BEHAVIORAL HEALTH TASK FORCE MEETING

CALIFORNIA HEALTH & HUMAN SERVICES AGENCY

August 28, 2024

WELCOME & INTRODUCTIONS

STEPHANIE WELCH, MSW, DEPUTY SECRETARY of BEHAVIORAL HEALTH, CalHHS

THIS IS A HYBRID MEETING

- The meeting is being recorded
- In-person people: wait for mic to speak
- All: Identify yourself as you start to speak – people may not see you
- American Sign Language interpretation in pinned video
- Live captioning link is provided in chat
- Remote people: Please stay ON MUTE when not speaking and utilize the raise hand feature if you have a question or comment
- Please turn on your camera as you are comfortable
- BHTF members can use chat for additional conversation

THIS IS A HYBRID MEETING (continued.)

- **MEMBERS OF THE PUBLIC** will be invited to participate during the facilitated brainstorming activity and the public comment period at the end of the meeting.

For additional feedback, please email:

BehavioralHealthTaskForce@chhs.ca.gov

ELEMENTS FROM BHTF GUIDING PRINCIPLES AND COMMITMENT TO ENGAGEMENT

- EQUITY: STRIVE TO EXAMINE AND ACT IN AN EQUITABLE AND INCLUSIVE MANNER
- RESPECT: ACTIVELY LISTEN, INVOLVE ALL
- STAY FOCUSED ON THE AGENDA
- ANCHOR DISCUSSIONS IN A PERSON-CENTERED APPROACH
- WORK TO REDUCE STIGMA
- THINK INNOVATIVELY AND WELCOME NEW IDEAS

MEETING AGENDA

10:00 Welcome

10:10 Evidence-Based Strategy to Develop California's Behavioral Health Workforce

11:15 Group Q&A & Discussion, then Facilitated Discussions/Activity

12:15 BHTF Member Reflections

12:30 30-Minute Break to Bring Lunch

1:00 Update on Proposition 1/BH Transformation Implementation

2:30 CalHHS and BHTF Member Updates

2:45 Public Comment

2:55 Closing

3:00 Adjourn

EVIDENCE-BASED STRATEGY TO DEVELOP CALIFORNIA'S BEHAVIORAL HEALTH WORKFORCE

PRESENTATION AND PANEL DISCUSSION

Improving Behavioral Health Access and Outcomes for Californians with Commercial Health Plans – Presentation

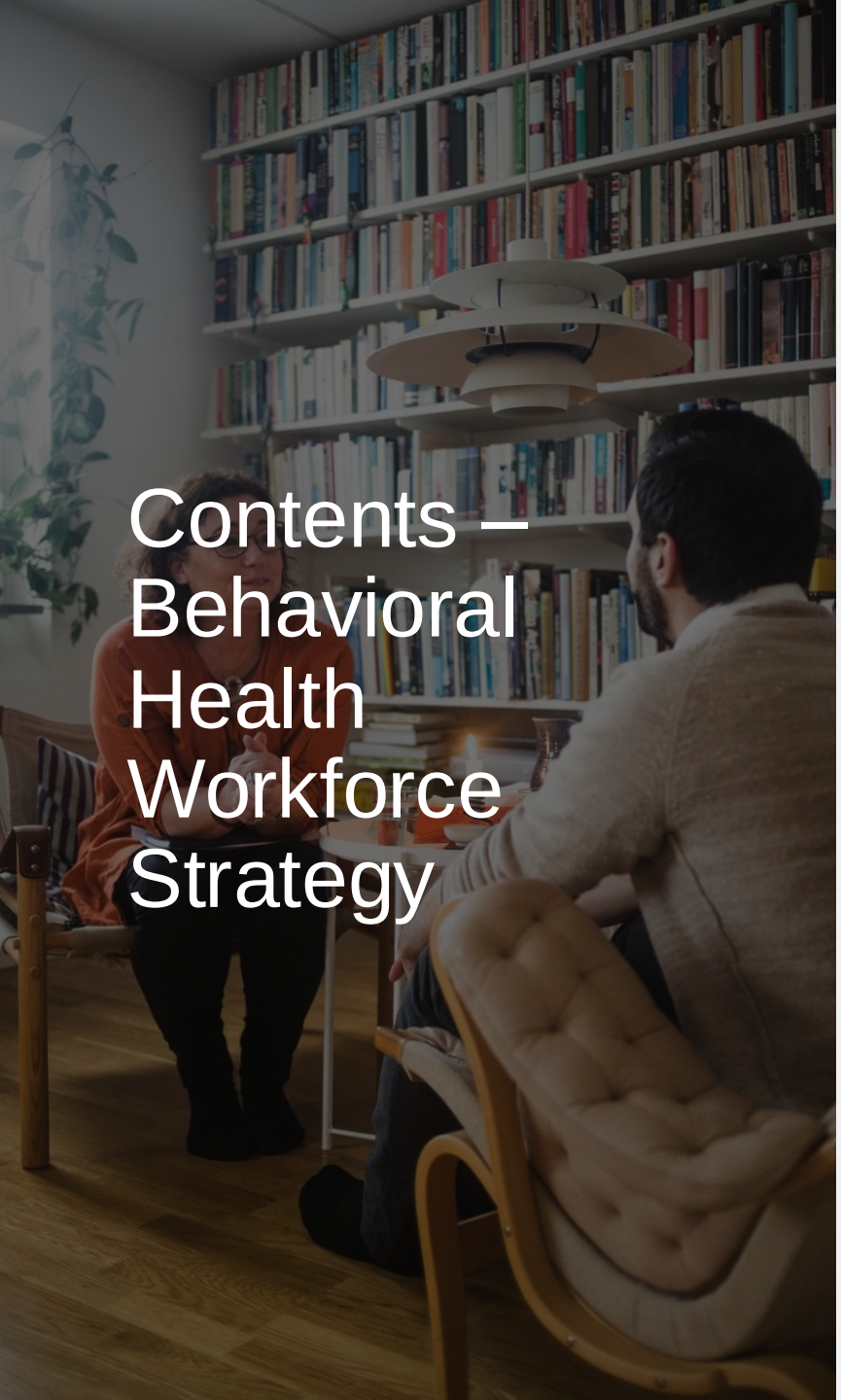
Libby Abbott, Deputy Director, Health Workforce Development, Department of Health Care Access and Information

HCAi
Department of Health Care Access and Information

Behavioral Health Workforce Strategy

Presentation for Behavioral Health Task Force

AUGUST 28, 2024



Contents – Behavioral Health Workforce Strategy

1. **Introduction**
   - HCAI 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
3. **Levers to address the problem**
   - Role of HCAI vs other entities
   - Innovative opportunities to address BH workforce challenges
4. **Strategy: Tailored interventions to target specific challenges**
   - Example role/geography-specific strategy
5. **Way forward**
   - Data sharing
   - How to provide feedback
6. **Panel discussion**
7. **Breakout session**

1

Introduction

HCAI's Vision and Mission

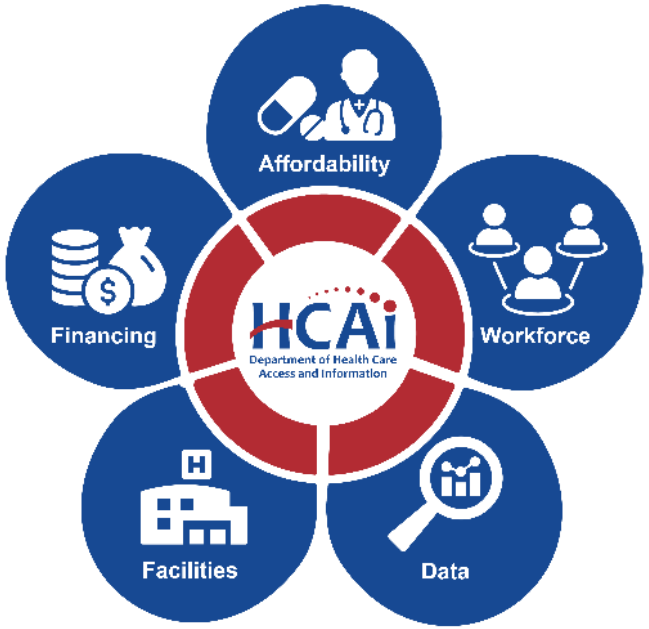
Vision

A healthier California where all receive equitable, affordable, and quality health care.

Mission

HCAI expands equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs.

HCAI Program Areas



Facilities: Monitor the construction, renovation, and seismic safety of California's hospitals and skilled nursing facilities.

Financing: Provide loan insurance for non-profit healthcare facilities to develop or expand services.

Workforce: Promote a culturally competent and diverse healthcare workforce.

Data: Collect, manage, analyze, and report actionable information about California's healthcare landscape.

Affordability: Improve health care affordability through data analysis, spending targets, and measures to advance value. Enforce hospital billing protections, and provide generic drugs at a low, transparent price.

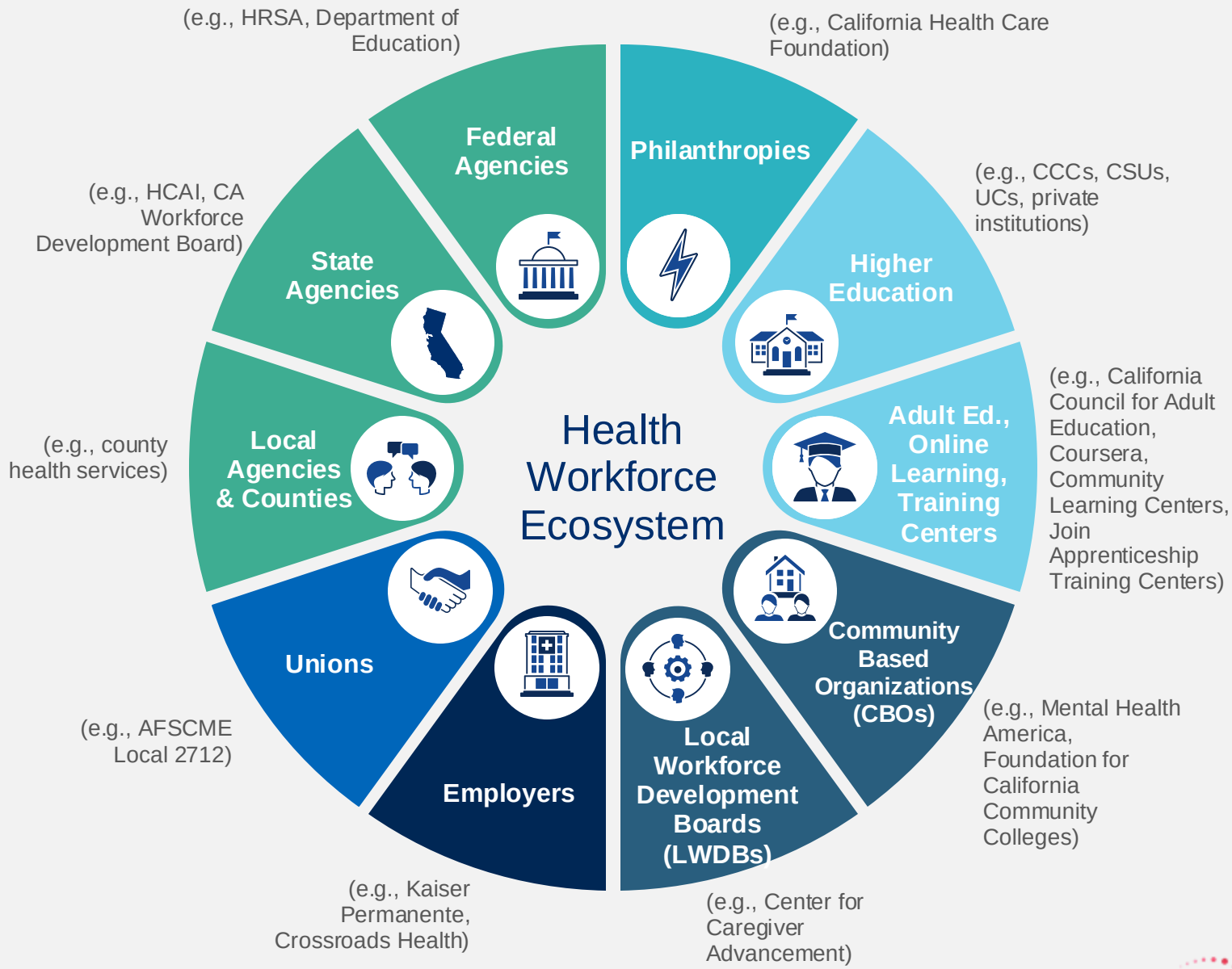
HCAI's purpose statement on workforce enables its vision and mission

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

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

By uniting with common goals and coordinating across organizations and sectors, we can achieve greater impact and drive meaningful change.

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



We are working on a data-driven strategy to address gaps in CA's behavioral health workforce

Purpose

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

Key workstreams

Supply & demand modeling: Design, architecture, and build of an analytical tool that enables continued use, with future improvements/expansions

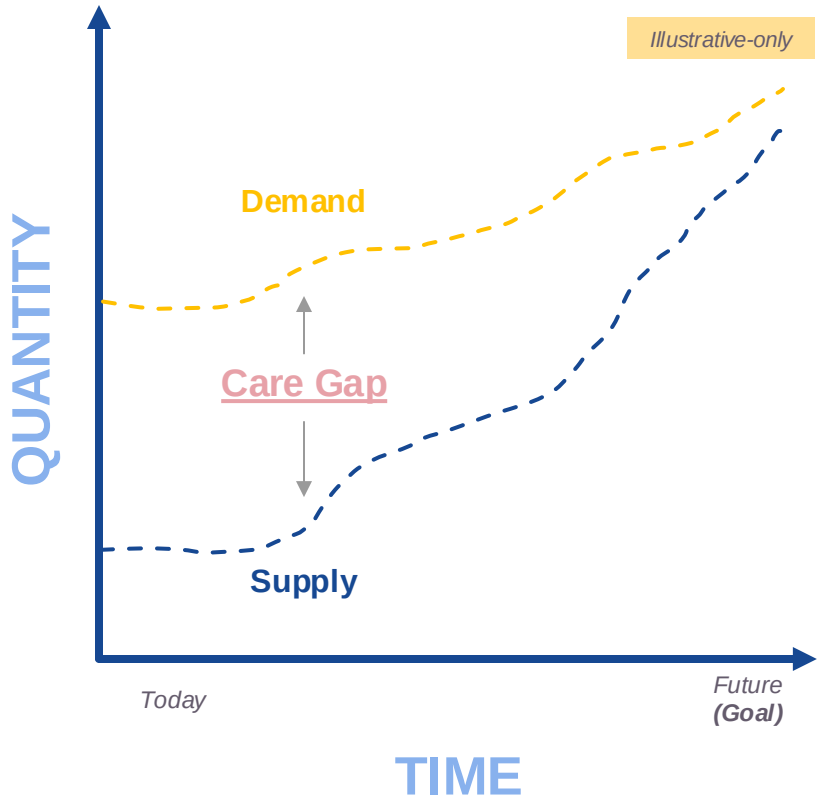
Strategic planning: A **data-driven** strategy that identifies **innovative and tested best practices** to resolve persistent workforce gaps and inequities, and creates **tailored intervention bundles** to target specific challenge and opportunities

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

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

Getting the right care to the right people starts with a robust understanding of supply and demand

Supply currently lags demand in today's complex healthcare labor market …



… with this care gap being driven by key interrelated factors:

- **Total roles staffed / needed by specialty**
- **Geographic distribution of professionals & community need**
- **Usage patterns and changes in delivery models**
- **Importance of culturally competent care**
- **Insurance coverage**
- **Education pipeline & licensure**
- **Attrition rates** *(e.g., migration, retirement, burnout)*

Creating a detailed Behavioral Health workforce model enables HCAI to **develop a targeted set of interventions to close the care gap** & focus on **investment avenues** with the **greatest lasting impact**

We examined 14 roles deeply in our BH supply and demand modeling exercise; plan to add additional roles 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

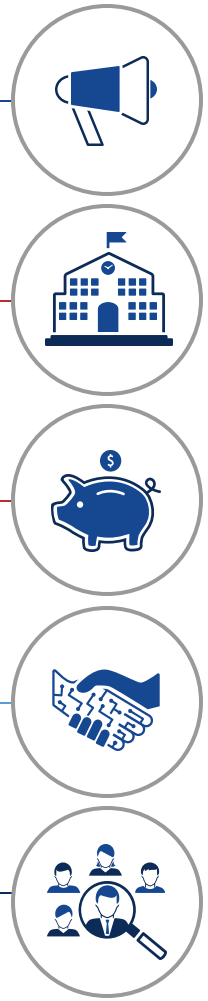
Our objectives for the health workforce model

