Behavioral Health Transformation Public Listening Session

Full-Service Partnerships (FSP)

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Public Listening Session Format

For each topic, DHCS will:

1. Present the information specified in the County Integrated Plan for Behavioral Health Services and Outcomes.
2. Solicit stakeholder feedback via the prompt(s).

Please note: DHCS is ***gathering information*** and will not be responding to questions during the public listening session. We will only offer points of clarification.

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How to Provide Feedback

1. Type your feedback/comments in the Q&A box (click the icon located on your control panel).
2. Send an email to BHTinfo@dhcs.ca.gov with the subject line "Public Listening Session." Feedback will be accepted through **November 6th, 2024**. Feedback received after this date will still be considered, but not included in the summary document.

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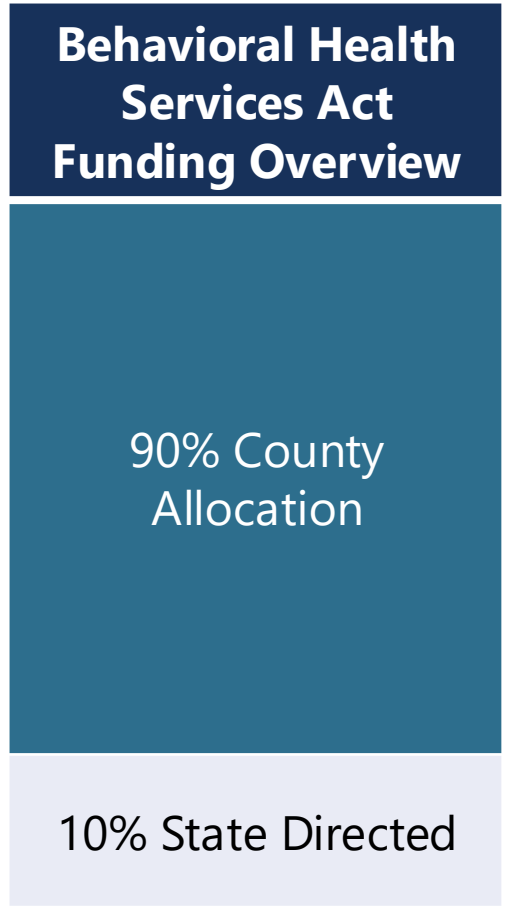
Behavioral Health Services Act

Behavioral Health Services Act:

- **Updates allocations** for local services and state-directed funding categories
- Broadens the target population to **include individuals with Substance Used Disorders (SUDs)**
- Focuses on the **most vulnerable and at-risk**, including children and youth
- Advances community-defined practices as a key strategy for **reducing health disparities** and **increasing community representation**
- Revises county processes and improves **transparency and accountability**



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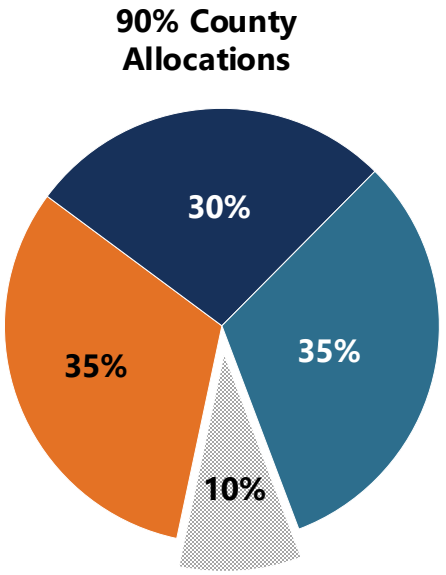
Behavioral Health Services Act Funding Breakdown

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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Full-Service Partnerships (FSP)

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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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Behavioral Health Services Act on FSP Programs

Per WIC Section *5887, each county shall administer a Full-Service Partnership program that includes the following services:*

