Engaging in the BHSA Community Planning Process

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

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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- **Posting Slide Deck:** Slides will be posted within the next 10 business days on the Behavioral Health Transformation webpage.

Topics

- Behavioral Health Transformation Recap
- Behavioral Health Services Act (BHSA) Integrated Plan
- Community Planning Process Overview
- Approach to Data-Informed County Planning
- Staying Involved in Community Planning
- Integrated Plan Local Review and Stakeholder Engagement Reporting
- Resources

Behavioral Health Transformation Recap

DHCS

Behavioral Health Transformation

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

Behavioral Health Services Act

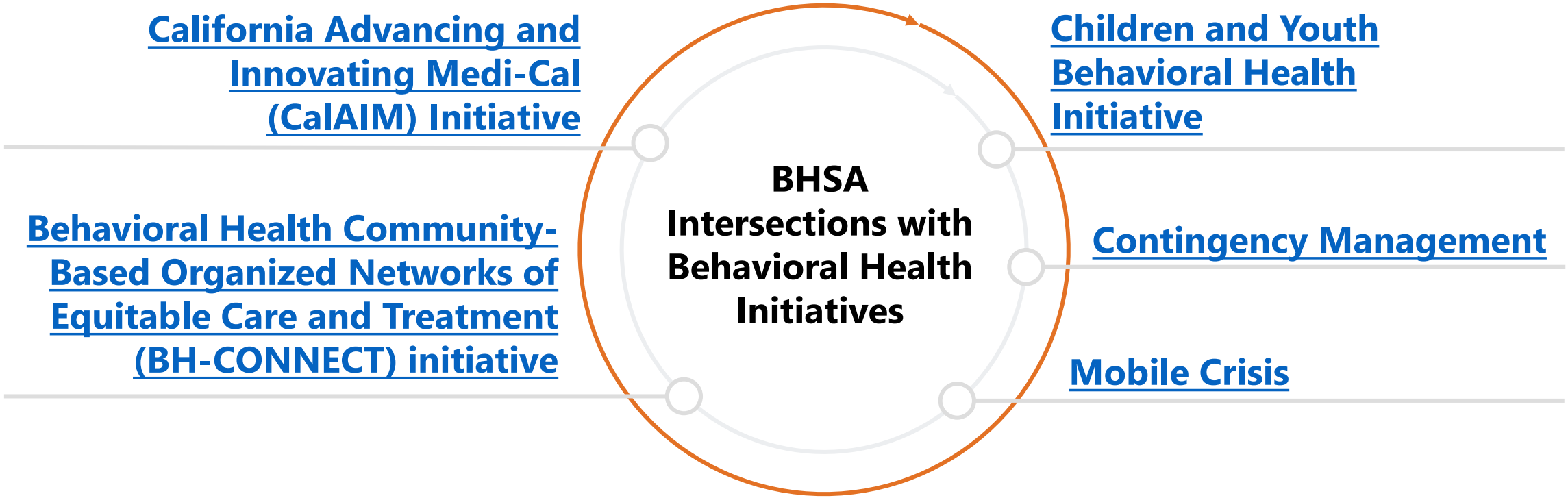
- Reforms behavioral health care funding to provide services to Californians with the most significant behavioral health needs.
- Expands the behavioral health workforce to reflect and connect with California's diverse population.
- Focuses on outcomes, accountability, and equity.

Behavioral Health Bond

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

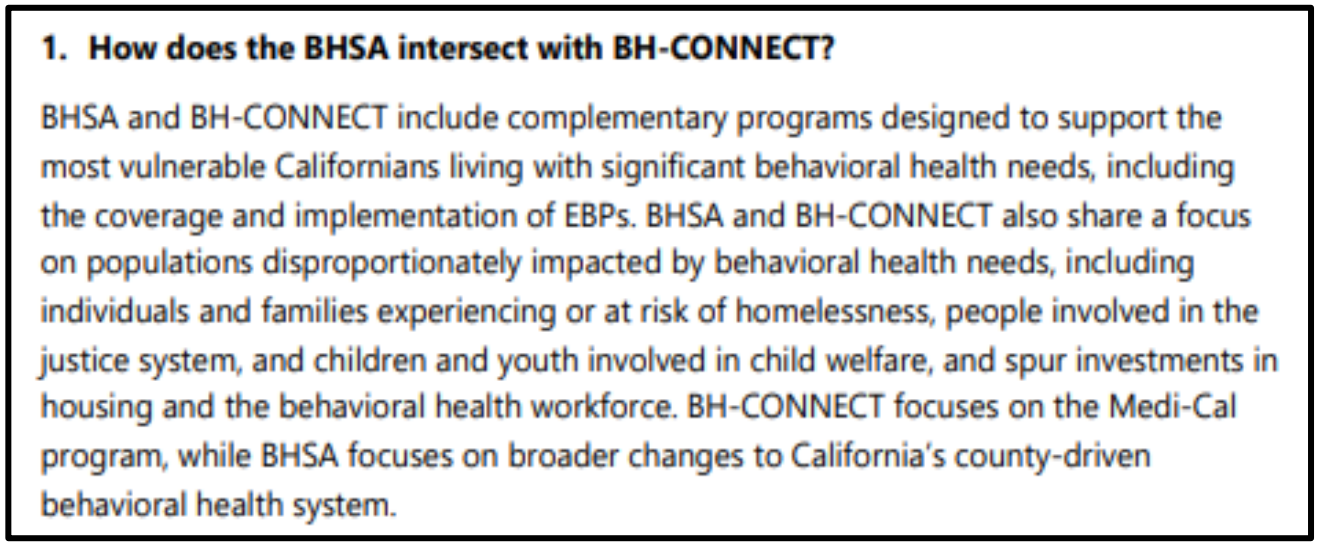
BHSA and Intersections with Behavioral Health Initiatives

The BHSA works in collaboration with a host of other behavioral health initiatives that have launched in recent years to bolster existing projects and provide counties with additional federal funding opportunities, including the following:



Resource: BHSA and BH-CONNECT Evidence Based Practices Overlap FAQ

- The BHSA and BH-CONNECT EBP Overlap FAQ contains frequently asked questions and responses related to the implementation of evidence-based practices (EBPs) included in both BHSA and BH-CONNECT.



