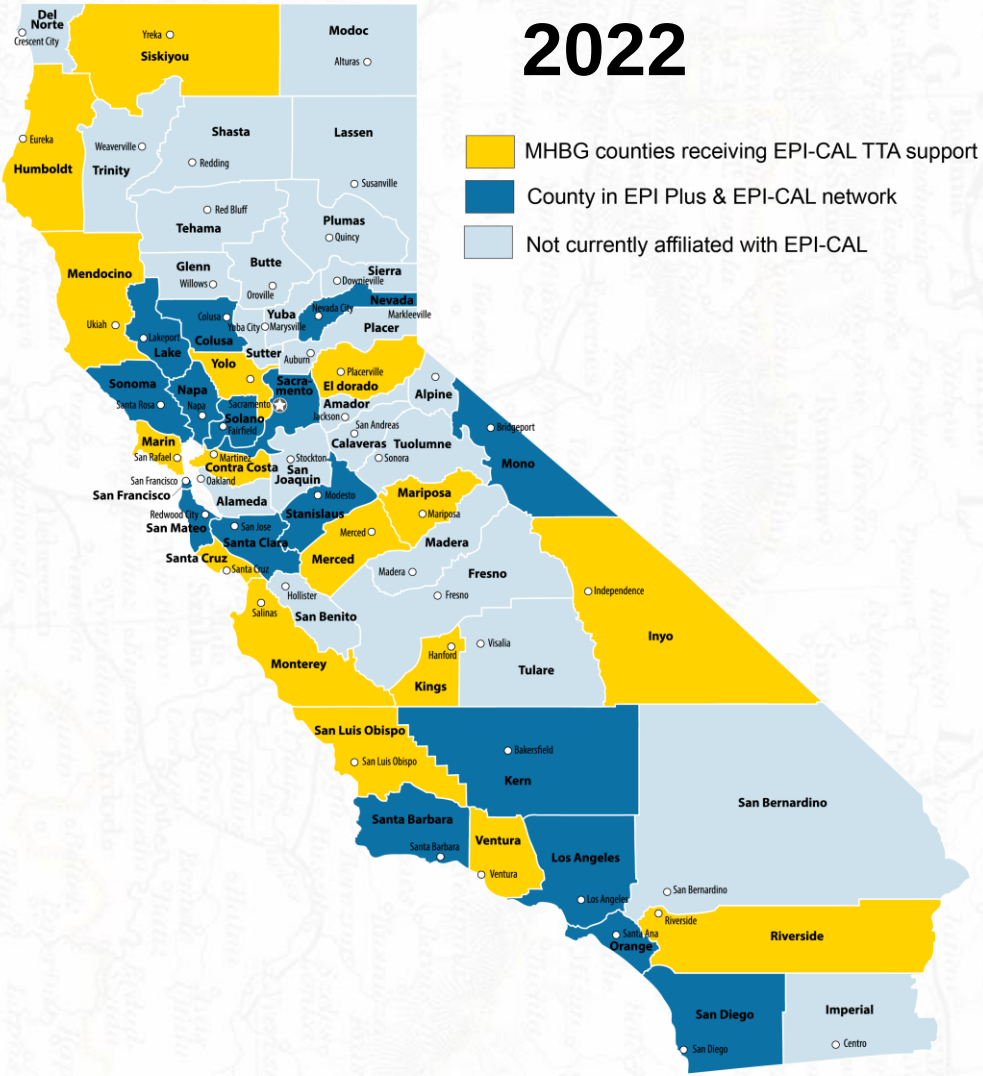
SPA coverage of a bundled CSC for FEP service could strengthen counties' existing programs and encourage other counties to offer CSC for FEP, while freeing up other funding sources for training, technical assistance, and outreach.

State Landscape: Growing EPI-CAL Programs

2019



2022



Preliminary Approach for BH-CONNECT:
Coordinated Specialty Care

Like with ACT, DHCS intends to cover all Medicaid-coverable components of Coordinated Specialty Care for First Episode Psychosis. It will be designed to build upon and complement work already underway in California to establish robust CSC programs.