(a)(1) **Mental health services, supportive services, and substance use disorder treatment services.**
(2) **Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) fidelity, Individual Placement and Support model of Supported Employment, high fidelity wraparound***, or other evidence-based services and treatment models, as specified by the State Department of Health Care Services.
(3) **Assertive field-based initiation for substance use disorder treatment services***, including the provision of medications for addiction treatment, as specified by the State Department of Health Care Services.
(4) **Outpatient behavioral health services**, either clinic or field based, necessary for the ongoing evaluation and stabilization of an enrolled individual.
(5) **Ongoing engagement services** necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and nonclinical services, including services to support maintaining housing.
(6) **Other evidence-based services and treatment models**, as specified by the State Department of Health Care Services
(7) **Service planning**
(8) **Housing Interventions** pursuant to Section 5830.
(e) Full-Service Partnership programs shall have an **established standard of care with levels based on an individual's acuity and criteria for step-down*** into the least intensive level of care, as specified by the State Department of Health Care Services, in consultation with the Behavioral Health Services Oversight and Accountability Commission, counties, providers, and other stakeholders.

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*Focus of today's presentation.

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*
- ACT/FACT** or FSP 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

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

FSP Integration With SUD

- **Expectations for the Behavioral Health Services Act**
  - Counties must conduct assertive field-based initiation; and
  - FSP teams must be capable of supporting individuals living with co-occurring mental health and substance use conditions.
- **NOTE:** The Behavioral Health Services Act 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). Drug Medi-Cal (DMC)-Organized Delivery System (ODS) is intended to cover a comprehensive continuum of care for SUD.

Feedback
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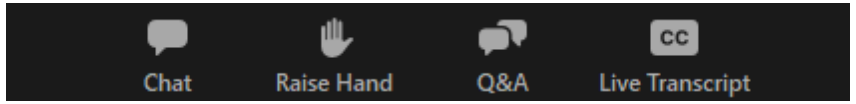

1. What are some effective models, or service components, to integrate SUD into FSP teams?

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Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT)

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ACT Eligibility Criteria

- To be eligible for ACT, individuals generally must:
  - Be ages 18+; **AND**
  - Have a current DSM diagnosis consistent with a serious and persistent mental illness; **AND**
  - Have significant functional impairment; **AND**
  - Have an indicator of continuous high-service needs.
- Criteria b) and c) are equivalent to having "serious mental illness" (SMI), although a state can set a higher bar for the level of functional impairment required to receive ACT. Criteria d) permits states more flexibility to determine the exact nature of the population requiring ACT.
- **DHCS's proposed ACT eligibility criteria is based on the SAMHSA toolkit and criteria from other states.** The proposed criteria was vetted as part of the BH-CONNECT ACT workgroup process.

ACT Service Components

FSP ACT programs must mirror the service components outlined in the Medi-Cal benefit and be made available to non-Medi-Cal members who receive FSP and are clinically eligible for the highest level of care. FSP funding can be used to cover additional non-clinical supports that are not covered by Medi-Cal, as needed.

- Assessment
- Crisis Intervention
- Employment and Education Support Services
- Medication Support Services
- Peer Support Services
- Psychosocial Rehabilitation
- Referral and Linkages
- Therapy
- Treatment and Planning

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ACT Fidelity Monitoring, Certification, and Training

- Under BH-CONNECT, DHCS is partnering with a Center of Excellence to provide support related to fidelity monitoring, training, and technical assistance for all ACT teams.
- FSP ACT programs will also be expected to meet initial certification and subsequent fidelity monitoring standards as provided for in forthcoming Medi-Cal guidance.

Forensic ACT Proposed Requirements

- FACT is ACT tailored to justice-involved individuals.
- Counties may adapt their FACT model based on local resources and needs (e.g., more populous counties may have dedicated FACT team, smaller more rural counties may integrate FACT within their ACT teams)
- ACT teams meet the FSP requirement to include FACT if:
  - Counties have dedicated FACT teams; **OR**
  - At least one ACT team member has lived experience; **OR**
  - All ACT team members complete FACT training.

