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California Behavioral Health Planning Council Workforce and Employment Committee: HCAI Behavioral Health Initiatives

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Presentation Agenda

1. **Statewide Behavioral Health Strategy**
   - Overview
   - Context of current workforce challenges
   - Overview of project scope and objectives
   - Strategy development process
2. **Findings**
   - Overview of key workforce shortages
   - Summary of preliminary results
   - Next steps
3. **Behavioral Health Transformation (BH-CONNECT)**
4. **Behavioral Health Services Act / Proposition 1**
5. **Work Plan for the 2026-2030 Workforce Education and Training Plan**

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Statewide Behavioral Health Strategy

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HCAI is committed to expanding and diversifying the behavioral health workforce

HCAI enables the expansion and development of a **behavioral health workforce that reflects California's diversity in order to address supply shortages and inequities**, by administering programs and funding and generating actionable data.

California will need to grow its behavioral health workforce to reach all Californians

California's behavioral health workforce is under significant pressure…

- **Workers leaving the field** or choosing to take private pay, driven by **burnout** & **desire for flexibility**
- **Increased burden of physical and behavioral care after** pandemic
- Mix of **staffing shortages & maldistribution** exacerbating challenges
- Existing workforce does not reflect the **diversity of California** in terms of race, ethnicity, **and** languages spoken
- Professionals experiencing **financial challenges**
- **Longstanding shortages** while demand continues to increase

… which ultimately limits access to affordable health care for Californians

Shortages & provider challenges result in:

- **Limited availability of behavioral health providers in network, limiting** access for those who can't afford to pay out of **pocket**
- **Increased costs** passed on from professionals and insurance coverage gaps increasing the real cost paid by consumers
- Compromised **quality of care**, e.g., due to reduced behavioral health professional engagement
- Access further constrained by **geography, ability to pay, & cultural competency**

Non-exhaustive

A statewide behavioral health workforce strategy is essential because no single organization or agency can solve workforce challenges alone.

By uniting with **common goals, actionable data, prioritization, and coordination** across organizations and sectors, we can achieve **greater impact.**

A data-driven statewide strategy to address gaps in California's behavioral health workforce

Purpose

Support the State to understand and equitably solve the supply/demand gap in behavioral health services & better serve Californians

Approach

Supply, demand & pipeline modeling: Modeling tools enable a **granular** (by role & geography) **and quantitative view** of current state workforce shortages and projected future needs (shortages & training supply). Model outputs can be used by many departments, agencies and actors to guide their decision making.

Strategic planning: A **data-driven** strategy that identifies **innovative and tested best practices** to resolve persistent workforce gaps and inequities, and creates **tailored intervention bundles** to target specific challenge and opportunities

Stakeholder engagement: **Significant stakeholder consultation and collaboration with experts inside and outside of government, including health workers;** ongoing validation and refinement of our strategy, shaped by evidence and experience

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The statewide strategy recognizes and seeks to leverage diverse stakeholders in the health workforce ecosystem

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Our behavioral health workforce supply and demand model aims to…

- **Quantify** the extent of challenges we know & address future-facing shortages and inequities before they emerge
- Drive **better and more targeted decision-making** for our funds and programs based on the **greatest gaps by role & geography**
- **Identify opportunities for collaboration** with other institutions and partners to solve identified gaps by informing shared priorities
- Track **progress on state equity goals** (e.g., racial and linguistic representation, Medi-Cal acceptance) and **address disparities**
- Position HCAI as a **go-to source** for the health workforce supply and demand; serve as an **exemplar within California and nationwide**

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Additionally, we are approaching the work with a strong equity lens, to identify key disparities in the workforce (e.g., racial, linguistic, Medi-Cal acceptance) and determine how HCAI and partner entities can address them

We deeply examined 14 roles in our BH supply and demand model – more will be added over time as data becomes available

Non-prescribing licensed clinicians ("BH-L")[1]

- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Professional Clinical Counselor
- Psychologist

Associate-level clinicians ("BH-A")[1]

- Associate Clinical Social Worker
- Associate Marriage and Family Therapist
- Associate Professional Clinical Counselor
- Registered Psychological Associate

- Licensed Educational Psychologist
- Psychiatrist
- Psychiatric Mental Health Nurse Practitioner (PMHNP)
- Substance Use Disorder Counselor (SUDC)
- Peer Support Specialist (PSS)
- Certified Wellness Coach (WC)

