
CalAIM Summary Client/Consumer Perspectives

Introduction

As part of Governor Newsom's priority to reform California's Public Mental Health System, the California Department of Health Care Services (DHCS) is undertaking comprehensive changes to California's Medi-Cal Program. DHCS released a proposal, CalAIM (California Advancing and Innovating Medi-Cal), on October 28, 2019. Within this proposal, DHCS states:

CalAim establishes a foundation where investments and programs within Medicaid can easily integrate, complement and catalyze the Administration's plan to impact the State's homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more integrated systems of care and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission

A summary of the proposed changes which have the **potential to impact adult behavioral health consumers** is outlined below, followed by Cal Voices' concerns, unanswered questions and recommendations. It is important to note that this is an initial proposal, with DHCS allowing for stakeholder involvement over the next few months to gather input.

According to DHCS, the goals of the new proposal, which they call CalAIM (California Advancing and Innovating Medi-Cal) are:

1. Identify and manage member risk and need through Whole Person Care Approaches and addressing the Social Determinants of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems, and payment reform

To accomplish these goals, DHCS is proposing a number of significant changes to Medi-Cal. We have summarized the elements that we believe will have an impact on adult behavioral health clients and consumers.

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PROPOSED CHANGES TO THE BEHAVIORAL HEALTHCARE DELIVERY SYSTEM

Integration of Behavioral Health (Eliminating the Mental Health Carve-Out)

Summary: With the goal of eventually eliminating the mental health and substance use disorder carve-outs, DHCS is proposing full integration pilots in some counties. Counties that participate in these pilots will have their Medi-Cal managed care, mental health managed care, substance use disorder managed care, and dental consolidated under a single contract with DHCS.

Because of the complexity of integrating behavioral health into managed care, this portion of the CalAIM proposal is still in its early stages. DHCS will be seeking stakeholder feedback to begin discussions about implementation. DHCS states that its Stakeholder Advisory Committee is comprised of “stakeholders/experts in their fields, including but not limited to, beneficiary advocacy organizations, and representatives of various Medi-Cal provider groups.”

Populations potentially affected: All Medi-Cal behavioral health clients/consumers

Timeline for implementation: Effective date of January 1, 2024 for counties that have opted to participate.

Unanswered Questions:

While eliminating the Specialty Mental Health Services carve-out appears to hold the potential to streamline access to health care, it is a daunting task which raises a number of questions, including, but certainly not limited to:

1. MHSA programs are currently used by counties for Federal matching funds in the carve out. How will integration of specialty mental health care into private managed care plans affect this?
2. How will this affect county-run MHSA programs?
3. Will people currently receiving specialty mental health services be required to access those through Medi-Cal Managed Care plans? If so, how do we ensure that services remain comprehensive and recovery-oriented?

Concerns:

Medi-Cal managed care plans operate on the medical model of health care. Cal Voices has serious concerns that if specialty mental health services are delivered by these plans, services will not be recovery-oriented, and thus will not incorporate the broad range of necessary services currently provided by counties.

Recommendations:

1. Clients must be the primary stakeholders in this process. Not only do they possess valuable knowledge about what their needs and the needs of the system, but they are the stakeholders who

will be most affected by changes to Medi-Cal. Currently, client stakeholders are omitted entirely from DHCS' Stakeholder Advisory Committee and Behavioral Health Stakeholder Advisory Committees.

Medical Necessity Criteria for Specialty Mental Health and Substance Use Disorder Services

Summary: Medi-Cal beneficiaries are eligible for outpatient specialty mental health services if they have been diagnosed with a covered mental health condition and, as a result of that condition, meet certain impairment criteria. Specialty mental health services are much more comprehensive than Medi-Cal managed care mental health services, and include recovery-oriented services not provided by managed care mental health services, including rehabilitative services and targeted case management provided by a variety of providers including peers. Geographic managed care providers do not provide specialty mental health care and do not operate under a recovery continuum, are not client driven, and do not comply with the Welfare & Institutions codes. Additionally, they often do not have any crisis services, and do not provide advocacy, peer support, employment services, psychosocial rehabilitation services, self help supports, and evidence based recovery programs.