1. How does the BHSA intersect with BH-CONNECT?

BHSA and BH-CONNECT include complementary programs designed to support the most vulnerable Californians living with significant behavioral health needs, including the coverage and implementation of EBPs. BHSA and BH-CONNECT also share a focus on populations disproportionately impacted by behavioral health needs, including individuals and families experiencing or at risk of homelessness, people involved in the justice system, and children and youth involved in child welfare, and spur investments in housing and the behavioral health workforce. BH-CONNECT focuses on the Medi-Cal program, while BHSA focuses on broader changes to California's county-driven behavioral health system.

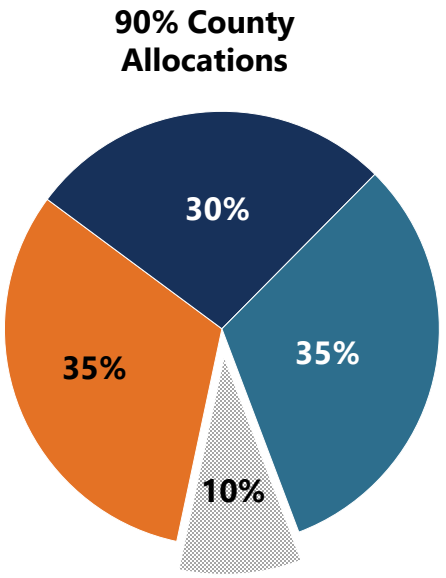
Behavioral Health Services Act Funding Breakdown

90% **County Allocations**

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

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

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



Priority Populations

The BHSA broadens behavioral health supports for eligible Californians by addressing historical gaps and new policy priorities. Each county develops and runs programs prioritizing specific populations in need.

Eligible adults and older adults who meet one of the following:

- Are chronically homeless or experiencing homelessness or are at risk of homelessness.
- Are in, or are at risk of being in, the justice system.
- Are reentering the community from prison or jail. Are at risk of conservatorship pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5.
- Are at risk of institutionalization.

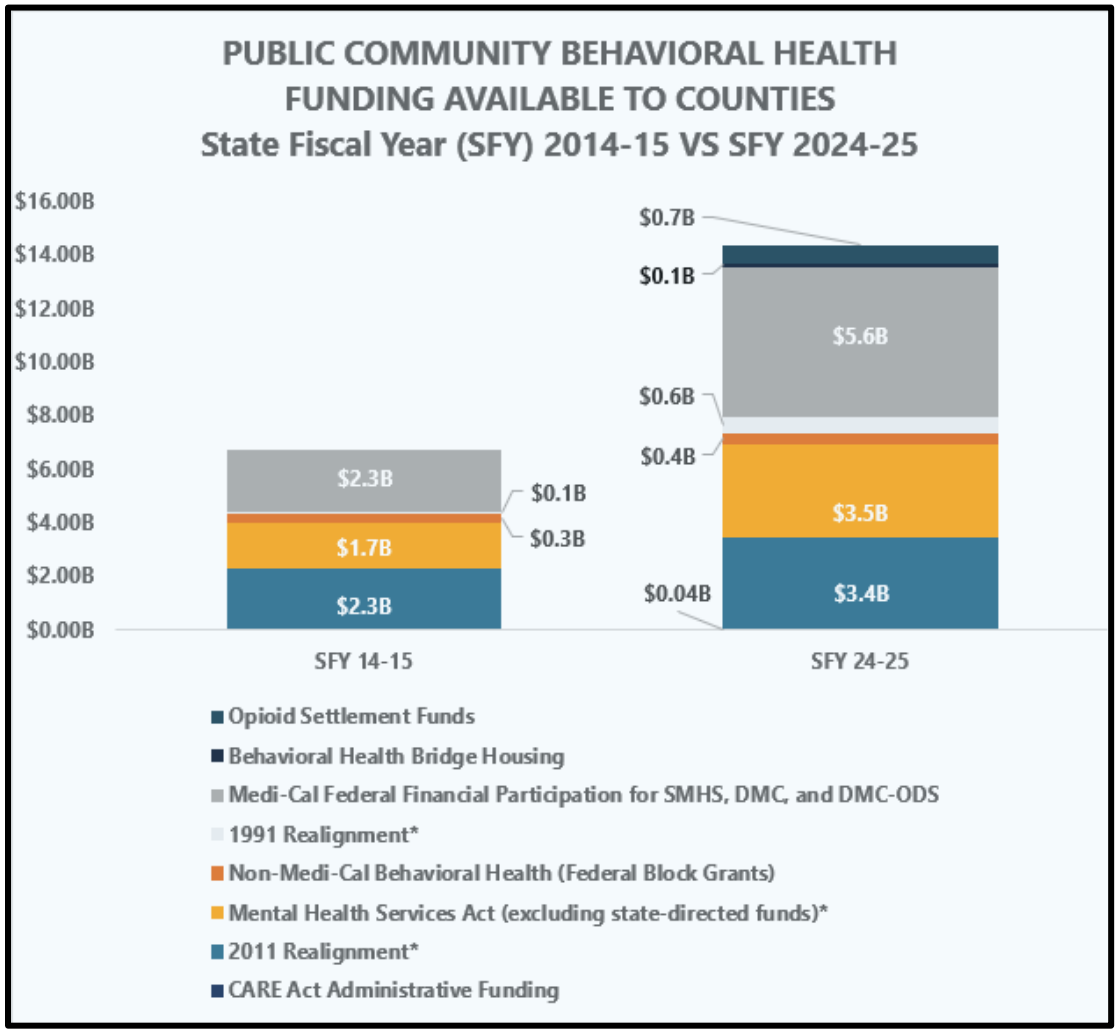
Eligible children and youth who meet one of the following:

- Are chronically homeless or experiencing homelessness or are at risk of homelessness.
- Are in, or at risk of being in, the juvenile justice system.
- Are reentering the community from a youth correctional facility.
- Are in the child welfare system pursuant to Section 300, 601, or 602.
- Are at risk of institutionalization.

