BEHAVIORAL HEALTH TASK FORCE MEETING

CALIFORNIA HEALTH & HUMAN SERVICES AGENCY

August 13, 2025

CalHHS
California Health & Human Services Agency

WELCOME & INTRODUCTIONS

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

INTRODUCING NEW MEMBERS & FACILITATION TEAM

Pete Weldy

CEO, California Alliance of Child and Family Services

Facilitation Team

THIS IS A HYBRID MEETING

- The meeting is being recorded
- In-person participants: 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 participants: 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

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THIS IS A HYBRID MEETING (continued.)

- **MEMBERS OF THE PUBLIC** will be invited to participate during the public comments period at the end of the meeting.

For additional feedback, please email:
BehavioralHealthTaskForce@chhs.ca.gov

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ELEMENTS FROM BHTF GUIDELINES AND COMMITMENT TO ENGAGEMENT

- SHARE THE AIRTIME – BE BRIEF AND BRILLIANT
- STRIVE FOR AN EQUITABLE AND INCLUSIVE MANNER
- RESPECT: ACTIVELY LISTEN, INVOLVE ALL
- STAY FOCUSED ON THE AGENDA
- WORK TO REDUCE STIGMA
- THINK INNOVATIVELY AND WELCOME NEW IDEAS

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MEETING AGENDA

10:00 Welcome

10:15 Transforming Behavioral Health: Housing is Health Panel Presentations

11:45 Transforming Behavioral Health: Questions for Panel

12:30 Lunch Break

1:00 Prop 1/ BHSA Implementation and Member Discussion

2:30 CalHHS & BHTF Member Updates

2:45 Public Comment

3:00 Closing & Adjourn

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Transforming Behavioral Health: Housing is Health

Panel Presentations and Discussion

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California Health & Human Services Agency

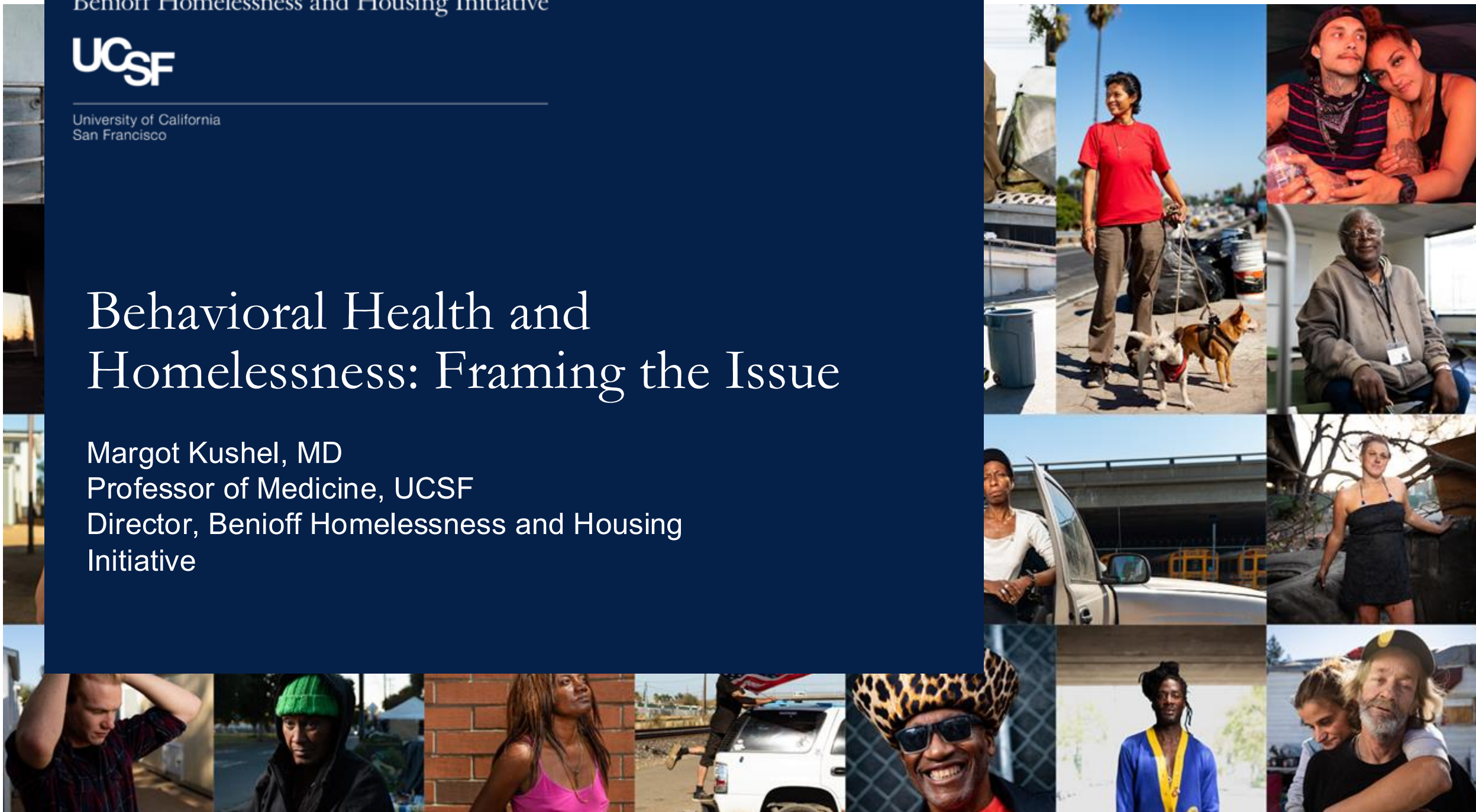
Benioff Homelessness and Housing Initiative