Note: The behavioral health professional ecosystem is especially complex, with many additional roles (e.g., MHRS, OTs, other qualified professionals, etc.) playing an important part in the care team & being critical to a well-functioning delivery model

Given the lack of sufficient data on these roles today, they have not been modeled in this version of the tool; however, these roles will be considered in our strategic interventions and are prioritized on our roadmap for future inclusion & data collection

1. In supply/demand modeling, demand for this set of roles has been calculated overall (combined) due to overlapping scopes of practice; supply results remain distinct across each role

Findings

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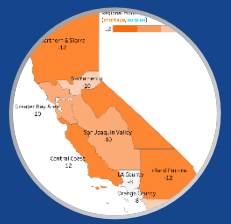
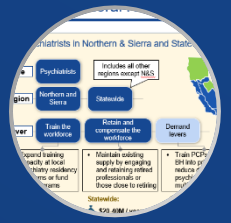
Summary of findings | Behavioral health workforce strategy (1/2)



All behavioral health roles examined have a **statewide shortage** with highest absolute shortage numbers in **non-prescribing licensed behavioral health clinicians**[1] and most severe shortages in **Northern & Sierra and San Joaquin Valley regions.** There are **racial and linguistic disparities** and **lower access** for certain populations.

Many licensed behavioral health professionals across California are also **unable to work at the top of their license due to a lack of supporting allied health professionals**, for which data is severely lacking *(potential area for HCAI to collect data).*



HCAI should take a **multi-pronged approach to supporting the behavioral health workforce**, including significant investments in **expanding training capacity, clinical supervision opportunities, scaling allied health roles, and retention initiatives,** with a focus on equity to ensure the workforce reflects California's diversity.

1. Includes LMFT, LCSW, LPCC, Psychologist

Summary of findings | Behavioral health workforce strategy (2/2)

HCAI should continue to **enable data collection and sharing about the behavioral health workforce**, especially as it pertains to allied health roles, and new / emerging roles.

Going forward, **HCAI remains committed to exploring innovative solutions** (e.g., supporting emerging roles) and understanding the important changes happening in behavioral health as professionals and care delivery models shift.

There are also **several interventions outside of HCAI's scope** that will be required to achieve workforce and access goals, such as improving financial incentives, reducing friction and burnout in the workplace, and reassessing educational and training requirements

Summary | Model findings on **roles**

All roles affected: Every behavioral health role examined faces a shortage (supply-demand gap) across the state

For example:

- Non-prescribing licensed clinicians[1] and associate-level clinicians[2] each face a 37% supply/demand gap statewide[3]; while this gap is forecasted to improve for associate-level clinicians, it is forecasted to worsen for licensed clinicians
- Psychiatrists also experience a large statewide gap (40%) that is forecasted to worsen[3]
- Substance use disorder counselors face a 16% shortage[3], with this gap forecasted to continue

Data Gaps: Allied health professionals play critical roles in behavioral health care; however, there is insufficient data to include most of these roles in a supply/demand model, so will be analyzed separately

