California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

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Anna Naify
BHT Quality and Equity Workstream Lead
California Department of Health Care Services

Marlise Perez
Behavioral Health Transformation Project Executive
California Department of Health Care Services

RE: **Population-Level Behavioral Health Measures**

Dear Anna Naify and Marlise Perez,

Pursuant to Welfare & Institutions Code § 5772, the Council serves as an advisory body to the Legislature and Administration on the policies and priorities that the state of California should pursue in the development and implementation of its public behavioral health system. The Council advocates for an accountable system, services that are strength-based, consumer and family member driven, recovery-oriented, culturally and linguistically responsive, and cost-effective. Our membership includes persons with lived experience of serious mental illness (SMI) and substance use disorder, family members, professionals, providers and representatives from state departments whose populations touch the behavioral health system. These perspectives are the foundation of our views on the challenges and successes of behavioral health services and best practices in California.

On February 12th the Quality and Equity Advisory Committee discussed the Behavioral Health Measures Selection process and presented the Goals and Measures to the Performance Outcomes Committee of the California Behavioral Health Planning Council. Committee Members and the public shared thoughts and comments that were used by the Council develop these recommendations.

Stakeholder Engagement and Inclusion of Persons with Lived Experience

The CBHPC would like to commend the Department of Health Care Services (DHCS) for their collaborative approach in developing the Goals and Performance Outcomes Measures for Behavioral Health Transformation. In particular, the Quality and Equity Advisory Committee (QEAC) recognized the value of stakeholder input, created an effective committee process, and has kept the Council well informed of their progress.

Since the Integrated Plans will be used to determine what services are funded at the county level, it is crucial that individuals that access these services are included in the development of the goals and measures. In addition, the CBHPC believes the Integrated Plans create a valuable opportunity to collect community input on the services provided in each county, which will result in better services and improved behavioral health outcomes statewide. Since the Integrated Plans are intended to be used by the public, they should be less complicated, easy to digest, and focused on measures that hold counties accountable while still being easy to use in the county planning process. In particular, the goals and data prepopulating the local plans must be easy to comprehend and related to the behavioral health system directly and specify where they are actionable and not actionable by the public behavioral health delivery system. In order to accomplish this, the goals and measures need to be vetted by the end users.

Recommendations:

- **We strongly encourage the inclusion of more persons with lived experience as consumers of services and family members in the Quality and Equity Advisory Committee.**
- **Persons with lived experience should be more involved in the development and implementation of the Goals and Measures as they continue to be developed.**
- **DHCS should consider re-evaluating the proposed goals and measures through the lens of the communities that will use them to determine what services are funded locally.**

General Concerns About the Goals and Performance Outcomes Measures Selected

The Council is concerned that some goals proposed are beyond the scope of the publicly funded Behavioral Health system. The goals and measures included in the Integrated Plans should be focused on components of the Behavioral Health Services Act (BHSA) and the systems that implement these services. Many of the measures selected do not specifically measure the states behavioral health system. In some instances, because of their inclusion in the Integrated Plan, the behavioral health system is perceived, correctly or incorrectly, as the main driver of broader factors that shape data.

We are concerned that community members that use the goals and measures to select services and evaluate their effectiveness may think that the behavioral health system is responsible for the Performance Outcome Measures selected. If the measures are not stratified by payer type it may reflect negatively on the public behavioral health system which cannot influence many societal aspects and system partner practices that play out in several of the measures selected. *As a result, the public may view the Behavioral Health Transformation Implementation as failing if they perceive the measures selected as directly tied to the services provided under the Behavioral Health Services Act (BHSA) when these measures do not improve despite effective implementation of services.*

One example of misrepresentation of data is around the goal of reducing homelessness. We believe the focus should only be on the target population of persons with serious mental illness (SMI) or substance use disorders (SUD). There are other factors influencing the current homelessness rate, such as a lack of affordable housing and a lack of employment with sufficient wages needed to afford housing in most of the state. The problem of homelessness extends beyond the behavioral health system. The limited amount of funding for building housing under Proposition 1 may not independently solve the state's homelessness problem. Using the general population data related to homelessness may not accurately show successes we may have in reducing homelessness in the BHSA's target population. This is just one of many examples of overreach in the proposed goals.

In concept, we agree with the idea of using global measures to create a statewide story, however doing so may put individual counties in a

challenging position of explaining data points without sufficient context or direct responsibility for behavioral health accountability. The Performance Outcome Measures should more accurately reflect the Behavioral Health Transformation's intention of results and better behavioral health outcomes statewide. Specialty Behavioral Health should only be held responsible for their beneficiaries and there should be a shared responsibility for population based Behavioral Health outcomes across all payer types. The measures selected do not translate well, making it difficult for stakeholders digest the implications of data and make thoughtful judgments and recommendations about what to fund during the planning process, especially if they do not understand the limitations of these global measures.

Recommendations:

- **DHCS should include background, definitions, and extensive notes including explanatory examples in the release of the Goals and Measures to assist the general public/community in their understanding of the implications of the Performance Outcomes selected.**
- **System partner accountability should be a part of what is measured; therefore, we should include comparable data points from Commercial Plans and Managed Care Plans in addition to Behavioral Health Plans (Mental Health and SUD-ODS).**
- **Data points should be stratified by payer type with side-by-side comparisons of Commercial Plans, Managed Care Plans, Behavioral Health Plans and ongoing funded projects by the Department.**

<u>Goals for Reduction of Institutionalization Measures</u>

The current definition of "institutionalization" includes non-comparable entities with very different purposes and functions such as Skilled Nursing Facilities, Emergency Departments, and Inpatient hospitals. To accurately measure institutionalization a better definition is needed, and a specific item identified to measure. There is a concern that recently passed legislation, SB 43, aimed at helping the most vulnerable individuals with serious mental illness (SMI) by providing the type of intensive services needed for recovery (including some forms of institutionalization based on the current definition) may increase statewide rates.

