California Behavioral Health Planning Council

Systems and Medicaid Committee Agenda

Thursday, January 16, 2025
8:30 am to 12:00 pm

Hilton La Jolla Torrey Pines
10950 North Torrey Pines Road
La Jolla, California 92037
Fairway III Room

Zoom Link
Meeting ID: 885 5527 3788 Passcode: SMC2025
Join by phone: 1-669-900-6833 Passcode: 8680138

8:30 am	**Welcome, Introductions, and Housekeeping** *Karen Baylor, Chair-Elect and All Members*	
8:35 am	**Review and Accept October 2024 Draft Meeting Minutes** *Karen Baylor, Chair-Elect and All Members*	**Tab 1**
8:40 am	**Overview of Substance Use Disorder Services in Behavioral Health Services Act (BHSA) Full-Service Partnerships** *Marlies Perez, Behavioral Health Transformation Project Executive and Chief of Community Services Division,* *California Department of Health Care Services*	**Tab 2**
9:20 am	**Public Comment**	
9:25 am	**Policy and Provider Perspective of Substance Use Disorder Services in Behavioral Health Services Act Full-Service Partnerships** *Elissa Feld, Director of Policy, California Behavioral Health Directors Association (CBHDA)* *Robb Layne, Executive Director, California Association of Alcohol and Drug Program Executive, Inc. (CAADPE)*	**Tab 3**
10:40 am	**Public Comment**	
10:45 am	**Break**	
11:00 am	**County Perspective of Substance Use Disorder Services in Behavioral Health Services Act Full-Service Partnerships** *Ian Kemmer, Behavioral Health Director, Orange County Health Care Agency*	**Tab 4**
11:45 am	**Public Comment**	

If reasonable accommodations are required, please contact the Council at (916) 701-8211, not less than 10 working days prior to the meeting date.

California Behavioral Health Planning Council

11:50 am **Public Comment**

11:55 am **Wrap Up/Next Steps**
Karen Baylor, Chair-Elect and All Members

12:00 pm **Adjourn**

The scheduled times on the agenda are estimates and subject to change.

Public Comment: Limited to a **2-minute maximum** to ensure all are heard.

Systems and Medicaid Committee Members

Uma Zykofsky, Chairperson	Karen Baylor, Chair-Elect	
Amanda Andrews	Javier Moreno	Walter Shwe
Jessica Grove	Dale Mueller	Marina Rangel
Ian Kemmer	Noel O'Neill	Tony Vartan
Steve Leoni	Liz Oseguera	Susan Wilson
Catherine Moore	Deborah Pitts	

Committee Staff: Ashneek Nanua, Health Program Specialist II

TAB 1

California Behavioral Health Planning Council
Systems and Medicaid Committee (SMC)
Thursday, January 16, 2025

Agenda Item: Review and Accept October 2024 Draft Meeting Minutes

Enclosures: October 2024 Draft Meeting Minutes

Background/Description:

The Systems and Medicaid Committee will review the draft meeting minutes for the October 2024 Quarterly Meeting and have a chance to make corrections. The committee will then accept the meeting minutes.

Systems and Medicaid Committee (SMC)

Meeting Minutes - Draft
Quarterly Meeting – October 17, 2024

Members Present:

Uma Zykofsky, Chairperson	Karen Baylor, Chair-Elect	Jessica Grove
Catherine Moore	Walter Shwe	Noel O'Neill
Steve Leoni	Marina Rangel	Javier Moreno
Tony Vartan	Elizabeth Oseguera	Lanita Mims-Beal

Ian Kemmer (stand-in for Veronica Kelley)

Staff Present: Ashneek Nanua

Presenters: Waheeda Sabah, Dr. Nitumigaabow Champagne, Kelsey Stuhr, Soo Jung, Sandra Hernandez

Meeting Commenced at 8:30 a.m.

Item #1 Review and Accept June 2024 Draft Meeting Minutes

The Systems and Medicaid Committee reviewed the June 2024 draft meeting minutes. The committee accepted the meeting minutes with requested edits requested.

Action/Resolution
The approved minutes will be posted to the Council's Website.

Responsible for Action-Due Date
Ashneek Nanua – October 2024

Item #2 Overview of Behavioral Health Continuum Infrastructure Program (BHCIP) Round 1 Crisis Care Mobile Unit (CCMI) Grant

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Waheeda Sabah from the California Department of Health Care Services (DHCS) provided an overview of the Behavioral Health Continuum Infrastructure Program (BHCIP) Round 1 Crisis Care Mobile Unit (CCMU) Grant. The presentation included information about eligibility requirements, program scope, number of counties and tribal entities awarded, and amounts awarded by county and program. Waheeda then described how the state monitors the program and shared implementation findings. Key findings include the need for mobile crisis services, outreach, and flexibility on how funding is utilized.