UCSF

University of California
San Francisco

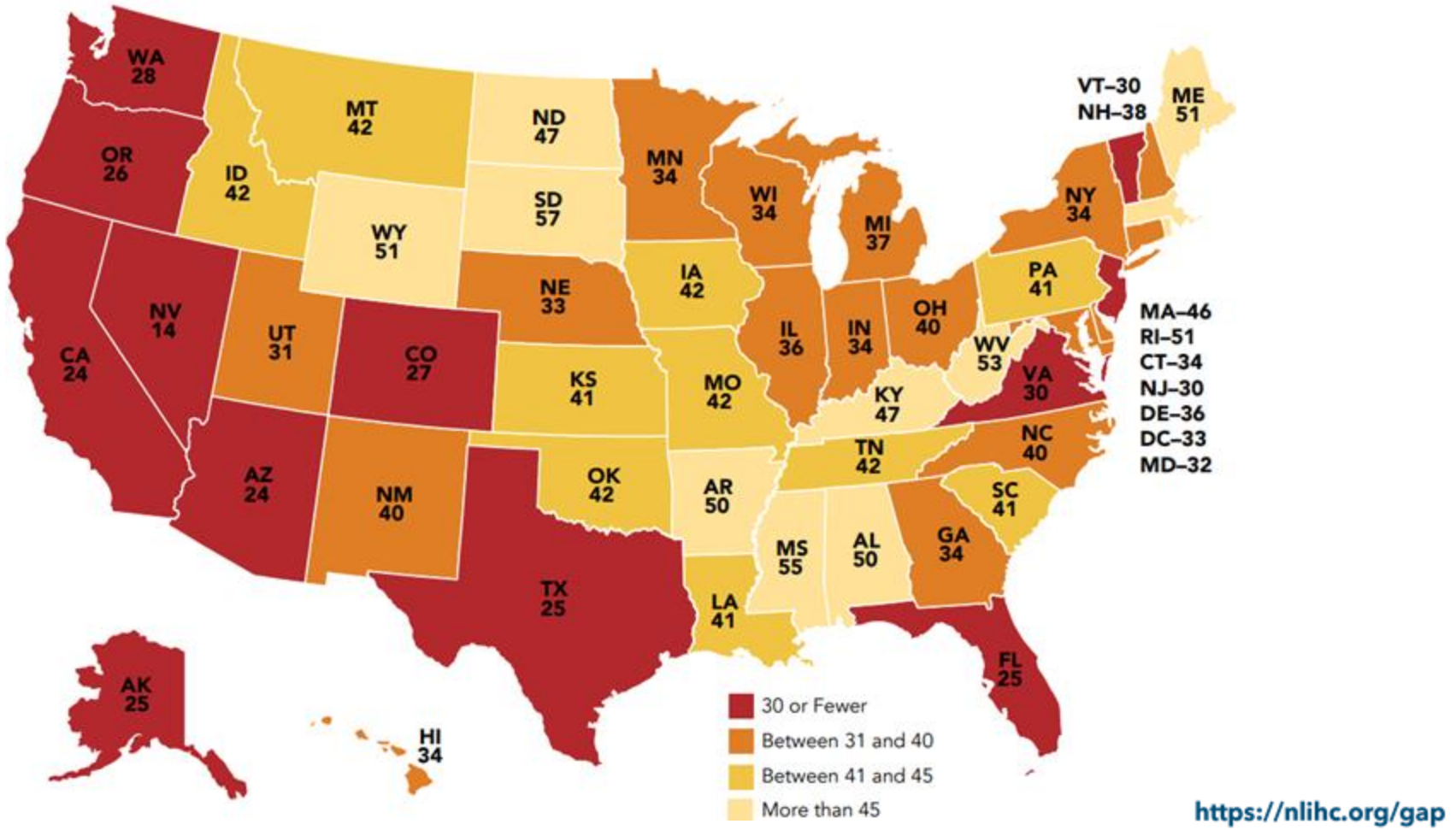
Behavioral Health and Homelessness: Framing the Issue