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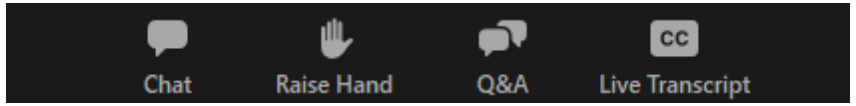

2. For FSP teams currently implementing ACT and/or FACT, are there lessons learned that can be shared or resources/supports that would have been helpful for implementation?

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Intensive Case Management (ICM)

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Intensive Case Management (ICM)

- ICM is a well-known service 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**.

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Who Might FSP ICM Serve?

- Individuals receiving FSP ICM may include **members who were receiving ACT and have been clinically determined to be ready for a step-down** level of care
- Individuals may also enter an FSP program **needing a moderate to significant level of support** but do not meet the qualifications for ACT
- Individuals living with **co-occurring SMI/SUD**
- Individuals ages 18-26 or younger who are **not connected to children's services**, if determined to be clinically and developmentally appropriate

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How Might FSP ICM Eligibility Compare to ACT?

Dark Blue* = ACT **Blue**** = ICM Black*** = Both

To qualify for **ACT*/ ICM****, a member **must**:

- **Be over age 18*** and have a current DSM diagnosis consistent with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED)***, **Substance Use Disorder (SUD)** (at county option)** or co-occurring SMI and SUD***; and
- Have **significant*/ moderate to significant**** functional impairment, including:
  - **Consistent inability*/ difficulty**** to perform practical daily tasks
  - **Persistent or recurrent failure*/ difficulty**** to perform daily living tasks, except with significant support
  - **Consistent inability** to be employed and maintain*/ **Difficulty maintaining** consistent employment** or a safe living situation
- Have an indicator of continuous high-service needs, including:
  - **High use of acute psychiatric hospitalization or emergency services*/ Risk of hospitalization or crisis/emergency care without support****
  - Intractable severe major symptoms***
  - Coexisting SUD***
  - High risk of recent involvement with criminal justice system and/or homelessness***

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Note: Clinician and team determine appropriate level of care. Additionally, movement between tiers may be fluid (i.e., client may also need to step back up).

Determining Appropriate Level of Care

- While DHCS is developing guidelines for FSP ICM eligibility criteria, DHCS recognizes the role of clinician and team judgement in determining the appropriate level of care.
- DHCS recognizes movement between tiers may be fluid (i.e., client may also need to step back up).
- The County Office of Education (COE) will provide technical assistance and monitoring support to counties
- DHCS monitoring of FSP programs will focus on ensuring all BHSA required FSP services/components are available, including FSP Levels of Care.

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FSP ICM: Proposed Services

FSP ICM participants may need some or all of the same service components as ACT.

- Assessment
- Crisis Intervention
- Employment and Education Support Services
- Medication Support Services
- Peer Support Services
- Psychosocial Rehabilitation
- Referral and Linkages
- Therapy
- Treatment and Planning
- Housing supports
- ***Note:*** *This list is not exhaustive. Additional services may be provided on an as needed basis.*

A Note on Permanent Supportive Housing:
Pairing intensive behavioral health services like ACT and FSP ICM with permanent housing is a recommended best practice for achieving long-term housing stability.

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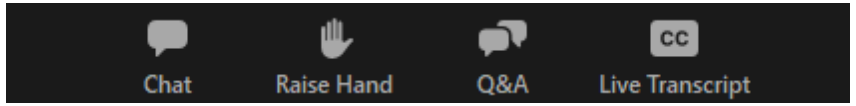

3. What other components should be looked at when serving individuals under ICM?

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Supported Employment: Individual Placement and Support (IPS)

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Overview: Individual Placement and Support (IPS)

Over 60% of clients with severe mental illness want to work, but less than 20% are employed.[1] The IPS model of supported employment is an evidence-based intervention that engages people with severe mental illness in finding and maintaining *competitive* employment or education *of their own choice*.