For Measure 4.5, in addition to the average a range should be identified as the average can be misleading depending on where the Inpatient hospital

is located, incentives to hospitalize and whether a “step-down” is available or not.

Recommendations:

- **DHCS should create a definition of institutionalization for the purposes of Behavioral Health Transformation (BHT). The CBHPC and other partners should be consulted on development of a definition.**
- **A specific measurement should be identified based on the BHT specific definition.**

<u>Goal for Reduction in Suicide Rates and Self-Harm</u>

Using global suicide and self-harm rates as a measure of a community’s health is problematic as they are related to the resources and funding available which can vary greatly between Managed Care Plans, Specialty Mental, and Substance Use Disorder systems. The general public may see these measures as the public behavioral health systems responsibility. External factors outside of the behavioral health system’s control also play a big role in these rates, including underlying issues in different communities such as who uses Emergency Departments, who takes individuals to Emergency Departments, and the role of law enforcement.

The way the measures are currently proposed are not broken down by payer type or systems. One example of a large system in California is the military. Some communities in California have a large military presence and these individuals are not served by the public behavioral health system but would be included in the global measures as proposed. This results in holding counties accountable for suicide rates that they cannot/do not independently or directly influence.

Recommendations:

- **Delay the selection of measures related to suicide rates to Phase 2.**
- **Stratify data by payer type to clearly demonstrate individuals are served in the public behavioral health system as compared to those in other health systems. This clarifies the responsibilities and interventions considered when meaningfully considering the data.**

Goal for Reduction of Children Removed from the Home

The number of children in the foster care system does not tell us much about their mental health or what caused them to enter the system. Reducing the number of children removed from their homes is an important community goal, however it does not tell the story about the circumstances that led them to be removed, their mental health, or the consequences that may have come about if they stayed in their home.

Many factors contribute to the removal of children from their homes, such as poverty, domestic violence, societal issues, and housing. Many of these factors are not related to behavioral health and therefore the services provided by the public behavioral health system may not directly influence these rates. We have concerns about the use of this goal but understand why it may be maintained as a general community wellness measure.

Recommendation:

- **We strongly recommend an additional measure that speaks directly to open child welfare cases reflecting specialty mental health or Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) penetration rates.**

Measures for Engagement in School

The measurement for on-time high school graduation does not measure anything related to the public behavioral health system. The court and community schools' data are overly broad and does not include information on youth struggling with behavioral health issues. This data also does not include how many students started and how many finished. This is not good data for the purposes of this goal.

Recommendation:

- **Remove on-time graduation as a measure of school engagement.**

Goal and Measures for Reduction of Overdose

The CBHPC believes that goals and outcomes measures for substance use disorders should be included. We support the use of follow-up measures after emergency department visits for substance use. However, since substance use disorder issues fall within the responsibility of both specialty behavioral health and managed care plans as well as commercial plans, we

strongly believe that all data must be stratified and explained when utilized as part of the Integrated Plan.

Additionally, the Department has made significant investments in reducing overdoses and overdose deaths through projects funded outside the public behavioral health and Medi-Cal systems, through community grants. Many of these initiatives may or may not be capturing overdose data accurately, potentially skewing countywide outcomes. To ensure a comprehensive understanding of SUD trends and impacts, we encourage a more robust approach to overdose data collection and reporting.

We are hopeful that more substance use disorder (SUD) data points will emerge as Behavioral Health Transformation develops in the coming years.

Recommendations:

- **SUD Data points should be stratified by payer type with side-by-side comparisons of Commercial Plans, Managed Care Plans, Behavioral Health Plans and ongoing grant funded projects.**
- **A statewide metric should be established requiring education and referral to treatment following every overdose occurrence, ensuring connections to community providers**
- **Meeting timeliness standards should be a requirement for all providers receiving department funding, ensuring individuals experiencing an overdose are promptly triage and have access to treatment**
- **The Department should dedicate time to inventorying all grant-funded projects and evaluating their data collection processes. Additionally, efforts should be made to establish a standardized approach for collecting and integrating data from these projects to ensure a more accurate and comprehensive understanding of substance use disorder trends and outcomes.**

Thank you for the opportunity to provide input on the proposed Behavioral Health Transformation Population Level Behavioral Health Measures. The Performance Outcomes Committee closely examined the proposed goals and measures and agreed with most of the goals and measures selected. Specific comments on each proposed measure were provided to the QEAC. This letter outlines the California Behavioral Health Planning Council's outstanding areas of concern.

The California Behavioral Health Planning Council will continue to review and comment on the goals and measures for the Behavioral Health Transformation as we are committed to ensuring its successful implementation.

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

Sincerely,

Jenny Bayardo, Executive Officer
On behalf of the Officer Team and the BHT Ad-Hoc Committee

CC: Michelle Baass, Director, DHCS
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Paula Wilhelm, Deputy Director of Behavioral Health, DHCS
Tyler Sadwith, State Medicaid Director, DHCS
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