Margot Kushel, MD
Professor of Medicine, UCSF
Director, Benioff Homelessness and Housing Initiative



Lack of deeply affordable housing drives homelessness

No State Has an Adequate Supply of Affordable Rental Housing for the Lowest Income Renters



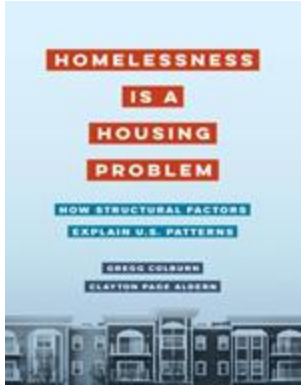
Drivers vs. Precipitants of Homelessness

Drivers: Systemic factors that create overall homelessness rates and explain the difference in homelessness rates between communities

- Lack of affordable housing
- Income inequality

Precipitants: Individual risk factors that increase the chance that any individual within a community becomes homeless

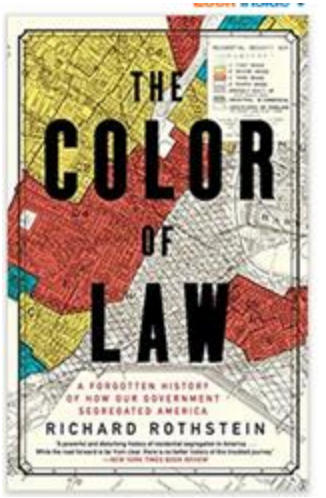
- Substance use disorders
- Mental health problems

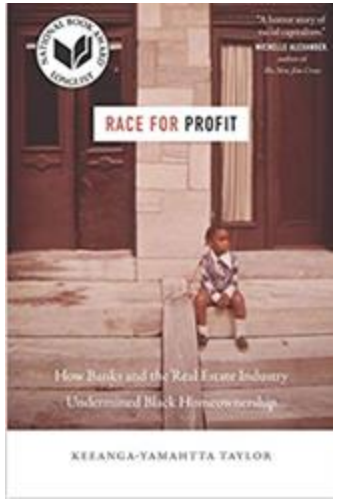


Aldern and Colburn, 2022

Homelessness is a racial (in)justice issue

- Home ownership primary means of wealth-building
- Legal discrimination in home ownership
  - Racial Covenants - segregated neighborhoods
  - Redlining - restricted access to mortgages in segregated neighborhoods
- Predatory lending
- Ongoing discrimination in rental market
- Criminal justice, employment and educational discrimination
- **Black Americans at 3 to 4 times increased risk of homelessness**






PHYSICAL AND BEHAVIORAL HEALTH PROBLEMS
TRAUMA
HOMELESSNESS

Stages of the Homelessness Response System

Toward a New Understanding

The California Statewide Study of People Experiencing Homelessness

June 2023

Benioff Homelessness and Housing Initiative

UCSF

University of California
San Francisco

Study Methods

- **8 counties** representing 8 regions (exact counties confidential)
- Target population: **Adults 18+** experiencing homelessness
- Mixed Methods—Cross Sectional
  - **3,200 questionnaires**
  - **365 paired in-depth interviews**
- English and Spanish (and interpreters)
- Community engaged practices (3 community advisory boards)

© Sam Comen

- **26%** reported a Black racial identity (vs. 7% statewide)
- **12%** reported Native American, Alaskan Native or Indigenous identity (vs. 3% statewide)
- **35%** reported a Latina/o/x identity