DHCS is proposing to shift the eligibility criteria from diagnosis *and* level of impairment to just a person's level of impairment. This would mean that beneficiaries could receive some initial mental health services prior to receiving an official diagnosis. However, this would also mean that the determination of whether a person receives mental health services through Medi-Cal managed care or through the county carve-out would be made solely based upon the person's level of impairment instead of their diagnosis. DHCS is currently seeking stakeholder input to determine a statewide, standardized assessment tool to determine a person's level of impairment that could be used statewide to determine a person's eligibility for specialty mental health services.

Currently, to be covered by Medi-Cal, specialty mental health services (also called Rehabilitative Mental Health Services) must be provided in accordance with the Medi-Cal State Plan and meet additional service criteria. DHCS is proposing to eliminate the additional service criteria (listed on page 77 of the proposal), and only require services to be provided in accordance with the State Plan. The current state plan describes Rehabilitative Mental Health Services as:

...services recommended by a physician or other licensed mental health professional within the scope of his or her practice under State law, for the maximum reduction of mental or emotional disability, and restoration, improvement, and/or preservation of a beneficiary's functional level. Rehabilitative Mental Health services allow beneficiaries to sustain their current level of functioning, remain in the community, prevent deterioration in an important area of life functioning, and prevent the need for institutionalization or a higher level of medical care intervention...Rehabilitative Mental

Health Services are provided in the least restrictive setting, consistent with the goals of recovery and resiliency, the requirements for learning and development, and/or independent living and enhanced self-sufficiency.

Populations potentially affected: All Medi-Cal specialty mental health clients/consumers

Timeline for implementation: Effective date of January 1, 2021

Analysis: This proposal may have the potential to improve mental health care for Medi-Cal beneficiaries. Allowing treatment to be provided immediately to an individual, without waiting for a diagnosis will allow treatment to begin earlier for individuals in need, and reduce the stigma that may be associated with a diagnosis. Similarly, expanding the definition of medical necessity by removing some of the additional criteria should also improve care for individuals. The State Plan definition above clearly states that care must be consistent with the goals of recovery and resiliency, and provided in the least restrictive setting.

Concerns: Currently, individuals are not always able to access the specialty mental health care services that they need. It will be essential that this provision is utilized to increase the level of services that are provided to individuals, and not as a means to limit access to treatment or maintain current levels of access to necessary specialty mental health services. However, system capacity is currently inadequate in many counties, and capacity must be increased proportionately to the increased access to services.

Recommendations:

1. Cal Voices strongly recommends that a pathway be created for individuals to seamlessly acquire or return to specialty mental health services. Stressful life events can change a person's level of impairment dramatically and quickly and there needs to be a protocol which is clearly understood by clients, providers, and referral systems for guiding individuals into specialty mental health care.
2. Clients must be the primary stakeholders in this process. Not only do they possess valuable knowledge about what their needs and the needs of the system, but they are the stakeholders who will be most affected by changes to Medi-Cal.
3. The assessment tool to determine eligibility for specialty mental health services should include, but certainly not be limited to the following:
 - a. Past risk factors, including prior hospitalizations and lack of social supports
 - b. Potential impending risk factors, such as stressful life events that might require a person to need more support, or put a person at risk (moving, starting a new job, losing a job, the death of a loved one, etc.).
 - c. Homelessness, incarceration, or social isolation
 - d. Employment

Inpatient Specialty Mental Health Services

Summary: Important to note is that DHCS is proposing to make it easier for providers to authorize inpatient mental health care. Current state law requires all of the following documentation before a person is admitted to inpatient care:

- A physician's certification authorizing inpatient care
- A physician or nurse practitioner's recertification authorizing inpatient care
- Medical, psychiatric and social evaluations
- A written plan of care

DHCS is proposing to only require a physician's certification and recertification that the services are necessary and provided at the appropriate level of care. This will likely increase the numbers of individuals admitted to inpatient care.