Understanding the Behavioral Health Services Act

- The Behavioral Health Services Act (BHSA) made no cuts to behavioral health funding. Instead, the BHSA requires a needed change: county behavioral health care must now focus on helping the most seriously ill and unhoused, and counties will have increased accountability for achieving results.

- Change to the status quo can be hard; some local services may see funding decrease or shift to another source, and other services will be increased with this new focus.



Resource: Understanding the Behavioral Health Services Act Myths vs. Reality

- The Understanding the BHSA Myths vs. Reality guidance clarifies and dispels misconceptions or "myths" about the Behavioral Health Services Act.
- Topics include funding, provider and system capacity, stakeholder engagement, and behavioral health services.

Myth: The BHSA reduces the amount of behavioral health funding available to counties.

- **Reality**: The BHSA shifts the way funding is utilized for behavioral health services in California, within a broader context of new and additional funding opportunities available to counties that make the BHSA dollar go farther.

Behavioral Health Services Act Goal

The Behavioral Health Services Act goal is to create a more effective and integrated system, not to dismantle existing services.

- Counties need to conduct a thorough needs assessment and develop a three-year plan that balances prevention, early intervention, and intensive services across all county behavioral health funding sources, including the Substance Abuse and Mental Health Services Administration (SAMHSA) and Opioid Settlement Fund funding, which may be used for prevention activities.

- Counties must prioritize services based on local needs and be informed by stakeholder engagement through their Community Planning Process.

Behavioral Health Services Act Integrated Plan

DHCS

Integrated Plan for Behavioral Health Services and Outcomes

The Integrated Plan is a prospective plan and budget for **all county behavioral health services**.

- **Goal:**
  - Collect local and aggregate information on all planned behavioral health services statewide.
  - Increase transparency and accountability in county reporting and ensure counties are efficiently using federal dollars.
- **Timing:**
  - Counties are required to develop their Integrated Plan every three years.
- **Key Elements:**
  - Planning budget in disaggregated mental health and Substance Use Disorder (SUD) continuum of care frameworks for all county behavioral health funding sources.

Integrated Plan Goals

Using the Integrated Plan as a planning tool is key for successful implementation of the Behavioral Health Services Act.

» **For Counties:**

- Understand capacity.
- Support community planning.
- Integrate program planning.
- Develop outcome metrics unique to the County, and strategies to improve outcome metrics identified statewide.
- Leverage county reporting and monitoring.

» **For Stakeholders:**

- Transparency in the County's progress towards their behavioral health goals.
- Transparency in allocation of all county behavioral health funding.
- Opportunity to provide feedback and meaningful engagement on local priorities.

Resource: County Funding Sources for Integrated Plan

- As counties draft their Integrated Plan, they can utilize various local funding sources coming from federal grants, DHCS, and court settlements.
- Counties and stakeholders can use the County Funding Sources for Integrated Plan resource to understand different streams of funding and find links to county apportionments and other helpful resources.

Funding Source Examples:

- SAMHSA Grants
- Medi-Cal
- Realignment Funding
- Behavioral Health Services Act
- Opioid Settlement Funds

Resource: Prudent Reserve Funding Levels

- DHCS has published the BHSA FY 2025-26 Prudent Reserve.

- Counties are required to reassess and certify the maximum local prudent reserve every three fiscal years and include the assessment in the Integrated Plan; the next assessment is due with the FY 26-29 Integrated Plan.

Prudent Reserve Max Percentage	Prudent Reserve Maximum
20%	22,919,331.04
25%	379,958.89
25%	929,612.70
25%	2,372,229.60
20%	3,372,250.76
25%	1,071,265.75
25%	765,128.55
20%	15,355,289.75
25%	835,665.82
25%	3,085,083.61
20%	15,981,260.54

Integrated Plan Timeline

2025

STAKEHOLDER ENGAGEMENT
Community engagement for Integrated Plans became effective.

EARLY SPRING 2026

DRAFT INTEGRATED PLAN DUE MARCH 31, 2026
Draft FY 2026 – 2029 Integrated Plans due to DHCS with exemptions and transfer requests.

SPRING 2026

PUBLIC COMMENT
Each county must conduct a minimum 30-day public comment period between March and June 2026.

EARLY SUMMER 2026

FINAL INTEGRATED PLAN DUE JUNE 30, 2026
Includes DHCS-required updates and revisions based on public comment feedback.

SUMMER 2026

INTEGRATED PLANS GO INTO EFFECT
Counties Integrated Plans become effective.

Community Planning Process Overview

Stakeholder Engagement Requirements

Counties must meaningfully engage with stakeholders on:

- Proposed changes to allocation percentages in the county's Integrated Plan (WIC § 5863.03).
- The county's plan for expenditure of funds exceeding the maximum amount of the prudent reserve (WIC § 5892).

A key element of the BHSA stakeholder engagement requirements is **providing transparency** into how the counties use their behavioral health funding so stakeholders can meaningfully participate in the community planning process.

Key Changes to Community Planning

Counties already engage in extensive community program planning and engagement with their communities under the **Mental Health Services Act** (MHSA).

The **Behavioral Health Services Act** (BHSA) builds upon the MHSA requirements to meaningfully engage with stakeholders with a few key changes.

Key changes to community planning process:

- Stakeholder list expanded to include SUD.
- Key stakeholder groups updated to include but are not limited to:
  - 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.
  - Health Plans, Education, Housing and Social Services.