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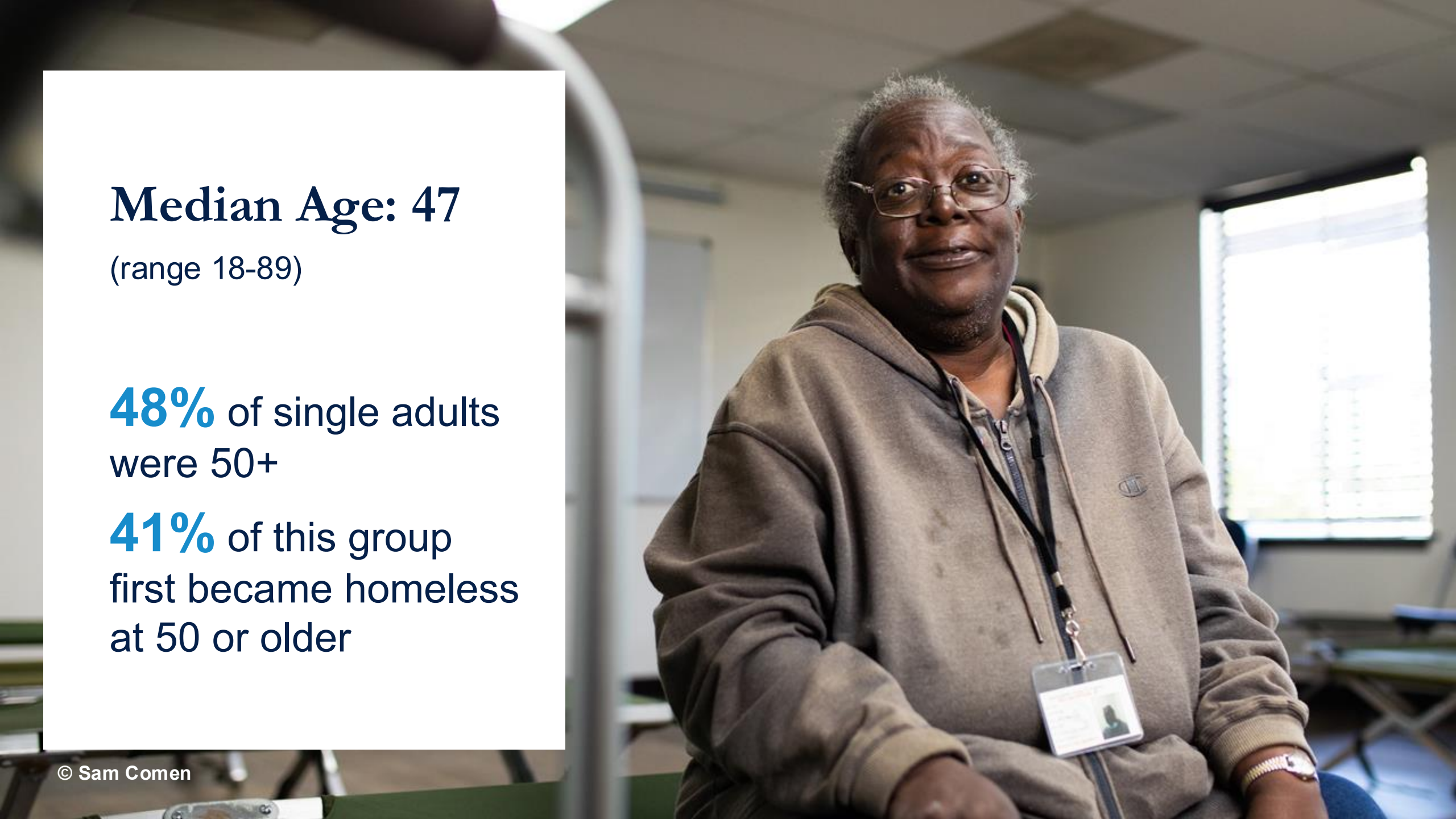
- Gender:
  - **69%** cisgender men
  - **30%** cisgender women
  - **1%** transgender/non-binary/other gender identified



Median Age: 47

(range 18-89)

48% of single adults were 50+

41% of this group first became homeless at 50 or older

© Sam Comen

Entrances into homelessness:

- **Institutional settings: 19%**
- Housed: Non-leaseholders: **49%**
- Housed: Leaseholders: **32%**

*“Most of the time we're ...running around, **trying to figure out where we're going to sleep at night** … We're not worried about going to the doctors or going to see somebody or going to get help with our mental state.”*

-CASPEH Participant

Places slept most in past 6 months:

