California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

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Behavioral Health Transformation
Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

RE: Behavioral Health Services Act (BHSA) Module 3 Release

Dear Behavioral Health Transformation Team:

The California Behavioral Health Planning Council appreciates the considerable effort invested in releasing Modules 1, 2, and 3 of the Behavioral Health Services Act County Policy Manual, along with the County Population-Level Behavioral Health Measure Workbook and Integrated Plan template. The Council has been actively engaged in reviewing these modules and providing feedback, drawing on public input and the lived experiences of our members, many of whom have firsthand experience with serious mental illness and substance use disorders.

We applaud the Department of Health Care Services for addressing many of our Module 3 recommendations, especially regarding the enhancements to the Integrated Plan Budget Template, the exemption request process, and the Integrated Plan submission workflow. We are submitting additional feedback on Module 3 of the Behavioral Health Services Act, specifically Section 3: County Integrated Plan of the County Policy Manual V1.3.0, the County Population-Level Behavioral Health Measure Workbook, and the Integrated Plan Budget Template to enhance the process for stakeholders to provide feedback.

Please refer to the following general comments regarding Section 3.B.3 Public Comment and Updates to the Integrated Plan, Section 3.E.6.2 Primary and Supplemental Measures, and the County Population-Level Behavioral Health Measure Workbook. These comments are followed by concerns and recommendations about the linked data sources in Section 3: County Integrated Plan.

> The Council supports the policy provision in Section 3.B.3 that requires local behavioral health boards to review the draft Integrated Plans at the time the plans are released publicly, and for

the behavioral health boards to conduct a public hearing following the 30-day comment period for the draft Integrated Plan per Welfare and Institutions (W&I) Code 5963.03(b)(1). The Integrated Plan planning process plays a key role in determining what services are selected and funded at the local level. While we recognize that the 30-day comment period may be a tight turnaround for some of the behavioral health boards, this activity is critical to the overall process.

1. Regarding Section 3.E.6.2, we were pleased to see the inclusion of the "All Drug-Related Overdose" dashboard under the heading, "Additional Statewide Behavioral Health Goals for Improvement." This dashboard's clear design and user-friendly interface can assist stakeholders with easily accessing and understanding key data measures.

2. We support and acknowledge that the updated County Population-Level Behavioral Health Measure Workbook is structured with charts and graphs for easier data interpretation. Additionally, the workbook allows counties and stakeholders to easily benchmark their performance against statewide averages, enhancing their ability to identify trends and prioritize areas for improvement. However, because the web page and data are constantly updated, it may be difficult for public stakeholders to make good use of and analyze the data.

Issues with Linked Data Sources

In reviewing the linked data sources under Section 3: County Integrated Plan, we encountered challenges that we believe will affect other stakeholders who lack large data-analysis teams.

1. The dashboard for "Specialty Mental Health Services Penetration Rates for Adults" is organized into multiple age ranges; however, there is no definition of what age range defines the "older adults" category for the Integrated Plan.

    a. Additionally, the dashboard lacks a statewide penetration rate for "all adults," displaying only selected demographic breakdowns (Adults 21-32, Adults 33-44, Adults 45-56, Adults 57-68, Adults 69+). It is difficult to compare county and state penetration rates for "adults/older adults" for the integrated plan.

2. The link for "Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth" leads to a dashboard containing only data for children and youth. Data about the Non-Specialty Mental Health Services penetration rates is missing from this dashboard.
3. The link for "Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth" does not lead the user directly to the data source. Instead, the link navigates to the Department of Health Care Services (DHCS) Behavioral Health Reporting Data Hub, where stakeholders must scroll to the bottom to find the link to the SUD Drug Medi-Cal and Drug Medi-Cal Organized Deliver System Penetration Rate Dashboard. This indirect path may confuse individuals navigating this data source.
4. The link for "Initiation of Substance Use Disorder Treatment" leads to the CalAIM Bold Goals: 50x2025 webpage, which has several dashboards that are not clearly organized or labeled. It is unclear where the relevant data is located on this webpage.
5. The link for "Follow-Up After Emergency Department Visit for Mental Illness (FUM-30)" leads to an Excel sheet that contains two key issues:
    a. In the Measure Abbreviations tab, FUM-30DAY in Column A, Row 22 is incorrectly labeled as "Follow-Up After Emergency Department Visit for Substance Use."
    b. Region and Managed Care Health Plan delineate this data. It does not display a statewide rate.

Recommendations

In its current format, the Council is concerned that stakeholders may spend too much time locating the basic data behind the Integrated Plan Template. While the stakeholder process is still in its early stage, we are concerned that non-system participants, particularly community members and those with lived experience, are disadvantaged in navigating and providing feedback on Module 3 documents and templates. To improve clarity and equity, we recommend the following:

1. Simplify the charts with data so that the statewide rate is front and center as the comparison point for all the county rates as modeled by the All Drug-Related Overdose Dashboard.
2. Provide technical assistance to help stakeholders better understand and utilize behavioral health data. This includes:
    a. Clarifying the inconsistent age cutoffs currently used to define adult and older adult populations.
    b. Establishing a clear and consistent framework for group ages that can be applied uniformly across all counties to ensure consistent reporting and comparability.

3. The primary focus of the Implementation Plan for the Integrated Plan is on Phase I measures, many of which are broad in scope and may fall outside the direct influence of the public behavioral health system. Phase II measures will not be addressed until later in the stakeholder process, so it is vital to remind stakeholders of the focus of Phase 1 measures as we transition from the Mental Health Services Act to the Behavioral Health Services Act.

4. We recommend that the Department clearly outline expectations for stakeholder engagement, including:
    a. Reaching out to diverse community-based providers, clients, and advocates.
    b. Documenting stakeholder feedback and how it is incorporated into the Integrated Plan.
    c. Prioritizing meaningful engagement of individuals with lived mental health and substance use disorder experience to ensure their voices are heard. Considering the increase in stakeholder groups involved in the feedback process, we are concerned that people with lived mental health or substance-use experience may be overlooked.
    d. Per Section E.4.1 County Portal, we support the goal of transparency and accountability and seek further clarification on what public access entails and how it aligns with existing protocols.

5. We recommend that counties be allowed to implement parts of the Integrated Plan in realistic and prioritized phases, determined through stakeholder engagement and consultation with the

Department of Health Care Services. It is crucial to acknowledge that the administrative burden of the Integrated Plans and the budgeting process might be overwhelming for smaller counties with limited staff.

The Council appreciates the opportunity to provide feedback, and we look forward to continuing our partnership in shaping policies that promote equity, resilience, and recovery.

For questions, please contact Jenny Bayardo, Executive Officer, at Jenny.Bayardo@cbhpc.dhcs.ca.gov or at (916) 750-3778.

Sincerely,

Tony Vartan
Chairperson

CC: Stephanie Welch, Deputy Secretary of Behavioral Health, CHHS
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