DEPARTMENT OF HEALTH CARE SERVICES
Behavioral Health Stakeholder Advisory Committee (BH-SAC)
February 17, 2022
12:25 – 1:30 p.m.

MEETING SUMMARY

Behavioral Health Stakeholder Advisory Committee (BH-SAC) Members Attending: Barbara Aday-Garcia, California Association of DUI Treatment Programs; Jei Africa, Marin County Health Services Agency; Ken Berrick, Seneca Family of Agencies; Le Ondra Clark Harvey, California Council of Community Behavioral Health Agencies; Jessica Cruz, NAMI; MJ Diaz, SEIU; Vitka Eisen, HealthRIGHT 360; Steve Fields, Progress Foundation; Sara Gavin, CommuniCare Health Centers; Brenda Grealish, California Department of Corrections and Rehabilitation; Andy Imparato, Disability Rights California; Veronica Kelley, San Bernardino County; Kim Lewis, National Health Law Program; Linnea Koopmans, Local Health Plans of California; Farrah McDaid Ting, California State Association of Counties; Maggie Merritt, Steinberg Institute; Aimee Moulin, UC Davis/Co-Director, California Bridge Program; Jonathan Porteus, WellSpace Health; Hector Ramirez, Consumer Los Angeles County; Kiran Savage-Sangwan, California Pan-Ethnic Health Network; Cathy Senderling, County Welfare Directors Association of California; Al Senella, California Association of Alcohol and Drug Program Executives/Tarzana Treatment Centers; Chris Stoner-Mertz, California Alliance of Child and Family Services; Mandy Taylor, California LGBTQ Health and Human Services Network, a Health Access Foundation program Catherine Teare, California Health Care Foundation; Gary Tsai, MD, Los Angeles County; Rosemary Veniegas, California Community Foundation; Bill Walker, MD, Contra Costa Health Services; Stephanie Welch, California Health and Human Services; Jevon Wilkes, California Coalition for Youth.

BH-SAC Members Not Attending: Michelle Doty Cabrera, County Behavioral Health Directors Association of California; Alex Dodd, Aegis Treatment Centers; Carmela Coyle, California Hospital Association; Sarah-Michael Gaston, Youth Forward; Britta Guerrero, Sacramento Native American Health Center; Laura Grossman, Beacon Health Options; Robert McCarron, MD, California Psychiatric Association; Deborah Pitts, University of Southern California Chan Division of Occupational Science and Occupational Therapy; Libby Sanchez, Service Employees International Union; Al Senella, Tarzana Treatment Centers; Jonathan Sherin, MD, Los Angeles County Department of Mental Health.

DHCS Staff Attending: Michelle Baass, Kelly Pfeifer, MD, Jeffrey Callison, Morgan Clair.

Public Attending: There were 362 members of the public attending.

Welcome and Announcement of New Member
Michelle Baass, DHCS Director

Baass welcomed BH-SAC members to the meeting and noted BH-SAC has a new member, Laura Grossman from Beacon Health Options.

Contingency Management
Kelly Pfeifer, MD, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/021722-BH-SAC-presentation.pdf

Pfeifer provided information on the launch of the new contingency management (CM) program. CM is an evidence-based treatment for stimulant use disorder. California is first in the nation to offer this as a Medicaid benefit and other states are following our progress. CM includes motivational incentives, such as gift cards, and counseling and educational services. CM is structured as a 24-week program followed by six or more months of recovery support. Participants earn incentives that increase in value as they move through treatment and recovery. The launch is limited to a pilot in counties that opt in to participate and are Drug Medi-Cal Organized Delivery System (DMC-ODS) counties. It is also limited to stimulant treatment for individuals in non-residential programs and not enrolled in other CM programs (e.g., grant programs). Pending evaluation results, DHCS will consider expanding CM to a statewide benefit. There is extensive training and readiness activity being conducted by UCLA, which will also serve as pilot program evaluators.

Questions and Comments

Stoner-Mertz: As counties send in their Letters of Intent to provide services, will the list of counties and their partnerships with community providers be available publicly?

Pfeifer: I will take this back for discussion. We do want to make available which counties are participating and be thoughtful to make sure everybody knows which providers are participating so that clients are served. We do not have an age limit.