- The IPS model uses a strength-based approach to support individuals living with serious mental illness[1] **find and maintain employment**, which plays a crucial role in their **recovery and integration into the community**.
- Supported Employment can be **integrated into other FSP services** such as ACT, HFW, and Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP,) to offer a comprehensive approach to recovery that addresses both clinical and functional needs.
- BHT Supported Employment programs will align with the evidence-based IPS model and **mirror the Medi-Cal benefit** being developed through BH-CONNECT[2].
- Compared to traditional vocational rehabilitation approaches, IPS has demonstrated **higher rates of competitive employment** for individuals with behavioral health disorders.[3]

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[1] IPS Employment Center, 2024
[2] Under BH-CONNECT, Supported Employment will be available at county option in the SMHS **and** DMC/DMC-ODS delivery systems
[3] Recent research has also demonstrated the effectiveness of the IPS model in supporting individuals living with SUD gain employment (Marsden et. al, 2024)

Individual Placement and Support (IPS)

- IPS is an important part of **psychosocial rehabilitation**, providing structure, purpose, and social connection to reduce isolation and combat stigma for individuals with SMI.
- The evidence-based model is designed to help individuals with serious mental illness **find and maintain jobs as part of their recovery and is based on 8 core principles**[1,2]**.**

IPS Core Principles

- Zero Exclusion
- Competitive Employment
- Rapid Job Search
- Systematic Job Development
- Integrated Services
- Benefits Planning
- Time-Unlimited Supports
- Worker Preferences

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[1] IPS Employment Center, 2024

[2] There are other evidence-based models of Supported Employment for individuals with I/DD to get and keep competitive integrated employment in the community.

IPS Supported Employment Eligibility Criteria

Proposed eligibility criteria aligns with best practices, prioritizing inclusivity and client choice.

Proposed Eligibility Criteria

To be eligible for Supported Employment services, an individual must:

a) Meet FSP eligibility criteria[1]; **AND**

b) Express interest in receiving Supported Employment Services

» This approach is grounded in national best practices including **"zero exclusion criteria"** from the official IPS fidelity scale and "**eligibility is based on consumer choice"** from SAMHSA's Supported Employment toolkit.

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[1] **Note:** Counties opting-in under BH-CONNECT can provide IPS to a broader population of individuals who meet SMHS and/or DMC/DMC-ODS access criteria, as defined in BHIN 21-073

Proposed Service Components

The proposed Supported Employment service components are categorized as Pre-Employment Services and Employment Sustaining Services.

Note on Supported Employment Medi-Cal Coverage

Historically, Centers for Medicare and Medicaid Services (CMS) has not approved all supported employment service components under the state plan and advises states to implement the full breadth of the supported employment model through 1915(c) and (i) authorities. Under BH-CONNECT, California is partnering with CMS to approve the full model as a bundled service through a State Plan Amendment.

- **Pre-Employment Services** are those directly related to an individual's recovery goals, such as pre-vocational assessment, person-centered planning, job development and placement activities, and benefits education and planning.
- **Employment Sustaining Services** are those directly related to supporting an individual manage their behavioral health condition and addressing challenges as they work to sustain employment and achieve their recovery goals, such as career advancement services, job analysis, job coaching, benefits education and planning, asset development, and follow-along supports.

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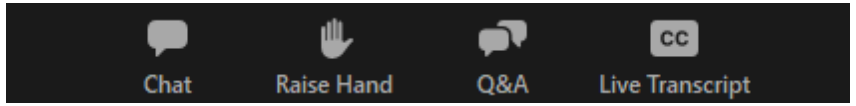

4. Are there opportunities for counties and providers to partner with local entities to implement IPS?

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High Fidelity Wraparound (HFW)

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Overview: High Fidelity Wraparound (HFW)

HFW is a **team-based** and **family-centered evidence-based practice** that includes an **"anything necessary"** approach to care for children/youth living with the **most intensive mental health or behavioral challenges**. HFW is regarded as an **alternative to out-of-home placement for children with complex needs,** by providing intensive services in the family's home and community.

- HFW centers family voice and decision-making in developing a care plan to reach desired family outcomes by providing a structured, creative, and individualized set of strategies that result in plans/services that are effective and relevant to the child, youth, and family.