- Become a **leader and go-to source** for the health workforce supply and demand; serve as an **exemplar within California and nationwide**
- **Address health workforce shortages and inequities** before they emerge
- Drive **better and more targeted decision-making** for our funds and programs
- **Identify opportunities for collaboration** with other institutions and partners to solve identified gaps
- Track **progress on state equity goals** (e.g., racial and linguistic representation, Medi-Cal acceptance) and **address disparities**

Our model will have many potential use cases

Use case: a ***practical action*** *(program, funding decision, partnership, etc.)* ***focused on areas of highest need (supply / demand gap, equitable lens)*** *informed by the data and analysis in our model*

Use cases will be targeted activities in specific geos, populations, and roles such as:



Investing in programs that **increase access to and interest in health workforce roles** *(e.g., apprenticeship programs, recruitment & marketing initiatives)*

Partnering with educational institutions to **expand & create training programs** *(e.g., increase Masters programs spots/acceptance criteria for students coming from key geographies)*

Directly **funding scholarships, loan replacement programs, and training programs** for students from underserved communities

Partnering with educational institutions to **upskill health workforce** *(e.g., adult learner wraparound services)*

Partnering with employers to identify health workforce / recruiting needs and **promote hiring & retention initiatives**

Over time, identified outcomes from use cases will inform future activities/interventions

Our strategy process: We are following a rigorous process of gathering available data, inputs, and perspectives, all of which inform our strategy

Many inputs have gone into developing our strategy…

Workforce supply / demand model

***50+** provider interviews & focus groups*

Current state analysis & deep literature review

Thorough evidence review of intervention efficacy

Clear definition of HCAI's role

***100+** stakeholder and expert interviews*

Comprehensive research & data analysis

And we are following a rigorous process to develop the behavioral health workforce strategy

Setting the stage

- Defined HCAI's purpose, vision, guiding principles, and role in the ecosystem
- Developed problem statement based on comprehensive data analysis and 150+ interviews

Understanding the problem

- Modeled supply and demand for behavioral health roles at multiple geographic levels to understand greatest shortages
- Assessed racial, linguistic, and Medi-Cal representation between professionals and population
- Defined 90+ levers to make change against the problem and collected evidence to test efficacy of each

Developing HCAI's strategy

- Determined interventions 'in scope' for HCAI to lead or influence
- Based on shortage drivers for role and geography combinations, created strategy with specific interventions to target most significant shortages

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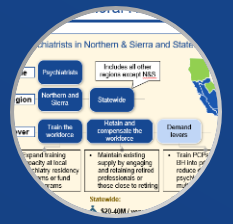
Findings

Summary of findings | Behavioral Health Workforce

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 (e.g., Medi-Cal).

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, and retention initiatives,** with a focus on equity to ensure the workforce reflects California's diversity.

HCAI should also 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 behavioral health roles) and understanding the important changes happening in behavioral health as professionals and care delivery models shift.

1. Includes LMFT, LCSW, LPCC, Psychologist

We created a model to assess roles, geographies, and populations to understand the workforce shortage for roles with data

What **roles** are facing a shortage?

What **geographies** in California?

What **populations** (e.g., racial, linguistic)?

What do **insurance acceptance patterns by providers** tell us about access issues?[1]

1. Results are still in development, so are not shared in these materials

Before diving into the findings of our supply / demand modeling, we want to recognize that ***all models have limitations, and no forecast of the future is guaranteed to be fully accurate …***

… but we've stuck to a few key tenets in our modeling that give us confidence in the results

Our model methodology & assumptions are **informed by existing & well-substantiated approaches to workforce modeling**

We've been **guided by input from a diverse array of experts** (including health workers) to ensure we are grounded in actual practice

Where data was unavailable or imperfect, **we've made reasonable assumptions that we have vetted and tested** with a range of stakeholders

We are **not evaluating the results in a vacuum**, but alongside qualitative input from stakeholders and additional supporting data

Summary | Model findings on **roles**

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

Certain roles hit harder today:

- Non-prescribing licensed clinicians[1] face a 37% supply/demand gap statewide
- Associate-level clinicians and psychiatrists both experience a 38% gap
- Substance use disorder counselors face a 18% shortage, with no improvement expected

Gaps projected to continue: Gaps forecasted to persist and even widen for non-prescribing licensed clinicians, Psychiatrists, and SUD counselors

Regional variability: Gaps vary by region, with shortages worsening when accounting for professionals' language & racial / ethnic representation

Data Gaps: Allied health professionals play key roles in behavioral health, but limited data exists on these roles

1. LCSW, LMFT, LPCC, and Psychologist

Every behavioral health role faces a shortage across the state today and most will in the future.

California Statewide | BH gaps by role

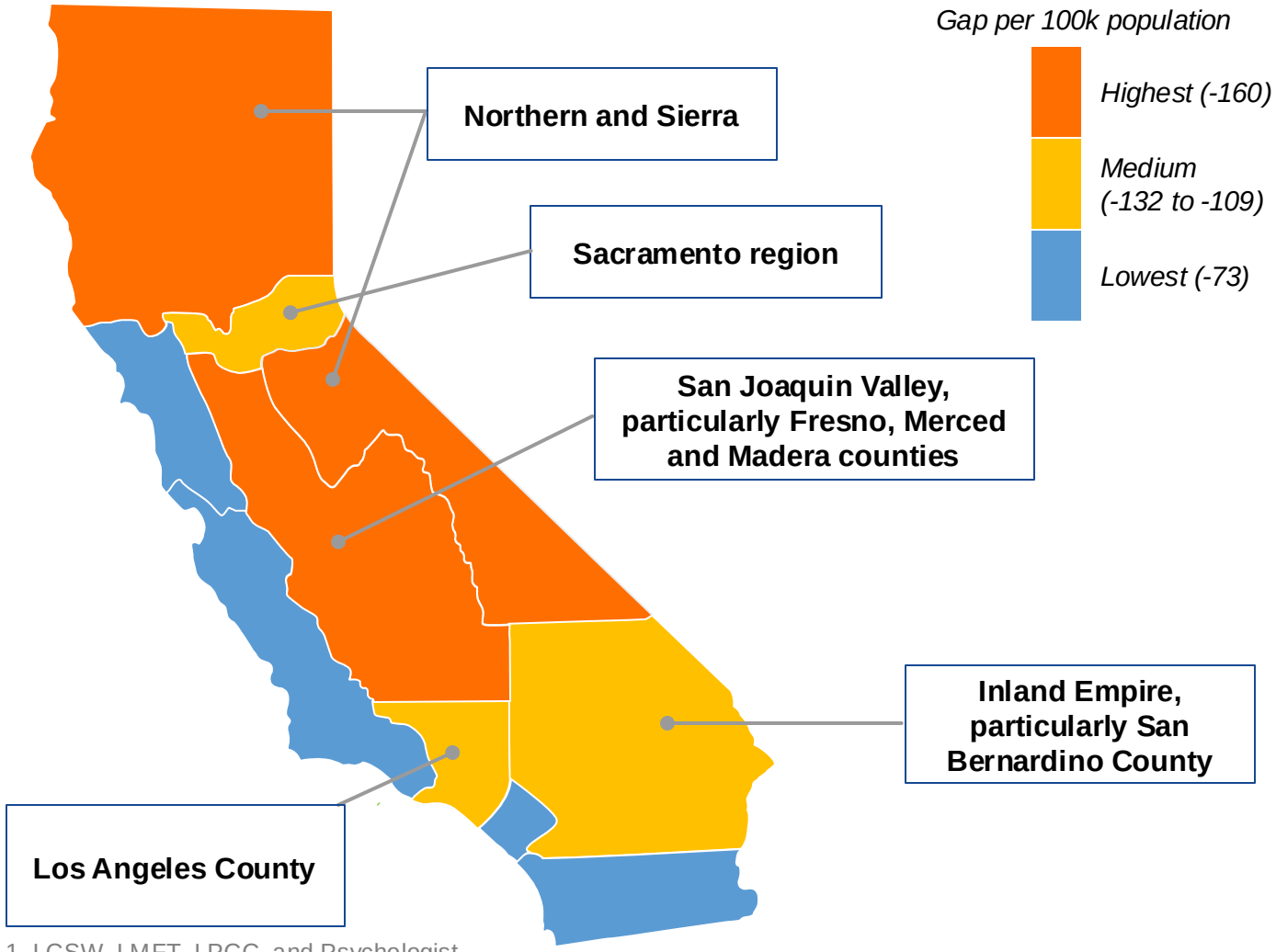
Role	Current state gap	2033 forecast gap	Gap trend
Non-prescribing licensed clinicians	**37%** (~44K)	**34%** (~58K)	↑
Associate-level clinicians	**38%** (~15K)	**18%** (~10K)	↓
Substance Use Disorder Counselor	**18%** (~3K)	**17%** (~3K)	–
Psychiatrist	**38%** (~3K)	**53%** (~6K)	↑
Licensed Educational Psychologist	**8%** (~0.1K)	**-13%** (~ -0.2K)	↓
Peer Support Specialist	**47%** (~3K)	*TBD considering models to account for changes in role over time, similar to 'target approach' in CWCs*	
Psychiatric Mental Health Nurse Practitioner	**48%** (~2K)	*Insufficient historical PMHNP data to support high confidence forecast*	
Certified Wellness Coach[3]	N/A	*Given CWC is a new role, value in model based on "target value" of ~6k in 2033, not supply / demand*	

↑ *Worsening gap* – *Steady gap* ↓ *Improving gap*

Note: Negative gap implies 'surplus'
1. Peer support specialist forecast may shift to account for additional expected increase in peer demand 2. PMHNP forecast tied to overall Nurse Practitioner demand, limited data availability for high confidence PMHNP forecast 3. Wellness Coach data reflects "target" values for wellness coach certification, given status as a new certification
Note: Negative gap indicates supply of professionals exceeds demand

Summary | Model findings on **regional shortages**

Non-prescribing licensed clinicians[1] workforce shortage areas
(all counties and regions face a behavioral health workforce shortage across roles)



1. LCSW, LMFT, LPCC, and Psychologist

***All regions & roles have a behavioral health workforce shortage**; for example, among non-prescribing licensed clinicians, Northern & Sierra and San Joaquin Valley have worst shortages*

Appendix includes regional shortage maps for other roles

Summary | Model findings on **populations**

Racial representation of professionals is imbalanced relative to population

- Asian and Latine communities face the largest professional-to-population disparities
- Black professionals are underrepresented in advanced roles like psychologists and psychiatrists

Language barriers persist across the workforce

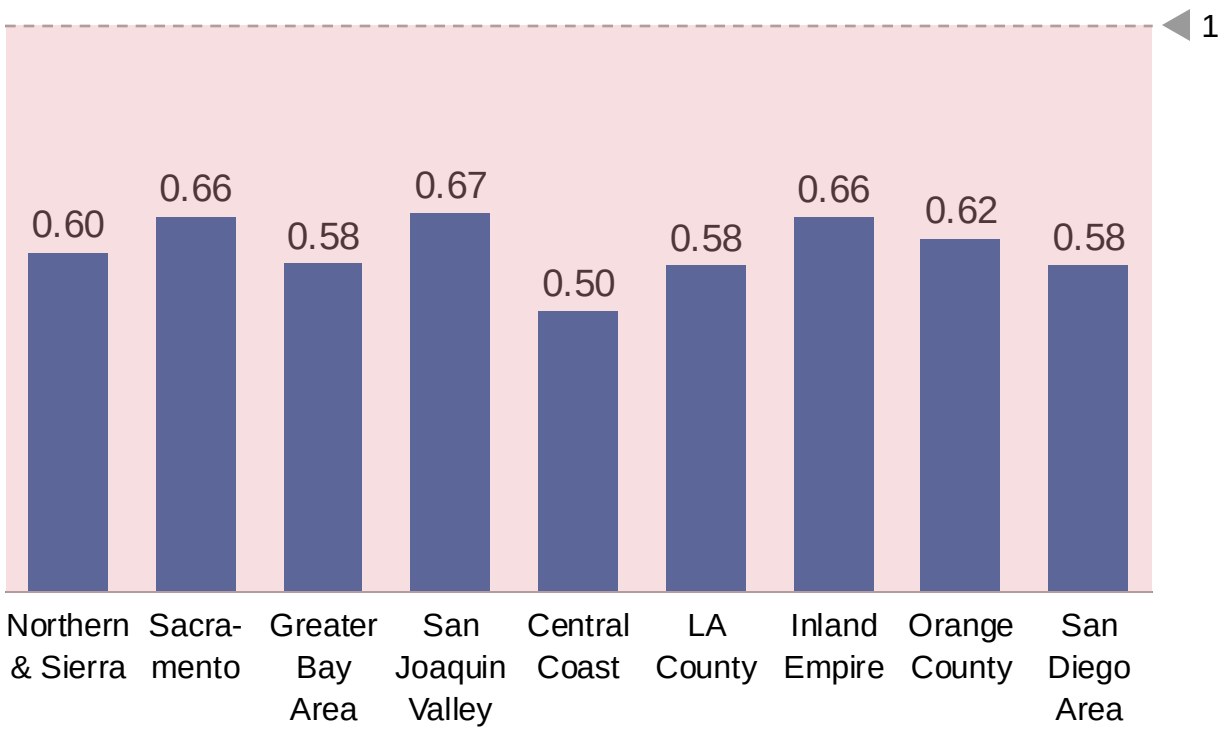
- Spanish-speaking professionals are underrepresented in all roles except Clinical Social Workers (licensed and associate) and Certified Wellness Coaches
- Asian and Pacific Island language-speaking professionals are underrepresented in all roles

There are disparities across race/ethnicity and language

Model includes role-level representation data; example shows underrepresentation of Hispanic non-prescribing licensed clinicians at both region and county level

Non-prescribing licensed clinician[1] Hispanic, any race, provider to population representation <u>by region</u>

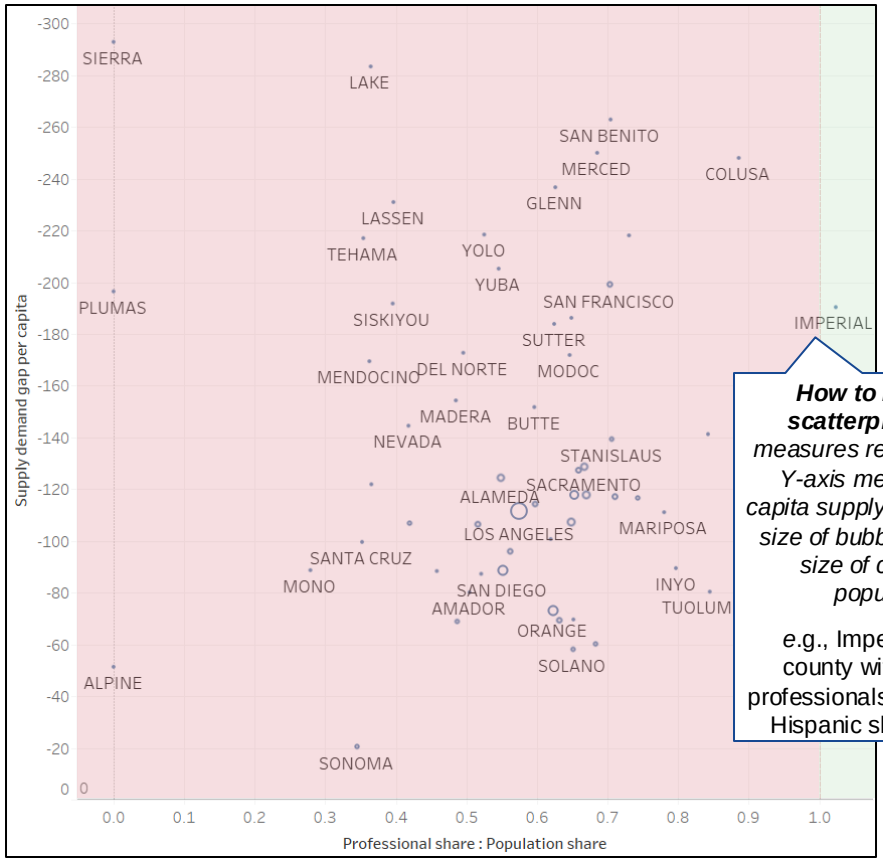
Share Hispanic, any race, providers / share of population that is Hispanic, any race



Representation <1.0 indicates that the share of the population that is Hispanic, any race, is greater than the share of providers that are Hispanic, any race

Non-prescribing licensed clinician[1] Hispanic, any race, provider to population representation <u>by county</u>

Provider share to population share vs. supply / demand gap per 100k



How to read this scatterplot: *X-axis measures representation; Y-axis measures per capita supply/demand gap; size of bubble measures size of county by population*

e.g., Imperial is only county with share of professionals that exceeds Hispanic share of pop.

