2025-2026: BEHAVIORAL HEALTH SERVICES ACT (BHSA) LOCAL PLANNING COLLABORATION TOOLKIT

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

TABLE OF CONTENTS

ABOUT THIS TOOLKIT

This toolkit is intended for county behavioral health departments (county behavioral health) to support their meeting Behavioral Health Services Act (BHSA) local planning requirements, as part of the broader Integrated Plan (IP) community planning process.

Effective as of January 1, 2025, these local planning requirements set expectations for county behavioral health to engage on local health jurisdiction (LHJ) community health assessment (CHA) and community health improvement plan (CHIP) processes. As county behavioral health faces increasing budgetary pressures and navigate evolving federal and state regulations, this collaboration is essential for streamlining processes, meeting statewide goals and measures, advancing health equity, and solving complex problems that no one sector can solve alone.

Although this toolkit primarily focuses on offering resources and supports to county behavioral health to meet their local planning requirements, it can be a helpful resource for local health jurisdictions (LHJs) and Medi-Cal managed care plans (MCPs) to understand the county behavioral health local planning requirements and their expected roles and participation. This toolkit provides resources, recommended strategies, and promising practices. It is organized into four tools: 1) pre-planning and level-setting, 2) collaboration, 3) stakeholder engagement, and 4) data sharing. County behavioral health may use this toolkit to:

- Strengthen understanding of BHSA local planning requirements
- Evaluate gaps and strengths in current engagement processes
- Establish communication protocols with LHJs and ways to contribute to their CHA/CHIP process
- Streamline stakeholder engagement and data-sharing around shared priorities

This toolkit offers a range of recommended resources and strategies that may be tailored to different circumstances. Recognizing that county behavioral health and LHJs may be approaching this work at different starting points, BHSA local planning requirements were intentionally written to afford ample flexibility to county behavioral health on how they align IP and CHA/CHIP processes. Some county behavioral health departments already have strong partnerships with their LHJs, especially if both report to the same overseeing county agency and may have even previously collaborated on CHAs/CHIPs. For others, the relationship with local health is entirely new. As such, county behavioral health are encouraged to select which resources are most helpful to them depending on their stage of cross-sector partnership.

Key Definitions:

See appendix for more detailed glossary.

Integrated Plan (IP): Under the BHSA, county behavioral health develop IPs, which are three-year prospective global spending plans that describe how county behavioral health intend to use all available behavioral health funding to advance statewide and local goals, reduce disparities, and address unmet needs in a community.

Community Planning Process: County behavioral health must engage with local stakeholders to develop each element of their IP. See Appendix 4 for a list of stakeholders that must be engaged. County behavioral health is required to demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on behavioral health (inclusive of mental health and substance use disorder (SUD) policy), program planning and implementation, monitoring, workforce, quality improvement, evaluation, health equity, evaluation, and budget allocations.

Local Planning Requirements: As part of the Community Planning Process, county behavioral health is required to work with LHJs, along with Medi-Cal Managed Care Plans (MCPs), on the development of CHAs and CHIPs. County behavioral health must also consider the CHA and CHIP in preparing their IP and annual update.

Community Health Assessments (CHA) & Community Health Improvement Plans (CHIP): As part of their local planning processes, LHJs develop CHAs and CHIPs. CHAs are community driven processes that describe the status of population health within a jurisdiction. Informed by the CHA, the CHIP identifies how LHJs will work with community partners to address key issues elevated in the CHA, which are focused on upstream interventions. While CHAs/CHIPs vary across communities informed by the needs, strengths, and preferences, their essential feature is that they involve extensive community engagement with a wide array of stakeholders and robust data collection. As of January 1, 2024, MCPs have been required to meaningfully participate in the LHJ CHA/CHIP process in terms of collaboration, stakeholder engagement, data-sharing and resource contribution.

BACKGROUND

In March 2024, California voters passed Proposition 1, a two-bill package, to modernize the state's behavioral health care system, including the BHSA and the Behavioral Health Bond. By enacting changes from Proposition 1, California's behavioral health transformation expands ongoing efforts to support vulnerable people living with the most significant mental health conditions and SUD.

The BHSA requires county behavioral health to engage in a community planning process to develop an IP—a three-year prospective plan and global budget—that engages over 20 different stakeholders and is representative of their collective needs, preferences, and insights. LHJs and MCPs have also conducted robust community and population health assessment processes that often involve many of the same stakeholders and similar community engagement and data collection activities as required by the BHSA IP community planning process.

Recognizing these overlaps, the BHSA local planning requirements seek to promote greater cross-sector alignment among these community planning processes and set specific expectations for county behavioral health to engage with the LHJ CHA/CHIP processes. See below for a summary of BHSA Local Planning requirements.

Summary of County BHSA Local Planning Requirements

As detailed in the BHSA County Policy Manual, county behavioral health are required to:

- ***Collaborate in*** LHJ CHA/CHIP meetings and governance (as requested by the LHJ)
- ***Share relevant data*** and
- Identify overlapping ***stakeholder engagement*** activities

These requirements streamline processes and strengthen cross-sector alignment, which is essential to achieving statewide population behavioral health goals and advancing overall health equity.

This background section contextualizes the BHSA local planning requirements within the broader policy shifts towards greater alignment among community planning processes and collective accountability.

Policy Shift Towards Greater Alignment

BHSA local planning requirements are part of a larger policy shift led by DHCS, in collaboration with California Department of Public Health (CDPH), to promote greater alignment among community planning policies—and eventually community investment policies—among county behavioral health, MCPs, and LHJs.

The DHCS policy shift towards greater alignment seeks to help county behavioral health, MCPs, and LHJs strengthen cross-sector partnerships, promote a streamlined approach to community planning and assessments, reduce community fatigue, enhance data insights, create more effective messaging around interventions and programs, and result in more impactful investments that ultimately benefit the community, improving overall health and wellbeing. See **Appendix 1** for a more detailed value proposition.

Impacts of Recent Federal Actions:

- Dramatic increase in the number of individuals becoming uninsured.
- Weakened health delivery infrastructure, including hospital closures in rural and underserved areas, overcrowded emergency departments and longer wait times.
- Weakened public health infrastructure, making it harder to conduct routine disease surveillance and other public health functions.
- Growing health disparities, leading to delays in diagnosis and treatment and preventable illness and death.
- Potential increase in institutionalization of individuals with behavioral health and housing needs due to recent executive orders.
- Potential impacts to the health care and caregiving workforce as the result of changes to immigration policy.

The recent enactment of HR1 and other federal changes make this alignment more important than ever. With these sweeping changes to Medi-Cal, public health and the health care safety net, millions of Californians will lose access to health care coverage (up to 3.4 million Medi-Cal members) and other social supports. Collaboration is critical to:

- Increase efficiency and optimize resources

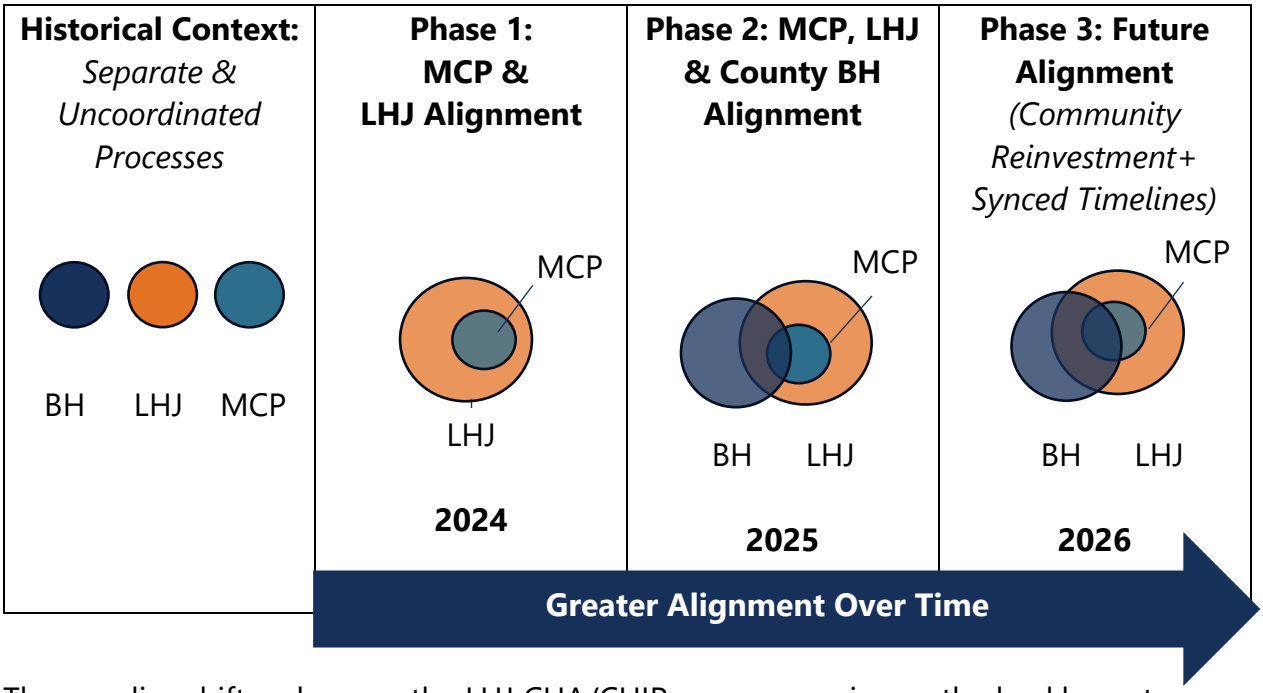
- Make progress on health equity and outcomes
- Mitigate potential harm and prevent service deterioration
- Enhance accountability and transparency
- Foster innovation and creativity
- Build public trust