Successes for the program include increased coordination with law enforcement, better collaboration with schools, and improved understanding of behavioral health issues. Challenges and potential delays include workforce hiring and retention, inadequate or non-existing electronic health records (EHR) or dispatch systems, long contracting processes for additional rounds of funding, and supply chain issues with vehicle purchasing. Waheeda then demonstrated how to utilize the Criss Care Mobile Unit Data Dashboard. The question-and-answer session included a comment about the crisis mobile vans not appearing to be crisis-friendly for the consumer.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #3 Public Comment

Lynn Rivas, Executive Director for the California Association of Mental Health Peer-Run Organizations (CAMHPRO), stated that her organization would like to see a requirement that peers be included in every response team for future funding rounds. She added that most peer crisis response teams do not include a police officer on the national level. This is because police officers have a terrible reputation of how they treat people with a mental health crisis. Therefore, Lynn recommended that law enforcement be excluded from the mobile crisis teams. Lynn also encouraged funding for peer respite centers.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #4 Dry Creek Rancheria Band of Pomo Indians Presentation on Behavioral Health Continuum Infrastructure Program Round 1 Crisis Care Mobile Unit Grant Implementation

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Dr. Nitumigaabow Champagne, Executive Director of the Dry Creek Rancheria Band of Pomo Indians and the Program Director for Tribal Wraparound Services, Kelsey Stuhr, presented to the committee on their organization and implementation of the Behavioral Health Continuum Infrastructure Program (BHCIP) Round 1 Crisis Care Mobile Unit (CCMU) Grant. The presentation included information about the components and approach of the organization's wraparound services. Dry Creek Rancheria offers the following wraparound Services as it pertains to housing:

- **Bringing Families Home (BFH):** Reduces the number of families in the child welfare system experiencing or at risk of experiencing homelessness, increase family reunification, and prevent foster care placement.
    - Offers financial assistance and housing-related wraparound services.
- **Home Safe:** Offers strategies to address and prevent homelessness and support ongoing housing stability for Adult Protective Services.
- **Housing and Disability Advocacy Program (HDAP):** Includes core requirements such as outreach and case management, disability benefits advocacy, and housing assistance.
- **Homeless Housing, Assistance and Prevention (HHAP):** Offers rapid rehousing, street outreach, service coordination, systems support, operating subsidies, prevention and shelter diversion, and the delivery of permanent housing and innovative housing solutions.
- **Behavioral Health Bridge Housing (BHBH):** Addresses the immediate housing needs of individuals experiencing homelessness with serious behavioral health conditions.
    - Includes intensive case management, direct services, rapid rehousing, short-term, mid, and long-term housing, and emergency services via crisis response.
- **Crisis Care Mobile Unit (CCMU) Program:** Provides vehicles, maintenance, and fuel for use in behavioral health services including crisis response.
    - Includes 2 electric high-end sedans and 1 hybrid high-end 12-15 passenger van.
    - All vans must be used to connect individuals with behavioral health services.

The presenters then described the model the organization uses for tribal wraparound services. The model includes weekly face-to-face intensive case management and crisis care planning and response. Services are culturally appropriate and built on strengths-discovery, meeting the needs of the client, and utilizing natural and informal community resources and supports. The presenters then walked through the steps for developing effective individualized crisis plans. Dr. Nitumigaabow Champagne stated that the organization should have quality data on outcomes to support the effectiveness of the program in about two years. Committee members invited the presenters to provide a follow-up once the data is available.

The question-and-answer session included the following topics:

- Acknowledgement for the great reputation of the Pomo Tribe for taking care of their members.
- Appreciation of how the Crisis Care Mobile Unit Grant is being integrated into the program's other initiatives for a whole-care systems approach.
- Appreciation that the program resembles the original intent of the Mental Health Services Act (MHSA) Full-Service Partnerships (FSPs).
- Question about how the program addresses individuals who are not from federally recognized tribes and if that creates barriers to service.