78% Unsheltered

- 21% Vehicle
- 57% Non-vehicle

22% Sheltered

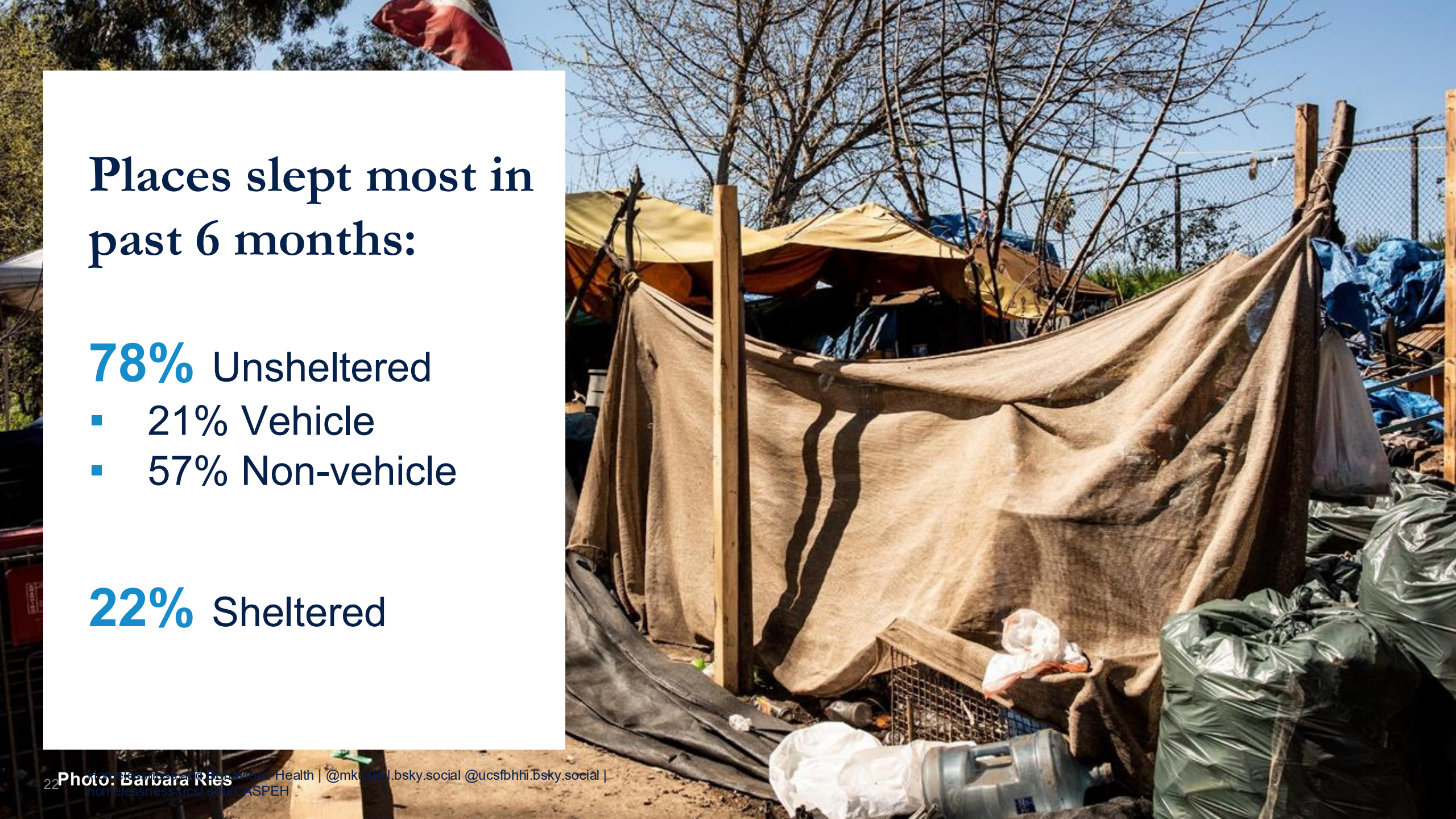


Photo: Barbara Ries

- **45%** reported poor or fair health
- **60%** had one or more chronic health condition
- **34%** reported a difficulty with an activity of daily living