Specific CSC service components *may* include:

- ✓ Assessment
- ✓ Medication management
- ✓ Individual, group, and family therapy
- ✓ Vocational/educational support services
- ✓ Peer and family peer support services
- ✓ Person-centered planning

CSC team members *may* include:

- ✓ CSC for FEP team leader
- ✓ Psychiatrist or other prescriber
- ✓ Vocational specialist
- ✓ A team member who can work with clients on goals that require social or coping skills training and attention to substance use
- ✓ A team member dedicated to establishing and maintaining a referral network and evaluating potential members

Discussion Questions

Please share any feedback you have about DHCS' early thinking on the approach to covering CSC for FEP under Medicaid for members experiencing their first psychotic episode.

- What learnings can workgroup members share about their experiences implementing CSC for FEP in California or in other states?
- What potential barriers should DHCS anticipate in the design and implementation of CSC for FEP?
- What potential issues should DHCS expect when continuing to scale to fidelity in additional counties?
- What advice do workgroup members have to ensure a Medicaid-covered CSC for FEP service builds on and complements existing work underway in California using MHSA and/or MHBG funding.

Child and Adolescent Needs and Strengths (CANS) Tool

Overview: Aligned Use of the Child and Adolescent Needs and Strengths (CANS) Tool

Currently, although both child welfare and specialty mental health use the CANS, they use different variations of the tool and have different requirements. As part of BH-CONNECT, DHCS proposes to develop an aligned CANS tool to be used across the child welfare and specialty mental health systems.

The CANS tool is used to:

- **Support decision making**, including level of care and service planning
- Allow for the **monitoring of outcomes** of services
- **Guide conversations** about the well-being of children and youth

Alignment of the CANS tool across the two systems is intended to:

- Ensure that both child welfare and behavioral health providers are **using the same CANS tool** with the same modules
- Ensure that the CANS tool is **administered in the same way**, whether done by a specialty mental health provider or by a child welfare worker, so that outcomes are being measured consistently and can be tracked over time
- Support a **cohesive approach to decision making and service planning across systems**, with the goal of improving outcomes and wellbeing for children and youth

CANS Tool Elements for Alignment

Element	DHCS Tool: CANS-50	CDSS Tool: CANS-IP
Ages	6 to 20 years old	5 to 21 years old
Cadence	• At beginning of treatment • Every 6 months • At end of treatment	• At intake (within 60 days of opening a case) • Every 6 months
Who Administers	Only Professionals Certified as CANS Providers: SW, (CFT) Facilitator, MHP	Those actively CANS-certified through the Center for Innovation in Population Health (IPH, formerly Praed) and recertified on an annual basis
Sharing CANS	Placing Agency & MHP must share CANS and upload to their respective Agency Data System	
MH Screening	For Children/Youth who are already in Foster Care and not currently receiving SMHS - The CANS tool may function as the required MH Screening	
Redaction	CANS Questions #8 (Substance Use) and #48A (Caregiver Substance Use)	

Provisional Alignment Decisions

DHCS and CDSS have had monthly workgroup meetings to discuss alignment of the CANS tool. The provisional alignment decisions below are examples of the types of changes that would need to be made for alignment.

Current CDSS Guidance	Current DHCS Guidance	Provisional Alignment Decision
CANS must be administered during the first 60 days after a case plan opens, and every 6 months until closure of the case plan (i.e., permanency or reunification) (ACL No. 18-81)	CANS assessments are to be administered on new clients entering treatment, every 6 months thereafter, and at the end of treatment (BHIN 17-052)	To align with DHCS' requirement, CDSS proposes to update its policy to explicitly state that the **CANS must be administered at closure** of the case plan
CDSS requires that the individual responsible for completing the CANS assessment tool be trained, actively CANS-certified and maintain annual certification through IPH (formerly Praed) (ACL No. 18-81)	DHCS expects MHPs to provide/arrange for training to all clinicians who administer CANS and references Praed as an optimal resource for MHPs to leverage for formal training (BHIN 17-052)	To align with CDSS' policy, DHCS proposes to require CANS administrators to be **certified through IPH**