Hispanic professional population share *greater* than Hispanic pop. share

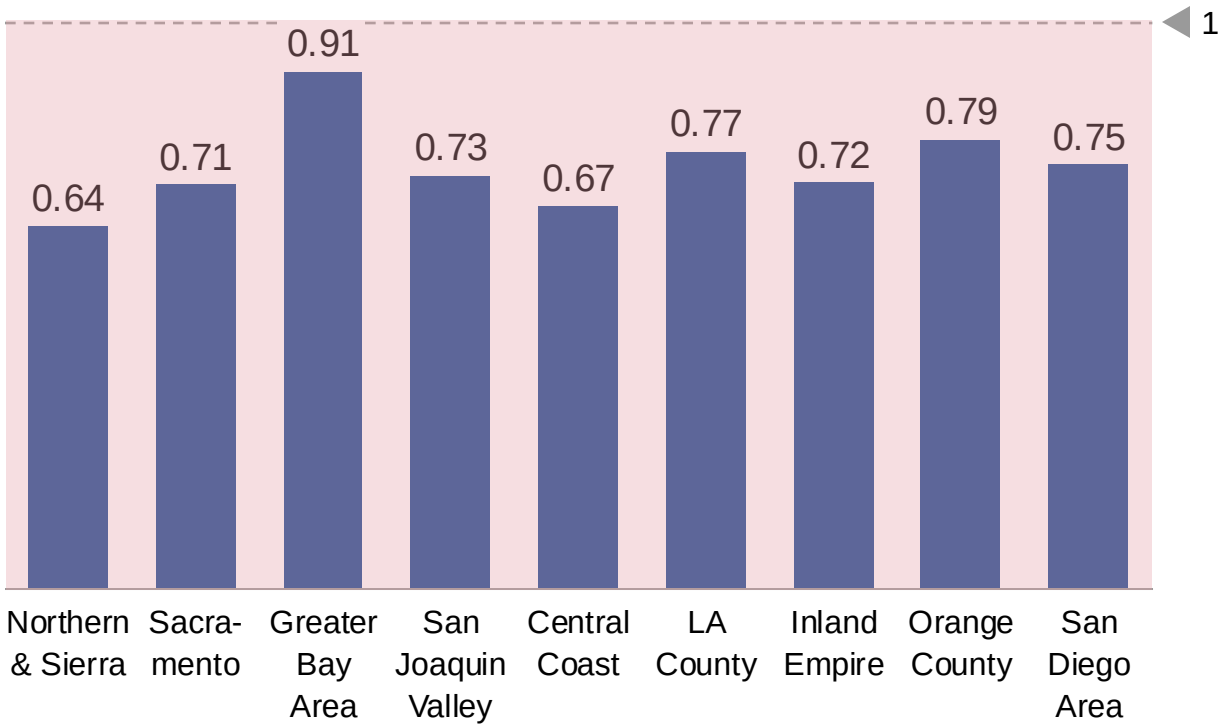
Hispanic professional population share *less* than pop. share

1. (LCSW, LMFT, LPCC, Psychologist) 2. Trinity County excluded for viewability; provider to population value: 2.93, gap per 100k: -238; Note: not all counties labeled in scatterplot, size of dot corresponds to county pop.

Source: American Community Survey (U.S. Census Bureau), HCAI license renewal survey

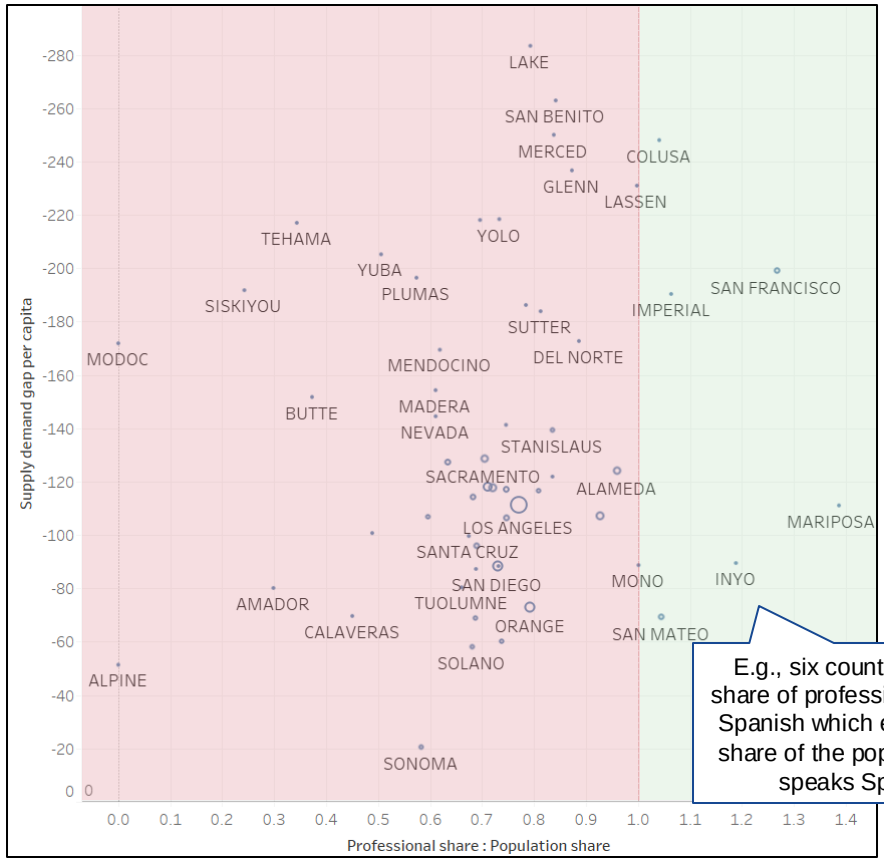
Representation data is available for provider language data; example shows regional underrepresentation for Spanish speaking providers

Non-prescribing licensed clinician[1] Spanish speaking provider to population representation by region
Share Spanish speaking providers / share of Spanish speaking population



Representation <1.0 indicates that the share of the population that speaks Spanish is greater than the share of providers speaks Spanish

Non-prescribing licensed clinician[1] Spanish speaking provider to population representation by county
Provider share to population share vs. supply / demand gap per 100k



1. (LCSW, LMFT, LPCC, Psychologist)
Note: not all counties labeled in scatterplot, size of dot corresponds to county population
Source: American Community Survey (U.S. Census Bureau), HCAI license renewal survey

Problem statement at each stage of professional journey

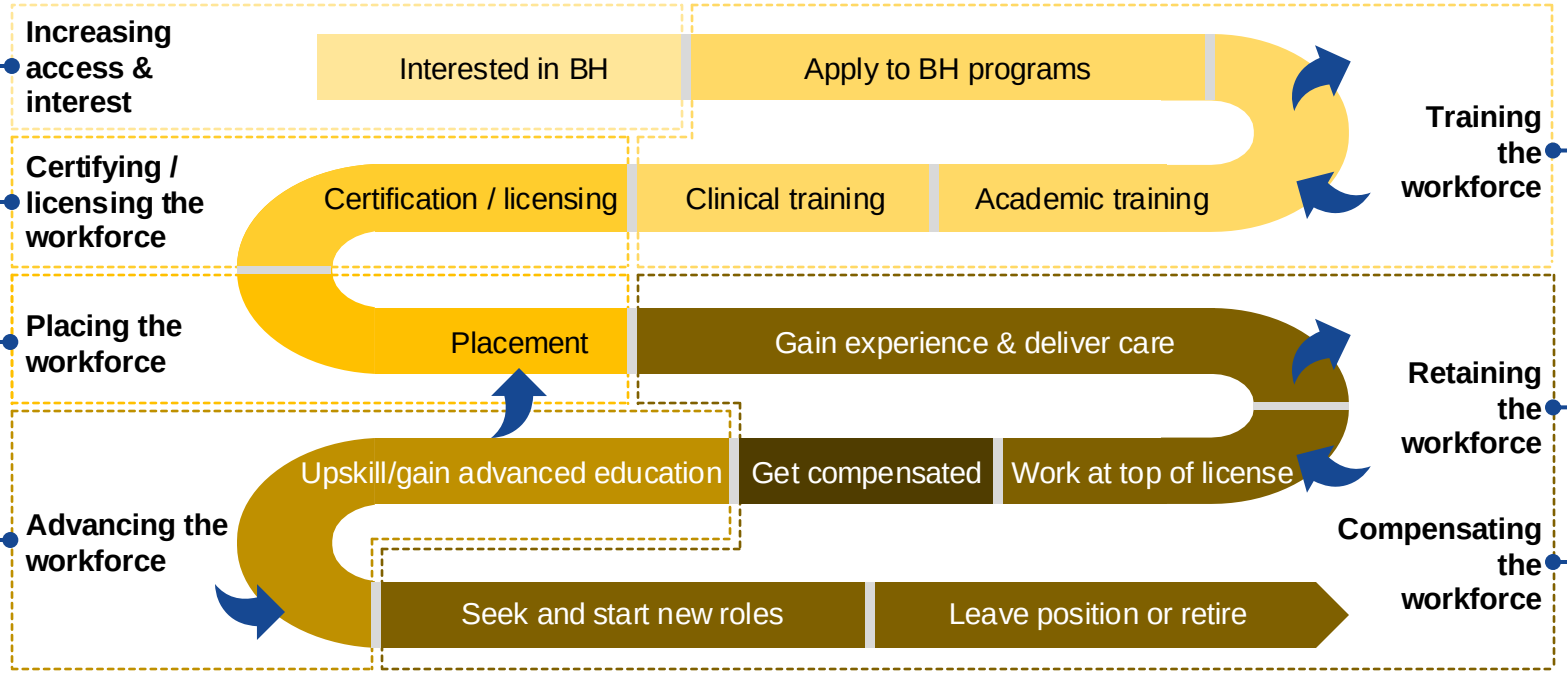
What are the problems / barriers to achieving the mission on healthcare workforce at each stage of the professional journey?

Some[1] behavioral health jobs may be **less attractive or accessible** to target populations, driven in part by the required **time and tuition**, **relatively limited economic mobility**

Certification / licensing processes can be **complex, costly, and time consuming** for professionals

Available workforce is not **practicing, migrating, or staying in pops / areas of highest need,** due to **personal preferences**, or **financial and prof. development factors**

Professionals may not **upskill / advance their careers**, despite a desire to, driven by a combination of **financial and non-financial/life barriers**, such as low wage rates in some roles and childcare needs



Potential pipeline is not entering or completing training due to **insufficient training capacity**, **financial and non-financial/life barriers,** unclear process steps, and training facilities **not in communities with greatest gaps**

Professionals are leaving the workforce due to **workplace conditions** and **administrative burden**, which contribute to professional burnout

Professionals are **insufficiently compensated** (wages and benefits) for their work, leading to **low satisfaction and morale**

On-ramps and off-ramps for professionals who leave and re-enter workforce

Meeting demand and increasing consumer access

Demand exceeds supply, partly due to lack of investment in prevention of serious illness; **Consumer access low for target pops (**due to financial barriers, stigma, etc.); current payment models have misaligned incentives

Care delivery models

Care delivery models **do not effectively meet demand** (incl. care team composition and use of technology to optimize care)

1. Some roles may have high interest (e.g., due to high pay) but low access to pathways, while others have low interest but greater access (e.g., certified roles)

We are very excited to **connect these findings** to be able to better direct our **programs and grant making**

Over the next few months, in coordination with the Health Workforce Education and Training Council and working with other agencies, we'll continue to share and analyze the findings, **detail our strategy and begin to apply the learnings to our programming** for Prop 1 and other funding streams

3

Levers to address the problem

Pre-read only

Understanding the problem via data and behavioral health professional / stakeholder interviews led to the development of levers that HCAI and others can pull, to make change against the problem

Desired outcomes

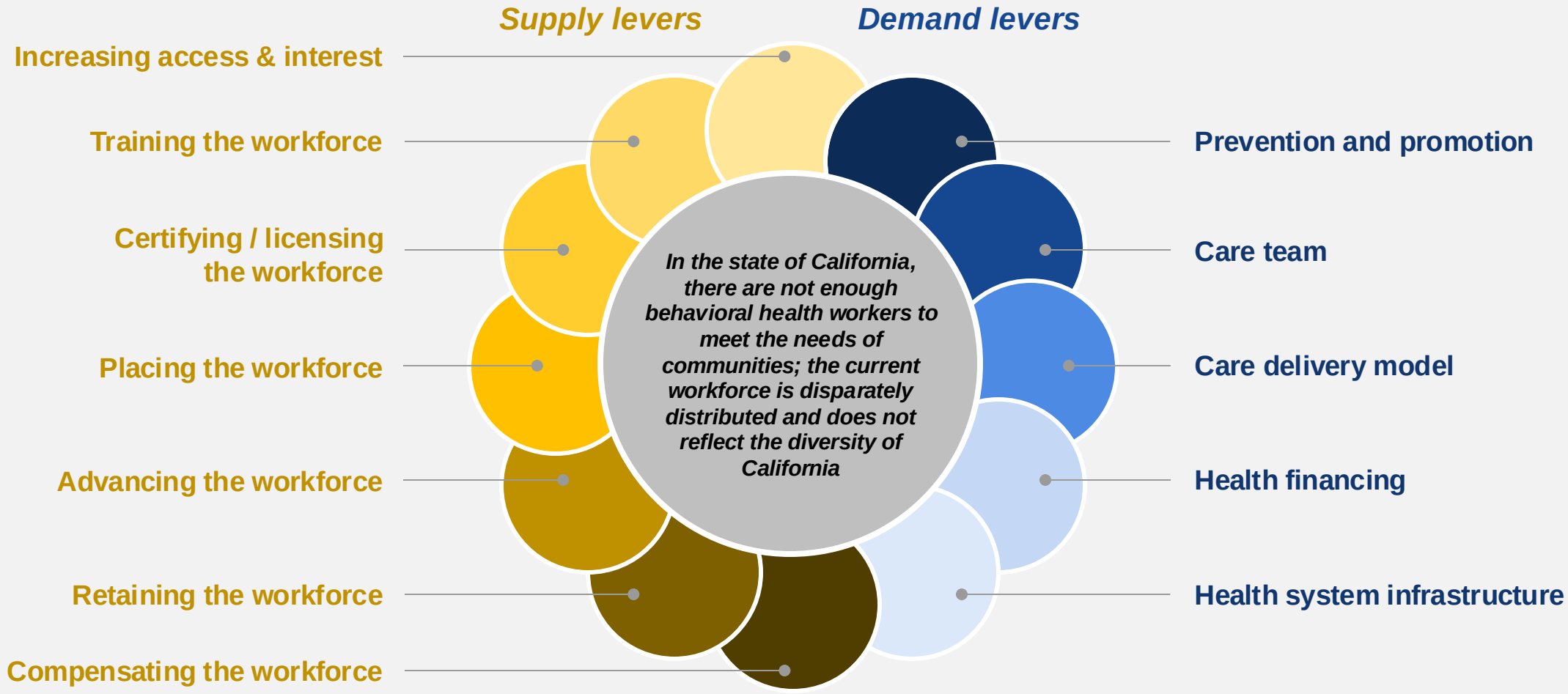
Sufficient supply and distribution of behavioral health workers that addresses geographic shortages, ensuring all Californians have access to equitable, affordable and quality behavioral health care

Behavioral health workforce that **reflects the diversity of California**, increasing economic opportunities for professionals from underserved communities

Improved health outcomes and equity, with clients able to access care in every setting where they need it

We reviewed evidence for a list of 90+ interventions categorized across supply and demand "levers"

What are all the levers to make change against this problem?



Supply levers aim to increase and diversify the health workforce

Demand levers aim to optimize demand, by improving workforce utilization

Pre-read only

Where HCAI sees its role

Detailed framework: Levers to make change

What are all the levers to make change against this problem?