- The presenters stated that the organization is contracted by the state to provide services in Sonoma, Mendocino, and Lake counties which encompasses 33,000 American Indians.
- The program does resource referral and follow-up whether the individual is native or non-native and does cross-coordination if services are outside the organization's service area. The organization will help the entire family regardless of whether there are members in the family who are not labeled as Native Americans.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #5 Santa Clara County Presentation on Behavioral Health Continuum Infrastructure Program Round 1 Crisis Care Mobile Unit Grant Implementation

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Soo Jung, Director of Adult and Older Adult Cross Systems Initiatives and Crisis Services at Santa Clara County Behavioral Health Services, and county staff, Sandra Hernandez, presented on the county's implementation of mobile crisis services and the Behavioral Health Continuum Infrastructure Program (BHCIP) Round 1 Crisis Care Mobile Unit (CCMU) Grant. The presentation began with information about the county's 988 in-person and phone response options. Mobile programs include Psychiatric Emergency Response Teams (PERT) which is activated via 911 calls. Mobile Crisis Response Teams (MCRT) are another component that are activated through county behavioral health services call centers or the 988 hotline. Mobile Response Stabilization Services (MRSS) for youth are a mobile program activated through Pacific Clinics phone line or the 988 hotline. The Trusted Response Urgent Support Teams (TRUST) is a program activated through county behavioral health services call center or 988 hotline.

The presenters then provided an overview of *Salesforce*, which provides a comprehensive solution for 988 crisis centers and behavioral health care coordination. It includes crisis center response, coordinated care support, integrated services delivery, crisis trend tracking and reporting, and community engagement. The program uses a scheduling and dispatching system to ensure the right case worker addresses the individual in crisis. The scheduling system allows real-time visibility of schedules and upcoming appointments, improves scheduling efficiency and flexibility, automates scheduling and optimization to maximize productivity, and ensures proper coverage.

The *Salesforce* Program has a mobile application that allows employers and contractors to operate more effectively in the field. Individuals in crisis may use the mobile application which includes wait time for a crisis responder and automatically syncs offline data including service appointment and account details to maintain efficiency

when cell phone signal is not available. The presenters shared the average field response times for each of the mobile crisis programs as well as the age range of clients, peak response times and days, and total number of calls and field visits.

The Santa Clara County representatives shared that coordinated care after crisis includes housing and navigation services. Many individuals served are unsheltered so emergency shelters as well as temporary and permanent housing are resources. Navigation services connect individuals to intensive outpatient programs and expand outreach and engagement services.
The question-and-answer session included the following topics:

- Question about how the county addresses assessments because it is common for providers to conduct assessment at every step of crisis contact.
    - Presenters stated that the mobile crisis team does assessments for individuals if they have the potential to be placed on a 51/50 involuntary hold, but it is not a traditional assessment that an outpatient provider would do. The county's Electronic Health Record (EHR) helps different providers read notes to reduce the number of times assessments are done. The teams look at psychiatric hospitalizations and medications in the chart so that the first responders and providers have the information available to them in real-time.
- Question about how to inform Managed Care Plans (MCPs) in the area that this program exists to mitigate emergency rooms as a first step to care.
    - Presenters stated that the county responds to all individuals regardless of insurance status with information about resources on the county's website and connects clients to local agencies. The presenters added that the program is very well-known throughout the community.
- The Salesforce system is a contracted service, not a county program. There was a question on how the county interfaces with *Salesforce*.
    - The presenters stated that 988 triage team at the county has access to the Electronic Health Record system and can see the access points. There is no interface of Electronic Health Records with *Salesforce* but the county meets with *Salesforce* regularly. Mobile Crisis Response Teams can see all the records. It is less about the interface and more about assessing the situation, responding to the crisis, and connecting them to the appropriate resource.
- Question about the strategy of deciding which mobile team is deployed to respond to the crisis and how level of care is determined.
    - Presenters stated that the 988 system is the triage system with trained staff and volunteers who are familiar with all levels of care. These individuals direct the person in crisis to the appropriate resource. The staff at the crisis scene also helps determine the level of care needed for the individual with warm hand-offs.
- Question about the composition of the teams and how the Peer Support Specialists and peer voice is integrated into the mobile crisis teams.
    - The Trusted Response Urgent Support Teams team and Mobile Response Stabilization Services team incorporates peers in their

programs. Trusted Response Urgent Support Teams has a first responder, emergency medical technician (EMT), Peer Support Specialist, and Crisis Intervention Specialist.
    - The Mobile Response Stabilization Services includes a clinician and a youth specialist (over 18 years old).
    - Peers are incorporated as a follow-up in the Mobile Crisis Response Teams and Psychiatric Emergency Response Teams to link them to appropriate resources which includes peer services.
- Question on how 911 triages individuals to the 988 system.
    - Presenters stated that the county created an information sheet on directing individuals to the appropriate resource. 911 teams will route individuals to 988 if 988 is the more appropriate resource.
- Question on whether the centralized dispatch center is the 988 center and how the county overcame staffing challenges to have teams available 24/7.
    - Presenters stated that 988 determines dispatch and routes a caller to the Trusted Response Urgent Support Teams call center. Staff determines who responds to crisis based on the *Salesforce* system. The 988 will direct a call to the mobile crisis response manager who determines who will respond.
    - Staffing has been a challenge for county programs and contractors. For the county team, staff are working specific hours. It is challenging to find individuals to work non-traditional work hours but the county offers a signing bonus as an incentive and focuses on recruitment efforts in existing 24/7 locations such as jails. There is a lot of de-escalation training provided to staff and law enforcement in Crisis Intervention Training (CIT).