Populations potentially affected: All Medi-Cal specialty mental health clients/consumers at risk of hospitalization

Timeline for implementation: Effective date of January 1, 2021

Unanswered Questions:

- What is the purpose of not having a written plan of care?
- What are the impacts of not having a written plan of care?
- What is the purpose of not having medical, psychiatric and social evaluations?
- What are the impacts of not having medical, psychiatric and social evaluations?

Concerns: Cal Voices is concerned that this provision will increase the numbers of individuals involuntarily admitted to inpatient facilities. Cal Voices believes that involuntary treatment should only occur as a last resort, and that the best hope for recovery from mental health conditions comes from access to voluntary mental health treatment and services that are comprehensive, community based, recovery-oriented and culturally and linguistically competent. ¹ The Lanterman-Petris-Short Act (Welfare and Institutions Code Sections 5000 et seq) sought to, "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders."

There are also significant capacity issues related to inpatient treatment, with plans such as Kaiser not offering any inpatient treatment at all. With too few beds available today, increasing inpatient admissions will only worsen this problem. Additionally, inpatient care is the most costly of all services. Increasing inpatient admissions will utilize funds that are necessary to provide others with effective services.

Recommendations:

1. Cal Voices strongly recommends that DHCS retain the current provisions for authorization of inpatient care. At a bare minimum, Cal Voices recommends that any provisions intended to simplify authorizations for inpatient care be postponed until after whole person care approaches are successfully implemented throughout California. CMS authorizes IMD waivers on the condition that extensive effective mental health services are provided in the community to improve care and reduce the need for hospitalization.
2. Effective and comprehensive whole person care approaches can eliminate the need for most involuntary commitment. Cal Voices recommends that DHCS focus its resources on significantly improving outpatient care for individuals living with a mental health condition.

WHOLE PERSON CARE APPROACHES**Population Health Management**

Summary: DHCS proposes that all Medi-Cal managed care plans be required to develop a population health management program. The goal of these programs is to provide continuity of care for beneficiaries across their full continuum of care, including medical, behavioral health, dental and long-term services and supports. Within this requirement, Medi-Cal managed care plans will be required to conduct an initial assessment of **every** Medi-Cal client. These assessments are required to determine each individual's status and risk in the areas of behavioral health, physical health, oral health, and social determinants of health. Managed care plans will also need to determine how often members are reassessed, and what events will trigger a reassessment.

These comprehensive assessments must be followed by relevant, culturally and linguistically competent referrals for necessary treatment, wellness and preventive care, social services or referrals to community-based organizations. Members with multiple needs will be provided with case management services, which will include an individual care plan and an assigned case manager for each member. DHCS proposes that additional "In Lieu of" services be integrated with case management for certain people, however these services are voluntary to both members and Medi-Cal managed care plans.

Recovery-oriented elements: The Case Management elements of the CalAIM Population Health Management proposal includes several recovery-oriented elements, including:

- Ongoing review of the member's goals and care plan
- Access to person-centered planning, including education and training for providers and families
- Ensuring a person-centered and family-centered approach by identification of member's circle of support or caregiver(s)
- Developing relationships with local community organizations to implement social determinant interventions (e.g. housing support services, nutritional classes, etc.)

- Promoting recovery using community health workers, peer counselors, and other community supports
- Assisting members in relapse/crisis prevention planning that includes development and incorporation of recovery action plans and advance directives for individuals with a history of frequent mental health readmissions or crisis system utilization

Populations potentially affected: All Medi-Cal behavioral health clients/consumers

Timeline for implementation: Effective date of January 1, 2021

Concerns: Recovery-oriented services and support are essential elements of a whole-person care approach to behavioral health care. The provisions mentioned above, represent some, but not all, of the elements of a recovery-oriented system of care. Strict enforcement of these provisions will be essential to the success of population health management.