Three Phases of Alignment

Since 2024, DHCS and CDPH have been implementing a cohesive set of policies to align the community planning process among county behavioral health, LHJs, and MCPs. These policies are being implemented over phases moving away from separate and uncoordinated processes towards greater alignment. See Image 1 below.

Image 1: Policy Shift in Three Phases

Each phase is described in more detail below



These policy shifts rely upon the LHJ CHA/CHIP process serving as the backbone to support county behavioral health and managed care meet their community planning requirements, inform community reinvestment activities, and achieve statewide population behavioral health goals to which they are held accountable. CHAs/CHIPs are ideal forums to support these endeavors and other large transformation efforts aimed at advancing overall health equity, as they:

- Are **driven by the community** and focus on the priorities of the community-at large and not on any one stakeholder group.
- Promote **transformational relationships** rather than transactional engagements with the community.
- Rely upon **inclusive governance structure and diverse participation** from numerous stakeholders beyond the public health sector.
- Use of robust and methodological stakeholder engagement.
- Use of **comprehensive broad-based data**, including primary and secondary sources.
- Focus on **upstream factors and interventions** addressing the root of most physical and behavioral health outcomes.

Historical Context: Separate and Uncoordinated Processes

County Behavioral Health, LHJs, and MCPs historically have conducted separate and distinct community planning processes:

- **County Behavioral Health**: Required to develop expenditure plans, per the Mental Health Services Act (precursor to the BHSA) every three years that involved input from stakeholders to evaluate existing programs and recommend improvements.
- **MCPs**: Required to conduct a Population Needs Assessment (PNA), as outlined in APL 19-011, and submit an annual PNA deliverable (inclusive of action plan) to DHCS that identified priority needs and health disparities of local communities and members and required MCP community advisory committee input.
- **LHJs**: Several LHJs in California have been conducting CHAs/CHIPs to meet voluntary Public Health Accreditation Board standards. With introduction of the 2022 Budget Act, all 61 LHJs must now submit a "Public Health Plan," (also known as a local Future of Public Health workplan), which should be informed by a CHA, CHIP, and/or Local Strategic Plan, by December 30, 2023, and by July 1 every three years thereafter.

Phase 1: MCP & LHJ Alignment (2024)

Phase 1 of alignment has been a critical component of advancing DHCS Population Health Management (PHM) program, which was launched in 2023 and establishes a cohesive framework for MCPs to respond to health and social needs of members and their preferences across the continuum of care. As part of the PHM program, DHCS

reimagined MCP's existing PNA requirements—which were solely focused on Medi-Cal members—to align with LHJ CHA/CHIP processes—which focus more broadly on upstream community-wide interventions and involve more robust data inputs and stakeholder engagement strategies. Effective as of 2024, MCPs no longer need to conduct and submit a separate PNA deliverable but rather must meaningfully participate in the LHJ CHA/CHIP process in terms of collaboration, data-sharing, stakeholder engagement, and resources.

Phase 2: MCP, LHJ Alignment and County Behavioral Health Alignment (2025)

Phase 2 of alignment occurred with the passage of BHSA. Recognizing the overlaps among stakeholder and engagement activities with the CHA/CHIP process, the BHSA introduced the new requirement that county behavioral health must align with the LHJ CHA/CHIP to streamline efforts and reduce redundancies. LHJ CHA/CHIP focus on upstream factors and interventions that are at the root of most behavioral health outcomes and many also set behavioral health priorities. As of January 1, 2025, county behavioral health must align with CHAs/CHIPs in same domains as MCPs (noted above): collaboration, stakeholder engagement, and data-sharing.

Phase 3: Future Alignment (2026)

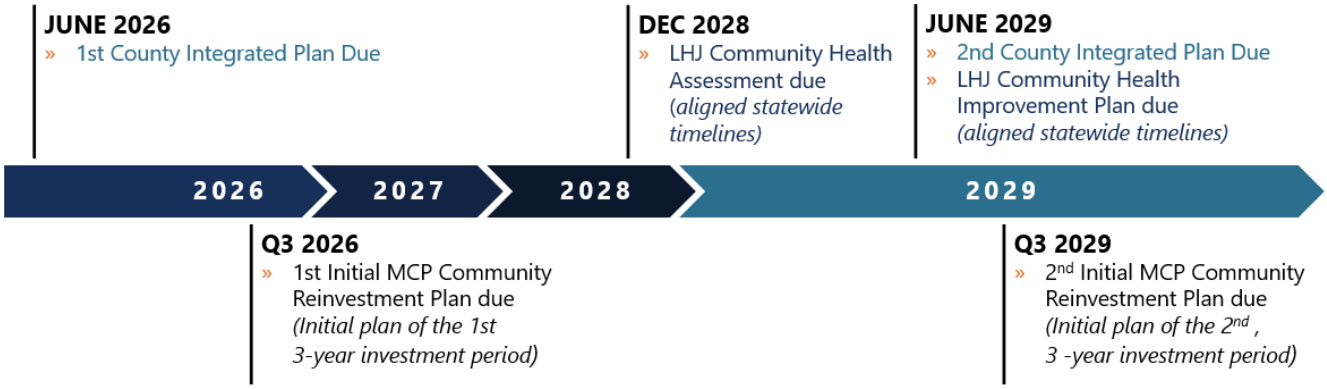
Like community planning, community reinvestment activities have been disparate. They have also have not been connected to community planning efforts. As part of Phase 3, DHCS is aligning community reinvestment policies with community planning and statewide policy goals among behavioral health, public health, and managed care to further advance health equity and statewide behavioral health goals and streamline processes and reduce redundancies.

- **BHSA Funding**: The County behavioral health IP, which set their global budget, must be informed by LHJ's CHA/CHIP.
- **MCP Community Reinvestment**: MCPs must allocate 5-15 percent of net income based on revenues and performance to communities in which they serve. MCP Community Reinvestment activities must be informed by the CHA and are strongly encouraged to be directed towards activities identified in the CHIP and IP. MCP Community Reinvestment Plans must include attestation from the county behavioral health director and public health director. The attestation must indicate that the investment strategy is generally agreeable to the LHJ and county behavioral health and aligns with the CHA/CHIP.

- **CDPH BHSA Population-based Prevention Funding**: DHCS is collaborating with CDPH to develop policies that align public health prevention dollars with statewide population behavioral health goals.

Future alignment will be further supported by syncing community planning and community reinvestment timelines. See Image 2 below. Currently, CHAs/CHIPs are on different cycles; either being completed every three or five years. In 2028, CHA/CHIP development cycles will become standardized across California and synced with the County Behavioral Health IP submission processes and MCP Community Reinvestment planning.

Image 2: Future Alignment, Timeline: June 2026+



Policy Shift Towards Greater Collective Accountability

Going forward, county behavioral health, MCPs, and LHJs will be held accountable to statewide population behavioral health goals and forthcoming quality measures associated with each goal. See Table 1 below.