Supply levers

Increasing access & interest
Generate interest from low-income, diverse individuals and improve access to pathways
Outcome: Larger, more diverse pipeline, economic mobility

Training the workforce
Lower barriers to training professionals, locate training in areas of need to address geo mismatch
Outcome: Larger, diverse pipeline, economic mobility

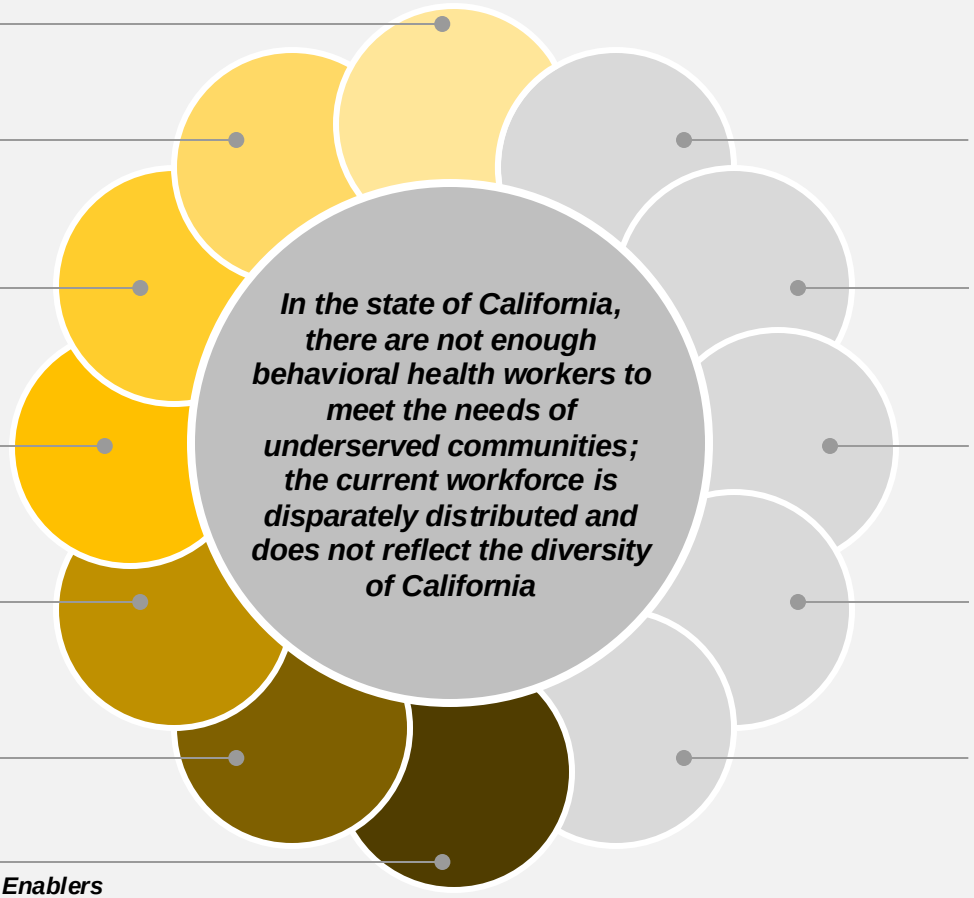
Certifying / licensing the workforce
Support workforce in becoming certified / licensed, particularly in target populations
Outcome: Larger, diverse pipeline, economic mobility

Placing the workforce
Enable workforce to practice, migrate to, and stay in areas of highest need
Outcome: More equitable access to care in areas of need

Advancing the workforce
Support workforce to upskill and advance
Outcome: More advanced professionals and economic mobility

Retaining the workforce
Address attrition drivers (e.g., admin burden, burnout)
Outcome: Preserve supply, improve care quality by retaining experienced professionals

Compensating the workforce
Improve compensation (wages & benefits)
Outcome: Enhanced satisfaction and morale, attract better talent



Demand levers

Prevention and promotion
More investment in screening and prevention (e.g., primary care, reducing stigma)
Outcome: Lower demand for acute care, improve client outcomes

Care team
Optimize care team composition to meet demand (e.g., scope of practice, professional ratios)
Outcome: Improve utilization of workforce

Care delivery model
Improve efficiency of care delivery models (e.g., through technology)
Outcome: Serve additional demand, improve care quality

Health financing
Promote adoption of alternative payment models; improve reimbursement
Outcome: Improve client outcomes, healthcare affordability

Health system infrastructure
Invest in additional infrastructure (e.g., healthcare facilities, transportation, etc.)
Outcome: Serve additional demand, improve client outcomes

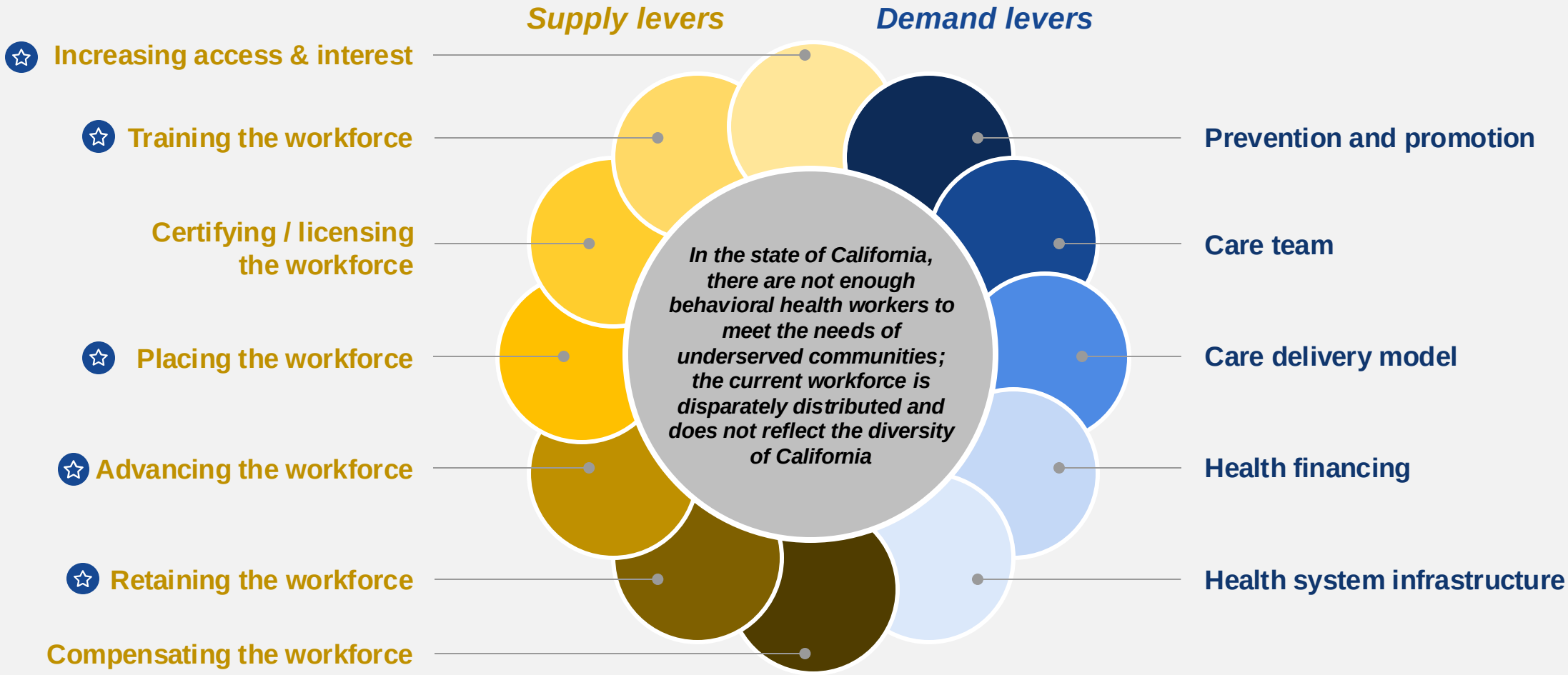
Enablers

- *Data governance & quality (including labor market data)*
- *Continuous learning & improvement*
- *Mentorship & support*
- *Tracking effectiveness over time*
- *Centering on voice of the worker*
- *Removing administrative barriers*
- *Centering on DEI principles*
- *Driving awareness / communication of process steps & opportunities*

Where HCAI sees its role

We see HCAI's primary role on the supply side of the equation, though we hope our data will support decision making across these levers

Where do you see the role of other entities?



Supply levers aim to increase and diversify the health workforce

Demand levers aim to optimize demand, by improving workforce utilization

HCAI will then define the menu of interventions it can lead versus those where it is better suited to convene or inform other actors

Interventions for HCAI to lead: Strong evidence with opportunity to scale

1. Fund increased education capacity, particularly in underserved areas
2. Fund increased clinical supervision opportunities, particularly in rural and underserved areas
3. Provide incentives to redistribute existing workforce (e.g., stipends)
4. Fund peer and mentor networks for BH professionals
5. Lower individual financial barriers to train / upskill the workforce (e.g., scholarships)*
6. Fund non-financial completion supports for training and upskilling (e.g., childcare, living accommodation)*
7. Offer tuition reimbursement and loan repayment to existing BH professionals
8. Offer health career-oriented high school programming
9. Offer "Earn and Learn" programs (paid apprenticeship / internship)
10. Train PCPs to integrate BH into primary care

Innovative interventions for potential investment: Evidence still emerging

1. Launch marketing and info campaigns to promote health professions (esp new roles)
2. Fund pay / incentives (e.g., bonuses) for faculty and staff recruitment and retention
3. Scale certified programs / roles (e.g., Wellness Coaches)
4. Fund adult re/up-skilling programs with on ramps and off ramps (e.g., stackable credentials)
5. Embed and prioritize cultural humility and competency in training
6. Lower financial barriers to certification / licensure (e.g., subsidize exam fees)
7. Attract and support workforce from outside of California (e.g., visa waiver)
8. Provide financial incentives to stay long term in underserved areas (>5 years)
9. Provide incentives for employers to support workers upskilling (e.g., funding for trainings while working)
10. Offer programs that reduce time and effort to upskill
11. Engage and retain retired BH professionals or those close to retirement (e.g., funding for employers to extend career length)
12. Implement workforce stability standards *(via OHCA)*
13. Incentivize alternative payment models *(via OHCA)*

Example interventions outside HCAI scope

1. Offer elementary and middle school programs (e.g., early exposure to health careers, health and science clubs)
2. Enable partners to fund health profession education based on need
3. Standardize pre-requisites across schools
4. Reduce time and effort needed to complete a degree (e.g., credit for prior learning)
5. Increase support / guidance for students (e.g., advising services)
6. Provide job placement assistance, esp. for underserved areas
7. Increase health system funding in underserved areas to prevent closures, and maintain financial stability and employment
8. Reduce administrative barriers to working in underserved areas
9. Increase reimbursement rates for professionals in areas of unmet need
10. Ensure sufficient addt'l training or supervision in underserved areas
11. Create clear pathways to advanced roles and certification assistance programs (e.g. stackable credentials)
12. Incentivize health systems to offer and BH professionals to use telehealth to work remotely
13. Offer more part-time opportunities / flexible work schedules
14. Reduce administrative and documentation workload
15. Offer retention bonuses or support with major purchases (e.g., down payment)
16. Offer workplace family support programs such as childcare
17. Provide competitive benefits (e.g. mental health services)
18. Use community-based health promotion
19. Decrease stigma of behavioral health and care
20. Provide incentives to promote multidisciplinary care teams
21. Establish recognition for high standards in team-based care
22. Support increases of client telehealth usage for maintenance / management of chronic conditions
23. Encourage policies that assign PCPs and reduce ED use
24. Increase reimbursement rates from payors / lower copay
25. Build healthcare facilities to improve access & employment opps.
26. Support establishment of mobile health clinics to provide care in underserved and rural areas
27. Support funding for low income / rural communities' internet access for telehealth by sharing data on priority telehealth expansion areas

We will narrow down this menu of options based on evidence and stakeholder feedback, and tailor these interventions to role and geography-specific shortages.

***Interventions need to work together as bundle**

We are also exploring promising, **innovative ideas** for Behavioral Health workforce development that we have not yet considered / discussed

- Innovative interventions related to existing role types that are not currently being modeled
- Innovative interventions related to new role types

Feel free to share ideas with us for consideration

4

Strategy: Tailored interventions to target specific challenges

Some interventions will be required statewide across roles

These interventions are largely within HCAI's scope

In addition to role-specific interventions, there are some interventions needed across behavioral health roles:

Expanding public educational capacity: Fund increased public education capacity, particularly in shortage areas *(for licensed roles)*

- Use model data to understand areas of highest need, to inform decisions on where to expand educational capacity

Expanding clinical supervision: Fund increased clinical supervision opportunities, particularly in rural and shortage areas *(for licensed roles)*

Recruit and retain faculty: Fund pay / incentives (e.g., bonuses) for faculty and staff recruitment and retention

Lowering barriers to training: Lower financial barriers to train / upskill the workforce (e.g., scholarships) and fund non-financial completion supports (e.g., childcare, living accommodation, transportation) – *these interventions are known to improve equity*

Recruit and retain BH professionals in targeted settings: Offer tuition reimbursement and loan repayment, and provide financial incentives to stay long-term (e.g., stipends, bonuses), particularly in shortage areas and in safety net settings – *these interventions are known to improve equity*

Where possible, interventions should be targeted to decrease racial, linguistic, Medi-Cal and other disparities

In addition, there are interventions outside of HCAI's scope that may be required to achieve workforce and access goals

Not exhaustive

Some of these interventions may include:

- Increasing **reimbursement rates**
- Reducing **professional : client ratios** to reduce burnout
- Increasing **usage of telehealth** for professionals and clients
- Improving **compensation for professionals**, and competitive benefits
- Offering more **part-time** opportunities and **flexible work schedules**
- Reducing **administrative barriers** to working in shortage areas (e.g., Medi-Cal approval process, streamline billing)
- **Standardizing pre-requisites** across schools
- Expanding **scope of practice** (e.g., expanding PMHNP responsibility)
- Develop **clear career pathways** (e.g., upskilling from certified to licensed roles) and **stackable credentials**

From the model results, some role x geography combinations had especially severe shortages, while all roles had statewide shortages

Role / geography combinations with especially severe shortages

- **Non-prescribing licensed professionals** – *Northern & Sierra and San Joaquin Valley*
- **Psychiatrists** - *Northern & Sierra*

Roles with statewide shortages

- **Psychiatric Mental Health Nurse Practitioners** – *statewide*
- **SUD Counselors** – *statewide*
- **Peer Personnel** – *statewide*
- **Non-prescribing licensed professionals** – *remainder of state (Sacramento, Inland Empire, LA County, Greater Bay Area, Central Coast, San Diego Area, Orange County)*
- **Psychiatrists** – *remainder of state (Sacramento, Inland Empire, LA County, Greater Bay Area, Central Coast, San Diego Area, Orange County, and San Joaquin Valley)*

We combine findings from the role-specific shortage areas and the evidence-based interventions to develop tailored intervention bundles

Identified areas with highest workforce shortages from model output

Additionally, model has overlays for race, language and Medi-Cal acceptance, as shortages are not only defined as where demand exceeds supply

Developed understanding of key drivers of shortages by area, role and equity considerations

Interviews with BH professionals to identify key barriers

Data analysis and research to validate hypotheses of shortage drivers

Matched key shortage drivers with mitigating interventions to tailor solutions for each role x geography combination

Example: *Key shortage driver for non-prescribing licensed clinicians in San Joaquin Valley is insufficient didactic and clinical training capacity*

Therefore, a solution may be to partner to expand clinical supervision opportunities…

AND we might operationalize this by adapting HCAI grant scoring to give additional points to programs that address this need

Preliminary

Summary

Increasing supply and diversity of non-prescribing licensed clinicians in San Joaquin Valley and Northern & Sierra

Region: San Joaquin Valley, Northern & Sierra
- Counties with most significant gaps in current state are Sierra, Lake, Merced

Role(s): Non-prescribing licensed clinicians (e.g., LCSW)

Time period: 9 years

Potential investment required: TBD

Equity: Key disparities include Asian, Latine, American Indian, Pacific Islander, Asian & Pacific Island language-speaking, Other Indo-European language-speaking, Spanish-speaking professionals

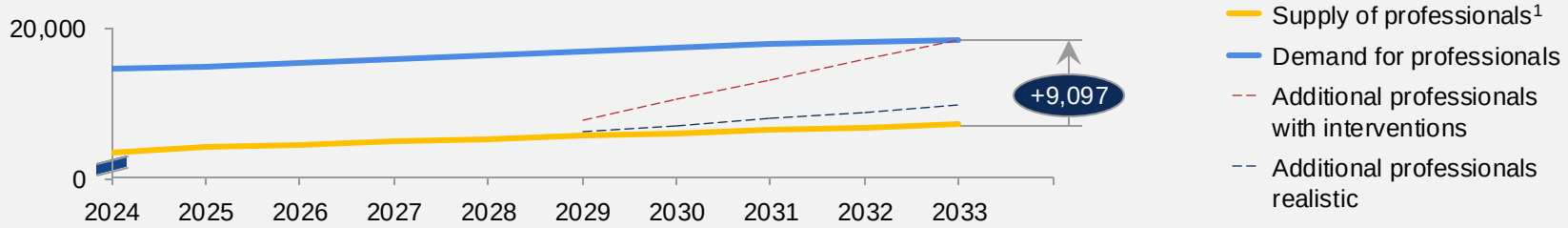
HCAI has an existing program for intervention