1. LCSW, LMFT, LPCC, and Psychologist
2. ACSW, AMFT, APCC and Registered Psychological Associate
3. Data as of 11/4/2024

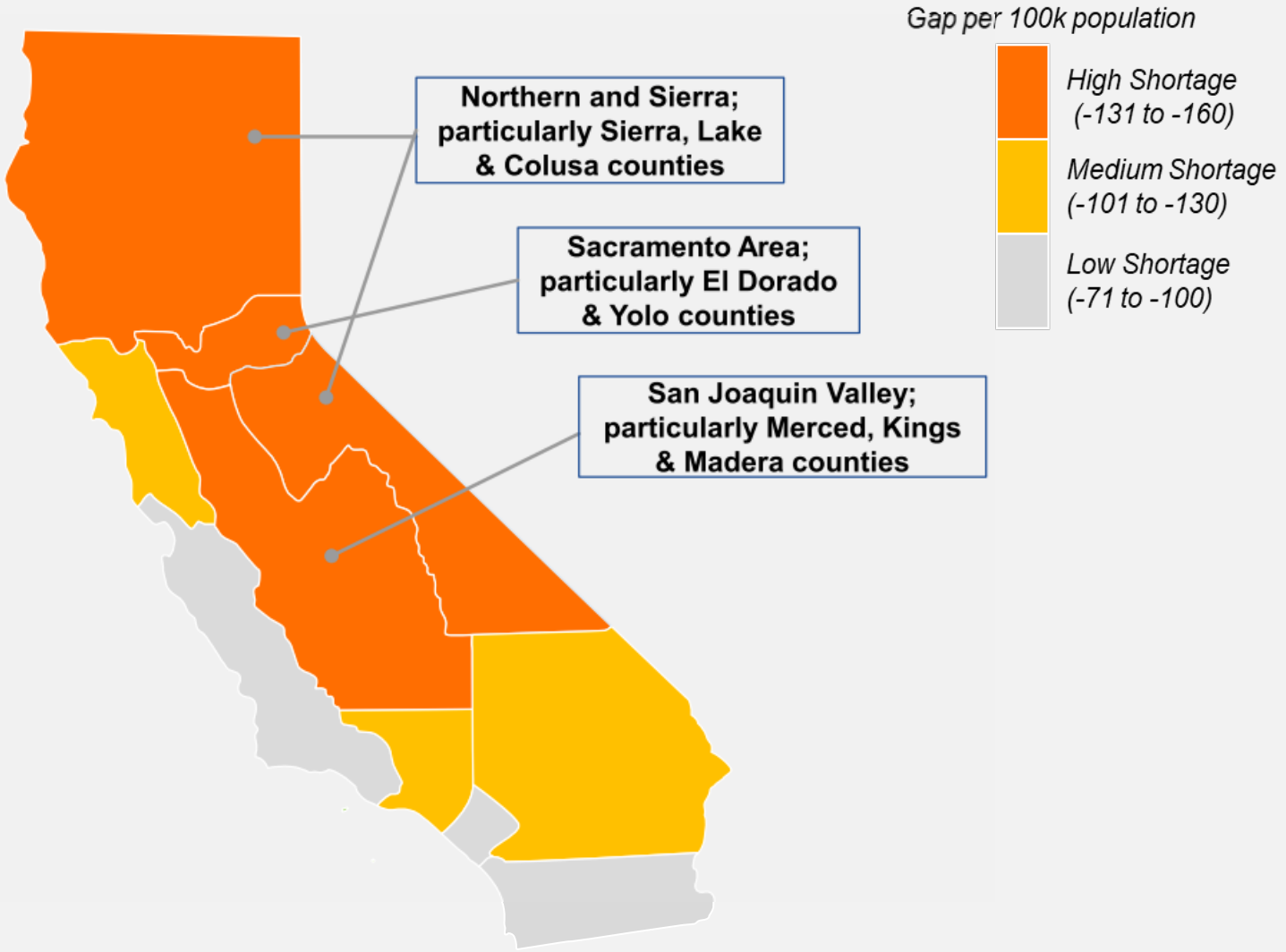
Example | How supply/demand model can be used to identify **regional shortages for specific roles**

1. LCSW, LMFT, LPCC, and Psychologist

Data as of: 11/4/2024

*All nine regions have a shortage of **Non-Prescribing Licensed Clinicians.** Largest shortages in **Northern and Sierra, Sacramento Area & San Joaquin Valley.***

Non-prescribing licensed clinicians[1] workforce shortage
(all regions face a behavioral health workforce shortage)



HCAI can directly lead or work with others to implement critical state-wide interventions

Expand educational capacity, particularly in public education institutions and underserved areas

Expand clinical supervision – A significant share of Master's level graduates do not achieve licensure, in part due to lack of clinical supervision opportunities[1]

Recruit and retain faculty, e.g., through incentives

Lower barriers to training – Through scholarships and non-financial completion supports (e.g., childcare, living accommodation, transportation); potentially linked to service obligations

Recruit / retain behavioral health professionals in targeted settings – Through tuition reimbursement, loan repayment with service obligation, or financial incentives to remain long term (e.g., stipends, bonuses)

Integrate behavioral health into primary care: PCPs play an extremely critical role in the behavioral health ecosystem, and primary care teams should be trained on how to treat behavioral health conditions, especially in underserved areas

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Next steps

- We will continue to refine the model over time to incorporate new data and methodology
- We will continue to incorporate input from our behavioral health partners and agencies across the state
- We will present additional results at future forums, such as the Health Workforce Education and Training Council
- We will use the results of the strategy process to inform allocation of expected behavioral health workforce funds