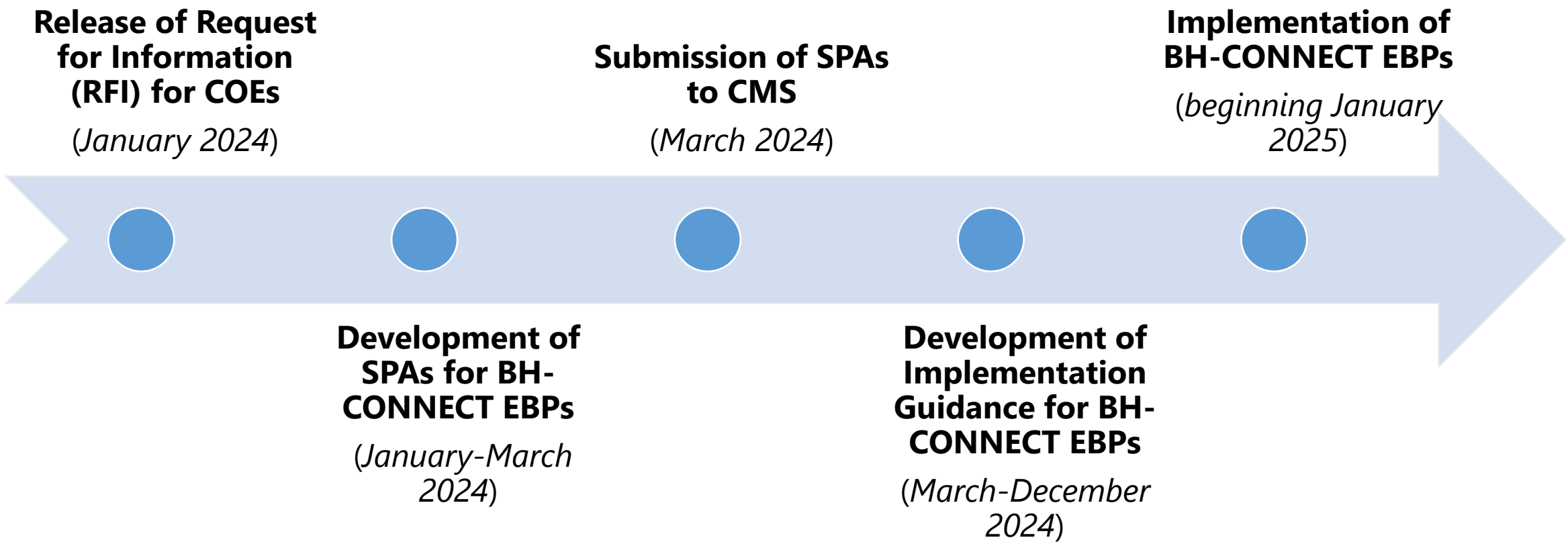
Discussion Questions

Please share any feedback you have about DHCS' early thinking on the approach to aligning the CANS across the child welfare and specialty mental health systems.

- What learnings can workgroup members share on their experience administering the CANS and leveraging CANS results?
- What potential barriers should DHCS anticipate in the alignment of the use of the CANS tool across the two systems?
- What advice do workgroup members have to ensure optimal alignment of the use of the CANS tool across the two systems?

Upcoming Milestones & Stakeholder Engagement Opportunities

Key Milestones: Implementation of BH-CONNECT Evidence-Based Practices



DHCS will continue to engage stakeholders on the design and implementation of BH-CONNECT EBPs on an ongoing basis, including in future CalAIM BH Workgroup meetings.

BH-CONNECT Stakeholder Engagement Opportunities

DHCS is committed to engaging with stakeholders on an ongoing basis throughout the design and implementation of BH-CONNECT.

Upcoming Stakeholder Engagement Opportunities

Previous Stakeholder Engagement

- Public comment process for BH-CONNECT concept paper and Section 1115 waiver application (multiple stakeholder forums)
- 10 ACT workgroup meetings including members representing county behavioral health agencies, academic institutions, and advocacy groups
- Targeted interviews with provider organizations and other states on the design and implementation of EBPs
- Presentations to DHCS' Youth Advisory Group on components of the demonstration which are specific to children and youth (e.g., CANS alignment)

Ongoing & Upcoming Engagements

- Continued stakeholder engagement during policy design and guidance development (including applicable public comment periods)
- At least quarterly convenings of the CalAIM BH Workgroup and BH-SAC
- CalAIM BH Workgroup will be a key forum to discuss BH-CONNECT EBPs
- Additional stakeholder meetings to review specific components of BH-CONNECT