Forecasted supply and demand

Ratio of professionals to population <1.0 indicates disparity

Key professional-to-population disparities:
- ~0.7 representation for Latine professionals in San Joaquin Valley; ~0.6 in Northern & Sierra
- ~0.6 representation for Spanish-speaking professionals in Northern & Sierra

non-prescribing licensed clinicians in San Joaquin Valley and Northern & Sierra



*By **2033**, we will **need ~9,000 more non-prescribing licensed clinicians in San Joaquin Valley and Northern & Sierra** to meet forecasted demand*

The following interventions should be done:

Intervention #1: Offer **scholarships** for low-income and underserved students from San Joaquin Valley and Northern & Sierra to attend relevant graduate programs, prioritizing students who are from and study in San Joaquin Valley and Northern & Sierra (to support "grow your own" efforts and increase likelihood students remain in San Joaquin Valley and Northern & Sierra long-term)
- **Target to close the gap**: Support ~9,000 students over the next 9 years
  - **Realistic target:** ~1,500 – 2,000 additional students over the next 9 years, given current number of completions / graduates in San Joaquin Valley and Northern & Sierra as well as historical growth rates of completions[2]

Intervention #2: Offer **tuition reimbursement and loan repayment** to existing professionals in San Joaquin and Northern & Sierra to improve retention, prioritizing underserved populations (e.g., Medi-Cal) or public employers (e.g., counties)
- **Target to close the gap :** Support ~7k professionals (roughly all existing professionals), each for a 2-year period
  - **Realistic target:** ~4 – 6k professionals, limited to professionals estimated to have student loan debt (around 60 – 80%[3, 4])

Intervention #3: Fund **clinical supervision** opportunities to lower burden of completing supervision (e.g., revenue replacement for employers / sites, stipends for supervisors or students) and lower barriers to expanding program sizes; if possible, prioritize local students to support "grow your own" efforts
- **Target to close the gap:** Support ~9,000 students / associate professionals over the next 9 years
  - **Realistic target:** ~1,500 – 2,000 additional students over the next 9 years

Intervention #4: Expand education capacity, especially at public institutions (e.g., CSUs, UCs)
- **Target to close the gap:** Support ~9,000 additional professionals over the next 9 years
  - **Realistic target:** ~1,500 – 2,000 additional students over the next 9 years, needing 300 – 400 additional slots, assuming it takes ~4 years to complete graduate education and experience needed to qualify for licensing exam

1. Includes pipeline, as projected supply 2. IPEDS 3. National Association of Social Workers (accessed August 2023), "Student Loan Debt Relief for Social Workers" 4. American Psychological Association (accessed August 2023), "Crushed by debt? Psychology graduate students are graduating with huge student loan debts."

Preliminary

Summary

Increasing supply and diversity of Substance Use Disorder Counselors statewide

Region: Statewide
- In current state, all regions have a shortage except Inland Empire and Sacramento
- The regions with most significant gaps in current state are Greater Bay Area, San Diego Area, LA County

Role(s): SUD counselors

Time period: 5 years

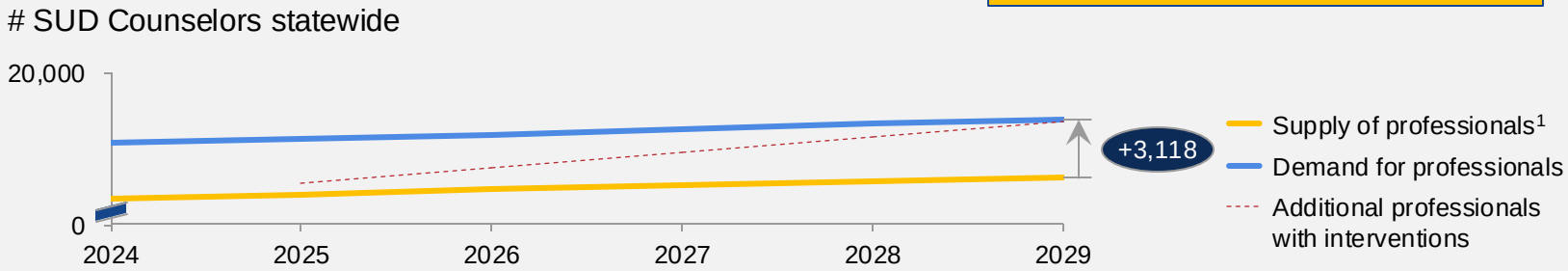
Potential investment required: TBD

Equity: SUD Counselors are generally more diverse than other BH professional types; key disparities include Asian and Latine professionals

HCAI has an existing program for intervention

Key professional-to-population disparities[2]:
- **Asian**: 2% of SUD Counselors; 15% of CA population
- **Latine**: 22% of SUD Counselors; 40% of CA population

Forecasted supply and demand



*By **2029**, we will **need ~3,000 more SUD counselors statewide** to meet forecasted demand*

The following interventions should be done:

- **Intervention #1:** Offer **scholarships** for low-income and underserved students from highest shortage regions to attend relevant programs (including funding non-financial competition supports such as housing)
  - **Target to close the gap**: Support ~3,000 students over the next 5 years
- **Intervention #2:** Offer **"Earn and Learn" programs** (e.g., paid internships) to reduce attrition from registered to certified professionals
  - **Target:** Support ~3,000 students / registered counselors over the next 5 years
- **Intervention #3:** Provide **incentives to redistribute existing workforce** from surplus to shortage regions (will address maldistribution but will not address statewide shortage)
  - **Target:** Support ~400 existing professionals (forecasted surplus across all surplus regions in 2029)

1. Includes pipeline, as projected supply
2. Data obtained from California Consortium of Addiction Programs and Professionals (largest certifying entity for SUD Counselors in California) and extrapolated to represent whole population of SUD Counselors in California. Data accessed May 2024.

5

Way forward

In partnership with other departments and key stakeholders, we will use findings to refine HCAI's program plans and to inform our Prop 1 funding approach

We will make findings and data available to other stakeholders as they set their own strategies

Additional opportunities to engage

Advanced results will be shared at the **September 16th Health Workforce Education and Training Council**

Additional strategic implications will be shared with stakeholders in late September

Additional opportunities for data sharing

We plan to post the regional results of supply / demand by role on our website; different regional breakdowns will be considered (e.g., CHIS, JobsFirst, CCC, etc.)

Please see next slide for how to provide feedback

How to provide feedback

If you would like to share feedback on these materials, please email **mancia.ana@bcg.com** with your input by August 30, 2024 at 5pm PT

Areas where we **would especially welcome feedback in today's breakout discussions**:

- Additional context / detail on key drivers of behavioral health workforce shortages (across roles and geos) – *See Section 2*
- Perspectives on the levers and menu of interventions to address the problem (e.g., interventions you have seen be effective / not effective in your experience) – *See Section 3*
- Innovative or promising ideas for behavioral health workforce development – *See Section 3*

6

Panel discussion

Introduction to today's panel

Karen Larsen

Chief Executive Officer at Steinberg Institute

Luke Bergmann

Director of Behavioral Health Services at County of San Diego

Carmen Katsarov

Executive Director of Behavioral Health Integration at CalOptima Health

Rebecca Ruan-O'Shaughnessy

Vice Chancellor for Educational Services and Support at CCC Chancellor's Office

Christine Stoner-Mertz

CEO of California Alliance of Child and Family Services

Our presentation will be followed by a panel discussion with representatives from across sectors who will speak to the roles of different organizations in using the evidence-based strategy to support behavioral health workforce development, as well as reflections on resonant and promising interventions.

Appendix

Appendix Contents

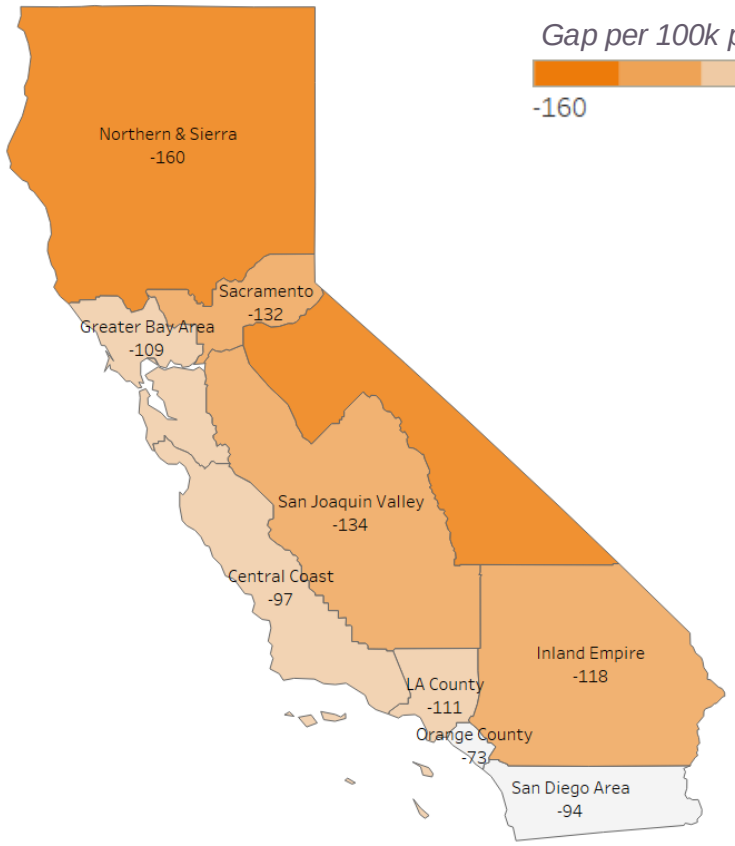
Supply / demand regional gap results for each set of roles

Methodologies and assumptions

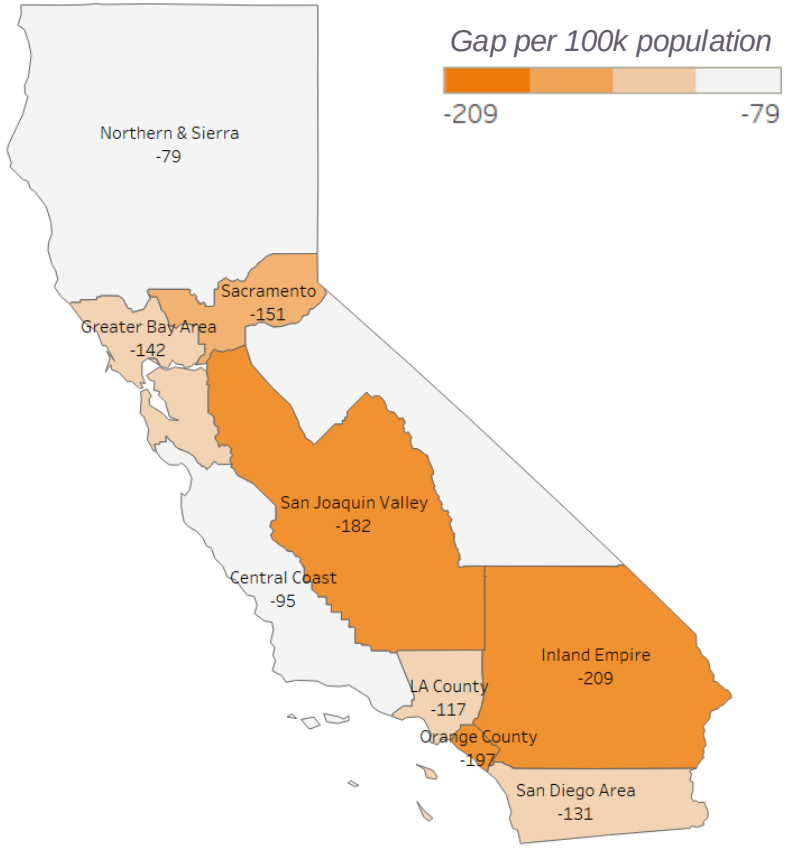
Results for each set of roles

Non-prescribing licensed behavioral health professional (region level)

Current state Non-prescribing licensed behavioral health professional
Regional model gap relative to pop [1] (severe shortage, less severe shortage)[2]



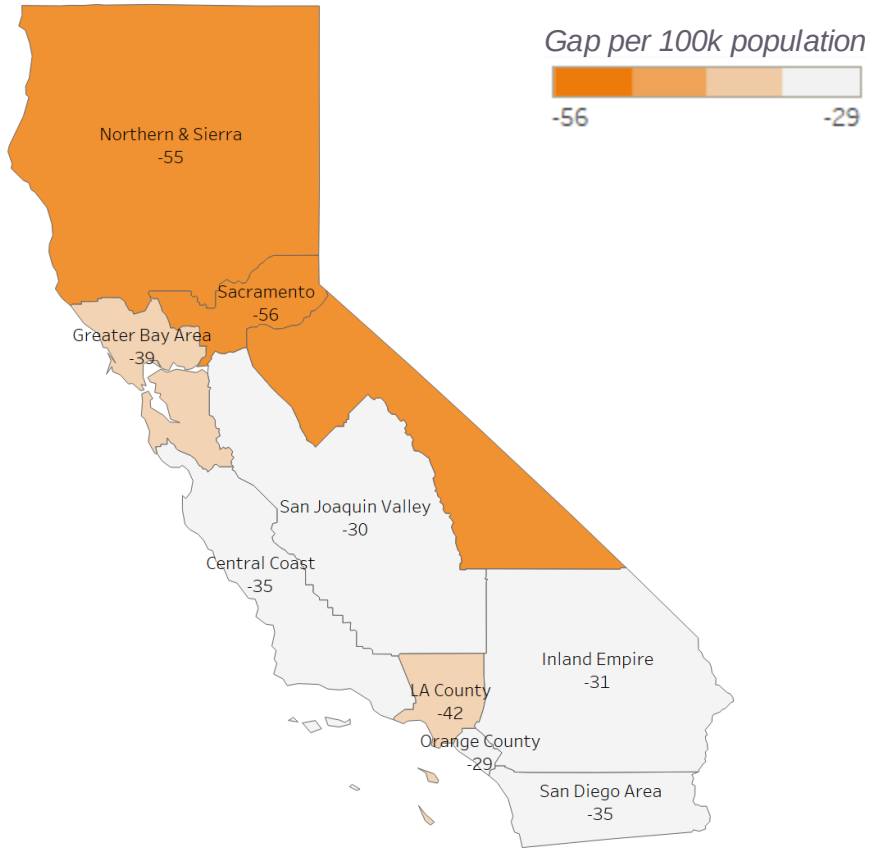
2033 forecast Non-prescribing licensed behavioral health professional
Regional model gap relative to pop[1] (severe shortage, less severe shortage)[3]



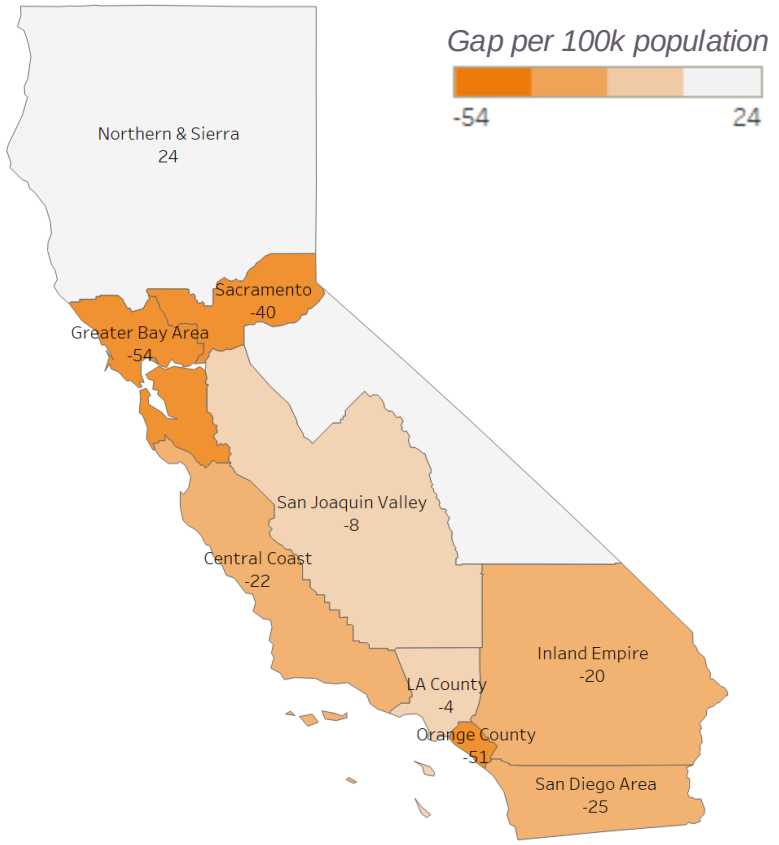
1. Per 100k population 2. Min = -160, max = -73. 3. Min = -209, max = -79.