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #6 Member Discussion of Behavioral Health Transformation Initiatives Behavioral Health Services Act, California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration (BH-CONNECT), and California Advancing and Innovating Medi-Cal (CalAIM) Initiative

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Systems and Medicaid Committee staff announced that the California Health and Human Services Agency (CalHHS) will release a draft report on the 988 Five-Year Implementation Plan. Committee members will have the opportunity to review the plan and provide recommendations on the draft plan in the coming weeks.

Committee members then held a discussion regarding areas of focus for various behavioral health transformation initiatives, specifically pertaining to the Behavioral

Health Services Act (BHSA) for the committee to advocate on issues related to the accessibility and effectiveness of behavioral health services. The committee reviewed sections of the Behavioral Health Services Act that the Council identified as priority areas to address. Committee members identified the following areas of focus for the Systems and Medicaid Committee:

- Definition of who can be served under the Behavioral Health Services Act (in collaboration with Legislation Committee and Housing and Homelessness Committee)
- Full-Service Partnerships (FSP) and the restrictive nature of who is eligible, including time limitations (In collaboration with the Legislation and Public Policy Committee)
- Integrated Plan (3-year County Plans)
- Housing Continuum (Housing and Homelessness Committee as the lead)
- Implementation of Substance Use Disorder (SUD) services in all parts of the mental health service system (in collaboration with Legislation and Public Policy Committee)
- Effective collaboration with partners in the behavioral health transformation for a statewide plan that serves all Californians (all Council committees)
- Voluntary and Involuntary Services (Patients' Rights Committee as the lead)
- Crisis Continuum
- Statewide Prevention (Non- Full-Service Partnership)
- Fiscal Implications/Sustainability (Executive Committee and Legislation and Public Policy Committee as the lead)
- Evidence-Based Practices and Community-Defined Evidence Practices (in collaboration with the Performance Outcomes Committee)
- Diversity, Equity, and Inclusion – How the Behavioral Health Services Act changes impact communities of color (in collaboration with the Reducing Disparities Workgroup)

Action/Resolution
Committee staff will update the Behavioral Health Services Act prioritization document to include welfare and institution codes relevant to the Systems and Medicaid Committee.

Responsible for Action-Due Date
Ashneek Nanua – November 2024

Item #7 Public Comment

Lynn Rivas, Executive Director for the California Association of Mental Health Peer-Run Organizations (CAMHPRO), stated that it is imperative that services are not restricted only to people who have a diagnosis as mental illness is highly stigmatized in marginalized communities. She added that Full-Service Partnerships should include

peer services as they were historically included but are seen as included now. Lynn also stated that Medi-Cal billing is not being made available to peer-run organizations in most counties which is a problem and would like that to be addressed. Lynn concluded her public comment by stating that evidence-based practices are critical and outcomes need to be tracked.

Action/Resolution
N/A
Responsible for Action-Due Date
N/A

Item #8 California Behavioral Health Planning Council (CBHPC) Workgroup Updates

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The Committee received updates on California Behavioral Health Planning Council's Workgroups. Uma Zykofsky and Javier Moreno shared that the Reducing Disparities Workgroup and Substance Use Disorder Workgroup will meet after the SMC meeting. Ashneek Nanua shared that the Children and Youth Workgroup is planning a youth event and panel.

Action/Resolution
Representatives will share activities of California Behavioral Health Planning Council's workgroups at future committee meetings.

Responsible for Action-Due Date
Uma Zykofsky, Javier Moreno, Noel O'Neill – Ongoing

TAB 2

California Behavioral Health Planning Council (CBHPC)
Systems and Medicaid Committee (SMC)
Thursday, January 16, 2025

Agenda Item: Overview of Substance Use Disorder Services in Behavioral Health Services Act (BHSA) Full-Service Partnerships

Enclosures: Behavioral Health Transformation Substance Use Disorder Services in Full-Service Partnerships Presentation

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

The purpose of this agenda item is to provide the committee with an ovesrview of Substance Use Disorder Services in the Behavioral Health Services Act (BHSA) Full-Service Partnership (FSP) Programs. The committee will use this information to help improve the coordination, access, and continuum of care for individuals living with Substance Use Disorders and co-occurring mental health conditions.