Additional feedback is always welcome at **BH-CONNECT@dhcs.ca.gov**

Workgroup Discussion

Behavioral Health Documentation Redesign Updates

DHCS

New Guidance: BHIN 23-068

- **BHIN 23-068** was published on November 20, 2023, and posted to the DHCS BHIN webpage (https://www.dhcs.ca.gov/provgovpart/Pages/2023-BH-Information-Notices.aspx).
- This BHIN **will supersede** previous CalAIM documentation guidance (BHIN 22-019) **as of January 1, 2024.**
- **Goals** for this update: Further **streamline and simplify** documentation requirements across mental health and substance use disorder Medi-Cal services, and **clarify key issues** identified by stakeholders.
- **Many thanks** to this workgroup and Medi-Cal stakeholders for engaging with DHCS over the past year to inform this guidance!

Background: Documentation Redesign

Assembly Bill 133 (2021)

2019 — **2022** — **Present**

Stakeholder Engagement & Policy Drafting

- CalAIM BH Workgroup [‘19 – present]
- Draft BHIN [August ’21]
- Targeted Stakeholder Engagement [January ’22]
- Informational and TA Webinars [‘21 – ’22]

April 2022: BHIN 22-019 Published

Stakeholder Feedback & Policy Revision

- Targeted (small group) Meetings
- 1:1 Stakeholder Meetings
- CalAIM BH Workgroup
- BH-SAC
- BHIN for Public Comment
- Ongoing DHCS analysis and review

Fall 2023: BHIN 23-068 Supersedes 22-019

Documentation Redesign Updates In BHIN 23-068

DHCS

Key Policy Updates: BHIN 23-068

- **Assessments:**
  - **Eliminates 30/60-day timeframes** for Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) assessments and aligns standard with Specialty Mental Health (SMH).
    - Providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice.
    - Medi-Cal behavioral health delivery systems shall not enforce standards for timely initial assessments, or subsequent assessments, in a manner that fails to permit adequate time to complete assessments when such time is necessary due to a member's individual clinical needs.
  - **Requires DMC/DMC-ODS counties and providers to adopt validated, DHCS-approved ASAM assessment** tools by **January 1, 2025.**
  - **Clarifies requirements** related to crisis assessments, MAT assessments, and assessments required as part of DHCS Level-of-Care Designation.

Key Policy Updates: BHIN 23-068

- **Progress Notes:**
  - **Clarifies required elements** for notes, and **expectations for narrative**
    - Notes shall support the procedure code(s) selected and effective clinical care and coordination among providers
    - DHCS does not require a "one-size-fits-all" approach to narrative notes
  - **Distinguishes between** progress note **requirements for individual and group services**
    - Narrative for non-group services shall include a brief description of how the service addressed the member's behavioral health needs, and a brief summary of next steps
    - Narrative for group services shall include a brief description of the member's response to the service

Key Policy Updates: BHIN 23-068

- **Care Planning:**
  - **Identifies services, programs, and facility types for which state or federal law continues to require care plans** and/or specific care planning activities, and includes citations to relevant law or guidance
  - **Establishes one standard for documentation of care planning:** Care plan information must be documented within the member record, and providers must be able to produce and communicate the contents of the care plan.
    - DHCS does not require a particular format or location for care plan information. Medi-Cal Behavioral Health Delivery systems shall not impose requirements for the location, format, or other specifications of the care plan that differ from those described in the BHIN and its Enclosures.

FAQs and Technical Assistance

Technical Assistance

- An initial Technical Assistance (TA) webinar is scheduled for **December 13, 2023, from 12 p.m. – 1:30 p.m**. Registration is required. More information can be found on the CalAIM webpage.
- DHCS will continue to update the FAQs on the CalAIM website, and will also provide further updates on upcoming TA opportunities.
- Documentation trainings and resources on current policies remain available on the CalMHSA website. (Much of this content is still applicable.)

Discussion Prompt

- What policy questions would workgroup members like DHCS to address during the upcoming TA webinar?
  - Questions may also be submitted in writing through the webinar registration link.

Workgroup Discussion

Wrap Up

- If you have additional questions, please email DHCS at BHCalAIM@dhcs.ca.gov with the subject Line “CalAIM BH Workgroup – December 2023.”

Public Comment

Public Comment

Members of the public may use the raise hand feature to make a comment.

Comments will be accepted in order of when hands are raised.

When it is your turn, you will be unmuted by the meeting host.