- HFW is delivered by a **HFW Facilitator**, who leads a team through a prescribed process, which is both flexible and responsive to child and family-identified strengths and needs.

- At its core, high fidelity is defined as **adherence to the four phases of the HFW model:**

Phase 1: Engagement and Team Preparation	Phase 3: Implementation
Phase 2: Plan Development	Phase 4: Transition

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Evidence Base for HFW

When wraparound is delivered with high fidelity to the practice model, there is a strong evidence base for positive impact on youth and families.

- Various programs emphasize "wraparound" as a component of service delivery, but there is a difference between wraparound as a philosophy of care, and HFW, which is an **evidence-based practice (EBP).**

- Programs that implement HFW achieve more favorable outcomes. For example, studies have found that families who received HFW **practiced to fidelity** achieved better outcomes such as:
  - **Child behavior and parent satisfaction**
  - **Improve mental health functioning**
  - **Reduce absences and suspensions from school**
  - **Cost savings** through reduced claims expenses for Emergency Room and inpatient psychiatry visits.

Note: What constitutes an EBP is debated in the field as there is no one source of truth. The California Evidence-Based Clearinghouse for Child Welfare recognizes wraparound (not HFW), and ICC using HFW facilitation, as practices which is supported by **promising** research evidence.

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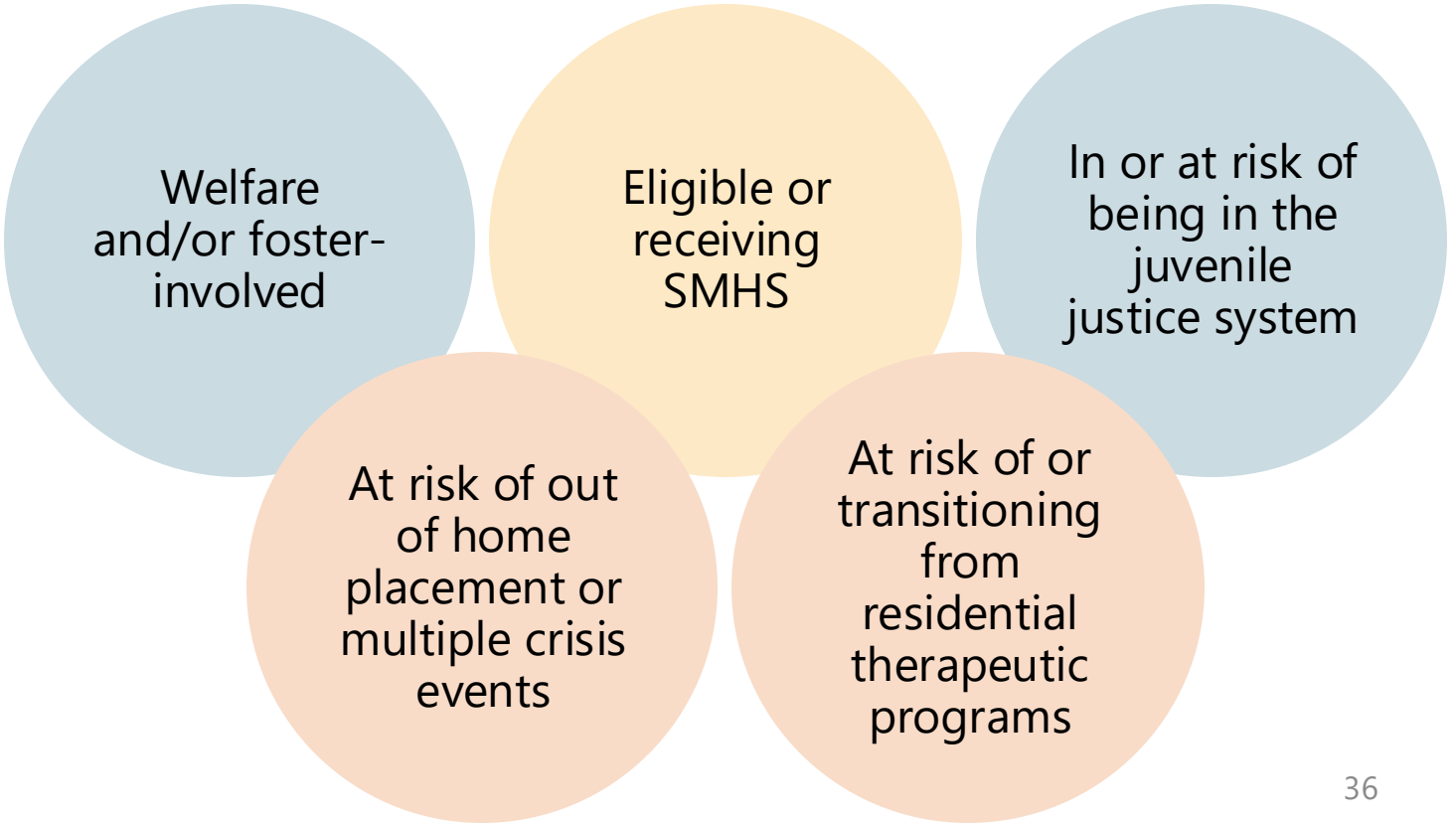
Expanding the Population of Children and Youth Served by HFW