Background/Description:
Behavioral Health Transformation (BHT) is an initiative implemented through Proposition 1. It aims to modernize the behavioral health delivery system, improve accountability, increase transparency, and expand the capacity of behavioral health care facilities for Californians. The Transformation includes Senate Bill 326: Behavioral Health Services Act. The Act replaces the Mental Health Services Act of 2004. It reforms behavioral health care funding to prioritize services for people with the most significant mental health needs while adding the treatment of Substance Use Disorders, expanding housing interventions, and increasing the behavioral health workforce.

Full-Service Partnerships are one component of the Mental Health Services Act with the philosophy to do “whatever it takes” to help individuals achieve wellness and their goals. These programs embrace client driven services and supports with each client choosing services based on individual needs. Under the Behavioral Health Services Act, Full-Service Partnerships will include Substance Use Disorder services.

Marlies Perez, Behavioral Health Transformation Project Executive and Chief of the Community Services Division at the Department of Health Care Services, will present an overview of Substance Use Disorder services in Full-Service Partnerships. Marlies will also share information on Assertive Field-Based Substance Use Disorders, what entities provide this service, and how the state defines the term, “Severe Substance Use Disorders.” The committee will have time to ask questions after the presentation.

Behavioral Health Transformation
Substance Use Disorder Services in Full-Service Partnerships

Marlies Perez, Division Chief
BHT Project Executive
Department of Health Care Services

January 16, 2025

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Housekeeping

- You may type your comments into the chat box throughout the presentation.
- Once we reach the discussion portion of our workgroup meeting, please raise your hand to speak and we will go in the order of raised hands.

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Meeting Agenda

- Behavioral Health Transformation
- Severe Substance Use Disorder (SUD)
- Full-Service Partnership (FSP)
- Assertive Field-Based Initiation for SUD Treatment Services Update
- Discussion & Resources

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Behavioral Health Transformation

DHCS

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Behavioral Health Transformation

In March 2024, California voters passed Proposition 1, a two-bill package, to modernize the state's behavioral health care system. It includes a substantial investment in housing for people with behavioral health care needs.

Behavioral Health Services Act

- Reforms behavioral health care funding to provide services to Californians with the most significant behavioral health needs
- Expands the behavioral health workforce to reflect and connect with California's diverse population
- Focuses on outcomes, accountability, and equity

Behavioral Health Bond

- Funds behavioral health treatment beds, supportive housing, and community sites
- Directs funding for housing to veterans with behavioral health needs

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Behavioral Health Transformation Milestones

Below are high-level timeframes for several milestones that will inform requirements and resources. Additional updates on timelines and policy will follow throughout the project.

Started Spring 2024

Stakeholder Engagement

Stakeholder engagement including, **public listening sessions,** will be utilized through all milestones to inform policy creation.

Started Summer 2024

Bond BHCIP: Round 1 Launch Ready

Requests for Applications (RFA) for up to $3.3 billion in funding leveraging BHCIP.

Started Late 2024

Policy Manual and Integrated Plan Guidance

Policy Manual Module 1 and Module 2 were **released for public comment.** Additional modules will be released in 2025.

Summer 2026

Integrated Plan

New Integrated Plan, fiscal transparency, and data **reporting requirements** go-live in July 2026 (for next three-year cycle).

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Severe Substance Use Disorder (SUD)

DHCS

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Severe Substance Use Disorder Definition

"Severe substance use disorder" means a diagnosed substance-related disorder that meets the diagnostic criteria of "severe" as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders

Definition sourced from SB-43 FAQs

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Full-Service Partnership (FSP) Integration With Substance Use Disorder (SUD)

Expectations for the Behavioral Health Services Act

1. Counties must conduct assertive field-based initiation; and
2. FSP teams must be capable of supporting individuals living with co-occurring mental health and substance use conditions.

NOTE: *SB 326 does not prohibit counties from establishing FSP programs for individuals with primary SUD diagnoses (i.e., without co-occurring significant mental health needs), however, counties are not required to develop new, dedicated Levels of Care specific to SUD, or FSPs that are exclusively for SUD (apart from implementing new, field-based initiation of SUD care requirements). DMC-ODS is intended to cover a comprehensive continuum of care for SUD.*

Full-Service Partnership (FSP)

DHCS

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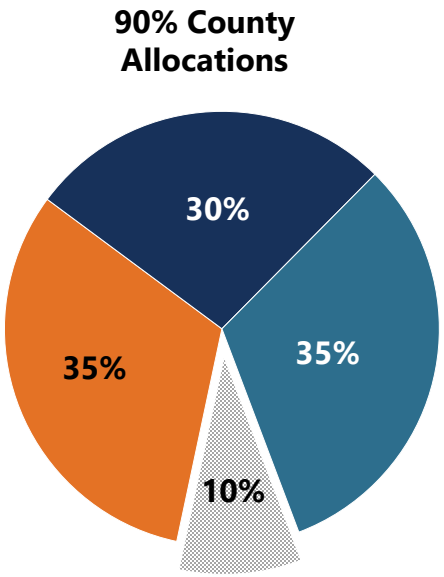
Behavioral Health Services Act Funding Breakdown

90% **County Allocations**

30% **Housing Interventions**
Interventions include rental subsidies, operating subsidies, shared housing, family housing for eligible children and youth, and the non-federal share of certain transitional rent.