Recommendations:

1. To be effective, recovery-oriented population management and case management systems and services will require extensive system change within agencies and health plans. Systems change is always difficult, but it is necessary. Therefore, strict enforcement by DHCS of these provisions will be essential.
2. To truly embody systems of recovery, population health management must also include the following elements:
 - a. Significant education and training of providers and staff in the Recovery Model.
 - b. Simply hiring people with lived experience does not create a recovery-oriented system. Well-trained peers must have meaningful positions in all systems, with the ability to advocate for systems change for client populations, along with opportunities for career advancement.

Enhanced Care Management

Summary: The enhanced care management benefit is designed to replace and build upon the current Health Homes Program. This program is designed for Medi-Cal beneficiaries who use services from multiple delivery systems (managed care, mental health, substance use disorder, dental, etc.). The goals of the program include improving care coordination, integrating services, facilitating community resources, and addressing the social determinants of health.

Target populations include (but are not limited to):

- Individuals with SMI who are at risk of hospitalization

- Individuals transitioning from incarceration
- Individuals experiencing chronic homelessness or at risk of becoming homeless

Individuals provided with enhanced care management by their Medi-Cal managed care plan will be assigned a care manager who is the individual's primary point of contact, and who is encouraged to develop relationships with members and their families, and who engages members and families in needs assessment and care planning. For individuals with a primary SMI diagnosis, county behavioral health staff will generally be the enhanced care management provider.

Recovery-oriented elements in Enhanced Care Management:

- Health promotion
- Member and family supports and referral to community and social services
- Coaching members on how to monitor their health, identify and access helpful resources
- Helping beneficiaries obtain and maintain housing

As with Population Health Management, Enhanced Care Management will require significant systems change. In its 2018 *Report to Congress on the Medicaid Health Home State Plan Option*², the U.S. Department of Health and Human Services states:

*Practice transformation is a process of growth and refinement in response to new payment and delivery models, changing Medicaid rules and policies, and the increase in the proportion of patients requiring complex care. Because providers have to continue to provide services while acquiring new skills or adopting new technologies, practice transformation is often a fatiguing process. **Strong state support throughout this process, including educational resources, training opportunities, and financial support, can promote smoother, more effective transportation. The need for support is greatest for behavioral health integration, connecting patients with services for the social determinants of health, and other health home activities that are significant changes from the status quo.***

Populations potentially affected: Medi-Cal behavioral health clients/consumers at risk of hospitalization, transitioning from incarceration, and people experiencing or at risk of homelessness

Timeline for implementation: Effective date of January 1, 2021 for most enhanced care management. January 1, 2023 is the proposed effective date for enhanced care management for individuals transitioning from incarceration.

Unanswered Questions:

- How many mental health clients will receive Enhanced Care Management?
- Who will serve as the Care Manager?

Recommendations:

1. DHCS must ensure that **all** individuals who access services from multiple delivery systems have access to enhanced care management. Navigating multiple systems is challenging and individuals invariably fall through the cracks. Additionally, recovery-oriented services and services that address the social determinants of health must be provided to all individuals who access mental health services.
2. The Care Manager must be a consumer-focused, recovery-oriented professional, ideally a peer. Currently, care managers are often low paid staff with little training. These positions have high turnover which impacts continuity of care.
3. Strong state support and enforcement by DHCS will be imperative to ensure that the necessary systems changes are implemented, and implemented in a timely manner.