Methods of Engagement

Counties must demonstrate a partnership with constituents and stakeholders as part of their community planning process. Examples of local involvement and engagement may include, but are not limited to:

- Public comment and hearings on Integrated Plan drafts and updates
- Focus groups
- Surveys
- Key informant interviews
- Conference calls
- Client advisory meetings
- Consumer and family group meetings
- Listening sessions
- Engaging with subject matter experts
- Town hall meetings
- Video conferences
- Media announcements
- Targeted outreach
- Stakeholder workgroups and committees
- Other strategies that demonstrate meaningful partnership with stakeholders
- Training, education, and outreach related to community planning

Resource: Community Planning Resources for Counties

- The Meaningful Engagement: A Guide to the Community Planning Process guidebook represents a fresh approach to community planning. It was crafted with a key question in mind: How can we make the Community Planning Process authentic and purposeful?
- It includes clear timelines, structured processes, decision points and tools to help counties lead the way toward a new model for behavioral health in California.
- Related training: Community Planning Process Walkthrough Webinar.

Community Planning Process Funds

Counties may allocate up to 5% of Behavioral Health Services Act funds to support stakeholder engagement. Use of funds may include:

Staffing & Training

- Train designated staff managing the community planning process.
- Training for stakeholders to be meaningfully involved.

Planning Cost

- Infrastructure and technology.
- Laptops, web-based meeting platforms, accessibility tools.

Stakeholder Support

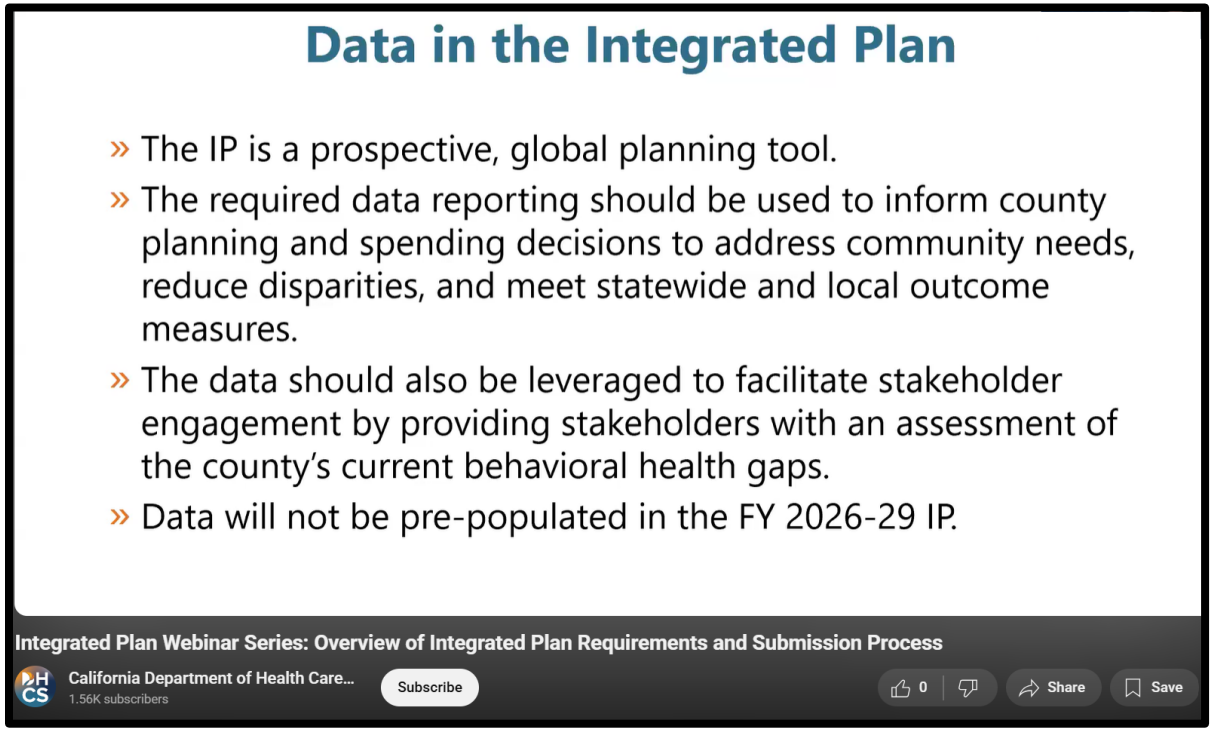
- Stipends/wages for participating consumers and family members.
- Travel and transportation.
- Childcare/eldercare.

Resource: Community Planning Process Infographic

- DHCS has released a [quick reference guide]on the Community Planning Process that can be shared with individuals, groups, or other stakeholders who want to get involved.
- It includes all required stakeholder groups and provides an overview of the Integrated Plan.
- Counties can use this as resource to share with the public and direct them towards information.

Resource: Learning About the Integrated Plan Requirements

- The Integrated Plan & County Portal FAQ was developed to answer common questions and support counties as they navigate the Integrated Plan process.
- Three recorded Integrated Plan Walkthrough Webinars offer guidance about requirements, processes, and available resources for Integrated Plan development.
- The Integrated Plan Budget Manual is a guide that provides standardized step-by-step instructions, timelines, and requirements to help counties develop and submit the BHSA Integrated Plan Budget.



Resource: Continuum of Care Inventory

- DHCS has developed a Behavioral Health Care Continuum for counties to report spending across the sources of behavioral health funding in the Integrated Plan and Behavioral Health Outcomes, Accountability, and Transparency Report.

- The Behavioral Health Care Continuum Inventory is a recommended tool to support county reporting within distinct substance use disorder and mental health frameworks of the Behavioral Health Care Continuum.