35% **Full-Service Partnership Services**
Comprehensive and intensive care for people at any age with the most complex needs (also known as the "whatever it takes" model).

35% **Behavioral Health Services and Supports**
Includes early intervention, outreach and engagement, workforce, education and training, capital facilities and technological needs, and innovative pilots and projects.



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Behavioral Health Services Act (Senate Bill 326) FSP Funding Requirements

- 35% of the funds distributed to counties **must be used for Full-Service Partnership (FSP) Programs**
- Per WIC Section 5887(a)(2), counties with a population of less than 200,000 may request an exemption from certain components of the required 35% allocation of Behavioral Health Services Act funds for Full-Service Partnership (*Note: exemption process under development*)
- Counties have the flexibility to move 7% of funds to/from Full-Service Partnerships into another category (Housing Interventions or Behavioral Health Services Supports) for a maximum total shift of 14%.

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FSP Continuum

- FSP programs are comprised of required and allowable services. FSP programs must make required services available as a condition of receiving Behavioral Health Services Act funding. Allowable services are additional services that may be offered and can be paid for using Behavioral Health Services Act FSP funds.

Required Services

Required services are outlined in statute and must be included in FSP programs:

- Mental health services, supportive services, and SUD services
- Assertive field-based initiation for SUD
- Outpatient behavioral health services for evaluation and stabilization
- Ongoing engagement services
- Service Planning
- Housing Interventions*
- Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT)** or FSP Intensive Case Management (ICM)
- High-Fidelity Wraparound (HFW)**
- Individual Placement and Support (IPS) model of Supported Employment**

Allowable Services

Allowable services may be included in addition to, or in conjunction with, required services. They include, but are not limited to:

- Primary SUD FSPs
- Additional Evidence Based Practices (EBPs)
- Outreach and Engagement
- Other non-clinical services

*Housing Interventions pursuant to WIC Section 5830 must be funded through Housing Interventions funding.
**Services eligible for small county exemption requests.

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

SUD in FSP Programs

- Draft Policy Manual:
- B.3.2 Baseline Requirements
- Given the expansion to include individuals living with substance use disorder (SUD) in the Behavioral Health Services Act, county FSP programs must include SUD treatment services where appropriate.
- County FSP teams must be capable of supporting FSP participants living with co-occurring mental health and substance use conditions by providing integrated behavioral health care as part of the FSP program, inclusive of mental health and SUD services, or by closely coordinating the provision of SUD care for FSP participants.

Overview: Adult FSP Levels of Care

- To meet new Behavioral Health Transformation requirements, DHCS and stakeholders have developed a **model for the Adult FSP standards of care** with levels based on an individual's need for service intensity.
- Since ACT is a required service and an evidence-based practice (EBP) for those with the highest acuity, **ACT will be the highest level of care** for an adult in the FSP program.
- **The standardized step-down level from ACT will be, FSP Intensive Case Management (ICM),** which will capture individuals who may not meet ACT eligibility criteria, but still have significant behavioral health needs and can benefit from FSP supports.
- WIC Section 5892(k)(8)(A) defines adult and older adults as those 26 or older. For the purposes of FSP programs, **the Adult FSP is for those 26 or older as well as Transitional Age Youth or younger, if determined to be clinically and developmentally appropriate.**

Adult FSP Levels of Care Framework

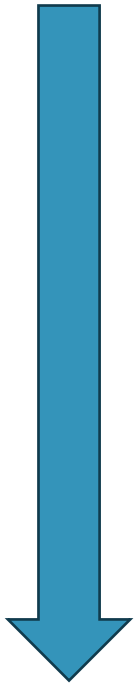
The framework includes two levels of coordinated care for adults and older adults with ACT as the highest level and a step-down level from ACT, that we are calling FSP Intensive Case Management (ICM).

Full-Service Partnership Eligible

- Level 2: **Assertive Community Treatment (ACT):** Stand-Alone EBP for Highest Need Adults and Older Adults
- Level 1: **FSP Intensive Case Management (ICM):** Higher Need Adults and Older Adults

BHSS Eligible

- **Outpatient Specialty Mental Health Services (SMHS):** Individuals stepping down from FSP ICM no longer meet the threshold for FSP and should receive outpatient SMHS BH services, as needed.