"In Lieu of" Services (ILOS)

Summary: DHCS is proposing to provide Medi-Cal managed care plans with financial incentive payments to encourage the implementation of voluntary in lieu of services (ILOS). ILOS are useful and cost-effective wraparound services that can be covered under California's Medi-Cal State Plan. These services are designed to address the social determinants of health and to avoid the need for other services such as hospitalization. In lieu of services for mental health clients/consumers may include:

- Housing transition/navigation services
- Housing deposits
- Short-term post-hospitalization housing
- Home modifications

Managed care plans that choose to implement in lieu of services will integrate these services into their population health management plans, often in combination with their new enhanced care management benefit.

Populations potentially affected: Medi-Cal behavioral health clients/consumers in counties which implement in lieu of services.

Timeline for implementation: Effective date of January 1, 2021

Concerns: In lieu of services have the potential to dramatically improve behavioral health care, but these services are currently proposed to be voluntary. Given the lack of understanding of the recovery model within private and not for profit managed care plans, Cal Voices is concerned that these provisions will be under-utilized.

Recommendations:

1. DHCS should provide meaningful training to all managed care plans about the Recovery Model, collection of recovery-oriented outcomes, and explanation of recovery-oriented systems to encourage broad use of in lieu of services.
2. DHCS should mandate the use of In lieu of services by managed care plans.

Section 1115 IMD (Institution of Mental Disease) Waiver

Summary: DHCS is exploring the possibility of applying for a Section 1115 IMD waiver. Currently, the Federal Government does not allow California to receive federal matching funds for adult Medi-Cal members who are hospitalized in most psychiatric facilities, so the counties must cover those costs. A Section 1115 IMD waiver would allow California to recoup federal matching funds for individuals' short term stays in mental health hospitals. To be approved for an IMD waiver, California must first demonstrate extensive funding for outpatient community mental health services, so that hospitalization remains a last resort.

DHCS states in their proposal that it is often difficult to receive Federal approval for these waivers and that to date only the District of Columbia has applied. Because of this, DHCS is seeking stakeholder feedback to determine if the waiver is worth pursuing.

Populations potentially affected: All Medi-Cal specialty mental health clients/consumers

Timeline for implementation: Effective date of January 1, 2021

Concerns: Cal Voices is opposed to policies which increase hospitalization of people with mental health conditions. Because counties currently cover the costs for inpatient treatment, it is unclear whether this waiver would increase the amount of inpatient treatment provided to beneficiaries, or if it would simply result in a change of funding for treatment. Additionally, to receive a Section 1115 IMD Waiver, California would be required to demonstrate a commitment to improving community-based mental health care, ensure good quality of care in IMDs, engage people in mental health care as early as possible, and ensure a continuum of care for people with SMI. The goal of the Federal government in allowing these waivers is to ultimately reduce the number of people with SMI who end up hospitalized.

Counties have developed less restrictive alternatives to IMD's, such as 16-bed psychiatric health facilities (PHF), and other alternatives for acute inpatient hospitalizations. Cal Voices is concerned that an IMD waiver may reduce incentives for funding these less restrictive options.

Recommendations:

1. This proposal holds potential to improve care for people living with mental health conditions, but its success will require:
 - a. Guidance to counties
 - b. Outcome measures
 - c. Consequences for counties who do not use the funding appropriately
2. DHCS must implement standardized instruments to measure outcomes based on funds spent on in lieu of services.
3. Tools used to measure effectiveness of in lieu of services must be developed through a stakeholder process which incorporates significant meaningful involvement of people with lived experience to ensure that services are recovery-oriented.

Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

Currently, 56 mental health managed care plans administer the specialty mental health services program for all California counties, 30 counties administer the substance use disorder (SUD) managed care program (covering 93% of the Medi-Cal population), and the remaining 28 counties provide a less comprehensive SUD program through a fee for service delivery program. Currently at the county level, specialty mental health and SUD services are administered through separate county programs, requiring individuals who require mental health and SUD services to navigate two separate systems. The goals of this integration are to 1) improve outcomes for individuals; and 2) reduce administrative burdens on counties, providers, and the State.