SUD Framework Service Category	Service Category Definition (from BHSA Policy Manual)
Primary Prevention Services[b]	Includes services and activities that educate and support individuals to prevent substance misuse and substance use disorders from developing. These services/activities offer communities suppor in identifying and addressing issues, tools for coping with stressors and information on ways to promote resiliency. They may also include services and public health campaigns focused on overdose prevention. Services may be funded by sources including, but not limited to: SUBG Prevention Set-Aside, SAMHSA PATH Block Grant, Opioid Settlement Funds, and 2011 Realignment.
Early Intervention Services[c]	Includes interventions that take a proactive approach to identifying and addressing substance use issues among individuals who are showing early signs, or are at risk, of a substance use disorder. These interventions, such as outreach, access and linkage, and treatment services, help avert the development of a severe and disabling condition, discourage risky behaviors and support individuals in maintaining healthy lifestyles. Services may be funded by sources including, but not limited to: BHSA-EI, Medi-Cal, Opioid Settlement Funds, SAMHSA SUBG Block Grant, and

MH Framework Service Category	Service Category Definition (from BHSA Policy Manual)
Primary Prevention Services[a]	Includes services and activities that educate and support individuals to prevent acute or chronic conditions related to mental health from ever developing. These services/activities may offer communities support in identifying and addressing issues before they turn into problems, tools for coping with stressors and information on ways to promote resiliency. Services may be funded by sources including, but not limited to: Medi-Cal, 1991 Realignment,
Early Intervention Services[b]	Includes interventions that take a proactive approach to identifying and addressing mental health issues among individuals who are showing early signs, or are at risk, of a mental health disorder. These interventions, such as outreach, access and linkage, and treatment services, help avert the development of a severe and disabling condition, discourage risky behaviors and support individuals in maintaining healthy lifestyles. Services may be funded by sources including, but not limited to: BHSA-EI, Medi-Cal, SAMHSA MHBG and/or PATH Block Grants,

Approach to Data-Informed County Planning

Statewide Behavioral Health Goals

DHCS has established **14 statewide behavioral health goals** (BH Goals) aimed at improving well-being and reducing adverse outcomes. The 14 behavioral health goals are divided into two categories: Priority Goals and Additional Goals**.**

Goals for Improvement

- Care experience
- Access to care
- Prevention and treatment of co-occurring physical health conditions
- Quality of life
- Social connection
- Engagement in school
- Engagement in work

Goals for Reduction

- Suicides
- Overdoses
- Untreated behavioral health conditions
- Institutionalization
- Homelessness
- Justice-Involvement
- Removal of children from home

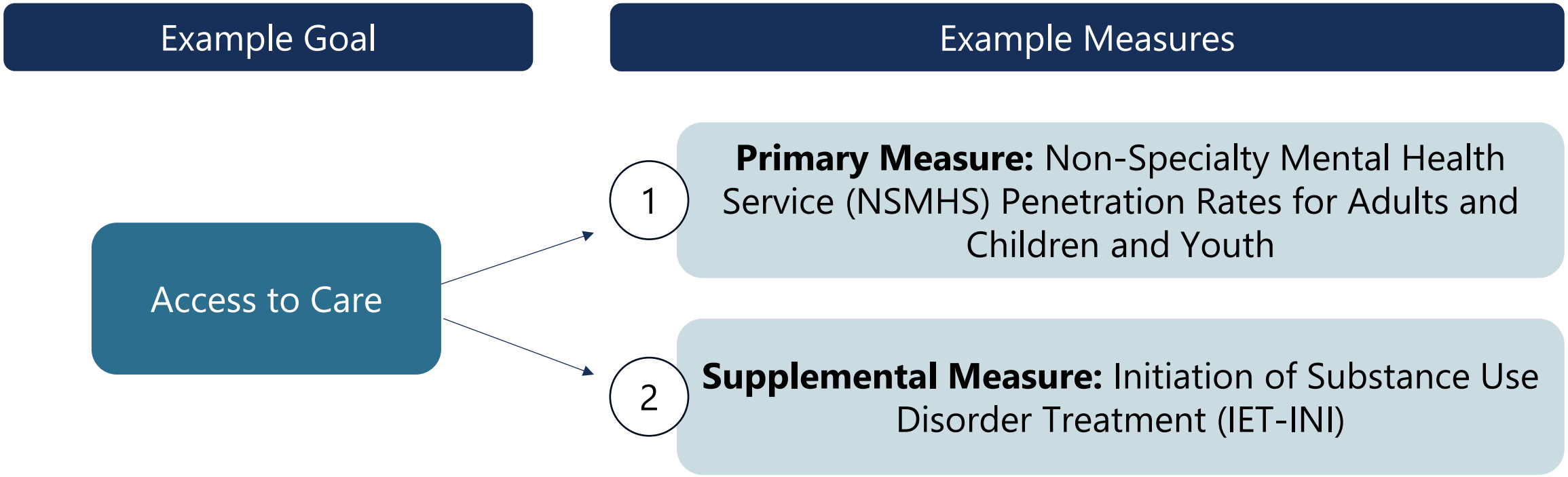
Health equity will be incorporated in each of the Behavioral Health Goals

Additional information on the statewide behavioral health goals is available in the BHSA County Policy Manual.

Population-Level Behavioral Health Measures

To support **data-informed planning**, DHCS has identified **population-level behavioral health measures** associated with each behavioral health goal. These measures are publicly available and focused on **population-level** behavioral health measurement.

Each goal has **primary measures** that reflect the community's status and well-being, and **supplemental measures** that provide additional context to inform planning.



Approach to Data-Informed County Planning

- Behavioral Health Plans (BHPs) are required to review the population-level behavioral health measures associated with each statewide behavioral health goal and **compare their status to the statewide rate or average.**
- BHPs will address the **six priority goals** and select **at least one additional goal to work towards**.
- The self-selected goal should reflect an area where the county does not meet the statewide rate and **should be chosen based on community needs and stakeholder input**.
- BHPs will also be asked to identify disparities and choose data-informed strategies to improve community health and well-being.