Level of Intensity

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Overview: Intensive Case Management (ICM)

- ICM is a service that is well known and documented in the literature.
- ICM includes a **comprehensive set of community-based services** for individuals with significant behavioral health conditions.
- Compared to standard care, ICM has been shown to improve general **functioning, employment and housing outcomes, and reduce length of hospital stays**.
- ICM does not have set fidelity criteria like ACT but generally **combines the principles of case management** (assessment, planning, linkages) with **low staff to client ratios**, **assertive outreach**, and **direct service delivery**.

Sources:
1. Dieterich M, Irving CB, Bergman H, Khokhar MA, Park B, Marshall M. Intensive case management for severe mental illness. Cochrane Database of Systematic Reviews. 2017, DOI: 10.1002/14651858.CD007906.pub32
2. Schaedle, R.W., Epstein, I. Specifying Intensive Case Management: A Multiple Perspective Approach. *Ment Health Serv Res* 2, 2000. https://doi.org/10.1023/A:1010157121606
3. Meyer, P., and Morrissey, J. A Comparison of Assertive Community Treatment and Intensive Case Management for Patients in Rural Areas. Psychiatric Services. (2007). https://doi.org/10.1176/ps.2007.58.1.121

Assertive Field-Based Initiation for SUD Treatment Services Update

DHCS

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Working Definition

Assertive field-based initiation for substance use disorder treatment services

Outreach, engagement and initiation of treatment for substance use (e.g., alcohol misuse, stimulant misuse, opioid use) disorder **particularly medications for addiction treatment (MAT) in any low-barrier setting**, such as on the street, in homeless encampments, drop-in centers, syringe services programs and other easily accessible locations **to reach people wherever they are**.

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Assertive Field-Based Initiation for SUD Treatment Services Requirements

Counties are required to provide **rapid access to** all Food and Drug Administration (FDA)-approved MAT directly or through referrals

» **Rapid MAT access** means:

- County field-based – mobile field-based and open-access – programs are **expected** to work towards ensuring **same day MAT access**
- Field-based programs can **have MAT prescribers on staff or refer** to providers who are able to rapidly initiate MAT, including Federally Qualified Health Centers (FQHCs), Indian Health Clinics, and Narcotic Treatment Programs (NTPs)
- County field-based programs that are not certified to dispense methadone must provide referrals to NTPs, medication units, mobile NTPs, and Emergency Departments (EDs) to rapidly initiate methadone
- Counties can utilize **telehealth models** to ensure access to MAT
- Field-based programs must provide or refer individuals initiated to programs for MAT maintenance
- Counties must detail how and when they will be able to assure same day access to MAT in their initial Integrated Plan

Assertive Field-Based Initiation for SUD Treatment Services Requirements

Counties will be required to provide rapid access to MAT by **strengthening**, **expanding existing**, and/or **standing-up** at least one initiative in each of the following three areas:

1. **Data-informed targeted outreach** to BHSA eligible individuals with SUD needs
   - May be performed by Mobile Field-Based teams (below) or delivered via other models

2. **Mobile Field-Based Programs**
   - Teams that conduct "on the ground" field-based outreach to provide engagement, harm reduction support, trust building, motivational interviewing, and directly provide or facilitate rapid access to MAT and other SUD services
   - Can use street outreach programs with an embedded prescriber or mobile NTPs

3. **Open-Access Clinics**
   - Outpatient settings providing low barrier, low-threshold rapid access to MAT
   - Can use syringe services programs with drop-in clinic services, medication units, drop-in clinics with open access scheduling (e.g., FQHCs, community mental health centers, ambulatory outpatient CA Bridge sites)

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Best Practices for Outreach and Field-Based Programs

County assertive field-based programs are encouraged to provide the following activities:

- **Post-overdose follow-up engagement services** if they learn about an individual who has survived an overdose
- **Share harm reduction** supplies, such as harm reduction kits with naloxone, as well as fentanyl and xylazine testing strips
- **Provide primary care,** including necessary wound care, Hepatitis C and Human Immunodeficiency Virus (HIV) testing and care
- If a referral is provided, in lieu of direct services, complete **follow-up** to ensure MAT was provided
- **Work with Emergency Medical Services (EMS), law enforcement, and other partners to obtain data** on community overdose and SUD-related needs to inform their outreach

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Utilize Existing Field-Based Programs

- Counties can support **existing providers/programs** that may already provide all or some of the required components, for example:
  - FQHCs that prescribe MAT to operate as **open-access clinics**
  - Street outreach/medicine programs with an embedded prescriber to operate as **mobile field-based program**