Stoner-Mertz: Thank you, we are excited there is no age limit.

Kelley: Are polysubstance disorders eligible for CM? We hope there will be an opportunity to extend this beyond stimulant use for individuals with opioid, alcohol, or cannabis substance use disorder as the primary diagnosis.

Pfeifer: Yes, individuals with other substance use disorders or co-morbidities are eligible as long as they also have stimulant use disorder. The advice to us has been to go carefully to ensure the program works before considering expansion.

Veniegas: I want to applaud CM and acknowledge the key aspects of harm reduction reflected in the presentation. Individuals who may be using other substances and have problematic health conditions would not be excluded, and there is not a requirement to participate in all available services; the beneficiary will have a choice. Here in Los Angeles County, we expect an intersection with regard to race, ethnicity, age, as well as type of stimulant. I expect Los Angeles will be an active pilot.

Pfeifer: Yes, the data is very distressing in that African American, American Indians, and Alaska Native populations are dying at higher rates from substance use disorder, whether from stimulants alone or stimulants with opioids. This program is important for equity.

Eisen: I know there is a limit per year for this benefit. If an individual returns to substance use, would they be eligible to participate in CM in future years?

Pfeifer: Yes, this is a chronic relapsing condition and an entitlement. We understand that, just as with other chronic conditions, people drop out and come back. The current policy is through March 2024, and we will revisit these issues for a longer-term policy.

Lewis: We support this as a pilot and hope it will grow to a more established program in the long run. I want to raise some thoughts and will send this in written materials. I want to make sure DHCS is thinking about how to ensure intake into the program is sufficiently broad and referrals into the services are available through multiple avenues, including managed care plans (MCPs) or county mental health services. On provider participation, I hope DHCS will explore allowing CM providers to subcontract, perhaps with testing sites, or find ways for all DMC-ODS contracted providers to participate in the pilot. This would expand availability and coordination so CM is not operating in isolation to other services.

Pfeifer: That is helpful. We welcome ideas about how to make sure clients are aware of the service and have multiple doors into the service. We have robust participation from providers, and now we need a robust communication strategy to clients.

Moulin: I am very excited as we have been for so long without an effective therapy for stimulant use disorder. Is there a thought of expanding the incentives for eligibility beyond a urine toxicology screen in the future? I didn't realize that there was no age limit so that this would be open to youth and adolescents. Will this be considered a behavioral health intervention where a youth would not need parental consent to participate?

Pfeifer: Those are good questions. Yes, we are open to broadening incentives to reward other behaviors after the pilot. On your second question, yes, this will follow the consent policy in place for behavioral health treatment. If a youth wants treatment and meets the criteria for stimulant use disorder, there is a minor consent process within the existing structure.

Ramirez: On the topic of outreach, I want to flag that Los Angeles consumer groups created a promotora project some years ago and were able to use pandemic funding to expand it. They are now health promoters for COVID-19 housing and other topics beyond mental health. The program has amazing outcomes. It was well accepted by the community. The information was accurate, trusted, and functioned as a lifeline for communities of color. I wonder if, for example, through California Advancing and Innovating Medi-Cal (CalAIM), the counties could fund similar health promoter programs to get CM information out. There is a growing peer community and a need to have culturally appropriate services. What better way to accomplish that than to have informed community members sharing information on the benefits?

Pfeifer: Thank you for the good input and ideas.

Behavioral Health Assessment
Kelly Pfeifer, MD, DHCS
Slides available: https://www.dhcs.ca.gov/services/Documents/021722-BH-SAC-presentation.pdf

DHCS commissioned a behavioral health assessment to provide a framework for a core continuum of behavioral health services. This is a point-in-time assessment, completed in a compressed timeline, to offer an understanding of the starting place for implementing the ambitious initiatives to transform behavioral health. The report highlights key issues and opportunities for specific populations that have been hard hit by the pandemic and were already underserved by the system. Three populations highlighted are children and youth, American Indian and Alaska Native individuals, and justice-involved individuals. The assessment defines a core continuum of behavioral health services and identifies the elements of a strong and effective behavioral health system. The assessment describes challenges and opportunities across the state to improve prevention services and treatment options. Many are already a focus of DHCS' behavioral health agenda. For example, there is a need for a comprehensive approach to crisis services, community-based living options, more treatment services for children and youth, and more focus on prevention and early intervention. The assessment also highlights other needs DHCS recognizes, and is working on, to address disparities and equity, promote evidence-based and community defined practices, and support individuals who are justice-involved.