Access To Care

Primary Measures

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

1. How does your county status compare to the statewide rate?
    a. For adults/older adults [above/below/same]
    b. For children/youth [above/below/same]
2. What disparities did you identify across demographic groups or special populations? [Multi-select]
    a. Age
    b. Gender
    c. Race or Ethnicity
    d. Sex
    e. Spoken Language
    f. None Identified
    g. No Disparities Data Available
    h. Other [narrative box]

Engagement Opportunities

Local advocates and community members can review their community's status on each of the publicly available population-level behavioral health measures and collaborate directly to **set shared goals, develop targeted, data-informed strategies**, and **address local needs**.

Step 1:

Review and Analyze Data

Step 2:

Community Collaboration

Step 3:

Develop Data-Informed Strategies

Resource: Data Explainer Webinar

- CalMHSA hosted an educational series to support counties in advancing California's statewide behavioral health goals and population-level measures under the Behavioral Health Services Act.
- The Data Explainer Webinar Series - California Mental Health Services Authority and corresponding office hours helped counties incorporate these goals into Integrated Plans and strengthen data-informed strategies that improve population health outcomes — focusing on one or a related grouping of statewide goals and measures.

Resources to Support County Planning

- Behavioral Health Plans and community members can assess each county's status on all Phase 1 Measures using the:
  - County Population-Level Behavioral Health Measure Workbook
  - Measure Access Instructions and Notes Document

Staying Involved in Community Planning

Prepare for Community Planning

Prepare

Connect

Engage

Prepare:

» Review available resources on the **Behavioral Health Services Act**.

» Understand the expectations for the **stakeholder group(s)** you belong to.

Connect with Community Planning

Prepare

Connect

Engage

Connect:

» Reach out to your County BHSA Coordinator to understand:
- Whether or not your area has begun Community Planning.
- Where to find information on your local Community Planning Process.
- Upcoming Community Planning activities.

» The BHSA **County Coordinators list** is available **here**.

Engage in Community Planning

Prepare

Connect

Engage

Engage:

- Community engagement is an **on-going process.** Plan to stay engaged over time.
- Focus on the needs of your local area.
- Access resources to learn more about BHSA.

Integrated Plan Local Review and Stakeholder Engagement Reporting

DHCS

Integrated Plan Local Review Process

The local review process for Integrated Plans remains in place under the Behavioral Health Services Act.

The community planning process is an essential component of Integrated Plan development to gather input reflective of local needs.

- Draft plan developed during **community planning process**
- Circulated for public comment
- Hosted in public hearing by local behavioral health board
- Feedback is incorporated
- Approved by County Board of Supervisors

Local Review Process

Following development of Integrated Plans during the community planning process, counties must conduct a public comment period.

Public Comment

Local Behavioral Health Board Public Hearing

Feedback Incorporated

Approved by County Board of Supervisors

Public Comment:

- An Integrated Plan shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the plans.
- Counties may choose whether to circulate their Integrated Plan before or after they submit their draft Integrated Plan; however, it must occur prior to submitting the final Integrated Plan.

Local Review Process

In addition to the public comment period, the local behavioral health board must conduct a public hearing on the Integrated Plan.

Public Comment

Local Behavioral Health Board Public Hearing

Feedback Incorporated

Approved by County Board of Supervisors

Local Behavioral Health Board Public Hearing:

- The local behavioral health board shall conduct a public hearing on the Integrated Plan at the close of the 30-day comment period.
  - The California Association of Local Behavioral Health Boards and Commissions webpage provides a schedule of local behavioral health board meetings by county.
- Once an Integrated Plan is ready for public comment, the local behavioral health board is required to review the draft plan and make recommendations to the local behavioral health agency for revisions.

Local Review Process

After the 30-day comment period and public hearing are complete, counties are required to make the revisions to the Integrated Plan.

Public Comment

Local Behavioral Health Board Public Hearing

Feedback Incorporated

Approved by County Board of Supervisors

Feeback Incorporated:

- Each Integrated Plan should include a summary of substantive written recommendations.
- The Integrated Plan should also include a summary and analysis of the revisions made as a result of stakeholder feedback.

Local Review Process

The Board of Supervisors is required to confirm in each Integrated Plan that the county will meet their realignment obligations.

Public Comment

Local Behavioral Health Board Public Hearing

Feedback Incorporated

Approved by County Board of Supervisors

Approved by County Board of Supervisors:

- Counties must receive approval from the county Board of Supervisors and certification from the county Behavioral Health Director, before submitting the final Integrated Plan to DHCS by June 30 of the fiscal year prior to the fiscal years covered in the Integrated Plan.

Integrated Plan Stakeholder Engagement Requirements

- Counties must document a complete community planning process as described in Chapter 3, Section 3.B of the BHSA County Policy Manual.
- DHCS will evaluate for meaningful stakeholder engagement in the Integrated Plan.

Community Planning Process

Stakeholder Engagement

1. Please indicate the type of engagement used to obtain input on the planning process [multi-select check boxes; display those selected with ability to choose from options below]

a. County outreach through social media
b. County outreach through townhall meetings
c. County outreach through traditional media (e.g., television, radio, newspaper)
d. Focus group discussions
e. Key informant interviews with subject matter experts
f. Meeting(s) with county
g. Provided data to county
h. Public e-mail inbox submission
i. Survey participation
j. Training, education, and outreach related to community planning
k. Workgroups and committee meetings
l. Other [Logic: If l is selected, populate question 2]

Integrated Plan Comment Period and Public Hearing Reporting

- DHCS will evaluate for completion of a stakeholder comment period and public hearing in the Integrated Plan.

