California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

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MS 2706

November 6, 2024

Behavioral Health Transformation

Department of Health Care Services

P.O. Box 997413

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RE: October 30, 2024, Behavioral Health Transformation Public Listening Session on Full-Service Partnerships (FSPs)

Dear Behavioral Health Transformation Team,

The California Behavioral Health Planning Council (CBHPC) has the statutory authority to review, evaluate, and advocate for persons with Serious Mental Illness (SMI), youth with Severe Emotional Disturbances (SED), and individuals with Substance Use Disorders (SUD) in Welfare and Institutions Code §5771 and §5772. The recommendations outlined in this letter are in alignment with the Council's Policy Platform and our vision of a behavioral health system that makes it possible for individuals with lived experience of a serious mental illness or substance use disorder to lead full and purposeful lives.

The CBHPC appreciates the Department of Health Care Services (DHCS) for hosting listening sessions to engage stakeholders in the implementation of the Behavioral Health Transformation (Proposition 1).

CBHPC staff and Council Members attended the October 30, 2024, Behavioral Health Transformation Public Listening Session on the Full-Service Partnerships (FSPs). This letter includes our consolidated response to the questions posed in the listening session.

DHCS Question to Stakeholders: What are some effective models, or service components, to integrate SUD into FSP teams?

The Planning Council supports integrating SUD into FSP teams. This requires the state to rethink existing models and understand the

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complexities of integration. Please see our recommended key changes for effective integration below:

1. Retrain all FSP staff to reduce and remove historic biases and differences between mental health and SUD systems of care. This includes but is not limited to the following:
    a. Educate providers and staff about the needs and stigmas present in each system.
    b. Create a Speaker's Bureau to elevate the voice of individuals with lived experience. Such bureaus exist at the county level for individuals with mental illness. This would expand this effective client voice to SUD as well.
    c. Provide SUD monthly trainings with case presentations and education for mental health staff to equip staff with the basic knowledge, skills, and capabilities to serve both mental health and SUD populations.
    d. Provide updated specialized trainings for SUD providers including training for staff in harm reduction and Medication Assisted Treatment (MAT).
    e. While it is important to add SUD counselors to integrated teams, we recommend intentional integration efforts to promote organizational culture change and state of the art education.

2. Evidence Based Practices (EBPs) for the implementation of BH-CONNECT is effective for some population groups. These EBPs are also highlighted as an expectation in the BHSA Full-Service Partnerships. However, these EBPs can lack the necessary flexibility to adapt for some ethnic and cultural populations and diverse communities. Incorporating Community Defined Evidence Practices (CDEPs) explicitly in the expectations for FSP services is critical if equity and diversity goals are to be met.

3. There are examples across the state where separate billing structures for mental health and SUD housing projects have worked efficiently. For mental health and SUD treatment systems, we recommend simplifying certification standards to allow more efficient use of medical personnel in FSPs that have been designed with a mental health focus to give more clients access to both mental health and SUD services.

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4. Utilize effective field-based initiation: A successful model would need to make sure that Medication Assisted Treatment is available in an FSP in a similar way that psychiatric medications are available in an FSP. This would mean certified providers in an FSP model are able to deliver both services in the same clinic and receive full reimbursement. Recognizing that Psychiatrists and Nurse Practitioners can already prescribe MAT for FSP clients if they have the appropriate certification and training, Psychiatrists in the FSP that provide MAT could be the same medical staff that provides psychiatric medications. With changes in the federal guidelines that make MAT induction and continued follow-ups open to more sites, a successful model would integrate this into the field based FSP teams as well as the medication clinic and delivery system.

   This model would be especially beneficial to mental health co-occurring clients who are established with and trust their mental health provider and do not need to go elsewhere for their MAT follow-up care. It will also reduce wait times and maximize workforce efficiency if an FSP team can provide this service to its clients instead of having to navigate another resource. SUD treatment is effective when the client is ready and trusts their provider instead of them experiencing delays when navigating multiple systems. The Planning Council believes that this recommendation is in alignment with the spirit and intent of the BHSA.

5. SUD treatment is currently provided both in primary care, such as Federally Qualified Health Centers (FQHCs), and in specialty settings under the Drug Medi-Cal Organized Delivery System (DMC-ODS). The Planning Council asks DHCS to consider an FSP model of care where a Primary Care Physician or Nurse is embedded in the FSP teams and programs. This practice will would require some creativity in administrative setup, certification, and payment protocols. This recommendation may also increase basic health follow-ups as well as increase workforce flexibility. There are successful models of FSPs where dually certified physicians have provided medical consultation but not with payment and full integration. This is a recommendation to consider further in discussions with Managed Care Plans (MCPs) so that all systems maximize payment and reimbursement to providers of care.

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DHCS Question for Stakeholders: For FSP teams currently implementing Assertive Community Treatment (ACT) and/or Forensic Assertive Community Treatment (FACT), are there lessons learned that can be shared or resources/supports that would have been helpful for implementation?

Maintaining high fidelity is a workforce issue in terms of training and turnover, and it is expensive for providers to manage within their budgets. It is important to consider ways to address these issues with Centers for Excellence (COEs). We recognize that it is challenging to maintain high fidelity with the current workforce shortages. Fidelity to model should not be required for ACT since the staffing is so difficult to maintain. The CBHPC recommends that DHCS initiate a statewide discussion on this topic with counties who already implement these two EBPs at any level of fidelity they are operating.

DHCS Question for Stakeholders: What other components should be looked at when serving individuals under Intensive Case Management (ICM)?