In their lifetime

25% reported a PTSD diagnosis

31% attempted suicide

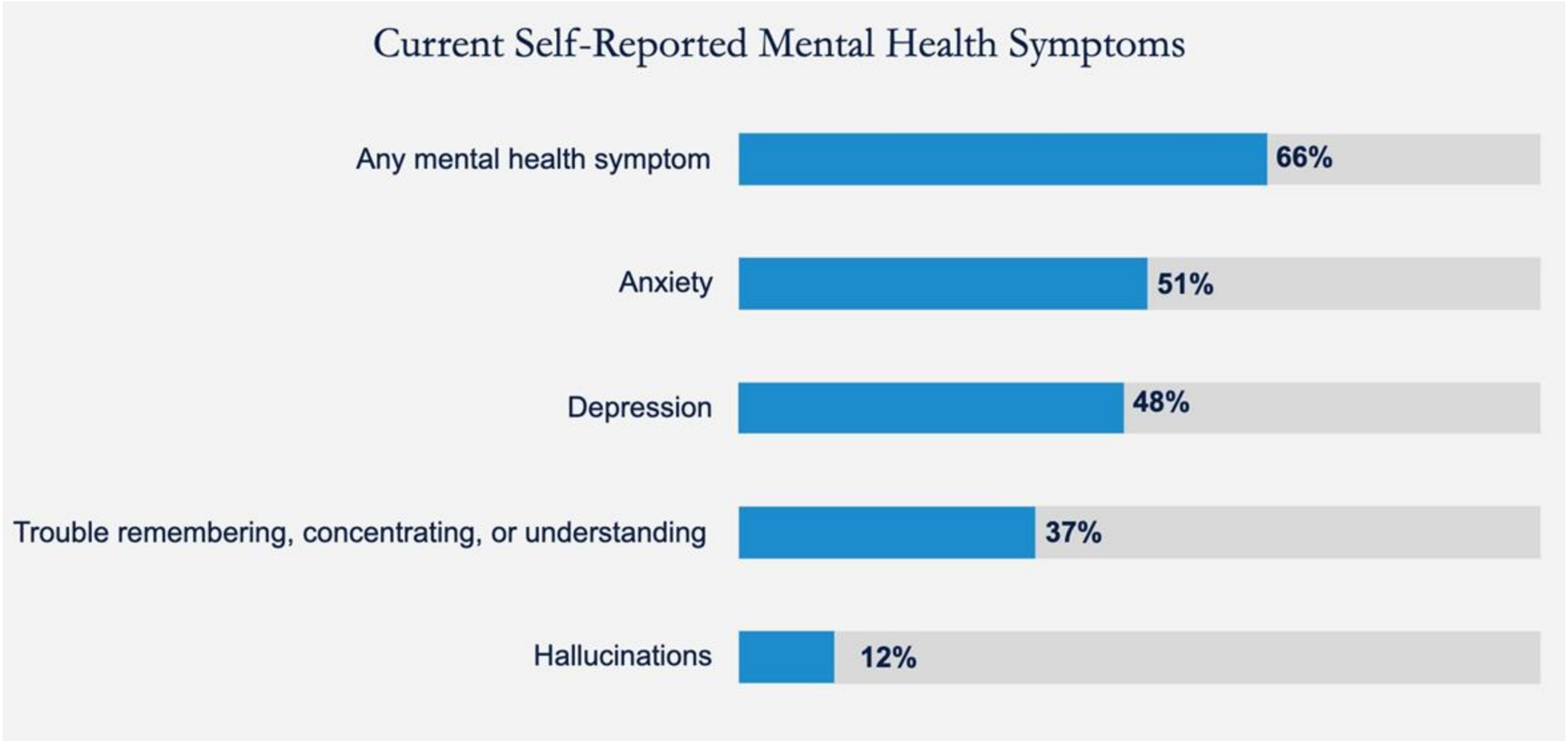
In their lifetime

27% experienced a psychiatric hospitalization

- **44%** of these experienced it after their first instance of homelessness

In the six months prior to homelessness

7% experienced a psychiatric hospitalization


Current Self-Reported Mental Health Symptoms
Any mental health symptom
66%
Anxiety
51%
Depression
48%
Trouble remembering, concentrating, or understanding
37%
Hallucinations
12%

38% experienced new or worsened mental health symptoms after becoming homeless

21% of those with mental health symptoms received any treatment (counseling or medications)

5% had an inpatient psychiatric hospitalization in the past 6 months

37% used illicit drugs 3x week or more during current episode

- 33% methamphetamines
- 10% opioids
- 3% cocaine

Assaf RD, Morris MD, Straus ER, Martinez P, Philbin MM, Kushel M. Illicit Substance Use and Treatment Access Among Adults Experiencing Homelessness. *JAMA.* February 19, 2025. doi:10.1001/jama.2024.27922

23% of all began using illicit drugs regularly after experiencing homelessness

Assaf RD, Morris MD, Straus ER, Martinez P, Philbin MM, Kushel M. Illicit Substance Use and Treatment Access Among Adults Experiencing Homelessness. *JAMA.* February 19, 2025. doi:10.1001/jama.2024.27922

*“I started, I guess you could say using, when I became homeless... meth… I would **use it to stay awake at night**. So, it’s not like I would need a fix in the daytime or nothing else."*

- CASPEH Participant

- **9%** current heavy episodic alcohol use (weekly)
- **40%** current either regular illicit drug or heavy alcohol use

Of those who reported current, regular illicit drug use or weekly heavy episodic alcohol use:

- **10%** currently receiving treatment or counseling
- **26%** wanted treatment during current episode of homelessness, but were unable to access it

Barriers to treatment included:

- ✕ Long waitlists.
- ✕ Limited availability.
- ✕ Lack of integration with housing services.