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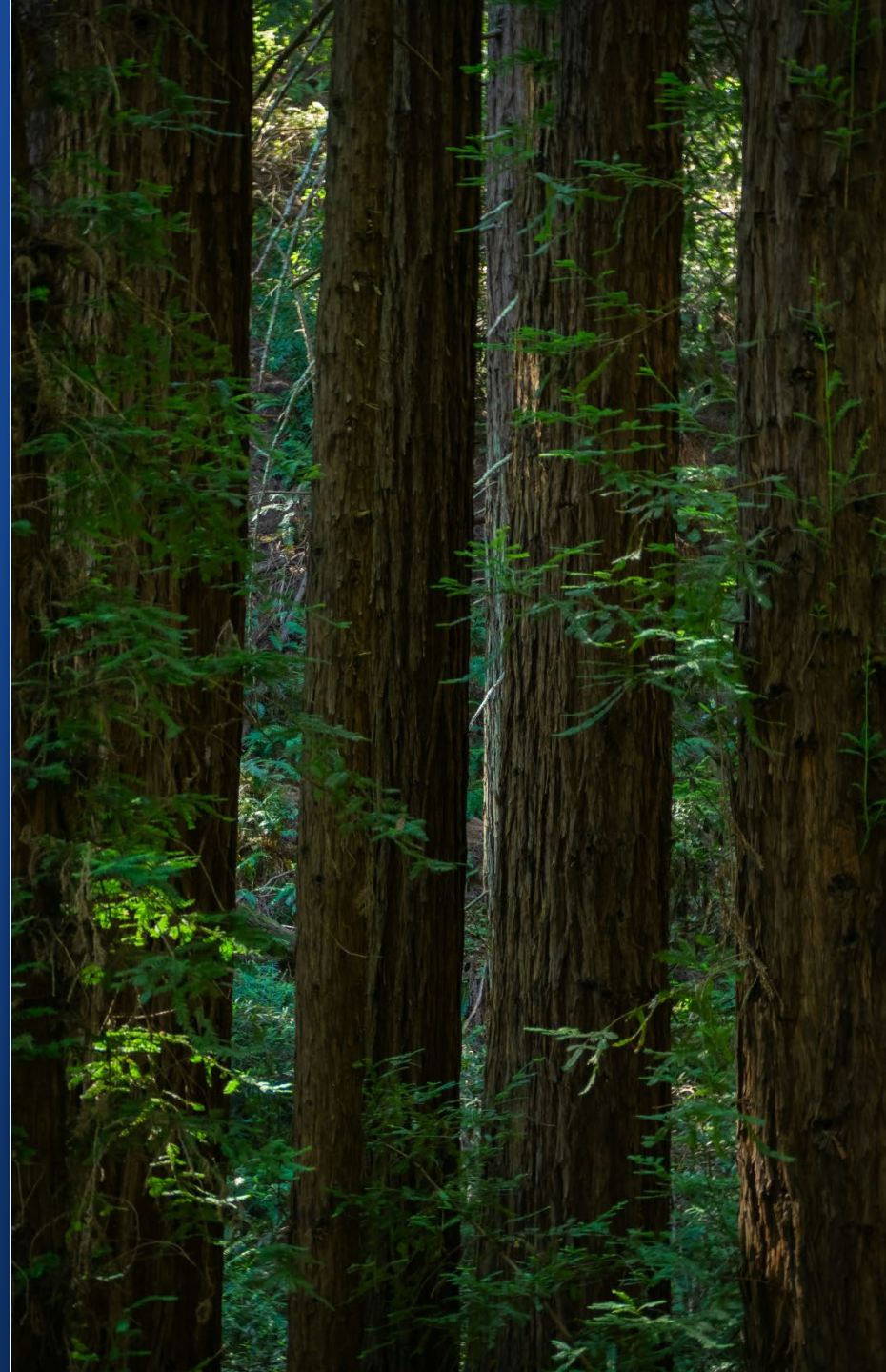
We welcome your feedback

If you would like to share feedback on these materials, please email with your input: **behavioralhealthworkforce@hcai.ca.gov**



Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)

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BH-CONNECT

The Department of Health Care Services has received a federal Medicaid Section 1115 Demonstration waiver to increase access to and improve behavioral health services for Medi-Cal members throughout California.

The **Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration**, aims to improve care for Medi-Cal members living with significant behavioral health needs through the expansion of a robust continuum of community-based behavioral health care services.