Table 1: Statewide Population Behavioral Health Goals

Goals for Improvement	Goals for Reduction
» Care experience	» Suicides
» Access to care	» Overdoses
» Prevention & treatment of co-occurring physical health conditions	» Untreated behavioral health conditions
» Quality of life	» Institutionalization
» Social connection	» Homelessness
» Engagement in school	» Justice-Involvement
» Engagement in work	» Removal of children from home

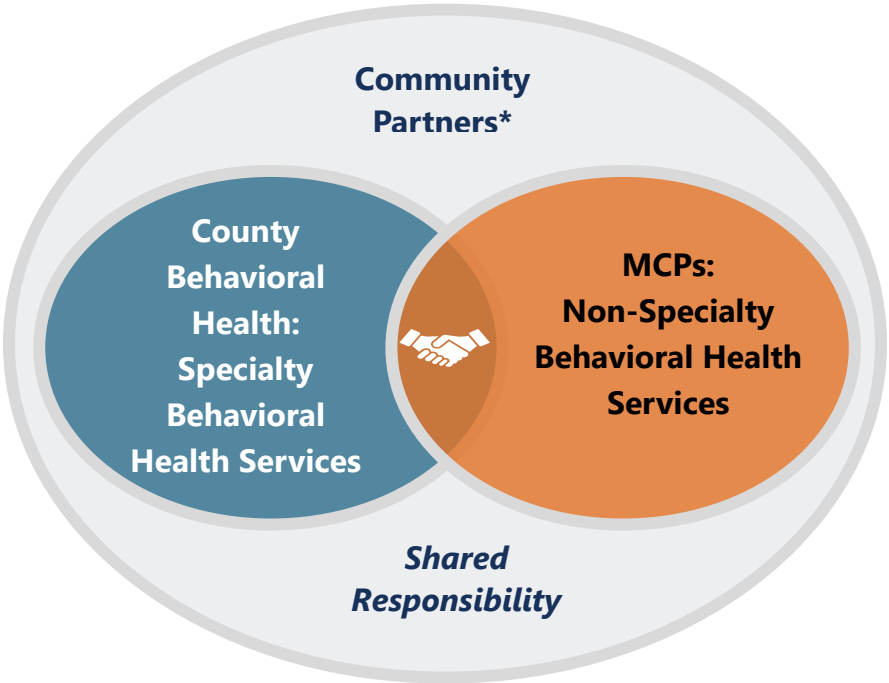
These goals and measures will guide planning and prioritization of resources across *all* delivery systems. See Image 3 below. Moving the needle on any one of these goals and measures will require a community effort, as they are impacted by a myriad of factors, including lack of housing, workforce shortages, mental health crises at both ends of the age spectrum from youth to older adults, and gaps in culturally responsive and diverse care. All of these make aligned local planning efforts critical at this time.

MCPs also are being held accountable to these statewide population behavioral health goals and measures and, as such, have a vested interest in collaborating with county behavioral health as part of the LHJ CHA/CHIP process to collectively improve outcomes. For county behavioral health, these CHA/CHIP processes are also strategic points of integration to engage MCPs, who are required to be part of the IP community planning process and must meaningfully participate in LHJ CHA/CHIP processes and across the same areas as county behavioral health: collaboration, stakeholder engagement, and data-sharing.

Historically, MCPs were required to submit a population needs assessment (PNA) deliverable to DHCS that identified (1) priority needs of their local communities and members and (2) health disparities. Since January 1, 2024, MCPs are no longer required to submit a PNA deliverable and have fulfilled their PNA requirement by meaningfully participating in the development of LHJ CHAs and CHIPs across four key areas: collaboration, stakeholder engagement, data sharing, and resource contribution.

Image 3: Shared Responsibility

Achieving statewide population behavioral health goals requires collaboration across every part of the delivery system.



***Inclusive of the following service delivery systems:**

- LHJs
- Schools
- Child welfare
- Legal system
- Commercial insurance plans
- Community-Based Organizations
- Housing partners

THE TOOLKIT

Tool 1: Pre-Planning and Level-Setting

As a precursor to meeting local planning requirements, county behavioral health will need to understand both the IP community planning processes and CHA/CHIP, and LHJs and MCPs will need to understand the IP community planning processes to help level-set and promote mutual understanding between these groups and other stakeholders.

Stakeholders have shared with DHCS that translation across the sectors is needed to work effectively together. County behavioral health, public health, and managed care often use different languages, acronyms, and definitions for similar concepts. They also have different cultures, with managed care and county behavioral health and public health having different regulations and legal standards that inform their practices and how they form relationships.

There are many ways that county behavioral health may prepare to meet BHSA local planning requirements, depending on their stage of readiness and how they have engaged with LHJs and MCPs in the past. Refer to the following internal pre-planning and level-setting reflection exercise, recommended strategies and additional resources, as your team assesses their readiness to coordinate with LHJs and MCPs on CHA/CHIP processes.

Internal Pre-Planning and Level-Setting Reflection

Reflect internally as a team on the following questions as you prepare to meet the specific BHSA local planning requirements.

- How much does your team understand about the LHJ CHA/CHIP process? What remains confusing?
- What do you see as the value proposition for closer alignment with CHA/CHIP processes? What opportunities come with strengthened partnerships with LHJs and MCPs?
- What are the biggest obstacles to meeting local planning requirements? How may they be overcome with strengthened LHJ and MCP partnerships?

Pre-Planning and Level-Setting Checklist

Use this checklist of recommended strategies to help guide your team pre-plan and level-set around BHSA local planning requirements.

Strategy	Recommended Action
 **Review key DHCS policy guidance and memos**	» Review the following documents: ○ For County Behavioral Health: Behavioral Health Services Act County Policy Manual , CalMHSA Community Planning Guide, and DHCS Community Planning Infographic ○ For LHJs: California Department of Public Health Memo: Alignment of MCP PNA and LHJ CHAs and CHIPs and most recent CHA/CHIP documents, if available, for county ○ For MCPs: Medi-Cal Population Health Management Policy Guide ○ For all: DHCS Webinar "Fierce Urgency for Community Partnerships" (October 30, 2025) » *Note: These documents may also be useful for LHJ and MCP partners to review.*
 **Assign leadership and staff**	» Identify an internal team that drives this work within the department to determine overall approach, how resources and staff will be assigned to this work. » Ensure that internal team includes key decision-makers so that this work may move forward without delays and with leadership support early-on in the process.
 **Establish regular internal meeting structure**	» Set up regular internal meetings dedicated to local planning requirements to provide training on the relevant requirements and to discuss approach for engaging with the LHJ on these requirements.

Additional Resources

Resource	Notes
Talking Points	See **The CalMHSA Guide on Community Planning** for useful talking points to help explain the BHSA overall and the community planning process specifically to stakeholders who may be less familiar with it.
Explanation of the value proposition for cross-sector collaboration	See **Appendix 1** for a table outlining the value proposition for aligning community planning process, articulating what county behavioral health, MCPs, and LHJs each bring to the table and gain from participating. County behavioral health are encouraged to work with LHJs and MCPs to further elaborate upon this table.
Crosswalk of policies	See **Appendix 2** for a crosswalk of how IPs and CHAs/CHIPs overlap. County behavioral health are encouraged to work with LHJs and MCPs to further elaborate upon this crosswalk.
Glossary	See **Appendix 3** for a glossary of terms often used by county behavioral health, MCPs, and LHJs, especially as they relate to local planning processes. County behavioral health are encouraged to work with LHJs and MCPs to continuously update this glossary with new terms and concepts that need further explanation.

Tool 2: Collaboration

This required component of local planning is focused on establishing relationships with LHJs and MCPs as part of the CHA/CHIP process, which is foundational to help county behavioral health, MCPs, and LHJs identify common areas of interest for data-sharing, overlapping stakeholders and engagement processes, and ways to streamline processes to improve outcomes. In 2028, the collaboration between county behavioral health, LHJs, and MCPs will only strengthen, as CHA/CHIP development cycles—which are currently varied county by county—will become standardized across the state and aligned with BHSA IP submission timelines.

BHSA local planning requirements were written to allow county behavioral health flexibility on how they collaborate with their LHJ and MCP partners, recognizing that county behavioral health are in different stages of cross-sector partnerships. Refer to the collaboration reflection exercise, recommended strategies and promising practices to help guide your team meet these requirements.

BHSA Local Planning, Collaboration Requirement:
County behavioral health must:

- Work with LHJs on the development of the CHA/CHIP along with MCPs; and
- Attend key CHA/CHIP meeting and serve on CHA/CHIP governance structures and CHA/CHIP subcommittees at the request of the LHJs.

Note on CHA/CHIP Collaboration and Governance

- CHA/CHIP governance structures vary by county, but they are characterized by diverse community representation and involve workgroups and/or subcommittees focused on priority areas identified by the community.
- Like county behavioral health, MCPs are required to participate on CHA/CHIP governance structures and workgroups at the request of the LHJ.

Collaboration Reflection Exercise

Reflect internally as a team on the following questions to help prepare your team to meet BHSA local planning requirements related to collaboration.

- Has your team participated on LHJ CHA/ CHIP governance structures in the past?
- If yes, what was the experience like, and what lessons may be applied here?
- If no, has your team collaborated with LHJs in the past? What was that experience like, and what lessons may be applied here?

Collaboration Strategies Checklist

Use this checklist of recommended strategies to help guide your team streamline stakeholder engagement activities between IP and CHA/CHIP processes.