Comment Period and Public Hearing

1. Date the draft Integrated Plan (IP) was released for stakeholder comment [date box, date format MM/DD/YYYY]
2. Date the stakeholder comment period closed [date box, date format MM/DD/YYYY]
3. Date of behavioral health board public hearing on draft IP [date box, date format MM/DD/YYYY]
    a. Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality [single-select list]
        i. Link
            1. [If link selected] Please provide the link to the public posting
        ii. PDF, image, or other document
            1. [if PDF, image, or document selected] Please upload the PDF image, or other file documenting the public posting
4. [Optional] If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page [validate link or option to upload PDF]
5. Please select the process by which the draft plan was circulated to stakeholders [multi-select list]
    a. Public posting
    b. Email outreach [if selected, attach email (no file type restrictions)]
    c. Other [logic: if selected, populate question 6 below]

Resources

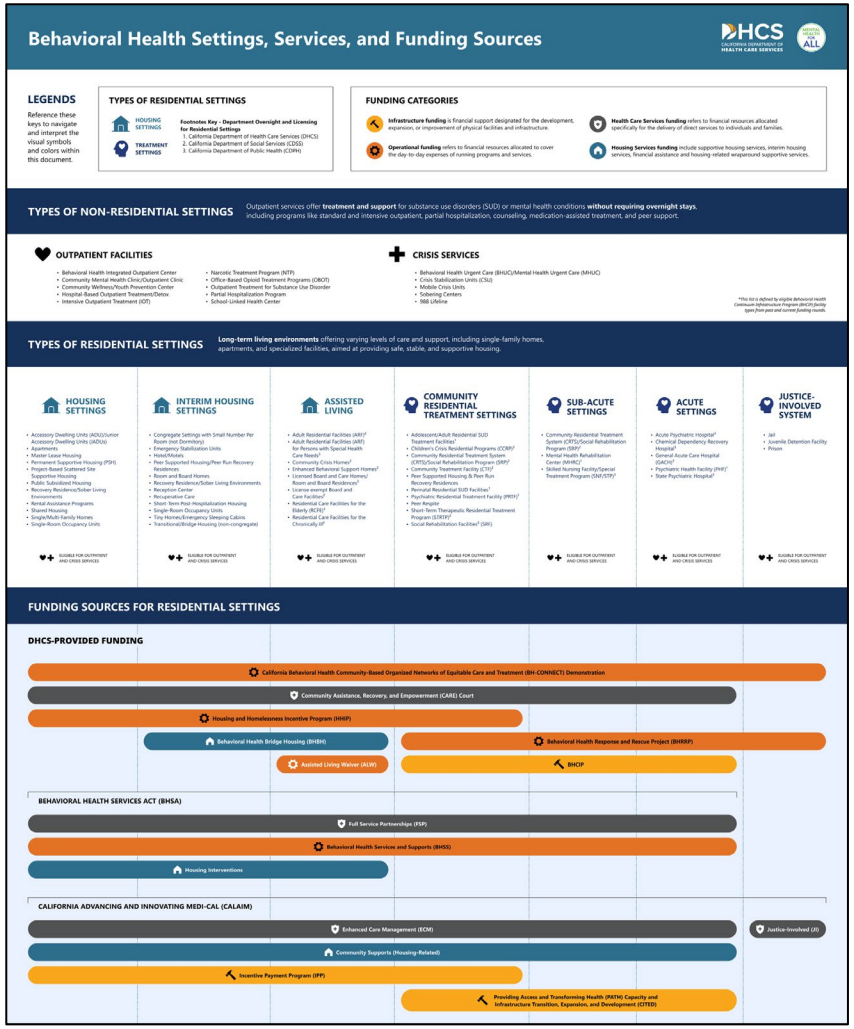
Resource: Full Service Partnership Adult Levels of Care Comparison Chart

- The Full Service Partnership - Adult Levels of Care Comparison Chart details the key components of Assertive Community Treatment (ACT)/Forensic ACT (FACT) and Full Service Partnership Intensive Case Management (ICM) as well as the differences between the two levels of care.
- The chart helps distinguish (1) who is best served by which level of care; (2) what the service components are in each level of care; and (3) how the team structures differ between levels of care.

ACT/FACT	FSP ICM	Key Differences
Have a diagnosis consistent with SMI or co-occurring SMI and substance use disorder (SUD), according to current Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems criteria and as determined by a clinician. » SMI diagnoses include, but are not limited to, bipolar disorder; schizophrenia; schizoaffective disorder; major depressive disorder with psychotic features; and other psychotic disorders	A current or **suspected,** Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis consistent with a serious mental illness (SMI), serious emotional disturbance (SED), substance use disorder (SUD), which may be co-occurring with SUD. Individuals with a primary diagnosis of intellectual/developmental disabilities (I/DD) are not appropriate for FSP ICM.	Before a person's referral to ACT is accepted by the ACT team, they will have an established diagnosis. Note: ACT teams can provide unbundled SMHS before an FSP participant is authorized for ACT. FSP ICM can be provided to individuals with a suspected DSM diagnosis consistent with SMI, SED, SUD, or co-occurring SMI and SUD.

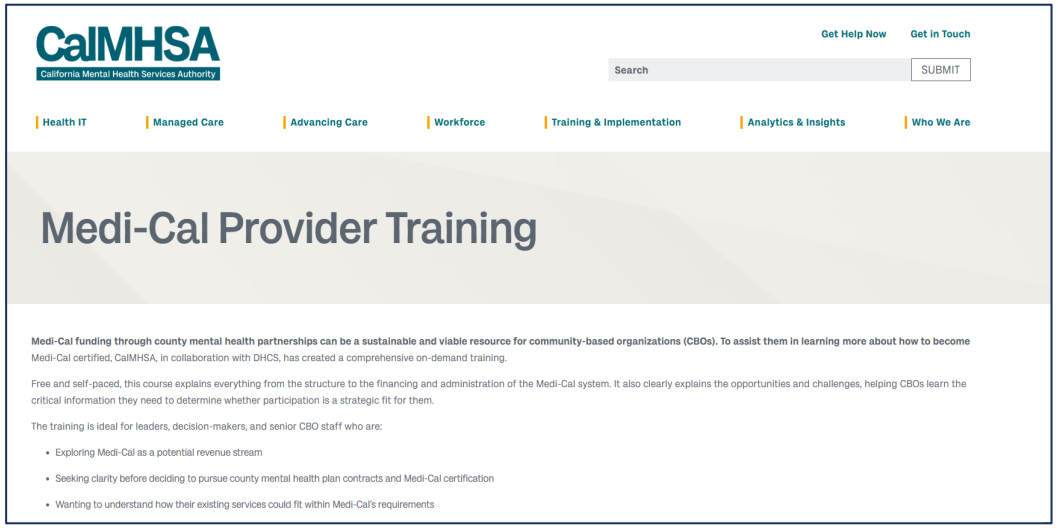
Resources: Housing

- Intersection of BHSA/other housing funding - Behavioral Health Settings, Services, and Funding Sources
  - This graphic details types of residential settings and funding categories to guide strategic alignment to enhance service delivery.
  - The infographic is posted online on the DHCS Behavioral Health Transformation Resources page under Infographics.
- Housing 101 Webinars - Housing Interventions - California Mental Health Services Authority
- BHSA Housing Interventions and Medi-Cal Community Supports FAQ