While many counties already have a 24 hour access line, this proposal would require all counties to have an integrated 24 hour access line to triage, screen, and refer beneficiaries to both specialty mental health and substance use disorder treatment services. DHCS also proposes standardized intake, screening and referral processes that are not only timely, but consider a “no wrong door” approach to helping people access services. Furthermore, DHCS proposes integrated treatment plans to concurrently treat mental health and substance use disorders, with the goal of more simplified, client-centered and strength-based approach to behavioral health treatment.

Populations potentially affected: All Medi-Cal specialty mental health clients/consumers

Timeline for implementation: Effective date of January 1, 2026

Concerns: Administrative integration of SUD and MH, and implementation of a “no wrong door” approach will require substantial changes within counties, and will not be effective without extensive training of county staff, and procedures to ensure that no individuals “fall through the cracks” during this transition time.

Recommendations:

1. DHCS should, with extensive client stakeholder involvement, develop standardized, recovery-oriented training for county staff on what a “no wrong door” approach entails.
2. DHCS should, with extensive client stakeholder involvement, develop best practices for training county staff on the administrative challenges that will result from this transition.
3. DHCS must ensure that this “no wrong door” approach includes people in crisis. The use of emergency rooms for individuals in crisis is a “wrong door”, and county staff must be well-educated in DHCS-provided alternatives.
4. All county staff who answer calls on the 24 hour access line must be consumer-focused, recovery-oriented professionals.

Mandatory Medi-Cal Application Process upon Release from Jail

Currently, behavioral health clients/consumers being released from jail do not receive linkage to county services before their release from jail. DHCS is proposing that California mandate that counties have an inmate pre-release Medi-Cal application process, and create a warm handoff from jail release to county behavioral health departments to promote a steady continuation of behavioral health treatment from the jail into the community.

Analysis: Combined with some of the whole person care approaches within the CalAIM proposal, linking to individuals transitioning from jail with a multitude of recovery-oriented services, including not only mental health care and SUD treatment, but additional services offered by the counties that provide in lieu of services will be highly valuable.

ADDITIONAL RECOMMENDATIONS**PEER SUPPORT**

Governor Newsom’s 2019 veto of peer support certification legislation, SB 10 (Beall), stated:

*As the Administration, in partnership with the Legislature and counties, works to transform the state’s behavioral health care delivery system, **we have an opportunity to more comprehensively include peer support services in these transformation plans.***

The Governor specifically mentioned comprehensively including peer support services in the State’s behavioral health care transformation plans, yet the CalAim proposal mentions peer support workers only in the concept of “community health workers and other community support”, **not** as individually covered services within Medi-Cal plans. Peer support services **must** be explicitly covered within Medi-Cal managed care plans and county mental health plans.

Research has demonstrated that client outcomes improve when individuals serve as peer specialists on care teams.³ Peer support has also been shown to increase participants' sense of hope and control, increase their self-care, and decrease their levels of depression and psychosis.⁴ In addition to improving care and recovery-oriented outcomes, increased peer support reduces workforce shortages, and increases employment rates for people with lived experience.

Recommendations:

1. California must create statewide peer certification with Medi-Cal billing codes.
2. DHCS must require counties to incorporate peer positions, including opportunities for advancement, in all aspects of Medi-Cal.
3. In keeping with the evidence base for peer support, peers must be allowed to advocate for their clients in their official roles, as part of ongoing system transformation.

RECOVERY-ORIENTED SYSTEMS AND SERVICES

It is well known that people can live meaningful lives in recovery from mental health conditions, but recovery requires broader services than simple medication management. DHCS has a unique opportunity with current waiver renewals to transform Medi-Cal into a recovery-oriented system.

While there are many definitions of recovery, a commonly used definition of recovery was published by SAMHSA in 2012. SAMHSA'S working definition of recovery defines the concept as:

***A process of change through which individuals improve their health and wellness,
live a self-directed life, and strive to reach their full potential.⁵***

SAMHSA'S Working Definition of Recovery identified **four major dimensions** that support a life in recovery:

1. **Health:** Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem— and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
2. **Home:** A stable and safe place to live.
3. **Purpose:** Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.
4. **Community:** Relationships and social networks that provide support, friendship, love, and hope.