Non-prescribing associate level clinicians (region level)

Current state Non-prescribing associate behavioral health professional
Regional model gap relative to pop [1] (severe shortage, less severe shortage)[2]



2033 forecast Non-prescribing associate behavioral health professional
Regional model gap relative to pop[1] (severe shortage, surplus)[3]

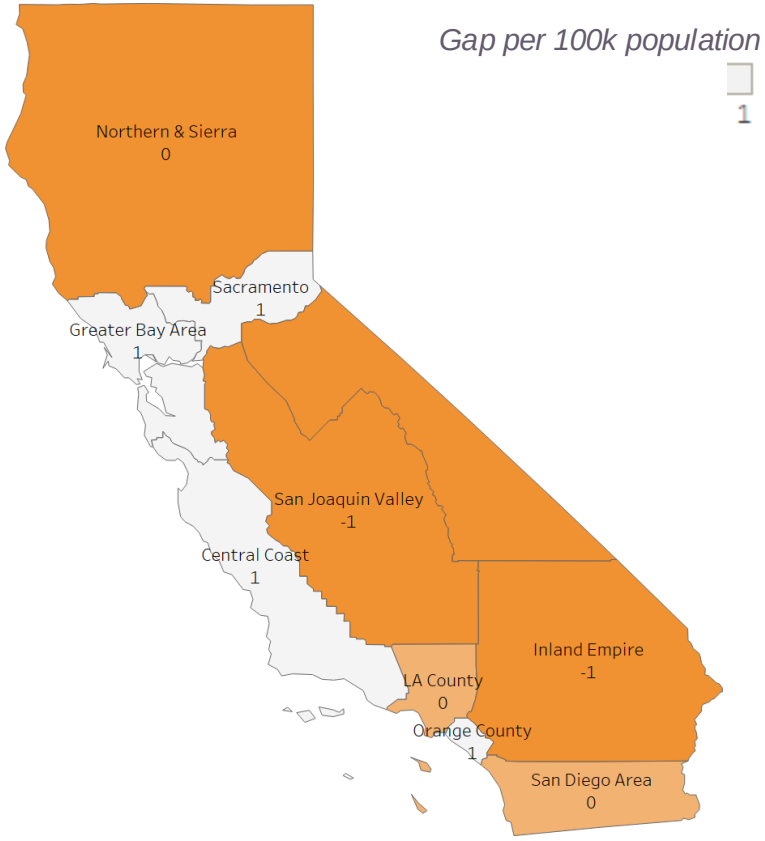


1. Per 100k population 2. Min = -56, max = -29. 3. Min = -54, max = 24.

Licensed educational psychologist (region level)

Current state License educational psychologist
Regional model gap relative to pop [1] (severe shortage, surplus)[2]

2033 forecast License educational psychologist
Regional model gap relative to pop[1] (severe shortage, surplus)[3]



1. Per 100k population 2. Min = -2, max = 2. 3. Min = -1, max = 1.

Peer support specialist (region level)

Current state Peer support specialist
Regional model gap relative to pop [1] (severe shortage, less severe shortage)[2]

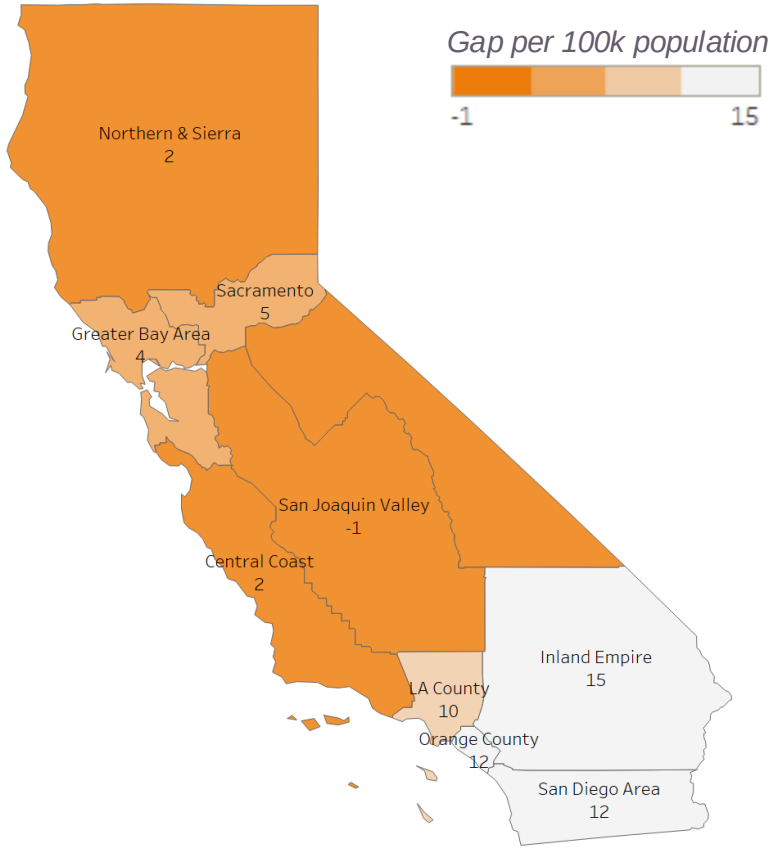
2033 forecast Peer support specialist
Regional model gap relative to pop[1] (small surplus, larger surplus)[3]

1. Per 100k population 2. Min = -8, max = -6. 3. Min = -5, max = 13.

Psychiatric mental health nurse practitioner (region level)

Current state Psychiatric mental health nurse practitioner
Regional model gap relative to pop [1] (severe shortage, less severe shortage)[2]

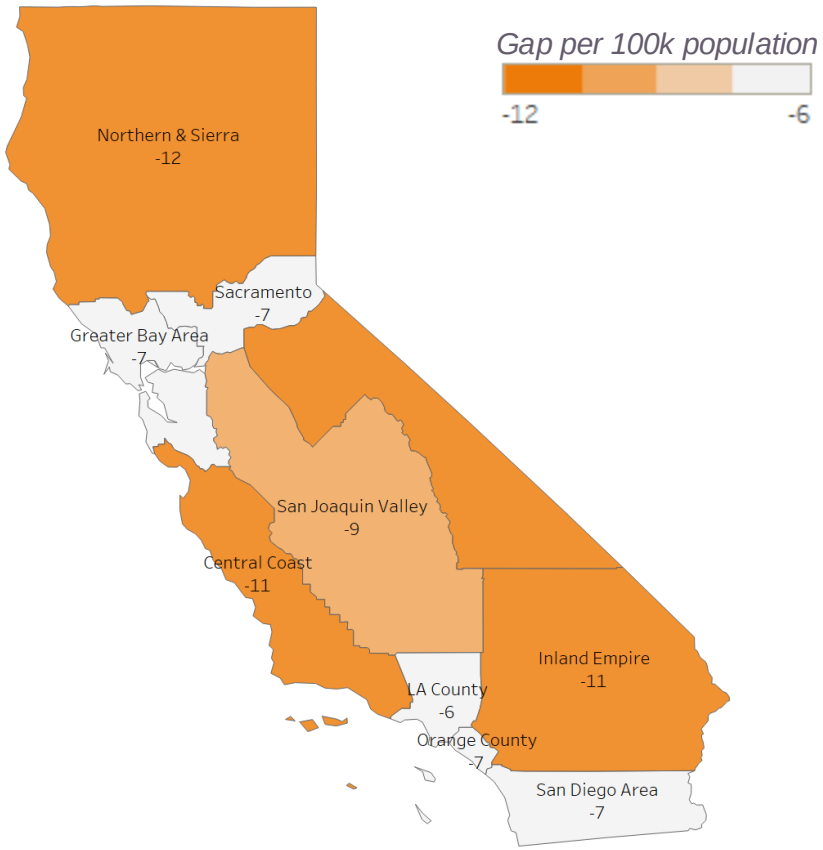
2033 forecast Psychiatric mental health nurse practitioner
Regional model gap relative to pop[1] (severe shortage, surplus)[3]



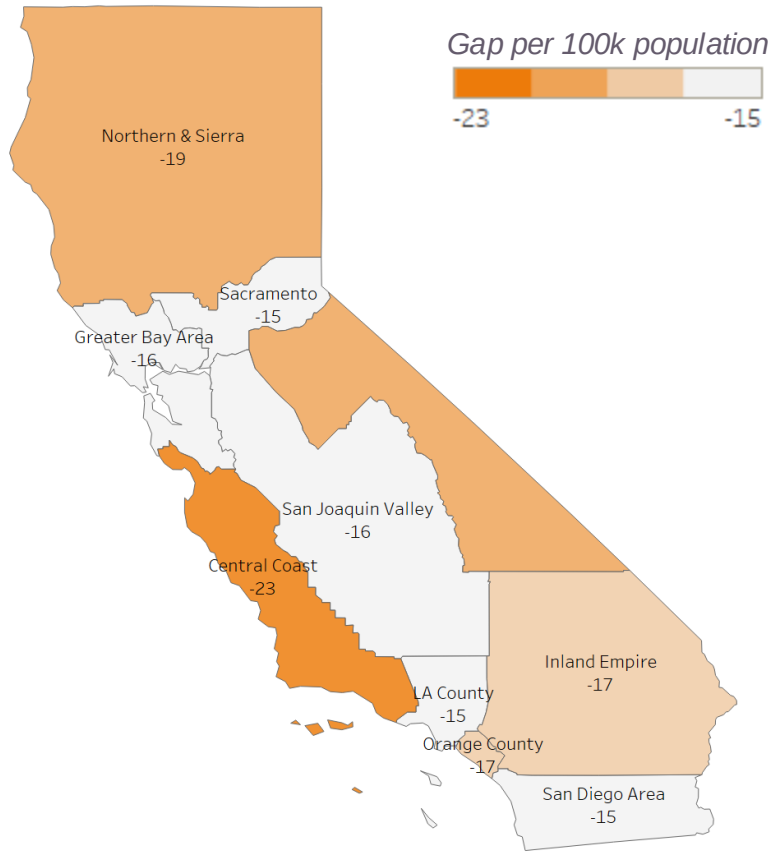
1. Per 100k population 2. Min = -6, max = -3. 3. Min = -1, max = 15.

Psychiatrist (region level)

Current state Psychiatrist
Regional model gap relative to pop [1] (severe shortage, less severe shortage)[2]



2033 forecast Psychiatrist
Regional model gap relative to pop[1] (severe shortage, less severe shortage)[3]

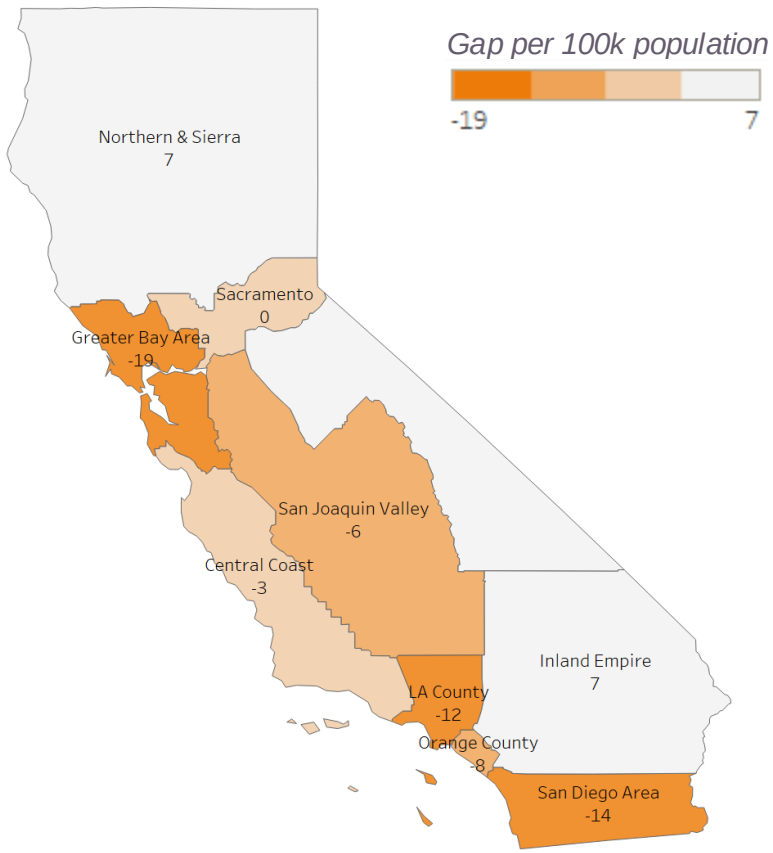


1. Per 100k population 2. Min = -12, max = -6. 3. Min = -23, max = -15.

Substance use disorder counselor (region level)

Current state Substance use disorder counselor
Regional model gap relative to pop [1] (severe shortage, surplus)[2]

2033 forecast Substance use disorder counselor
Regional model gap relative to pop[1] (severe shortage, surplus)[3]



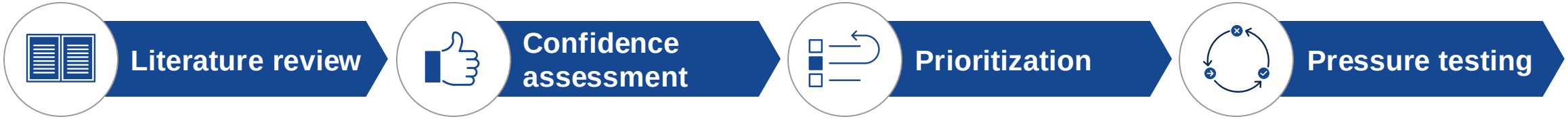
1. Per 100k population 2. Min = -15, max = 6. 3. Min = -19, max = 7.

Methodologies and assumptions

Assumptions are a critical component of modeling & we will ensure our assumptions are as data-driven as possible

- **Every model has assumptions**; no model is completely assumption-free
- However, they are **informed by available data and expert insights;** assumptions are not speculation
- They can **fill gaps where complete data is unavailable** or impractical to collect
- They can **simplify complex systems** to enable calculations that would otherwise be unwieldy
- They **enable forecasting scenarios** by providing levers that can be adjusted

Model assumptions & key variables have been validated with a multi-step approach that leverages existing research and expert/stakeholder knowledge



Conduct **thorough review of statutes, scientific literature, industry publications, and current practices** to identify preliminary assumptions

Assess level of confidence in each assumption based on data availability, ability to triangulate across multiple sources, and data source trustworthiness *(e.g., statute more trustworthy than industry association briefing)*

Prioritize assumptions for further pressure testing based on impact (e.g., assumptions for high-volume roles like RNs) and level of confidence

Pressure test priority assumptions with **experts/professionals and key CA healthcare stakeholders** to align on final assumption

The model is designed to enable **easy modification of assumptions** so that new learnings, data, and/or policy shifts can be incorporated. Additionally, **sensitivity analyses will be conducted for high-impact variables** (e.g., staffing ratios) to understand the right confidence intervals for model output

Core assumptions underlie baseline Behavioral Health model (I/II)

Model outputs and corresponding supply/demand gaps are informed by a core set of assumptions

Not exhaustive

Supply-driven demand

Calculating demand based on existing services means that **more demand will be observed where there are more or larger healthcare facilities**

Additionally, **service volume is often driven by available local supply of resources** (e.g., staffed beds) rather than medical necessity or patient preference; in behavioral health model, we are using reported need for behavioral services without seeking / receiving care (from UCLA's CHIS survey) to account for unmet demand

Professional location

Professional location is based on their license record which is self reported and could be a dwelling, not the license holder's location of practice

Many licensees do report their location of practice, and we expect the likelihood that professionals live where they practice to depend on cost of living and healthcare facility volume; to validate with commute flows analysis

Sets of roles for demand

Group demand for roles with highly overlapping scopes of care to reflect fungibility and avoid false precision

- **Licensed roles (non-prescribing)** – group LCSW, LMFT, LPCC, and psychologist given emphasis on psychotherapy and fungibility in statute

Recognize differences between these roles, **set for demand purposes only. Supply remains separate**

Care settings, actuals & ratios

Calculate demand bottoms-up based on **care setting** and either **actual staffing** patterns or **staffing ratios** (inpatient and residential treatment settings). In behavioral health model, calculate a **professional : population ratio for outpatient demand** based on care needed that was served vs. not

All staffing ratios will be pressure-tested with relevant experts (e.g., stakeholders, professionals, healthcare administrators)

Dual license-holders

To convert from total number of licenses to unique providers, **de-duplicate any dually licensed professionals**

Assume all professionals work at the top of their license given investment made in career and wage rates

Static care team staffing

In baseline model, assume **the "default" care team composition is unchanged** over the 10-year forecast

Any shifts in care team composition would be modeled as scenarios rather than in the baseline to enable more useful comparison

Core assumptions underlie baseline Behavioral Health model (II/II)

Model outputs and corresponding supply/demand gaps are informed by a core set of assumptions

Not exhaustive

Unmet demand care team composition

In MVP, assume that the appropriate **care team mix for current state will be the same between met and unmet demand**. This will be refined over time as better data is made available

In the data roadmap, consider how to better understand the differences between the care required for the demand that is currently met and unmet (e.g., working to understand current and potential avenues to better contextualize unmet demand)

Unmet acute demand

When calculating baseline unmet acute demand (i.e., in the inpatient or residential setting), **do not constrain demand based on infrastructure availability** and instead model demand based on ideal bed : population ratio

In scenario, constrain infrastructure used to calculate unmet demand based on buildout trends

Unmet demand in counties with low current supply

Outpatient unmet demand calculation for behavioral health relies in part on the existing supply of professionals in a county. To ensure we do not reproduce existing disparities, **counties that have below the statewide average number of BH professionals are allotted additional unmet demand to "true them up"** to at least the statewide average professional to population ratio.