Please keep comments to 2 minutes or less.

Thank you

DHCS

Appendix

ACT Service Components: Original ACT Model

The original evidence-based ACT model described in the SAMHSA Evidence-Based Practices Kit includes a comprehensive set of core services and a multidisciplinary ACT team with a variety of skills and experiences.

Service Components

- Crisis assessment and intervention
- Comprehensive assessment
- Illness management and recovery skills
- Individual supportive therapy
- Substance use treatment
- Employment-support services
- Side-by-side assistance with activities of daily living
- Intervention with support networks (family, friends, landlords, neighbors, etc.)
- Support services (medical care, housing benefits, transportation, etc.)
- Case management
- Medication prescription, administration, and monitoring

Team Members

- ACT leader (1 full-time mental health professional)
- 1 psychiatrist
- 2 or more nurses
- 2 or more employment specialists
- 2 or more substance use treatment specialists
- 1 full-time consumer/peer specialist
- Mental health professionals and paraprofessionals (master-level social workers, occupational therapists, rehabilitation counselors, psychologists)
- 1 program assistant

Note: *An ACT team in the SAMHSA model consists of 10-12 staff members who serve a caseload of approximately 100 members. Other ACT models have different team structures and may include multiple team sizes for different caseloads.*

ACT Fidelity Model & Team Structure: Variation Across ACT Models

The staffing and size of the ACT team are inextricably linked to the fidelity model used. DACTS and TMACT are the two most widely used models for ACT in the United States. Many other countries have implemented the Flexible ACT model.

Dartmouth Assertive Community Treatment Scale (DACTS)	• Original ACT fidelity scoring model; recommended in SAMHSA's evidence-based toolkit. • Has been adapted by researchers for different contexts (e.g., by Case Western University for use in Ohio and for use in Oregon), but the basic elements of the tool are the same. • Teams of ~10-12 providers support 100 patients each.
The Tool for Measurement of Assertive Community Treatment (TMACT)	• Newer ACT fidelity scoring model. • Used in North Carolina; has been adapted to create standards for different team sizes. • Small teams of ~6 support up to 50 patients; mid-sized teams of ~8 support 51-74 patients; and large teams of ~10 support 75+ patients.
Functional ACT or Flexible ACT (Flexible ACT)	• More flexible ACT model used primarily in Europe. Draws from DACTS but is distinct. • Uses a partly individual approach and partly team-based approach. • Teams of ~12 providers support 200 patients of varying need, including patients who do not need full ACT; the team's role varies in intensity based on the patient's needs.

Eligibility Criteria: Original ACT Model

Research has demonstrated significant positive outcomes from ACT for members with schizophrenia, schizoaffective disorder, and bipolar disorder. The SAMHSA Evidence-Based Practices Kit also recommends prioritizing individuals with significant functional impairment and/or continuous high-services needs.

Significant Functional Impairment

✓Consistent inability to perform practical daily tasks needed to function in the community, such as:

- Maintaining personal hygiene;
- Meeting nutritional needs;
- Caring for personal business affairs;
- Obtaining medical, legal, and housing services;
- Recognizing and avoiding common dangers or hazards to one's self and one's possessions.

✓Persistent or recurrent failure to perform daily living tasks, except with significant support or help from others, such as friends, family, or relatives;

✓Consistent inability to be employed at a self-sustaining level or to carry out homemaker roles;

✓Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).

Eligibility Criteria: Original ACT Model

Research has demonstrated significant positive outcomes from ACT for members with schizophrenia, schizoaffective disorder, and bipolar disorder. The SAMHSA Evidence-Based Practices Kit also recommends prioritizing individuals with significant functional impairment and/or continuous high-services needs.

Continuous High-Services Needs

- ✓ High use of acute psychiatric hospitalization (e.g., two or more admissions per year) or psychiatric emergency services;
- ✓ Intractable (i.e., persistent or recurrent) severe major symptoms (e.g., affective, psychotic, suicidal);
- ✓ Coexisting substance use disorder of significant duration (e.g., greater than 6 months);
- ✓ High risk or a recent history of being involved in the criminal justice system;
- ✓ In substandard housing, homeless, or at imminent risk of becoming homeless;
- ✓ Living in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live more independently if intensive services are provided; and
- ✓ Inability to participate in traditional office-based services.