With clarification of HFW as a Medi-Cal billable bundle, the **population of children and youth served by HFW will expand** to support a diverse range of needs and systems interaction, which are not mutually exclusive and include **(but are not limited to)** children and youth who are:

- *Note: DHCS will continue to explore these intersections in consideration of ongoing initiatives/reforms underway impacting children and youth served by these systems, but that is not the focus of today's discussion.*



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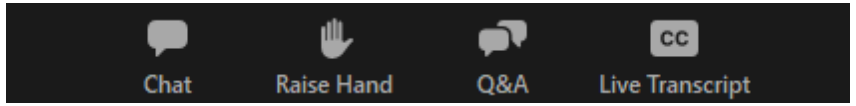

5. How are counties and providers that are currently providing HFW services aiming to ensure that these services are moving towards fidelity for BHSA? Are there specific areas of TA that are needed?

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Adult FSP Levels of Care

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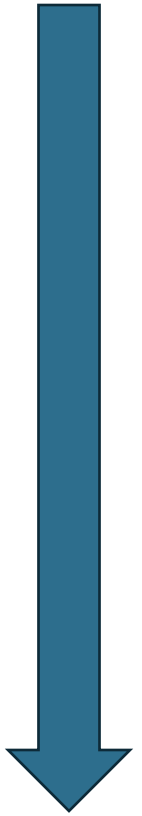
Overview: Adult FSP Levels of Care

- 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 acuity and criteria for step down.
- Since ACT is a required service and an evidence-based practice (EBP) for those with the highest acuity, **we propose that ACT be the highest level of care** for an adult in the FSP program.
- **DHCS proposes developing a standardized step-down level from ACT, using known terminology, 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. Many of California's current FSP programs include more than one level of care; this Behavioral Health Services Act policy will improve standardization across the state.
- 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

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FSP Levels of Care for Children/Youth

- DHCS will require High Fidelity Wraparound (HFW) for children/youth as an EBP, so that it is delivered with fidelity in each county.
- HFW subject matter experts/research do not support defining multiple levels of care in this scenario, given that HFW service design enables flexibility to adjust the level of intensity according to an individual's needs.
- The Behavioral Health Services Act does not prohibit counties from establishing FSP programs for children/youth that include multiple levels of care based on intensity of mental health or SUD needs. However, DHCS will not require counties to develop multiple, dedicated levels of care for FSP for children/youth.

Feedback
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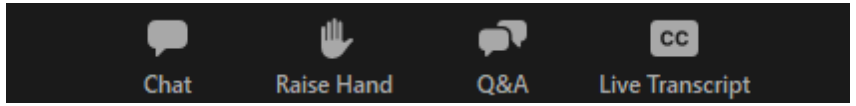

6. Please provide feedback on the proposed levels of care.

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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 More Information

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