Role of allied health and primary care professionals

Allied health and primary care professionals are not accounted for in the baseline model. Although these roles do provide some behavioral health services, there is limited data or consensus as to what volume and type of services should be done by behavioral health specialists vs. nonspecialists

A scenario will be developed to test the potential impact of task-shifting between non-prescribing licensed behavioral health clinicians (e.g., LCSW) and allied health workers


HCAi
Department of Health Care
Access and Information

EVIDENCE-BASED STRATEGY TO DEVELOP CALIFORNIA'S BEHAVIORAL HEALTH WORKFORCE

GROUP Q&A, CONVERSATION

CalHHS
California Health & Human Services Agency

FACILITATED DISCUSSIONS/ACTIVITY

PURPOSE

- Learn initial reactions to the Strategy
- Connect with other BHTF members

TIME: 30 minutes

IN-PERSON SMALL GROUPS:

- Identify note-taker, person who reports out
- **Group identifies ONLY two key ideas to share out**

ONLINE PARTICIPANTS: Whiteboard brainstorming – grouped by BHTF membership and the public.

CalHHS
California Health & Human Services Agency

WORKFORCE DEVELOPMENT QUESTIONS

1. Needs
    - 1A. Which of the needs/gaps shared today would you prioritize?
    - 1B. Thinking of the future and types of care models we'd like to see more of, what other needs/gaps need to be considered?
2. Interventions
    - 2A. Which of the strategies/interventions shared today would you prioritize?
    - 2B. What other innovative approaches hold promise to address BH workforce challenges?
3. Actions
    - What can you do to take action based on these findings – how can you share this information, help address these workforce needs, help with strategy implementation, and/or collaborate with other organizations?

CalHHS
California Health & Human Services Agency

BHTF MEMBERS REFLECTIONS

1. **In-Person: Group rep share ONE-TWO IDEAS ONLY the group found exciting or potentially impactful.**
2. **Remote Participants: After Jonathan shares major themes, add on with other themes, or exciting/potentially impactful ideas as time allows.**

CalHHS
California Health & Human Services Agency

LUNCH BREAK

30 minutes – back at 1:00 PM

CalHHS
California Health & Human Services Agency

UPDATE ON PROPOSITION 1/ BH TRANSFORMATION IMPLEMENTATION

MICHELLE BAASS, DIRECTOR, DEPT. OF HEALTH CARE SERVICES

STEPHANIE WELCH, MSW, DEPUTY SECRETARY OF BEHAVIORAL HEALTH, CalHHS

CalHHS
California Health & Human Services Agency

Behavioral Health Task Force

August 28, 2024

Michelle Baass
Department of Health Care Services, Director

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES | MENTAL HEALTH FOR ALL

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Meeting Agenda

- Introduction to the Behavioral Health Transformation
- Bond Guidance
- DHCS's Stakeholder Engagement
- Integrated Plans and BHOATR
- Local Engagement
- Feedback and Discussion

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Introduction to Behavioral Health Transformation

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES | MENTAL HEALTH FOR ALL

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Current Challenges Facing California

Serious Mental Illness & Substance Use

- **1 in 20 adults** is living with a serious mental illness (SMI).
- **1 in 13 children** has a serious emotional disturbance (SED).
- 30% of youth 12 to 24 years of age experience serious **psychological distress**.
- Veterans experience higher rates of **suicide, mental illness, and substance abuse**.
- **1 in 10 Californians** meet the criteria for a substance use disorder (SUD).

Intersection with Homelessness

- **82% of Californians** experiencing homelessness reported having a serious mental health condition.
- 27% of individuals experiencing homelessness have been **hospitalized for a mental health condition**.
- Nearly two-thirds (65%) of individuals experiencing homelessness had a period in their life in which they regularly used illicit drugs.
- In 2020, there were **more than 10,000 veterans** experiencing homelessness.
- Limited care facilities contribute to the **growing crisis of homelessness and incarceration** among people with a mental health disorder.

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES | MENTAL HEALTH FOR ALL

**The information included in this presentation may be pre-decisional, draft, and subject to change.*

Information referenced can be found on the April 2024 Public Listening Sessions Slides

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 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

DHCS CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES | MENTAL HEALTH FOR ALL

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Information referenced can be found on the May 2024 BH-SAC Meeting Slides

Behavioral Health Transformation

By enacting changes resulting from Proposition 1, Behavioral Health Transformation expands ongoing efforts to **support vulnerable people** living with the **most significant** mental health conditions and SUDs.

Behavioral Health Transformation at a Glance:

1. Evolves the Mental Health Services Act to the Behavioral Health Services Act
2. Includes bonds to increase infrastructure

High-level **aims of Behavioral Health Transformation** include:

Improving Accountability

Increasing Transparency

Expanding Capacity of Behavioral Health Facilities

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Information referenced can be found on the May 2024 BH-SAC Meeting Slides

Behavioral Health Transformation Milestones

Below are high-level timeframes for several milestones that will inform requirements and resources. Additional updates on timelines and policy will follow throughout the project.

Started Spring 2024

Partner Engagement

Stakeholder and tribal partner engagement including, **public listening sessions,** will be utilized through all milestones to inform policy creation.

Started Summer 2024

Bond BHCIP: Round 1 Launch Ready

Requests for Applications (RFA) for up to $3.3 billion in funding will leverage BHCIP.

Beginning Early 2025

Integrated Plan Guidance and Policy

Policy and guidance will be **released in phases** beginning with policy and guidance for integrated plans.

Summer 2026

Integrated Plan

New integrated plans, fiscal transparency, and data **reporting requirements** go-live in July 2026 (for next three-year cycle)

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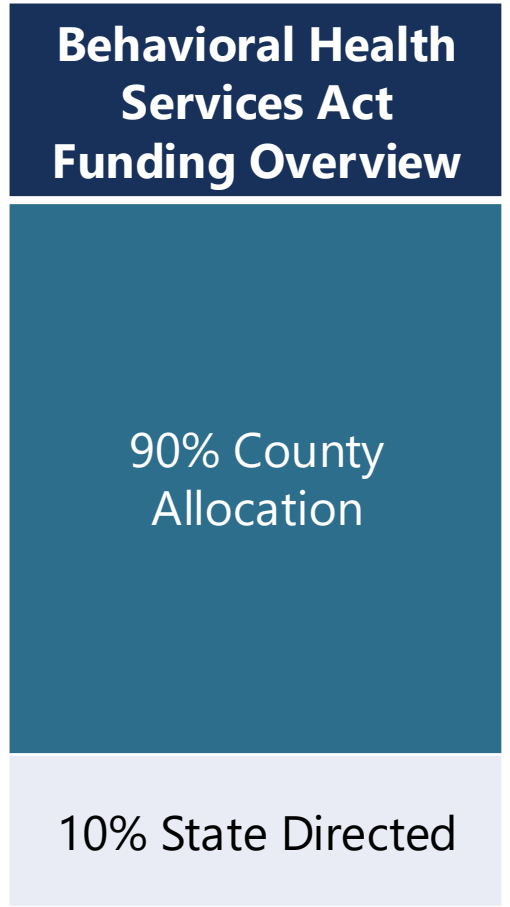
Behavioral Health Services Act

Behavioral Health Services Act:

- **Updates allocations** for local services and state-directed funding categories
- Broadens the target population to **include individuals with SUDs**
- Focuses on the **most vulnerable and at-risk**, including children and youth
- Advances community-defined practices as a key strategy for **reducing health disparities** and **increasing community representation**
- Revises county processes and improves **transparency and accountability**



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Information referenced can be found on the June 2024 All-Comers Webinar Slides

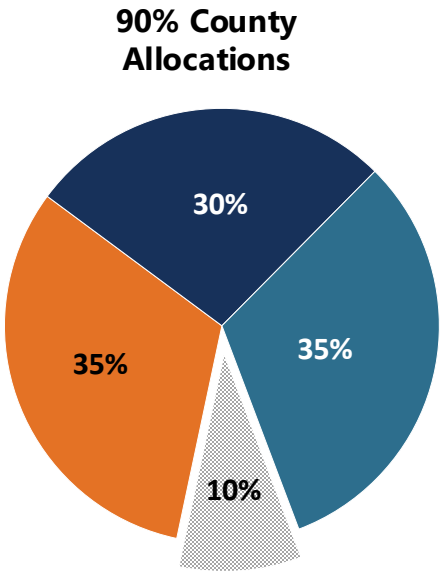
Behavioral Health Services Act Funding Breakdown

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.



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County Allocations:
BH Housing Interventions – 30%

- For children and families, youth, adults, and older adults living with SMI/SED and/or SUD who are experiencing or at risk of homelessness.
  - 50% is prioritized for housing interventions for the chronically homeless with BH challenges.
- Includes rental subsidies, operating subsidies, shared and family housing, capital, and the non-federal share for certain transitional rent.
  - Up to 25% may be used for capital development.
- Not limited to Full Service Partnerships partners or persons enrolled in Medi-Cal.
- County flexibility:
  - Allows small county exemption for 2026-29 and on-going if approved by DHCS.
  - Provides flexibility for the remaining counties commencing with the 2032-2035 planning cycle on the 30% requirement based on DHCS criteria for exemptions.

County Allocations: Full-Service Partnerships (FSP) Programs – 35%

- Includes mental health, supportive services, and SUD treatment services.
  - Medication-Assisted Treatment (MAT)
  - Community-defined evidence practices (CDEP)
- Assertive Community Treatment /Forensic Assertive Community Treatment, Supported employment, & high-fidelity wraparound are required.
  - Small county exemptions are subject to DHCS approval.
- Establishes standards of care with levels based on criteria.
- Outpatient behavioral health services, either clinic or field based, necessary for on-going evaluation and stabilization of an enrolled individual.
- On-going engagement services necessary to maintain enrolled individuals in their treatment plan inclusive of clinical and non-clinical services, including services to support maintaining housing.

County Allocations:
Behavioral Health Services and Supports – 35%

- Includes early intervention, outreach and engagement, workforce education and training, capital facilities, technological needs, and innovative pilots and projects.
- A majority (51%) of this amount must be used for Early Intervention services to assist in the early signs of mental illness or substance misuse.
  - A majority (51%) of these Early Intervention services and supports must be for people 25 years and younger.

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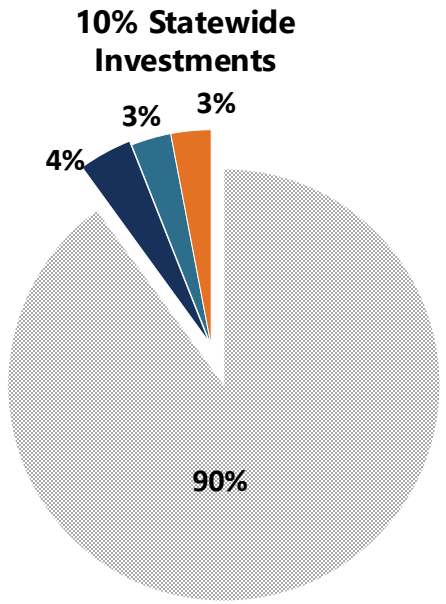
Behavioral Health Services Act Funding Breakdown

10% Statewide Investments

3% **Statewide Oversight and Monitoring Activities**
State entities will develop statewide goals, oversee county outcomes, train and provide technical assistance to counties and providers, research and evaluate, and administer programs.

3% **Workforce**
The Department of Health Care Access (HCAI) and Information will expand and support a culturally competent and well-trained statewide behavioral health workforce.

4% **Prevention**
The California Department of Public Health (CDPH) will administer statewide prevention services to reduce the risk of people developing mental health conditions or SUDs.



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State Responsibility: Statewide Oversight and Monitoring

- Used to develop statewide outcomes, conduct oversight of county outcomes, train and provide technical assistance, research and evaluate, and administer programs.
- Fund state directed activities.

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New State Responsibility: Workforce

- HCAI, in collaboration with CalHHS, will implement a behavioral health workforce initiative to expand a **culturally-competent and well-trained behavioral health workforce.**
- Medi-Cal BH-CONNECT demonstration workforce component ($2.4 billion over five years)
- A portion of the workforce initiative may focus on providing technical assistance and support to county and contracted providers to maximize the use of peer support specialists.

New State Responsibility: Population Based Prevention

- Administered by CDPH, in consultation with BHSOAC and DHCS
  - 51% of funding must serve people 25 years and younger.
  - Early childhood population-based prevention programs for 0-5 shall be provided in a range of settings.
- Reduce the prevalence of mental health and SUD.
- School-based prevention supports and programs can be at a school site or arranged for by a school on a schoolwide or classroom basis and shall not provide services and supports for individuals.
- Population-based prevention programs may be implemented statewide or in community settings.

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BHSA Allocations: Funding Flexibility

- **Counties will have the flexibility within the above funding areas to move up to 7% from one category into another, for a maximum of 14% more added into any one category**, to allow counties to address their different local needs and priorities – based on data and community input.
- Changes are subject to DHCS approval and can only be made during the 3-year plan cycle. The next cycle is Fiscal Year 2026-2029.
- **Innovation permitted in all categories.**

Engagement with Local Government

- **Accountability:**
  - County BH Outcomes, Accountability and Transparency Report.
  - Establish metrics to measure and evaluate the quality and efficacy of the BH services and programs.
- **Quality:**
  - Establish a biennial list of evidence-based practices and community-defined evidence practices (CDEP) for EI program.
  - Full Service Partnerships (FSP) services.
- **Flexibility:**
  - Exemption processes for requesting an exemption of statutory funding percentages throughout.
- **Funding:**
  - New costs to implement law that exceed existing county obligations for inclusion in the Governor's 2024–25 May Revision; BHSA Revenue Stability Workgroup.