Resources: Providers

- Maximizing the use of federal funds through Medi-Cal services is a requirement under BHSA.
- One lever is to increase the number of providers offering behavioral health Medi-Cal Services.
- One resource is Medi-Cal Certification Provider Training for Community Based Organizations (CBOs) (Medi-Cal Provider Training - California Mental Health Services Authority).



County and Provider TTA Focus Areas for the Next Year

- Community Planning
  - LHJ, CHA/CHIP Coordination
  - Board of Supervisors and Behavioral Health Board engagement
- Fiscal Policy
  - Federal Financial Participation (FFP) Maximization: 8-9 additional Tiger Teams, touchback support to original Tiger Team Counties, and 2 Behavioral Health leader convenings on best practices
  - Behavioral Health Fiscal Training & Documentation
- Housing Interventions
  - Integrating individuals with Substance Use Disorder
  - Homelessness and Management Information System (HMIS) and Continuity of Care (CoC) coordination and expertise
  - Coordinated Entry prioritization & assessment tools
- IT Systems/Data Collection
  - Integrated Plan and Annual Updates
  - Licensing and Certification Applications
  - Individual Service Level Data
- Phase 2 Measures Implementation
- Contracting and Engagement
  - County-Provider contracting practices
  - Medi-Cal provider enrollment support
- Full Services Partnership Field-Based SUD Initiation Services
  - Targeted Small County Technical Assistance
  - Statewide field examples and Medication Assisted Treatment (MAT) expansion

Additional Resources

BHT Website and Monthly Newsletter

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

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

Technical Assistance – New!

DHCS has began providing technical assistance, including developing informational materials, that counties can use in developing their Integrated Plan.

Questions and Feedback

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

Public Listening Sessions

Attend public listening sessions to provide feedback on Behavioral Health Transformation-related topics.

Registration links for all public listening sessions will be posted on the Behavioral Health Transformation website, along with their recordings, once available.

Thank you!

For Inquiries:
BHTinfo@dhcs.ca.gov

DHCS

Additional Goal Example – Step 1

Scenario: **County A** reviews the population-level behavioral health measures and finds that its drug-related overdose death rate **exceeds the statewide rate.**

Step 1: Review and Analyze Data

Step 2: Community Collaboration

Step 3: Develop Data-Informed Strategies

County A reviews the population-level behavioral health measures and finds its **overdose rate (42.5 per 100,000) exceeds the statewide average (28.8 per 100,000).**

- The county also reviews disparity data and identifies that overdose deaths among **residents ages 25–34 are 1.8x higher** than other age groups and **2x higher among Latino residents**.
- Local advocates and community members also review the data and identify priorities that align with local needs.

Additional Goal Example – Step 2

Step 1: Review and Analyze Data

Step 2: Community Collaboration

Step 3: Develop Data-Informed Strategies

County A convenes stakeholders and Tribal partners—including local providers, community organizations, people with lived experience, and residents—to share findings and gather input.

- Through **listening sessions, community surveys, and a town hall**, local advocates collaborate with Behavioral Health Plan officials to discuss priorities informed by the data.
- Behavioral Health Plan officials and local advocates **collectively identify and select** reducing overdoses as the **county's self-selected goal**.

Additional Goal Example – Step 3

Step 1: Review and Analyze Data

Step 2: Community Collaboration

Step 3: Develop Data-Informed Strategies

County A partners with community groups to design targeted interventions, such as:

- Expanding **naloxone distribution** through local harm reduction programs.
- Launching **peer recovery support** in emergency departments.

These strategies are integrated into County A's **BHSA Plan**, with **funding** allocated for implementation.

Priority Goal Example – Step 1

Scenario: **County B** reviews the population-level behavioral health measures and finds that its SMHS penetration rate is **below the statewide rate.**

Step 1: Review and Analyze Data

Step 2: Community Collaboration

Step 3: Develop Data-Informed Strategies

County B reviews population-level behavioral health measures and finds its **SMHS penetration rate (3.4%) is below the statewide average (5.2%)**.

- Further analysis shows significant disparities: the SMHS penetration rate is **2.1% for youth** (ages 12–17) and **1.8% for Black residents**, compared to **4.7% for white residents**.
- The county shares these findings with community members and partners and invites them to review in advance prior to participating in upcoming forums.

Priority Goal Example – Step 2

Step 1: Review and Analyze Data

Step 2: Community Collaboration

Step 3: Develop Data-Informed Strategies

County B engages stakeholders through multiple outreach efforts:

- **Focus groups** with youth and families to understand barriers to accessing services.
- **Provider roundtables** with community-based organizations and schools to identify capacity and referral gaps.
- **Virtual community forums** to discuss priorities and potential solutions.

Priority Goal Example – Step 3

Step 1: Review and Analyze Data

Step 2: Community Collaboration

Step 3: Develop Data-Informed Strategies

County B collaborates with community partners to design strategies aimed at improving access and engagement, including:

- Embedding **school-based mental health clinicians** in local districts.
- Partnering with **faith-based and cultural organizations** to host mental health awareness events and destigmatize care.
- These strategies are incorporated into County B's **BHSA Plan**.