SAMHSA's working definition of recovery also includes ten guiding principles.⁶ While all ten guiding principles of recovery are equally important to the individual, some of the more relevant of these for this paper include:

- Recovery occurs via **many pathways**
- Recovery is **holistic** (it encompasses an individual's whole life: family, housing, employment, transportation, education, clinical treatment, complementary and alternative services, and more)
- Recovery is **supported by peers** and allies
- Recovery is **culturally based** and influenced
- Recovery is supported by **addressing trauma**

To be truly recovery-oriented and client-driven, Medi-Cal mental health services must move well past the Medical Model's focus on illness management by incorporating all of these aspects into the culture of their systems, their services practices and delivery models, and outcomes tracking and measurement activities.

Recovery elements that must be strengthened in the CalAIM proposal include:

- Extensive integration of peers into all aspects of care
- Training and/or support groups to help clients prepare to leave the PMHS when ready/appropriate
- Client-directed treatment and services
- Training of staff in the recovery model
- A holistic range of options to help clients meet their medical, physical, social, occupational, psychological, emotional, intellectual, spiritual, and religious needs
- Collection of meaningful recovery outcomes
- Medication must not be a condition for clients to continue receiving services

MEASUREMENT OF RECOVERY-ORIENTED OUTCOMES

Implementation of recovery-oriented services must be accompanied by measurement, tracking and reporting of recovery-oriented outcomes, followed by ongoing analysis of client outcomes to continually inform and improve systems and services. This would include measures beyond medication adherence and level of impairment, such as:

- Housing status and stability
- Educational Status and attainment
- Income stability
- Overall health and wellness
- Daily living functions
- Overall life satisfaction
- Progress towards self-identified goals
- Social interaction and isolation

- Quality of relationships and social supports
- Transportation access and issues
- Resilience and effective coping skills
- Self-determination and self-efficacy
- Community engagement

Cal Voices recommends that DHCS require providers of mental health services measure recovery outcomes using a tool such as the MORS Scale.⁷ Ideally, providers will utilize multiple tools to assess an individual's recovery progress and the results of those outcome measurements will be used to not only assess an individual's treatment, but to determine strengths and weaknesses of systems or providers to improve care.

MEANINGFUL STAKEHOLDER INVOLVEMENT

DHCS created a Behavioral Health Stakeholder Advisory Committee to receive input on the CalAIM proposal, yet this committee includes no representation by the client/consumer community. Any large-scale system transformations, such as the CalAIM proposal have the potential to significantly impact the lives and functioning of behavioral health consumers. People who personally access the services have unique knowledge about challenges and opportunities related to system improvement. Clients must be at the table as equal stakeholders in all discussions related to transforming systems of care.

CONTINUITY OF SERVICE WHILE SYSTEMS CHANGES ARE BEING INCORPORATED

The large systems changes envisioned by DHCS have the potential to be disruptive while they are being implemented. It is imperative that DHCS recognize this and take steps to mitigate any disruptions that may occur during system transformation.

1 <https://www.mhanational.org/issues/position-statement-22-involuntary-mental-health-treatment>

2 <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/medicaidhomehealthstateplanoptionrtc.pdf>

3 Felton *et al.* (1995), as cited in U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute for Mental Health (1999).

4 <https://www.ncbi.nlm.nih.gov/pubmed/22654945>

5 <https://store.samhsa.gov/system/files/pep12-recdef.pdf>

6 <https://store.samhsa.gov/system/files/pep12-recdef.pdf>

7 http://archive.mhsoac.ca.gov/Meetings/PriorMeetings_2014/docs/Meetings/2014/June/CFLC_LowRecovWkqp_061714_MilestonesOfRecoveryScale.pdf