An important component of BH-CONNECT is to support workforce recruitment and retention and to promote the increased availability of behavioral health care practitioners who serve Medi-Cal members and uninsured individuals.

BH-CONNECT Initiative Programs

BH-CONNECT Program Summaries

Program	Description
Medi-Cal Behavioral Health Student Loan Repayment Program	Awards to behavioral health professionals with educational debt
Medi-Cal Behavioral Health Scholarship Program	Awards scholarships to individuals pursuing behavioral health degrees or certifications. • Individuals • Educational institutions/training programs
Medi-Cal Behavioral Health Recruitment and Retention Program	Awards grants to Medi-Cal organizations to provide stipends, recruitment and retention bonuses, supervision, licensure costs, and backfill costs to providers, includes an obligation for providers receiving funds

BH-CONNECT Program Summaries

Program	Description
Medi-Cal Behavioral Health Community-Based Provider Training Program	Awards grants to organizations to support the development of community-based providers such as CHWs, Peer Support Specialists, and SUD Counselors, includes obligations for individuals receiving support
Medi-Cal Behavioral Health Residency Training Program	Awards grants to psych. residency and fellowship programs to expand the number of graduate medical education slots. Funds pay the residents salary and require the residents to accept a loan repayment award for the length of their residency, includes an obligation for the residents after graduating from residency

Proposition 1:
Behavioral Health Services Act

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Proposition 1: Behavioral Health Services Act (Enacted March 5, 2024)

Proposition 1 is made up of **Senate Bill 326** (**BHSA**) and **Assembly Bill 531** (**Bonds**)

- **SB 326** continues the "**millionaire's tax**," a 1% tax on personal income over $1 million, and broadens the program provisions to include services to persons with severe mental illness and **substance use disorders and housing support services**
- Approves **$6.38 billion in bonds** for the state, counties and tribes to build treatment facilities (70% proposed) and housing (30% proposed) for persons with severe behavioral health conditions and the chronically homeless

➢ 3% earmarked for HCAI for a behavioral health workforce initiative

- 4% earmarked for **CDPH for population-based prevention**, of which 51% of which is for children & youth through age 25
- **Requires county behavioral health programs (CBHPs)** to expand services for both mental health and substance use disorders, allocating:
  - **35%** for **full-service programs** (comprehensive delivery systems for adults with SMI and children with SED)
  - **30%** for **housing—a new obligation for every county—half to house the chronically homeless**
  - **35%** for **various efforts**[2], with at least **51%** for **early intervention**, of which at least half be spent specifically for children and youth through age 25)
- Modifies the authority and responsibilities of the (renamed) **Behavioral Health Services Oversight and Accountability Commission** (BHSOAC)

2026-2030 Workforce Education and Training Five Year Plan

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WET Plan Introduction

- Welfare and Institutions Code Sections 5820- 5822 establish the guidelines and approval process for the five-year Workforce Education and Training (WET) Plan required by the Behavioral Health Services Act (Prop 1)

- Purpose of Statute: To establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

- Note: With enactment of Proposition 1, it now encompasses all of behavioral health by including attention to the service needs of individuals with serious substance use disorders.