Strategy	Recommended Action

 **Assign appropriate leadership and staff to participate in CHA/CHIP engagement**	- Consider the following factors to determine who is best to participate in CHA/CHIP engagement:
	  - **Skills and experience:** Depending on the needs of the CHA/CHIP, staff may need to have policy, stakeholder engagement, and/or data skills;
	  - **Relationships:** Staff should be willing to make and cultivate new relationships and/or have previous relationships with public health;
	  - **Bandwidth:** Ensure that staff have adequate bandwidth to meaningfully participate on CHA/CHIP, and to the extent possible, create redundancies so that proxies may be sent should the assigned representative not be able to attend;
	  - **Decision-making authority:** Ensure that the staff has adequate decision-making authority or may be able to obtain leadership approvals quickly to help advance decisions that need to be made.

Strategy	Recommended Action
 **Schedule regular cross-sector meetings**	» Set up regular check-ins with LHJ and MCP leadership and staff to discuss relevant policies, goals, and approach for working together, as well as build time for connection and building trust.
 **Collectively establish clear roles and responsibilities for different partners**	» Create goals with LHJ and MCP partners and regularly revisit these goals and adapt them as needed. If helpful, use tools such as: ○ Responsible, Accountable, Informed, and Consulted (RACI) frameworks (See the CalMHSA Guide for an example RACI template); and/or ○ Memorandum of understanding, commitment letter or promise notes, depending on how formal an agreement the county would like to have with the LHJ. » Use tools such as shared listservs, document sharing capabilities, project plans.
 **Have focused conversations with LHJs on CHA/CHIP and IP governance structures**	» Assign appropriate county behavioral health leadership representative(s) to discuss CHA/CHIP governance structures with appropriate LHJ representatives. » Request a governance overview if not familiar with existing CHA/CHIP governance structures. ○ Discuss whether there are opportunities for county behavioral health to participate in existing governance structures. » Discuss whether the LHJ is contemplating changing the LHJ governance structure in light of the 2028 CHA/CHIP requirements to be on the same development cycle. » Apart from CHA/CHIP and IP governance structures, discuss whether there should be workgroups that meet regularly on IP and CHA/CHIP alignment.

Collaboration Promising Practices

Below are examples of how behavioral health departments have collaborated with LHJs and MCPs in governance and planning activities.

Sutter County
Established a *Behavioral Health Learning Collaborative* in its 2023-2028 CHIP that includes behavioral health, public health, MCPs, school-based providers, and other community partners. This collaborative directly supports CHIP implementation by sharing resources and strategies via quarterly education sessions, participating in stakeholder forums co-hosted by County Health and Human Services, and informing the county's Behavioral Health Dashboard and Action Plan, which outlines shared goals and implementation steps. Behavioral Health also maintains weekly communication with LHJ leadership to support alignment across sectors.

Orange County
The Behavioral Health Services Department is embedded in multiple countywide governance structures, including the CHIP Steering Committee and the Population Health Steering Committee, both of which include MCPs and community-based organizations (CBO). Behavioral Health also participates in priority-specific workgroups (e.g., Mental Health, Substance abuse) contributing to the design and implementation of CHIP strategies.

Humboldt County
Humboldt used a year-long design process in their 2022-2027 CHIP to co-develop the Live Well Humboldt Steering Committee, a governance body that includes Public Health, Behavioral Health, MCPs, and community partners. Behavioral Health leadership participated in both the design and implementation phases and now plays a standing role in the Steering Committee and its workgroups. This structure has helped embed behavioral health priorities in broader health improvement efforts.

Tool 3: Stakeholder Engagement

The BHSA identifies more than 20 different stakeholder groups that county behavioral health must engage with in the development of the IP. As part of the stakeholder engagement requirement, county behavioral health should work with LHJs to look for opportunities where IP stakeholder engagement could be combined or integrated with CHA/CHIP processes. For example, both county behavioral health and LHJs may identify opportunities to coordinate community forums, listening sessions, focus groups, and surveys. This will not only reduce the administrative burden for the LHJ and county but also reduce community fatigue for stakeholders invited to participate in these activities and increase participation overall.

BHSA local planning requirements were written to allow county behavioral health flexibility on how they streamline stakeholder engagement activities with their LHJs and MCPs, recognizing that county behavioral health are in different stages of cross-sector partnerships. Refer to the stakeholder engagement reflection exercise, recommended strategies and promising practices as your team coordinates stakeholder engagements with LHJ and MCP partners.

BHSA Local Planning, Stakeholder Engagement Requirement:

County behavioral health must:

- Coordinate stakeholder activities/findings for IP development with LHJ/MCP engagement on the CHA/CHIP to the extent possible; and
- Consider input from diverse populations and a wide range of community stakeholders.

Note on CHA/CHIP Stakeholder Engagement Activities

- CHA/CHIP stakeholder engagement activities vary by community but involve similar stakeholders (e.g., hospitals, local education, social service agencies, CBOs, and persons with lived experience) and similar engagement activities as the IP community planning process, (e.g., interviews surveys, focus groups, town halls with a diverse array of community stakeholders).
- Several LHJ CHAs/CHIPs rely upon the Mobilizing for Action through Planned Partnerships (MAPP) Framework and the Association for Community Health Improvement (ACHI) Toolkit that offer structured frameworks and detailed guidance for robust community engagement to advance health equity.

Stakeholder Engagement Reflection Exercise

Reflect internally as a team on the following questions to help prepare your team meet BHSA local planning requirements related to stakeholder engagement.

- *Has your team previously participated in LHJ CHA/CHIP stakeholder engagement activities across LHJs and/or MCPs (e.g., surveys, listening sessions, forums)?*
  - *If yes, what was the experience like, and what lessons may be applied here?*
  - *If no, has your team collaborated with LHJs in the past in other types of stakeholder engagement activities, and what was that experience like, and what lessons may be applied here?*

Stakeholder Engagement Checklist

Use this checklist of recommended strategies to help guide your team streamline stakeholder engagement activities between IP and CHA/CHIP processes.

Strategy	Recommended Action
 **Set up regular meetings to discuss stakeholder engagement**	» Assign internal county behavioral health staff to work regularly meet with LHJ and MCP partners to discuss how to streamline and strengthen stakeholder engagement activities.
 **Identify overlapping stakeholders**	» Review public facing LHJ CHA/CHIP documents and meet with appropriate LHJ and MCP staff to determine who are the shared stakeholders engaged in both the IP and CHA/CHIP efforts. » Consider engaging in a stakeholder mapping exercise with LHJ and MCP partners to identify shared stakeholders and strengthen relationships. ○ Write down all stakeholders who participate in IP and CHA/CHIP processes on separate pieces of paper and place them on a whiteboard. ○ Identify those stakeholders who are shared between IP and CHA/CHIP processes and consider ways for

Strategy	Recommended Action
	all partners (county behavioral health, MCPs, and LHJs) to jointly engage with these stakeholders. ▪ Should any of these shared stakeholders be prioritized in terms of engagement? ○ Identify those stakeholders with whom either county behavioral health, LHJs, or MCPs have strong existing relationships. ○ Does any another partner want to further build upon these relationships and how to do so? ○ Identify those stakeholders with whom no partner has a relationship (or weak relationships). ▪ How do all partners collectively or separately build these relationships? ○ Identify those stakeholders (e.g., persons with lived experience) where there may be trust issues or sensitivities and it may make sense for the partner who has had a historical relationship with the stakeholder(s) to continue engage separately as opposed to engaging jointly with other partners. » Consider what are specific ways that county behavioral health, LHJs, and MCPs may reduce community fatigue among these stakeholders by combining activities, especially for those stakeholders with lived experience, whose time and resources may be limited.
Identify ways to streamline stakeholder engagement	» Consider which county behavioral stakeholder engagement activities to invite LHJs and MCPs to participate in that align with LHJ CHA/CHIP priorities. ○ How might they be able to contribute to this activity in terms of staffing, resources, and outreach? ○ How may they be able to leverage their relationships to strengthen participation/attendance in county-led activities? » Review public facing LHJ documents (e.g., most recent CHA/CHIP) or any materials you have received from

Strategy	Recommended Action
	meetings with LHJs that describe their stakeholder activities. ○ What LHJ stakeholder engagement activities (e.g., town halls, surveys, listening sessions) sessions should the team participate in that are focused on behavioral health priorities? ○ How may you be able to contribute to these activities in terms of staffing, resources, and outreach? ○ How may your team be able to leverage your relationships to strengthen participation/attendance in LHJ-led activities? » Consider what are other opportunities for county behavioral health, LHJs, and MCPs to co-design new stakeholder engagement activities that address statewide behavioral health goals and increase engagement opportunities, especially those with lived experience. » Consider what county-led stakeholder engagement responsibilities and activities may be streamlined and/or sunset given the cross-sector partnership with LHJs and MCPs. » Consider co-developing guidelines, policies, and practices with LHJ and MCP partners to build trust with community members, especially those with lived experience. See below resources: ○ AAMC Center for Health Justice: The Principles of Trustworthiness Toolkit; and ○ International Association of Public Participation Spectrum of Public Participation.
	» Work closely with LHJ and MCP leadership for opportunities to speak jointly to stakeholders about shared priorities. ○ E.g., Publicly share engagement calendars to promote greater collaboration.