36% of all experienced physical violence during their current episode of homelessness

10% experienced sexual violence during their current episode

- 16% of cisgender women
- 35% of transgender, non-binary, or gender non-conforming participants

Approximately half perpetrated by a stranger

- **83%** were covered by some form of health insurance
  - Mostly Medi-Cal

- **52%** reported having a regular source of non-emergency department (ED) healthcare
  - **12%** through a mobile clinic or street medicine team

- **39%** no healthcare visits (outside of ED) in prior year
- **24%** reported an unmet health care need
- **23%** reported an unmet need for medication

Fields JD, Assaf RD, Nguyen KH, et al. Health Care Access and Use Among Adults Experiencing Homelessness. *JAMA Health Forum.* 2025;6(5):e250820. doi:10.1001/jamahealthforum.2025.0820

- In the past 6 months
  - **39%** visited the ED
  - **22%** had an inpatient hospitalization for physical health

Fields JD, Assaf RD, Nguyen KH, et al. Health Care Access and Use Among Adults Experiencing Homelessness. *JAMA Health Forum.* 2025;6(5):e250820. doi:10.1001/jamahealthforum.2025.0820

26% received any help from a housing navigator at least once a month in the prior six months

48% have a complex behavioral health need

- Current regular illicit drug use
- Heavy episodic alcohol use (weekly)
- Current hallucinations or
- Recent psychiatric hospitalization

Among those with complex behavioral health needs

27% entered homelessness from an institutional setting

- More than twice as likely as those without (27% versus 12%)

Those with complex behavioral health needs had longer median episodes of homelessness than those without:

24 months versus **17** months

89% of those with complex behavioral health needs had spent most of their nights unsheltered settings

68% of those without complex behavioral needs did

45% of those with complex behavioral needs reported that they had wanted, but been unable to access, shelter

66% of those with complex behavioral needs reported having a serious chronic health condition

40% of those with complex behavioral health need reported at least 1 ADL limitation

22% reported three or more

43% of those with complex behavioral need had been in ED in prior six months (compared to 31% without)

37% of those with complex behavioral needs were in jail during this episode of homelessness (compared to **22%** of those without)

57% of those with complex behavioral needs reported being "roughed up" by the police during this episode (compared with **38%** of those without)

Those with and without complex behavioral needs were equally likely to receive help from a housing navigator at least monthly in the past six months **(26%)**

What do we do?

- Primary response to homelessness is to increase the availability and affordability of housing for lowest income households…BUT

There is a critical role for healthcare in this response…

Particularly the alignment between healthcare, homelessness and housing systems

At all stages of the homelessness response system, from prevention to post-homelessness

For those with Complex Behavioral Health Needs

For those with Complex Behavioral Health Needs

- ✓ **Interrupt Institutional Exits**
  - → Carceral Settings
  - → Drug Treatment
  - → Psychiatric Hospitalizations
- ✓ **Reach People at Risk at times of crisis**

For those with Complex Behavioral Health Needs

- ✓ **Assertive Outreach**
  - → Mobile FSP teams
  - → Mobile Substance Use treatment/harm reduction
- ✓ **Low Barrier Shelter**
- ✓ **Sobering Centers**
- ✓ **Non-police crisis response**
  - → Mental Health Providers

For those with Complex Behavioral Health Needs

✓ **Higher level care**

- → IMD/Mental Health Rehab Center; SNF-STP
- → RCF/ARF
- → Assisted Living

✓ **Permanent Supportive Housing**

- → Assertive Community Treatment
- → Intensive Care Management
- → Light touch

Homelessness Prevention

Use healthcare interactions to identify and intervene for those at highest risk for homelessness

- New models can predict who is likeliest to become homeless, but hard to find them.
  - Use healthcare sites to identify people for interventions
  - Use healthcare dollars/flex pool funding for brief interventions (CalAIM Housing Transition Navigation Services)
- Prevent people leaving institutional care from becoming homeless
  - Use healthcare dollars for interventions (CalAIM short-term post hospitalization housing, community transition services)

Mitigate the Impact of Homelessness

Medi-Cal can cover crucial services for people experiencing homelessness

- Street Medicine: Provision of healthcare directly to people who are unsheltered (walking teams, medical vans, outdoor clinics)

- Enhanced Care Management: Care Manager meets clients wherever they are

Mitigate the Impact of Homelessness on Health

Provide alternative sites to reduce reliance on acute care facilities

Recuperative Care (Medical Respite): Short-term medically supported residential care for people experiencing homelessness leaving hospitals

Sobering Centers: Short-term supportive environments for those experiencing public intoxication

Improve Homelessness Exits

- Housing navigation and flexible funding reduce critical barriers to exits

- Healthcare can identify those who need assistance, direct them to help, risk stratify them

- Some people need subsidized housing with routine supports
  - PSH with routine support services
- Others need subsidized housing with intense supports
  - PSH with ICM, ACT models; PSH tailored toward medically fragile or older adults
  - If appropriately targeted and staffed, PSH can successfully house >85% of those with the most significant behavioral health issues