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Cross-County Collaboration Approach

- To ensure individuals residing in adjoining counties can receive available and accessible MAT and other SUD treatment, **counties can collaborate to expand and support field-based mobile and open-access clinics**, and refer residents **across county programs**
- Under a cross-county collaboration approach, **counties may pool together financial resources** to design and support:
  - **Mobile field-based programs**, such as street outreach programs with an embedded prescriber or mobile NTPs, to rotate through locations across multiple counties on designated days
  - **Open-access clinics**, to provide care and accept MAT referrals from individuals residing in partnering counties

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Timeframe and Integrated Plan

- Counties will describe in their first Integrated Plan their approach and timeline for meeting assertive field-based requirements across all three requirements by July 1, 2029
- The description will include:
  - **Timeline for Meeting the Three Assertive Field-Based Requirements:** Counties will indicate when they will be able to meet requirements. Counties that do not anticipate that they will be able to meet requirements by July 1, 2026 will describe how they intend to phase in requirements by July 1, 2029.
  - **Program Design:** Counties will describe the outreach, specific types of field-based program models they will support, their programs' team composition, hours of operations, and location of their programs.

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Discussion

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Resources

Behavioral Health Transformation Website and Monthly Newsletter

Explore the Behavioral Health Transformation website to discover additional information and access resources.

Please sign up on the DHCS website to receive monthly Behavioral Health Transformation updates.

Infographics and FAQs

Explore our infographics and FAQs for additional insight in the Behavioral Health Transformation on the Behavioral Health Transformation website, along with this public listening recordings, once available.

Questions and Feedback

Please send any other questions or feedback about Behavioral Health Transformation to BHTInfo@dhcs.ca.gov.

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Thank You

For Questions

BHTinfo@dhcs.ca.gov

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HEALTH CARE SERVICES

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TAB 3

California Behavioral Health Planning Council (CBHPC)
Systems and Medicaid Committee (SMC)
Thursday, January 16, 2025

Agenda Item: Policy and Provider Perspective of Substance Use Disorder Services in Behavioral Health Services Act Full-Service Partnerships

Enclosures: None

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

The purpose of this agenda item is to provide the committee with policy and implementation considerations of Substance Use Disorder (SUD) Services in the Behavioral Health Services Act (BHSA) Full-Service Partnerships (FSP). The committee will use this information to evaluate statewide efforts being made to improve coordination, access, and continuum of care for individuals with SUD and co-occurring mental health conditions.

Background/Description:

Behavioral Health Transformation (BHT) is an initiative implemented through Proposition 1. The Transformation includes Senate Bill 326: Behavioral Health Services Act which replaces the Mental Health Services Act of 2004. Under the Behavioral Health Services Act, Full-Service Partnerships will include Substance Use Disorder Services.

Elissa Feld, Director of Policy at the California Behavioral Health Directors Association (CBHDA) and Robb Layne, Executive Director of the California Association of Alcohol and Drug Program Executive, Inc. (CAADPE) will present policy considerations of implementing Substance Use Disorder Services in Full-Service Partnerships. The presentation will include information about program eligibility, workforce considerations, capacity needs, local impacts, and implementation challenges and opportunities. The committee will have a question-and-answer session upon conclusion of the presentation.

TAB 4

California Behavioral Health Planning Council (CBHPC)
Systems and Medicaid Committee (SMC)
Thursday, January 16, 2025

Agenda Item: County Perspective of SUD Services in BHSA Full-Service Partnerships

Enclosures: None

How This Agenda Item Relates to Council Mission
To review, evaluate and advocate for an accessible and effective behavioral health system.

The purpose of this agenda item is to provide the committee with information regarding the local level implications of including Substance Use Disorder (SUD) Services in the Behavioral Health Services Act (BHSA) Full-Service Partnerships (FSP). The committee will use this information to inform their policy recommendations on the Behavioral Health Transformation Implementation as it relates to Substance Use Disorders.

Background/Description:

Behavioral Health Transformation (BHT) is an initiative implemented through Proposition 1. The Transformation includes Senate Bill 326: Behavioral Health Services Act which replaces the Mental Health Services Act of 2004. Under the Behavioral Health Services Act, Full-Service Partnerships will include Substance Use Disorder Services.

Ian Kemmer, Behavioral Health Director of Orange County Health Care Agency, will present on the local impacts of implementing Substance Use Disorder Services in Full-Service Partnerships under the Behavioral Health Services Act. The presentation will include information about how Orange County Health Care Agency will determine the needs for capacity, funding, workforce, harm reduction, treatment services, and outreach and engagement efforts. The committee will have a question-and-answer session upon conclusion of the presentation.