Strategy	Recommended Action
Identify additional joint communication opportunities	» Work closely with LHJ and MCP leadership to identify key messages that county behavioral health, MCPs, and local health want to emphasize with stakeholders.

Stakeholder Engagement Promising Practices

Plumas County
Plumas County's behavioral health department partnered with its LHJ and community resource centers to host bilingual surveys and "hot dot" polling at public events. These activities gathered input on key health issues and were used to inform both the CHA and CHIP, streamlining community engagement across sectors.

Orange County
Orange County has developed a robust engagement infrastructure through its Behavioral Health Equity Committee, which includes subcommittees for specific communities (e.g., LBGTQIA+, SUD, deaf/hard of hearing). These committees coordinated behavioral health workgroups that included MCPs (CalOptima), CBOs, and public health representatives. These stakeholders participated in shared listening sessions and workshops during both CHIP development and IP planning. Messaging and meeting timelines were aligned to maximize participation and minimize duplication of outreach and stakeholder fatigue.

Humboldt County
Public health and behavioral health departments jointly plan stakeholder engagement activities to align CHA/CHIP and Integrated Planning outreach. Humboldt streamlined survey development and focus groups to minimize duplication and fatigue. The county has also established workgroups (e.g., storytelling, equity) that allow stakeholders to participate based on capacity and interest while maintaining alignment across planning efforts.

San Diego
San Diego County developed regional stakeholder engagement calendars that aligned behavioral health-led listening sessions with CHA/CHIP engagement milestones. Shared communications, co-branded outreach, and community forums were hosted to support both IP and CHIP development.

Sutter County
Public health and behavioral health jointly participated in stakeholder forums during the CHIP development process. Community feedback during these forums led to behavioral health being elevated as a sub-priority under "Building Resilient Communities." Additionally, both departments co-host learning collaboratives that double as engagement platforms, ensuring that strategies are informed by community voices and responsive to cross-sector input.

Tool 4: Data-Sharing

County behavioral health, LHJs, and MCPs all have access to their own rich data reserves, but they are often not shared, resulting in a partial view of a community's health and wellbeing. When these partners share data to support CHA/CHIP and IP planning and development, it can be used to create a more holistic picture of upstream factors, trends and patterns, and ultimately inform targeted interventions that advance health equity and statewide population behavioral health goals. See table below.

For purposes of sharing data to inform the CHA/CHIP and IP, data is aggregated, meaning that the data is summarized in a way that prevents disclosure of personal identifiers, and it is de-identified, meaning that personally identifiable information has been removed or obscured so that it cannot be used to identify an individual, and there is no reasonable basis to believe it can be used to do so. Sharing aggregated, de-identified data is legally permissible for purposes of local planning requirements and critical to achieving statewide behavioral health goals. County Behavioral Health, LHJs, and MCPs, however, are sometimes hesitant to share data given their perceived or real concerns that federal and/or state law restricts them from doing so. **Health information that is**

BHSA Local Planning, Data Sharing Requirement:

County behavioral health must identify Statewide Behavioral Health Goals to:

- Share relevant data to support behavioral health-related focus areas of the CHA/CHIP; and
- Utilize and stratify relevant data from MCPs and LHJs to inform IP development.

Note on CHA/CHIP Data Resources

- Although California's LHJs use different data sources to inform their CHAs/CHIPs, they often emphasize wide community input and rely upon primary and secondary data as well as quantitative and qualitative data on various topics (e.g., social and economic factors, health systems, public health and prevention, health disparities, health inequities, and/or community resources and assets).
- MCPs are required to share agreed upon data in accordance with all applicable laws and facilitated via data sharing agreements and in formats that support LHJ capacity and priorities, as outlined in PHM Policy Guide.

protected by the Health Insurance Portability and Accountability Act (HIPAA), as well as certain substance use disorder (SUD) information protected by 42 C.F.R Part 2 (sometimes referred to as òPart 2ó), can be shared without consent once it has been de-identified.[1] This means that, for the IP and CHA/CHIP, partners can share aggregated, de-identified data.

BHSA local planning requirements allow county behavioral health flexibility on how they share data with their LHJ and MCP partners. Refer to the data-sharing reflection exercise, recommended strategies, promising practices, and use cases to help guide your team to meet these requirements.

Data-Sharing Reflection Questions

Reflect internally as a team on the following questions to help prepare your team to meet BHSA local planning requirements related to data-sharing.

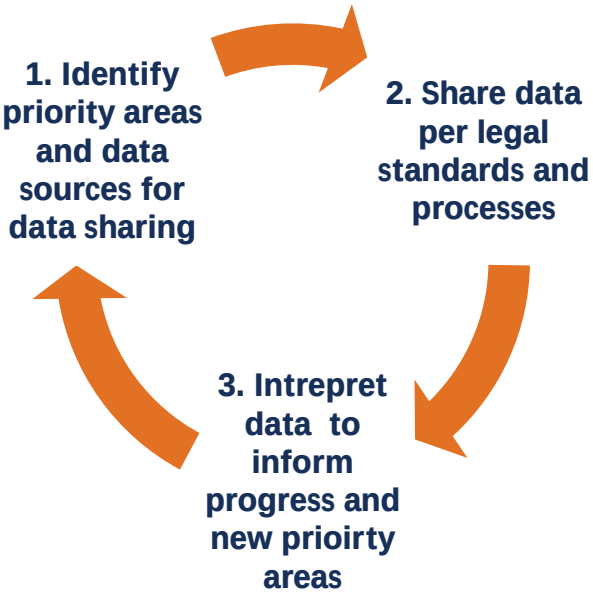
- Has your team contributed data to the CHA/ CHIP process in the past?
  - If yes, what was the experience like, and what lessons may be applied here?
  - If no, has your team shared data with LHJs and/or MCPs in the past, and if so, what was that experience like, and what lessons may be applied here?

Data-Sharing to Support Continuous Improvement

The below checklist includes three categories of recommended strategies, which are meant to be part of cyclical and continuous improvement processes to make progress towards statewide population behavioral health goals and health equity.

[1] 5 CFR 164.514 (specifying that information that is de-identified is not PHI, meaning that it is no longer subject to HIPAA). 42 CFR 2.11 (defining what constitutes òpatient identifying information,ó and clarifying that òrecordsó subject to Part 2 restrictions must include patient identifying information). Note that Part art 2 defines òpatient identifying informationó more broadly than HIPAA and may still restrict disclosure even when data is de-identified under HIPAA standards. Please refer to the DHCS de-identification guidelines SAMHSAôs FAQ document: FREQUENTLY ASKED QUESTIONS for more details on when and how Part 2 data may be shared.

Image 4: Data-Sharing Prioritization Journey Map



Data-Sharing Checklist

Use this checklist of recommended strategies to help guide your team in improving data-sharing activities for the IP and CHA/CHIP processes.

1. Identify priority areas and data sources for data sharing

Strategy	Recommended Action
Identify priority areas	é Work with the LHJ to identify behavioral health focus areas of their CHA/CHIP that align with statewide population behavioral health goals. ○ Identify alignment with the six priority statewide behavioral health goals that need to be reported in the IP: Access to Care, homelessness, institutionalization, justice involvement, removal of children from home, and untreated behavioral health conditions. ○ Statewide population behavioral health goals cover a wide range of issues and likely have several connection points to CHA/CHIP priority areas, which may not immediately seem to have a behavioral health focus but upon closer analysis, have upstream impacts. For example, many CHAs/CHIPs collect data and focus on upstream interventions that address poverty, education, and employment, which are essential to being able to

Strategy	Recommended Action
	move the needle on goals such as reducing homelessness and justice involvement in a community.
 **Identify what data is to be shared**	é **Determine what data your county needs** from MCPs and LHJs to support planning for the IP. See the data-sharing use cases below and consider the following: ○ The extent to which these data are used in the CHA/CHIP process. ○ The legal, technical, and resources challenges associated with sharing these data. ○ The opportunities or activities already undertaken to address these challenges. é **Determine what data county behavioral health should contribute** to support CHA/CHIP priorities that align with statewide population behavioral health goals. See the data-sharing use cases below and consider the following: ○ The legal, technical, and resources challenges associated with sharing these data. ○ The opportunities or activities already undertaken to address these challenges.