Questions and Comments

Imparato: As you define disparities, I encourage DHCS to think about subpopulations within the disability community that experience barriers, like the deaf and hard of hearing community or folks who are non-verbal and have a hard time finding providers.

Pfeifer: Good suggestion.

Fields: On the core continuum, the only reference to 24-hour services was institutional. Did the intensive community treatment systems include residential treatment services as well?

Pfeifer: Yes, while the graphic may not have the detail, the paper does clearly address mental health and substance use and references the need for more homelike, peer run, residential settings, and not just institutional settings.

Teare: I appreciate having all the data in one report. It might be useful for continued monitoring to identify some elements of the data as the basis for a dashboard to track.

Savage-Sangwan: Is this intended to look at the needed services and support for people living with serious mental illness/substance use disorders or meant to encompass the broader mental health needs of our state, including people experiencing mild to moderate or intermittent conditions? There may be more to tease apart on the types of prevention at individual and population levels.

Pfeifer: The report aims for a broad view of behavioral health. It is deeper on specialty

mental health/substance use disorders because those are the populations who are the most vulnerable and have the highest risk of poor outcomes. I agree there are areas that would benefit from a deeper dive not possible in this assessment report. Although the report may not be the vehicle, you will see more on prevention in the future.

Veniegas: I appreciate the listening and engagement sessions that you and Melissa Stafford Jones are holding to understand what needs to be done in youth behavioral health, whether it's mental health, substance use, or co-occurring disorders. One theme to highlight from this and other reports is that access is very limited for youth, whether it is the prevention gap for youth or psychiatric beds. The report draws connections across programs and funding. The more we can connect Mental Health Services Act (MHSA), CalAIM, Children and Youth Behavioral Health Initiative funding, and other programs, the more we will have a youth-centric, youth-focused continuum in the safety net.

Lewis: One thing I was looking for in the report was utilization data on existing services, including network adequacy and timely access for specific services. There was some reference to national data. I think we could benefit from data on the experience by service type and not just provider type.

Pfeifer: DHCS is doing work on dashboards to understand what services people receive. We will expand what we are able to share. In particular, payment reform will support better reporting by service type as we move to a new billing system based on codes for services. As we get data under the new system, we can report better service data.

Public Comment

Steve McNally, Orange County: I serve on one of the county behavioral health boards mandated by the state, however, my comments are from me personally. I learn a lot from these meetings. I am glad to hear about the assessment report and want to follow up with comments on prevention. California can spend up to 5 percent of MHSA on planning, which should be about $100 million of the $2 billion total. We are not spending anywhere near that on awareness, distribution of information, or, even more importantly, research. I suggest that California form a JPA for research to use some of the money to understand what capacity needs exist, what works, and what doesn't work. I am also excited about the stimulant program. I know many people have family members with that issue who can't seem to get any traction; possibly this will help. The focus for my comments is research and community planning, and I will try to move this forward where I live. Los Angeles, Orange, and Riverside counties are 45 percent of California’s population. It will take four directors, four Boards of Supervisors, and DHCS to make it happen. That doesn't seem insurmountable to me. The families and consumers who normally aren't at the table need this support. I am personally glad to champion this. I appreciate everything happening at the state level and am encouraged by what's going on in my county, slowly but surely.

Michael Humphrey, Sonoma County IHSS: I like what I am hearing. The counties do collaborate in a lot of ways. In Sonoma, we have been doing a great job collaborating across different programs, and hope to do more of that. Thank you for your good work.

Plans for 2022 Meetings, Next Steps, and Adjourn

Baass: Thank you for the discussion today. The upcoming BH-SAC 2022 dates are scheduled for May 12, July 21, and October 20. Please hold 9:30 a.m. - 1:30 p.m. for these meetings. We look forward to receiving your feedback on the new format for meetings. Your input will help us decide how we hold future meetings, including if they should be virtual, hybrid, or in person and how to structure our time together.