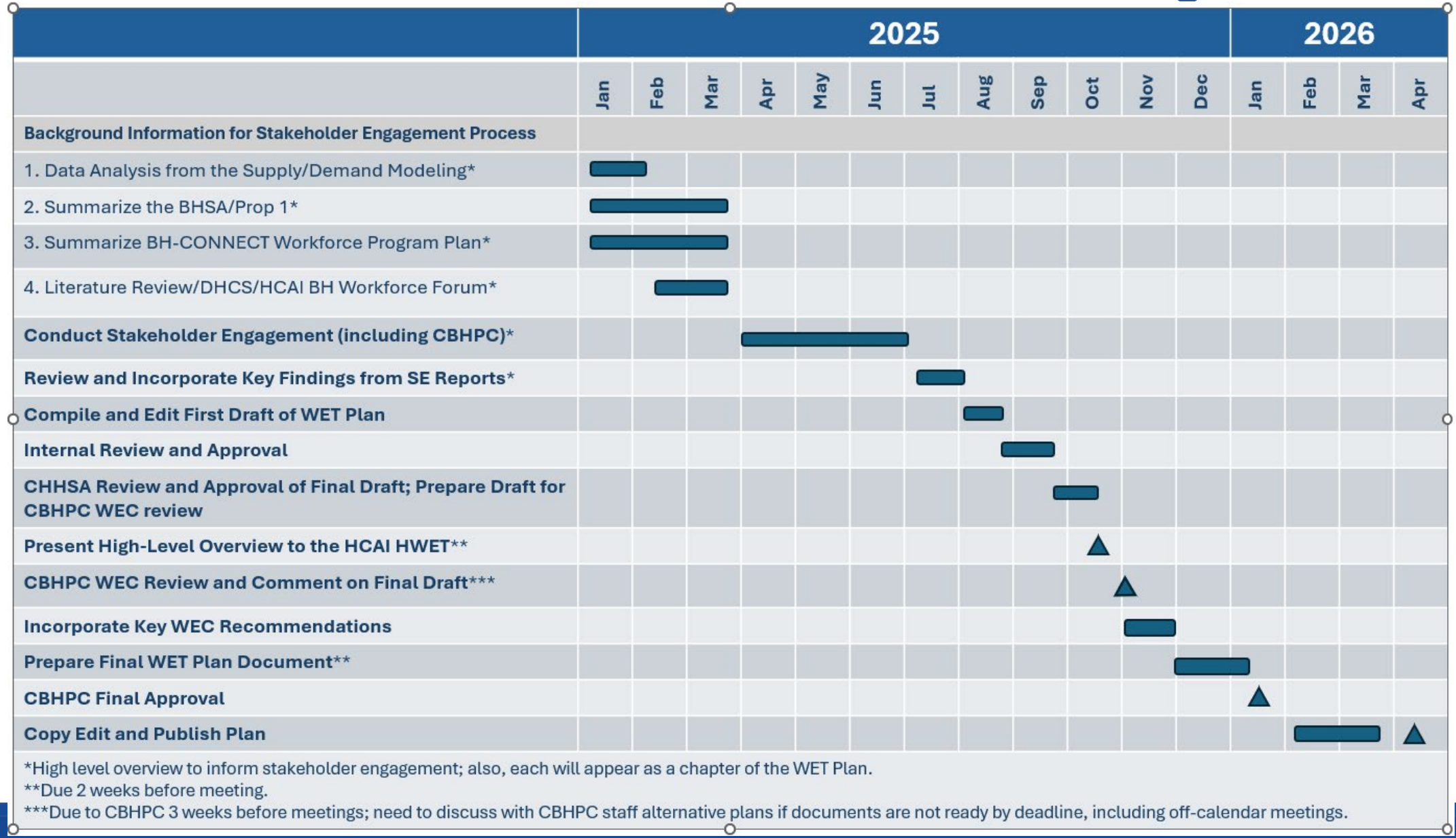
- The Statute envision collaboration between HCAI and CBHPC:
  - CBHPC helps HCAI identify statewide needs for Behavioral Health professions
  - CBHPC advises HCAI on WET policy development and provides oversight
  - CBHPC is responsible for reviewing and approving the finalized plan

- Today we will provide the Council with some background information that will be considered as we begin to work to prepare the 2026-2030 Five-Year WET Plan.

2026-2030 WET Plan Development Process

1. Data Analysis from the Statewide Behavioral Health Strategy
2. Summarize the BH-CONNECT Workforce Program Plan; BHSA/Prop 1; Literature Review
3. **Conduct Stakeholder Engagement (including CBHPC members) considering above information**
4. Review and Incorporate Key Findings from Stakeholder Engagement Reports
5. Prepare First Draft of the 2026-2030 Five Year WET Plan
6. Internal Review and Approval
7. California Health and Human Services Agency Review and Approval of Final Draft
8. California Behavioral Health Planning Council (CBHPC) Workforce and Employment Committee (WEC) review
9. High-Level Overview Presentation to the HCAI Health Workforce Education and Training Council
10. CBHPC WEC Review and Comment on Final Draft (may require separate convening)
11. Prepare Final WET Plan Document
12. Seek CBHPC Final Approval

2026-2030 Five-Year Workforce Education and Training Plan: Work Plan



*High level overview to inform stakeholder engagement; also, each will appear as a chapter of the WET Plan.
**Due 2 weeks before meeting.
***Due to CBHPC 3 weeks before meetings; need to discuss with CBHPC staff alternative plans if documents are not ready by deadline, including off-calendar meetings.

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Questions?