2. Share data per legal standards and processes

Strategy	Recommended Action
 **Review relevant guidance and policies**	é **Review relevant guidance and policies** to support public reporting and protection of personally identifiable information in compliance with all applicable federal and state laws and regulations. ○ DHCS Data exchange webpage that includes relevant data-sharing policies and resources, such as: ▪ Data-sharing Authorization Guidance provides an overview of relevant state and federal data-sharing and privacy regulations and focuses on the exchange of personally identifiable information (PII) about Medi-Cal Members. ▪ Data-sharing Authorization Toolkits, which provide more details on relevant use cases.

Strategy	Recommended Action
	▪ Managed Care Plans and Behavioral Health Plans/Counties data-exchange webpage. ▪ PHM Policy Guide, which includes specific data-exchange guidance related to MCP PHM programs. ▪ Community Based Organizations and Providers data exchange webpage. ▪ DHCS De-identified Data Guidelines describe a procedure to assess and de-identify data for public release in compliance with the California Information Practices Act (IPA) and the HIPPA to prevent the disclosure of personal information. o California Data Exchange Framework (DxF) includes a single Data-sharing Agreement (DSA) and common set of Policies and Procedures (P&Ps) for governing the exchange of electronic health and social service information across the state. MCPs are required to sign the DxF. Although LHJs and County Behavioral Health are not required to participate, LHJs and County Behavioral Health are encouraged to become signatories, and several already are. If an LHJ has a clinical laboratory, the laboratory is required to become a signatory. o CalHHS State Health Information Guidance (SHIG), which helps clarify federal and state laws that affect disclosure and sharing of health information. SHIG Volume 1.3 in particular provides details regarding the sharing of behavioral health information. See the public health example (scenario 18) delineated in SHIG (Volume 1.3). o DHCS Memorandum of Understanding Webpage that includes MOU templates to clarify roles and responsibilities between MCPs and Third Parties, including the exchange of information. o Additional References Resources: Authorization to Share Confidential Member Information (ASCMI) Form is a standardized consent form used by care partners to

Strategy	Recommended Action
	obtain authorization to share sensitive information (e.g., Part 2 information) about their clients to facilitate real time data exchange and care coordination for individual data-sharing. The ASCMI Form is not required to be used for aggregated de-identified information but is a useful reference resources to better understand data-sharing requirements. ▪ ASCMI Frequently Asked Questions (FAQs) for clients reviewing the ASCMI Form and for care partners administering the ASCMI Form.
 **Assign staffing towards data-sharing**	» Assign dedicated behavioral health leadership and staff to be responsible for both receiving data from LHJs and MCPs and transmitting data to these partners. Consider whether staff has: o Relevant legal and technical expertise and experience to share data with LHJ and MCP partners; and o Previous experience in sharing data with LHJ and MCP partners. » **Train staff** to expand legal and technical expertise to support data-sharing for IP and CHA/CHIP.
 **Form a cross-sector workgroup**	» **Establish a cross-sector workgroup with LHJ and MCP partners –** that includes technical, clinical, and legal experts focused on data-sharing, along with information, tools, and resources to support timely and effective data-sharing.
 **Standardize and set expectations for data-sharing**	» **Establish (or update existing) MOUs and/or DSAs with LHJs and/or MCPs**, to delineate roles and responsibilities and data-sharing expectations provisions related to BHSA local planning requirements. For a link to MOU templates with MCPs, see this DHCS webpage. » **Work with LHJ and MCP partners to develop and share processes, templates, and data dictionaries** to standardize how and when data is shared to support planning requirements.

Strategy	Recommended Action
Safeguard against reverse identification for small numbers	» **Use percentages rather than actual numbers or suppress information when the "n" is less than 10** to avoid reverse identification or re-identification and ensure compliance with relevant state and federal laws. o See DHCS De-identified Data Guidelines and this resource from Washington State on standards for reporting data with small numbers. » De-identify data when there are multiple variables that could lead to reverse identification (e.g., age plus zip code plus race).
Consider ways to share data publicly while protecting privacy	» **Work with LHJ and MCP partners to develop publicly available data dashboards** that highlight behavioral health trends, patterns, and hotspots in the county. o This can be particularly helpful to build trust and buy-in from stakeholders reluctant to share data.

3. Interpreting Data

Strategy	Recommended Action
Interpret the data to inform progress	» **Work with LHJ and MCP partners to interpret the data** collected for both the IP and CHA/CHIP process to ultimately determine if progress has been made and to identify new priority areas of focus to further advance behavioral health and overall health equity.

Data-Sharing Promising Practices

Humboldt County
Developed a public-facing dashboard (livewellhumboldt.org) that tracks progress on CHIP goals, including behavioral health-related indicators. This supports shared accountability and transparency among stakeholders.

Inland Empire Health Plan (IEHP)
IEHP has had BH data exchange agreements, MOUs, and processes in place with Riverside and San Bernadino counties. As a result of the recently published DHCS MOU template, IEHP updated the MOUs leveraging the DHCS template. The updated MOU has been beneficial to establish expectations, roles, and responsibilities of all parties.

Alameda County
Developed the Social Health Information Exchange (SHIE) to securely connect and integrate individuals' medical, mental health, SUD, housing social care, legal, incarceration, and crisis response data between medical and non-medical providers. Data from the SHIE feeds into the Community Health Record Portal where care team members can use the data to perform more coordinated care.

Data-Sharing Use Cases

The table below includes three hypothetical use cases to delineate what types of data each partner may contribute to shared IP and CHA/CHIP goals.

Shared Goal among IP and CHA/CHIP processes	County Behavioral Health data	LHJ data	MCP data
Reducing homelessness	» Utilization data on behavioral treatment for persons experiencing homelessness or housing instability	» Public health data that may include data on homelessness ○ *E.g., demographics, Vital statistics, hospital visits, (EMS)* » Data on common medical co-morbidities that individuals with SUD experience	» Medicaid claims data related to non-specialty behavioral health treatment for persons experiencing homelessness » Enhanced Care Management (ECM) data for persons experiencing homelessness » Community supports data for

Shared Goal among IP and CHA/CHIP processes	County Behavioral Health data	LHJ data	MCP data
		diseases, liver disease, other behavioral health issues » Other potential CHA/CHIP upstream data that may be related to homelessness ○ *E.g., poverty, education levels, housing shortages, violence, employment, adverse childhood experiences, Continuum of Care data*	experiencing homelessness
Reducing justice-involvement	» Utilization data on behavioral treatment for persons with current or justice involvement	» Public health data that may include data on justice involvement ○ *E.g., demographics, vital statistics, hospital visits, EMS* » Data on common physical health issues among individuals who are justice-involved	» Medicaid claims data related to non-specialty behavioral health treatment for persons with current or prior justice involvement » ECM data for persons with current or prior justice involvement

Shared Goal among IP and CHA/CHIP processes	County Behavioral Health data	LHJ data	MCP data
		○ *E.g., HIV, Hepatitis C, tuberculosis, STIs, chronic disease, behavioral health issues* » Other potential CHA/CHIP upstream related to justice-involved population ○ *E.g., poverty, education levels, housing shortages, employment, adverse childhood experiences, homelessness*	» Community supports data for persons with current or justice involvement
Reducing overdose deaths	» Utilization data on behavioral health treatment	» Vital statistics ○ *E.g., drug-related deaths* » Demographic information on those with drug-related deaths » Hospital visits » Emergency management services (EMS)	» Medicaid claims data related to non-specialty behavioral health treatment

Shared Goal among IP and CHA/CHIP processes	County Behavioral Health data	LHJ data	MCP data
		○ *E.g., naloxone administration* » Data on common medical co-morbidities that individuals with SUD experience ○ *E.g., HIV, Hepatitis, heart diseases, liver disease, other behavioral health issues* » Other CHA/CHIP data upstream related to overdose ○ *E.g., poverty, violence, education, employment, adverse childhood experience data*	

APPENDICES

Appendix 1: What's the Value Proposition for Alignment?

Level-setting requires not only understanding the technical aspects of a policy, but also the WHY behind the policy. This table outlines the value proposition for aligning the community planning process for each sector, articulating what each brings to the table and gains from participating. County behavioral health departments (county behavioral health), local health jurisdictions (LHJs), and managed care plans (MCPs) are encouraged to work together to further elaborate upon this table and tailor their WHY.