The tiered design for the Adult FSP Level of Care Framework under the BHT is a major change from the Mental Health Services Act (MHSA). The CBHPC recommends the following:

1. Individuals with lived experience have an urgent opportunity to understand this change and weigh in with their ideas on how to serve individuals under ICM prior to the finalization of this policy.
2. DHCS conduct more discussion on this point and develop different options regarding the organization of Tiers based on feedback provided from clients in the system.
3. DHCS clarify if it is required to have the Level 1 and Level 2 Tiers in the FSP funding category and Level 3 Tier in the BHSS funding category, or if it is optional for counties to organize the funding categories in this manner.
4. DHCS look at lessons learned from the experiences in many counties where step-downs in the level of care have been attempted, and that DHCS hear from counties on how transitions would work.
5. All three levels be in the same FSP funding category, rather than include two tiers under the FSP funding category and one tier under the Behavioral Health Services and Supports (BHSS) funding category.

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The way in which the tiered FSP system has been described in the public listening session poses challenges and unintended consequences. For instance, recovery is not linear in mental health or SUD and the system described in the listening session has more rules and treatment rigidity than the MHSA. The Level 2 Tier including ACT and FACT and the Level 1 Tier including ICM are clearly delineated, while Level 3 Tier that includes Outpatient Specialty Mental Health Services (SMHS) separates clients from the FSP funding category by placing them in the Behavioral Health Services and Supports (BHSS) funding category. This means that Level 3 Tier for Outpatient SMHS will be mixed with a crowded BHSS bucket, which may lead to programs in this level of care competing for resources.

Another unintended consequence of the tiered system is the challenge of having one provider rendering services for all three Tiers. This might result in the growth of large providers and the loss of the more diverse, community-based providers especially at the lowest acuity, Tier 3, which would impact local provider networks and diversity of services. The CBHPC would like to reiterate the importance of the client voice and choice in decisions about their healthcare when they are presumably doing well enough to be in the lowest acuity Tier, or treatment under the described model.

Clarification as outlined in our third recommendation is critical as counties will have less flexibility with their BHSA funds if the funding categories designated for each tier are required. Other considerations for this topic are the size and population of the county, how effectively staffed the county is, and how difficult transitions of care between the levels will be.

Additionally, managing client transitions is clinically complicated and different from system transitions. It involves each client being transitioned, assuming that client to staff ratios will be less robust in Level 3 Tier if it is not considered an FSP level of care. These level of care transitions have historically been traumatic and difficult for clients which results in decompensation and a loss of trust in the public service system. It also raises quality of care issues due to the likely difference in client ratios in Level 3 compared to the higher acuity Levels 1 and 2.

If this is not possible, we ask that DHCS further explain how the tiers will work and what populations the department envisions will reside in Level 3 care for Outpatient SMHS.

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Additional comments and recommendations for the challenges described above include the following:

- The diagram of the Adult FSP Levels of Care Framework may be confusing in terms of the level of acuity. We recommend that Level 1 be labeled as the highest level of acuity (ACT/FACT) and Level 2 be labeled as the medium level of acuity (ICM). We also ask that DHCS clarify if the levels are based on the populations of focus and how the populations are determined for each level.
- Regarding the continuity of care between Tiers, particularly for Tier Level 1 and stepdown into Tier Level 3, the CBHPC recommends that DHCS clarify the continuity of care protocols within the BHSA so that clients do not get lost in this stepdown transition process. We ask DHCS to clarify if the stepdown relates to current Medi-Cal protocols on continuity of care or it is separate and distinct.
- The CBHPC asks DHCS to clarify whether Level 3 Tier for Outpatient SMHS will continue to have housing supports available. For example, if a client gets housing supports under FSP Level 1 (ICM) and then gets stepped down to Tier 3, will the housing supports continue under the non-FSP service?
- The Tiers model is reminiscent of the Level of Care Utilization System (LOCUS) tool used by many counties at the acute level to determine level of service. It is important to consider discussing the intersection of Tier 3, Outpatient SMHS, with the role of Managed Care Plans to differentiate between Mental Health Plan and MCP responsibilities in care.
- The CBHPC recommends that DHCS clarify if there is movement from Tier 3 in the county Mental Health Plan to a MCP benefit once the individual moves into the mild-to-moderate behavioral health status, and if populations served in Level 3 are eligible for Enhanced Care Management (ECM).
- Please clarify the differences in role of County Office of Education that will provide technical assistance and monitoring compared to DHCS' monitoring responsibilities.

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DHCS Question for Stakeholders: How are counties and providers that are currently providing High Fidelity Wraparound (HFW) services aiming to ensure that these services are moving toward fidelity for BHSA? Are there specific areas of Technical Assistance.

The CBHPC recommends that DHCS include CDEPs in the High Fidelity Wraparound discussion as described in response to the first question in this letter that DHCS posed to stakeholders. This item is even more applicable for children and family services.

In addition to the responses above, the CBHPC would like to note that stakeholder engagement is currently done differently in every county, and we recognize that building an effective, robust stakeholder engagement process can be very difficult. We appreciate the focus on prioritizing stakeholder engagement and encourage the state to include persons with lived experience as well as family members as primary stakeholders.

Every individual who uses public behavioral health services should be invited to participate in the Integrated Plan development, particularly at the early stages of the process.

For questions, please contact Jenny Bayardo, Executive Officer, at Jenny.Bayardo@cbhpc.dhcs.ca.gov or by phone at (916) 750-3778.

Sincerely,

[redacted]

Deborah Starkey
Chairperson

CC: Paula Wilhelm, Interim Deputy Director, Behavioral Health, DHCS
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Marlies Perez, CEA, Community Services Division, DHCS