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Bond Guidance

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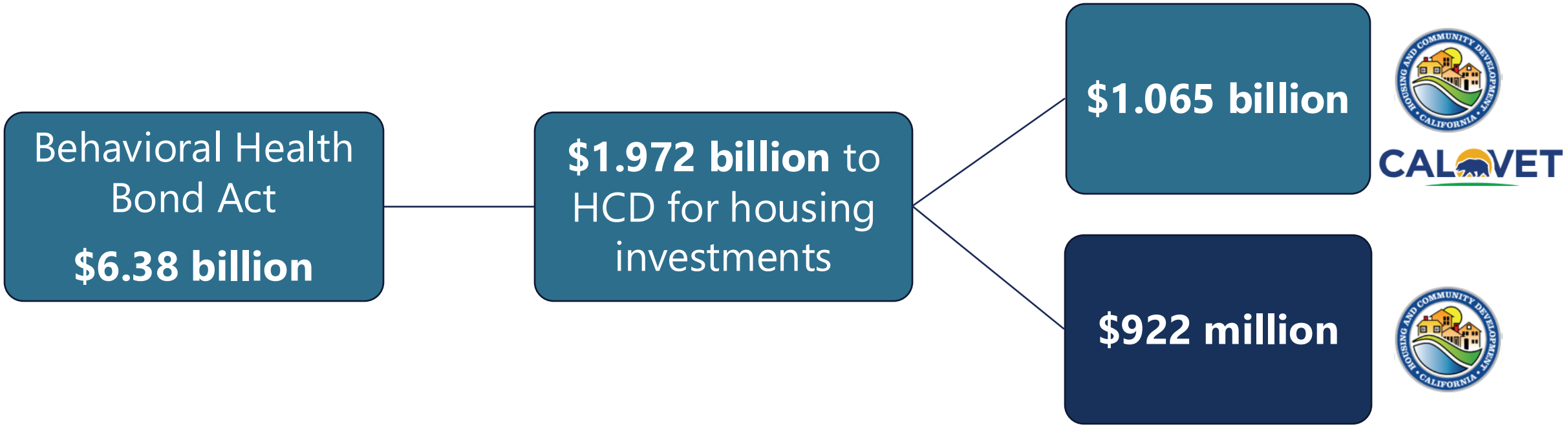
Behavioral Health Bond Act

- Behavioral Health Bond Act provides **$6.38 billion**, with up to **$4.4 billion** for competitive grants for counties, cities, tribal entities, nonprofit entities, and the private sector toward **behavioral health treatment settings**.
- Of the **$4.4 billion** available for treatment sites, $1.5 billion, with $30 million set aside for tribes, will be awarded through competitive grants **exclusively** to counties, cities, and tribal entities.
- Funds will be distributed through the current **Behavioral Health Continuum Infrastructure Program (BHCIP)**

Behavioral Health Bond Funding – Supportive Housing



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Bond BHCIP Round 1: Launch Ready

- May 14, 2024: DHCS released the **Bond BHCIP Round 1: Launch Ready**, which will provide up to **$3.3 billion** in funding for behavioral health treatment facilities statewide.
  - $1.5 billion open only to counties, cities, and tribal entities.
  - $1.8 billion open to counties, cities, and tribal entities, as well as nonprofit and for-profit organizations.
  - $30 million minimum to be awarded to tribal entities.
- A Request for Applications posted in **July 2024.**
- **Funds awarded in Spring 2025**

Eligible Facility Types – Inpatient/Residential (RFA Section 2.4) (Part 1)

- Mental Health Rehabilitation Center (MHRC)
- Acute Psychiatric Hospital
- Adolescent Residential SUD Treatment Facility
- Adult Residential SUD Treatment Facility
- Chemical Dependency Recovery Hospital
- Children's Crisis Residential Program (CCRP)
- Community Residential Treatment System (CRTS)/Social Rehabilitation Program (SRP)
- Community Treatment Facility (CTF)
- General Acute Care Hospital (GACH) for behavioral health services only

Eligible Facility Types – Inpatient/Residential (RFA Section 2.4) (Part 2)

- Peer Respite
- Perinatal Residential SUD Facility
- Psychiatric Health Facility (PHF)
- Psychiatric Residential Treatment Facility (PRTF)
- Short-term Residential Therapeutic Program (STRTP)
- Skilled Nursing Facility with Special Treatment Program (SNF/STP)
- Social Rehabilitation Facility (SRF)
- *Correctional facilities and schools are NOT eligible.

Eligible Facility Types – Outpatient (RFA Section 2.4)

- Behavioral Health Urgent Care (BHUC)/Mental Health Urgent Care (MHUC)
- Community Mental Health Clinic
- Community Wellness/Prevention Center (Tribal entities only)
- Crisis Stabilization Unit (CSU)
- Hospital-based Outpatient Treatment (outpatient detoxification/ withdrawal management)
- Narcotic Treatment Program (NTP)
- NTP Medication Unit
- Office-based Opioid Treatment (OBOT)
- Outpatient Treatment for SUD
- Partial Hospitalization Program (PHP)
- Sobering Center (funded under the Drug Medi-Cal Organized Delivery System and/or Community Supports

Encumbrance and Use Restrictions (RFA Section 2.6)

1

Applicants will be required to commit to operating services in the financed facility for a minimum of 30 years.

2

Project property assessor's parcel number(s) (APN[s]) will be encumbered with a Declaration of Restrictions and a Performance Deed of Trust for 30 years.

3

"Tribal Trust Land" applicants will **not** have a Performance Deed of Trust or Declaration of Restrictions recorded on their tribal lands.

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What's Next:

- Other Prop 1 bond construction funding **(up to $2 billion)** will be available to build permanent supportive housing (PSH) for veterans and others that are homeless or at risk of homelessness and that have mental health or substance use challenges.
  - HCD and CalVet are actively working to make applications for funding available by **late 2024**.
- The final round of Prop 1 Bond funding for behavioral health treatment sites **(up to $1.1 billion),** Bond BHCIP Round 2: Unmet Needs, will be made available in **mid-2025** from DHCS.
- All Bond funds will be awarded and put to work in communities **by 2026**.

County Behavioral Health Program Integrated Plans and Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)

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Capturing Behavioral Health Funding

- The Behavioral Health Services Act requires counties to submit three-year **integrated plans** for Behavioral Health Services and Outcomes that outline planned county activities and projected expenditures for all county mental health and SUD services funded under the following behavioral health funding streams[1]
  - Bronzan-McCorquodale Act (1991 and 2011 Realignment)
  - Medi-Cal behavioral health, including Specialty Mental Health Services, Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS)
  - Federal block grants
  - Opioid settlement funding
  - Behavioral Health Services Act

[1] 5963.02 (c)(1)

Expanded Focus of County Integrated Plan

The expanded scope for the IP will support the state in achieving the following goals:

- Collect local and aggregate information on all behavioral health services delivered statewide.
- Increase transparency and accountability in county reporting and ensure counties are efficiently using federal dollars.
- Conduct robust data analysis across counties, services, and funding streams and identify gaps in service delivery.

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Integrated Plan for Behavioral Health Services and Outcomes

	Three-Year County Integrated Plan
Purpose	Prospective plan and budget for all county behavioral health services.
Goal	Standardize data collection and reporting to increase transparency, promote stakeholder engagement, and improve local outcomes.
Frequency	Developed every three years.
Timing	First due on June 30, 2026.

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See Welfare and Institutions Code 5963.02 (SB 326 Sec. 109)

Integrated Plan Requirements Related to Local Planning Processes

Counties must consider both Managed Care Plan (MCP) and Local Health Jurisdiction (LHJ) local planning processes throughout the development of their IPs. Specifically, each county BHP must:

Work with its LHJ on the development of its **Community Health Improvement Plan** (CHIP) (5963.01.(b))

Work with each MCP that covers residents of the county **on the development of the MCP's Population Needs Assessment (PNA)*** (5963.01.(a))

Consider the CHIP of each LHJ that covers residents of the county in preparing their IP and annual update (5963.02.(b)(4))

Consider the PNA* of each MCP that covers residents of the county in preparing their IP and annual update (5963.02.(b)(3))

*SB 326 was written prior to the 2024 DHCS redesign of PNA requirements. MCPs no longer develop and submit a PNA to DHCS. Instead, beginning January 2024, MCPs must meaningfully participate in the development of LHJ CHAs and CHIPs and utilize them in their population health management initiatives.

Integrated Plan Local Review Process

The local review process for integrated plans remains in place under BHSA:

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Behavioral Health Outcomes, Accountability, and Transparency Report (BHOATR)

The Behavioral Health Services Act requires counties to submit BHOATRs to DHCS annually.

The BHOATR provides information on county adherence to their integrated plans, including reporting on actual mental health and SUD expenditures and activities undertaken during the reporting period.

DHCS will use county BHOATRs to develop a statewide BHOATR outlining activities and gaps in mental health and SUD delivery across California.

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Behavioral Health Outcomes, Accountability, and Transparency Report

- Counties will be required to **report annually** on expenditures of **all local, state, and federal behavioral health funding** (e.g., BHSA, SAMHSA grants, realignment funding, federal financial participation), unspent dollars, service utilization data and outcomes with health equity lens, workforce metrics, and other information.
- DHCS is authorized to impose corrective action plans on counties that fail to meet certain requirements.

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Local Engagement

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Effective Date

The stakeholder engagement requirements for the integrated plan become **effective January 1, 2025**, with the acknowledgement that some counties may begin (and some have already begun) preparing for the BHSA community planning process (WIC § 5963).

Key Changes

- Counties already engage in extensive community program planning and engagement with their communities under MHSA
- BHSA builds upon the MHSA requirements to meaningfully engage with stakeholders with a few key changes

Key changes to community planning process in WIC § 5963.03:

✓ Stakeholder list expanded to include Substance Use Disorder

✓ Key stakeholder groups updated to include:

- 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

Several Additional Stakeholder Groups have been added – Consult **WIC § 5963.03** for details

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Stakeholder Engagement Requirements

Counties must meaningfully engage with stakeholders on:

- The county's integrated plan (WIC § 5863.03)
- 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 Stakeholder Groups

WIC 5963.03(a)(1) Each integrated plan shall be developed with local stakeholders, including, but not limited to, all of the following:

*Newly added

Eligible adults and older adults.	Families of eligible children and **youth**, eligible adults, and eligible older adults.	Youths or youth mental health or **substance use disorder 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.	**Disability insurers.**	**Tribal and Indian Health Program designees.**	**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.**

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Community Engagement

County Behavioral Health (BH) Advisory Boards

- Must reflect the diversity and demographics of the county, additional membership to reflect modernization (e.g. + SUD perspective).
- Engages with stakeholders on 3-year plan through a 30-day comment period and public hearing.

County Integrated Plan for Behavioral Health Services and Outcomes

- Must be informed by meaningful stakeholder engagement from diverse viewpoints.
- Permits a county to provide supports, such as training and technical assistance, to ensure stakeholders have enough information and data to participate in the development of integrated plans and annual updates.
- Additional 2% (and up to 4% for small counties) of local BHSA revenue may be used to improve planning, quality, outcomes, data reporting, and subcontractor oversight for all county behavioral health funding, on top of the existing 5% county planning allotment.

BHSOAC

- New perspectives added to BHSOAC, with 27 voting members (up from 16 members).
- Administers the BHSA Innovation Partnership Fund.

DHCS's Stakeholder Engagement

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Stakeholder Engagement Overview

The Behavioral Health Service Act requires DHCS to participate in stakeholder engagement and consultation activities to support the planning and implementation of Behavioral Health Transformation

Participation: For most stakeholder engagement opportunities, topics and participation are determined by statute

Where possible, **existing forums** will be leveraged to provide opportunities for stakeholder engagement and feedback

To address all statutory requirements for stakeholder engagement and topic areas, **new forums** may be created as needed

Upcoming **Stakeholder Engagement** forums:

- **Public Listening Sessions:** gathers feedback from stakeholders/public.
- **BHSA Revenue Stability:** assess year-over-year fluctuations in tax revenues generated by BHSA, in recognition of the need for strategies for short- and long-term fiscal stability.
- **BHT Implementation Workgroup:** continues to collect feedback on various topics.

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Public Listening Session

DHCS seeks feedback from stakeholders and the public which **may be taken into consideration as DHCS continues to develop policy** and guidance related to BHT.

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Resources

Behavioral Health Transformation 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.

Public Listening Sessions

Attend public listening sessions to provide feedback on Behavioral Health Transformation-related topics. Registration links will be posted on the Behavioral Health Transformation website, along with recordings, once available.

Bond BHCIP Round 1: Launch Ready

Visit the BHCIP website to access the application and learn more.
Please send any other questions to bondbhciround1@ahpnet.com

Questions and Feedback

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

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Feedback and Discussion

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PROPOSITION 1/BH MODERNIZATION IMPLEMENTATION DISCUSSION: ACTIVITIES

1. What are BHTF members and affiliated organizations planning for education/engagement around Proposition 1/BH Transformation implementation?

Examples: CA Association of Local Behavioral Health Boards and Commissions, CA Behavioral Health Planning Council and the Mental (soon be to behavioral) Health Oversight and Accountability Commission

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PROPOSITION 1/BH MODERNIZATION IMPLEMENTATION DISCUSSION: ACTIVITIES

CA Association of Local Behavioral Health Boards & Commissions Resources

- Local Behavioral Health Board/Commission Requirements: www.calbhbc.org/legislation-mhb-wic
- Performance Outcomes: www.calbhbc.org/performance
- Stakeholder Requirements: https://www.calbhbc.org/ce
- CALBHB/C Community Engagement / Unconscious Bias Training
  - Includes: Behavioral Health Services Act 3-Year Integrated Plan requirements; cultural requirements
  - Saturday, Sept. 7, 1:00-3:30 PM (Zoom)
  - Registration: www.calbhbc.org/regla

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PROPOSITION 1/BH MODERNIZATION IMPLEMENTATION DISCUSSION: USING THE BHTF

2. How can we utilize the BHTF space to learn and engage on Proposition 1/ BH Transformation?

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CalHHS and BHTF MEMBER UPDATES

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988-CRISIS CARE CONTINUUM UPDATE

STEPHANIE WELCH, MSW, DEPUTY SECRETARY OF BEHAVIORAL HEALTH, CalHHS

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California Health & Human Services Agency

988 LIVED EXPERIENCE FOCUS GROUPS

Thank you for your emphasis on the importance of focus groups. Our team held 13 focus groups and received valuable input:

Individuals with Co-Occurring Disorders
Individuals with Co-Occurring Disorders
Individuals with Co-Occurring Disorders
Family Member Who Lost Someone to Suicide
Formerly Unhoused Individuals
LGBTQIA+ Individuals
Mothers with Children

Older Adults
Transitional Age Youth
Transgender Individuals
Rural/Elder Tribal Members
Youth Tribal Members
Urban Indian Tribal Members

CalHHS
California Health & Human Services Agency

KEY UPCOMING 988 DATES

988 5-Year Implementation Plan next steps:

- 9/18: **6th Policy Advisory Group Meeting** - review draft 5-year implementation plan
- 10/1 – 10/30: **Public comment period - We invite members of the BHTF and public to send comments to AB988Info@chhs.ca.gov**
- 11/20: **Final Policy Advisory Group Meeting** and plan review

Upcoming national events:

- National **988 Day**: 9/8
  - Toolkit available here: 988 Day Digital Toolkit | SAMHSA
- **Suicide Prevention: Month** (September), **Week** (9/8-9/14), and **Day** (9/10) - resources:
  - Suicide Prevention Resources - California Health and Human Services
  - Promote National Suicide Prevention Month - 988 Suicide & Crisis Lifeline (988lifeline.org)
  - Digital Toolkit for Suicide Prevention Month - National Institute of Mental Health (NIMH) (nih.gov)
  - Livestream Event: Suicide Prevention in Health Care Settings - National Institute of Mental Health (NIMH) (nih.gov)

Suicide Prevention (ca.gov)

CalHHS California Health & Human Services Agency

CYBHI
Children and Youth Behavioral Health Initiative

Initiative Updates

August 28, 2024

Office of Suicide Prevention

Every person and organization in California can play a role in suicide prevention.

- Learn the **warning signs of suicide, crisis resources, and how to support yourself or a friend** and familiarize yourself with the **988 Suicide & Crisis Lifeline.**
  - Never a Bother
  - Substance Abuse and Mental Health Services Administration (SAMHSA)
- Check out **how to message about suicide prevention** safely and effectively.

Did You Know? You don't have to be suicidal or in crisis to call the Lifeline.
People call to get help supporting a friend or loved one, and to talk about coping with a variety of struggles: substance use, economic worries, relationships, sexual identity, abuse, mental and physical illness, and loneliness.

Coming Soon

***Never a Bother* expansion of Caregiver Materials: Fall, 2024**

Join Us for the Next Quarterly Public Webinar

Thursday, September 12th, 2024

3:00pm-5:00pm PST

Register for the Webinar

https://cybhi.chhs.ca.gov/event/public-webinar-3/

PUBLIC COMMENTS

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CLOSING – REFLECTIONS AND NEXT STEPS

STEPHANIE WELCH, DEPUTY SECRETARY OF BEHAVIORAL HEALTH, CalHHS

CalHHS
California Health & Human Services Agency

ENGAGEMENT OPPORTUNITIES (1/2)

NEXT LUNCH AND LEARN PRESENTATION

- Population-Based Prevention in the Age of Behavioral Health Transformation – *October Date TBD*

NEXT HYBRID QUARTERLY MEETING

- **November 13, 2024**, 10 a.m. to 3 p.m.
- Population-Based Prevention Prop 1/BHT Update and Discussion (*Lead: CDPH*)

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ENGAGEMENT OPPORTUNITIES (2/2)

FOLLOW UP ON BHTF MEETING

- We welcome your feedback in the meeting evaluation:
  - Zoom attendees: see browser after you leave meeting
  - In-room attendees: watch your email inbox
- Meeting summary, recording, and materials will be posted on the Behavioral Health Task Force webpage

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Thank you!

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