What each partner CONTRIBUTES to cross-sector alignment

Contribution	County Behavioral Health	MCPs	LHJs
 **Data**	» **Critical specialty behavioral health data** from providing behavioral health services (inclusive of mental health and SUD) to the Medi-Cal and BHSA-eligible population.	» **Non-specialty behavioral health data, in addition to critical Medi-Cal population data** from providing essential services to their population, which comprises over 1/3 of California's total population.	» **Robust data from a myriad of sources** that include primary data (e.g., surveys, focus groups, interviews, and community dialogues) and secondary data (e.g., demographic data, health status data, socio-economic and environmental data and community resource data) to inform solutions that may apply across delivery systems to improve outcomes.

Contribution	County Behavioral Health	MCPs	LHJs
Unique Perspective	» **Expertise in Behavioral Health (Specialty Mental Health (SMH) and SUD) and perspectives from robust stakeholder engagement** via the IP community planning processes, which requires engagement with over 20 stakeholders.	» **Perspective and expertise in whole person care approaches** to inform community planning efforts.	» **Upstream perspective** on the root causes driving most health outcomes and from extensive experience with CHA/CHIP stakeholder engagement.
Relationships	» **Community relationships with behavioral health providers and deep community ties from robust stakeholder engagement** via the MHSA community planning process (20 years) and the IP community planning processes, which requires engagement with over 20 stakeholders.	» **Relationships with Medi-Cal providers and with community organizations**, especially through recent Cal-AIM initiative focusing on enhanced care management and community supports.	» **Deep community ties** from robust CHA/CHIP stakeholder engagement activities.

Contribution	County Behavioral Health	MCPs	LHJs
 **Other**	» **Experience with providing a robust community planning process under the MHSA** that is focused on local community voice and needs. The BHSA expanded the current list of required stakeholders that were under MHSA.	» **Resources required to be provided** (financial and/or in-kind staffing) to LHJ CHA/CHIPs; Encouraged to provide community reinvestment dollars to CHIP activities engagement process with diverse perspectives.	» **Inclusive governance structure** that can be leveraged to drive a meaningful community.

What each partner GAINS from cross-sector alignment

Value of Alignment	County Behavioral Health	MCPs	LHJs
 **Systemic change across systems**	» All sectors gain from creating real systemic change that is aligned and integrated across systems.		
Greater cross-sector support	» To achieve statewide **population behavioral health goals** to which they are held accountable.	» To achieve statewide **population behavioral health goals** and other **population health measures,** including Medi-Cal Managed Care Accountability Sets (MCAS), to	» To achieve statewide population behavioral health goals and other local **public health goals** aimed at advancing health equity and

Value of Alignment	County Behavioral Health	MCPs	LHJs
		which they are held accountable.	improving community health outcomes.
 **Streamlined approach, reducing community fatigue and creating greater efficiency and resource allocation**	» To meeting **BHSA community planning requirements**.	» To **meeting PHM community planning requirements** (also known as population needs assessment requirements).	» To collaborating with county behavioral health and MCPs on **CHA/CHIPs**.
 **More robust data insights**	» From **public health and MCPs** to inform the IP and meeting key measures.	» From **LHJs and county behavioral health** to inform population health strategies and targeted interventions that would improve outcomes.	» From **county behavioral health and MCPs** to inform CHIPs and create a more holistic picture of the factors contributing to a community's health.
 **Stronger messaging**	» That **frames behavioral health as a public health priority**, reducing stigma and creating greater awareness and a call to action.	» That demonstrates broader understanding of challenges facing communities, as aligned with LHJs and county behavioral health, which can **build public confidence in MCP interventions**.	» That is consistent with county behavioral health and MCPs **building confidence in public health**.

Value of Alignment	County Behavioral Health	MCPs	LHJs
More impactful investments	» Higher impact **BHSA fund investments**.	» Higher impact **MCP community reinvestments**.	» Higher impact **public health investments**.

Appendix 2: Crosswalk

The crosswalk below compares the Local Health Jurisdiction (LHJ) Community Health Assessment and Community Health Improvement Plan, the County Behavioral Health Behavioral Health Services Act (BHSA) Integrated Plan (IP), and the MCP Population Health Management Strategy.

As noted above, MCPs were historically required to submit a population needs assessment (PNA) deliverable to DHCS that identified (1) priority needs of their local communities and members and (2) health disparities. Since January 1, 2024, MCPs no longer are required to submit a PNA deliverable to the state and have fulfilled their PNA requirement by meaningfully participating in the development of LHJ CHAs and CHIPs in four key areas: collaboration, stakeholder engagement, data sharing, and resource contribution.

Area	BHSA IP	LHJ CHA and CHIP	DHCS MCP Population Health Management (PHM) Strategy
Purpose	» Comprehensive spending plan describing how county BH will use all available behavioral health funding across a care continuum, from prevention and wellness in schools and other settings to community-based outpatient care, residential care, crisis care, acute care, and housing services and supports.	» CHAs: Evaluate community health strengths and needs, including those of behavioral health » CHIPs: Informed by CHA, they provide an actionable improvement plan to address priority areas. Priority areas may include behavioral health.	» Report to DHCS that includes details on: ○ MCP engagement in LHJ CHA and CHIP processes ○ Progress toward statewide behavioral health goals ○ Community reinvestment activities ○ Other updates on MCP implementation of the PHM program.

Area	BHSA IP	LHJ CHA and CHIP	DHCS MCP Population Health Management (PHM) Strategy
Requirement Source	» The BHSA statute outlines county behavioral health requirements to develop and submit an IP, which are further elaborated upon in the BHSA County Policy Manual. » DHCS provides a template for county behavioral health to submit their IP and Annual Update.	» Public Health Accreditation Board: LHJs complete CHA/CHIPs to obtain PHAB accreditation. » With introduction of the 2022 Budget Act, all 61 LHJs must now submit a "Public Health Plan," (also known as a local Future of Public Health workplan) which should be informed by a CHA, CHIP, and/or Local Strategic Plan, by December 30, 2023, and by July 1 every three years thereafter. » By 2028, all CHA/CHIP will be on the same development cycle (pending legislation).	» The MCP Contract and PHM Policy Guide outline requirements for MCPs to submit a PHM Strategy to DHCS. » DHCS provides a template for MCPs to submit their PHM Strategy.
Scope and Content	» Focuses specifically on behavioral health services (SMH and SUD). » IP must include sections on: o County Demographics and	» Focuses broadly on public health population health and upstream interventions. » No specific requirements on what should be included as part of CHA/CHIP.	» Focuses on MCP PHM initiatives that include both population and behavioral health for Medi-Cal Members. See above purpose section.

Area	BHSA IP	LHJ CHA and CHIP	DHCS MCP Population Health Management (PHM) Strategy
	Behavioral Health Needs o Plan Goals and Objectives o Community Planning Process o Comment Period and Public Hearing o County Behavioral Health Care Continuum Capacity o Services by Total Funding Source o Behavioral Health Services Fund Programs o Workforce Strategy o Budget and Prudent Reserve		

Area	BHSA IP	LHJ CHA and CHIP	DHCS MCP Population Health Management (PHM) Strategy
Populations	» Individuals served through the county Medi-Cal BH Delivery System and individuals served through other county BH programs.	» General population within jurisdiction.	» Medi-Cal Managed Care Members (includes members that need specialty and non-specialty behavioral health services).
Cadence	» Every three years with annual updates.	» Varies by LHJ, typically every three to five years. In 2028, CHA/CHIP development cycles will become standardized and sync with IP timelines.	» Annual.
Data	» Performance measures and local data aligned with statewide behavioral health goals, including shared data from LHJs and MCPs for CHA and CHIP development.	» Comprehensive broad-based data (primary and secondary sources), including shared data from MCPs and county BH.	» Medi-Cal Member level data and data obtained through the CHA and CHIP collaboration.
Stakeholder Engagement	» Mandated engagement with over 20 stakeholders to develop each element of the IP. » Stakeholders must have opportunities to provide feedback on key	» Community-driven processes that emphasize inclusive governance, participation from diverse sectors to identify, and address key health priorities.	» Stakeholder engagement requirements are met via the meaningful participation requirements on the CHA/CHIP, which requires the MCPs to share relevant data, provide funding and/or in-

Area	BHSA IP	LHJ CHA and CHIP	DHCS MCP Population Health Management (PHM) Strategy
	planning decisions, including policy, program planning and implementation, monitoring, workforce, quality improvement, health equity, evaluation, and budget allocations. » Collaborate with LHJs on CHAs and CHIPs to inform IP development.		kind staffing, and participate in CHA/CHIP meetings and governance structures (at the request of the LHJ) and engage with the MCP Community Advisory Committee.

Appendix 3: Glossary

The below glossary defines terms often used by county behavioral health, MCPs, and LHJs, especially as they relate to community planning processes. County behavioral health are encouraged to work with LHJs and MCPs to continuously update this glossary with new terms and concepts that need further explanation.

- **County Behavioral Health:** Means the County Behavioral Health Department, two or more County behavioral health acting jointly, and/or city-operated programs receiving funds pursuant to W&I Code 5701.5 Reference: W&I Code section 5849.2, subdivision (f); W&I Code section 5701.5.
- **County Behavioral Health Mental Health Services Act (MHSA) Three-Year Plan:** Under the MHSA, County Behavioral Health were required to submit a three-year prospective spending plan that was focused solely on MHSA dollars. With the BHSA, county behavioral health is no longer required to submit an expenditure plan but instead required to submit an Integrated Plan (IP). Reference: W&I Code section 14184.101 subdivision (j).
- **County Behavioral Health Integrated Plans (IPs):** Under the BHSA, county behavioral health develops integrated plans, which are three-year prospective global spending plans, that describe how county behavioral health intends to use all available behavioral health funds to meet statewide and local outcome measures, reduce disparities, and address unmet needs in a community. Reference: W&I Code section 5963, subdivision (a), 5963.02, subdivision (a), BHSA County Policy Manual.
- **DHCS Population Health Management Strategy (PHM) Deliverable:** An annual deliverable that MCPs submit to DHCS to demonstrate that they are responding to identified community needs, to provide other updates on their PHM program as requested by DHCS, and to inform the DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts. Reference: DHCS PHM Policy Guide.
- **Local Health Jurisdiction (LHJ):** "LHJ" means county health department or combined health department in the case of acting jointly or city health department within the meaning of Section 101185. Reference: CA Health & Safety Code Section 124030(f) & DHCSDOC-2067478743-514 (http://ca.gov), W&I Code section 5963.01 subdivision (b).

- **Local Health Jurisdiction Community Health Assessment (CHA):** CHA is an assessment conducted by local health jurisdictions to systematically examine the health status indicators for a given population that is used to identify key problems and assets in a community. LHJs must complete a CHA and a Community Health Improvement Plan to obtain Public Health Accreditation Board (PHAB) accreditation. Reference: DHCS PHM Policy Guide; CDPH Memo: Alignment of Medi-Cal Managed Care Population Needs Assessment and Local Health Jurisdiction Community Health Assessments and Community Health Improvement Plans; Public Health Accreditation Board Standards and Measures.
- **Local Health Jurisdiction Community Health Improvement Plan (CHIP):** CHIP is the output of the Community Health Assessment. The Community Health Improvement Plan is the action plan developed by Local Health Jurisdictions for how a community will use the data identified in the Community Health Assessment to improve health outcomes. LHJs must complete a CHIP and a Community Health Assessment to obtain PHAB accreditation. Reference: DHCS PHM Policy Guide, Alignment of Medi-Cal Managed Care Population Needs Assessment and Local Health Jurisdiction Community Health Assessments and Community Health Improvement Plans, Public Health Accreditation Board Standards and Measures, W&I Code section 5963.02, subdivision (b)(4).
- **Community Planning Process:** County behavioral health must engage with local stakeholders to develop each element of their IP. See below for list of stakeholders that must be engaged. County behavioral health is required to demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on behavioral health policy (inclusive of specialty mental health and substance use disorder policy), program planning and implementation, monitoring, workforce, quality improvement, evaluation, health equity, evaluation, and budget allocations. Reference: W&I Code section 5963.03, BHSA County Policy Manual.
- **Local Planning Requirements:** As part of the Community Planning Process, county behavioral health is required to work with LHJs, along with MCPs, on the development of CHAs and CHIPs. County behavioral health must also consider the CHA and CHIP in preparing their IP and annual update. Reference: W&I Code section 5963.01, subdivision (a), W&I Code section 5963.01, subdivision (b), BHSA County Policy Manual.

- **National Committee of Quality Assurance (NCQA):** A non-profit organization dedicated to improving health care quality through accreditation, measurement, and research. NCQA evaluates health plans and other health care organizations based on evidence-based standards and measures, aiming to promote better health outcomes and a more patient-centered approach to care. Reference: NCQA website.
- **NCQA Health Plan Accreditation:** A national accreditation program run by NCQA that evaluates and recognizes health plans based on their performance in areas like clinical quality, consumer experience, and access to care. By January 1, 2023, all MCPs must meet NCQA Health Plan PHM requirements. By January 1, 2026, all MCPs must obtain NCQA Health Plan Accreditation and NCQA Health Equity Accreditation. Deliverables due to NCQA are separate from the deliverables that must be submitted to DHCS. Reference: NCQA Health Plan Accreditation webpage.
- **NCQA PHM Strategy and Population Assessment:** As part of NCQA Health Plan Accreditation, health plans are required to submit a "PHM Strategy" describing how it will meet the needs of its members over the continuum of care, with certain aspects being measured and updated annually. To inform its PHM Strategy for NCQA, each plan must annually complete an assessment of member needs and characteristics, including identification of subpopulations based on characteristics and needs. This is distinct from the DHCS Population Health Management Strategy. Reference: DHCS PHM Policy Guide, NCQA PHM Accreditation Standards webpage.
- **Medi-Cal Managed Care Plan (MCP):** "Medi-Cal Managed Care Plan" means any individual, organization, or entity that enters into a comprehensive risk contract with the department to provide covered full-scope health care services to enrolled Medi-Cal beneficiaries pursuant to any provision of this chapter or Chapter 8 (commencing with Section 14200). Reference: W&I Code section 14184.101 subdivision (j).
- **MCP Community Reinvestment Requirements:** MCPs must allocate 5–15% of net income based on revenues and performance on quality measures to communities. MCPs are required to annually submit a Community Reinvestment Plan and Report that details how the community will benefit from the reinvestment activities and the outcomes of such investments. Community Reinvestment Plans are strongly encouraged to be directed to activities in the IP, and they must be informed by the CHA and strongly encouraged to be directed towards CHIP activities.

Reference: APL 25-004, 2024 Managed Care Boilerplate Contract, Exhibit B, Subsection 1.1.17 (Community Reinvestment).

- **Non-Profit Hospital CHNA and Community Benefit Plan,** All nonprofit hospitals, meaning those that receive "charitable hospital" designation and 501(c)(3) status from the IRS and are exempt from federal or state corporate income taxes, must meet both federal requirements (i.e., to develop a community health needs assessment (CHNA) and implementation plan) and state requirements (i.e., to develop a CHNA and a community benefit plan). Reference: IRS webpage on CHNAs. Health and Safety Code Section 127350, Health and Safety Code 127340 – 127360, California Code of Regulations § 95100-95115, HCAI Community Benefits Plan webpage.
- **Public Health Accreditation Board:** A non-profit organization that serves as the sole accrediting body for public health in the United States. PHAB has established national standards for public health agencies and supports health departments to improve quality, accountability, and performance. Reference: PHAB website.
- **MCP Population Needs Assessment (PNA):** PNA is the mechanism that MCPs use to identify the priority needs of their local communities and members and to identify health disparities. Reference: DHCS PHM Policy Guide, W&I Section 5963.02 subdivision (b)(3).

Appendix 4: List of Required Stakeholders for Integrated Plan Community Planning Process

Stakeholder engagement requirements for the Integrated Plan (IP) are effective January 1, 2025. Counties must engage with local stakeholders to develop each element of their IP. The stakeholders that must be engaged include, but are not limited to:

- Eligible adults and older adults (individuals with lived experience)
- Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience)
- Youths (individuals with lived experience) or youth mental health or SUD organizations
- Providers of mental health services and substance use disorder treatment services
- Public safety partners, including county juvenile justice agencies
- Local education agencies
- Higher education partners
- Early childhood organizations
- Local public health jurisdictions
- County social services and child welfare agencies
- Labor representative organizations
- Veterans
- Representatives from veterans' organizations
- Health care organizations, including hospitals
- Health care service plans, including Medi-Cal Managed Care Plans (MCPs)

- Disability insurers (a commercial disability insurer that covers hospital, medical, or surgical benefits as defined in **Insurance Code section 106, subdivision (b)**)
- Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- The five most populous cities in counties with a population greater than 200,000
- Area agencies on aging
- Independent living centers
- Continuums of care, including representatives from the homeless service provider community
- Regional centers
- Emergency medical services
- Community-based organizations serving culturally and linguistically diverse constituents
- In addition to the required stakeholders listed above, stakeholders shall include participation of individuals representing diverse viewpoints, including, but not limited to:
- Representatives from youth from historically marginalized communities
- Representatives from organizations specializing in working with underserved racially and ethnically diverse communities
- Representatives from LGBTQ+ communities
- Victims of domestic violence and sexual abuse
- People with lived experience of homelessness