- A small group will require alternative models of care
  - Residential Care Facilities, Dementia Care facilities,

- The healthcare system can work alongside homelessness and housing systems to:
  - Identify who needs what level of support
  - Provide the supports
- Funding reform (CalAIM, BHSA, BH CONNECT) lower barriers to paying for the appropriate services and supports

Barriers remain

- Healthcare cannot solve this on their own
- CalAIM housing supports are one tool in a large toolkit
- Managed Care Organizations need more expertise/assistance to operationalize the potential
- Need to lower barriers for homelessness and housing sectors to collaborate with healthcare

Different individuals require different solutions.

People require different solutions at different parts of their journey.

Homelessness is preventable, if we reach the right people at the right time with the right interventions

When people are experiencing homelessness, we need a response that matches their needs

Healthcare system has important role to play, but can only operate in close partnership with homelessness and housing systems

Homelessness is solvable

BHHI gathers the data decision-makers need to end homelessness

Prevention Supports

- Shallow Subsidies
- Guaranteed Income

Data Sharing Across Systems

- COORDINATE Home

Encampment Resolution

- Berkeley RV Buyback Evaluation

Supporting Older Adults Experiencing Homelessness

- HOPE HOME
- Advance Care Planning in Permanent Supportive Housing
- HOME SAFE

How BHHI Helps Jurisdictions Improve Homelessness Responses

Prevention Supports

- **Shallow Subsidies:** Oakland Mayor's
- **Guaranteed Income:** Santa Clara Co. Office of Supportive Housing + Community Partners

Encampment Resolution

- **RV Buyback Program Evaluation:** City of Berkeley

Data Sharing Across Systems

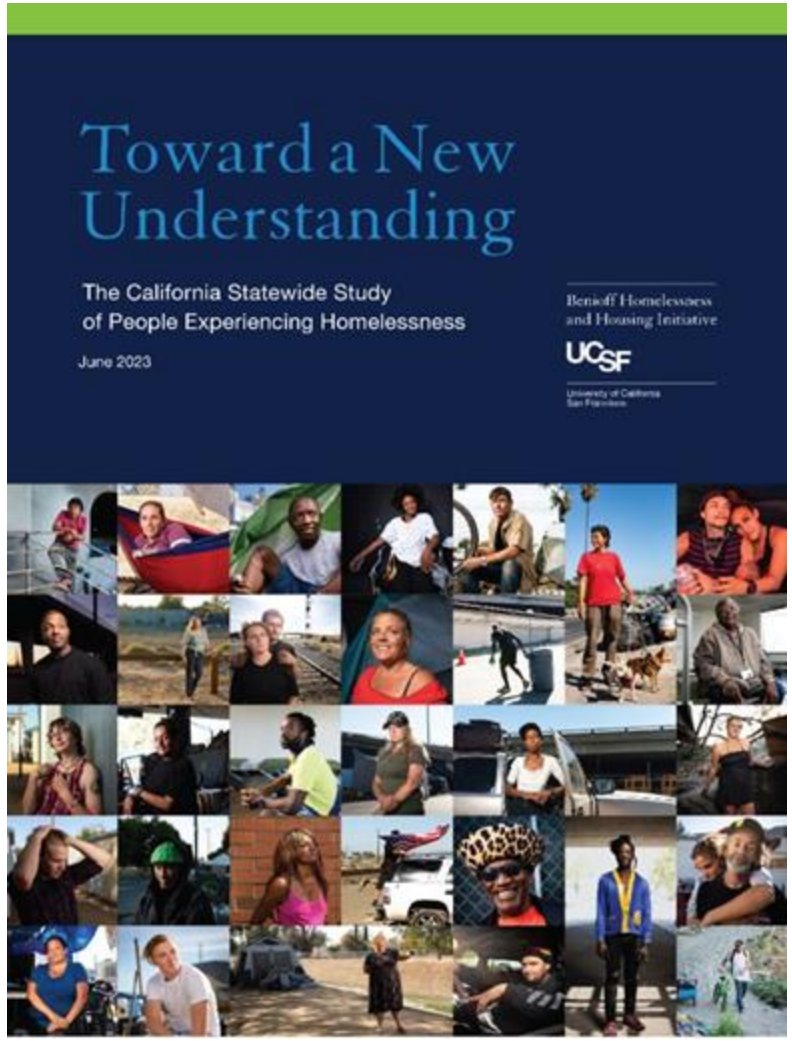
- **COORDINATE Home:** SF Depts of Public Health + Homelessness & Supportive Housing

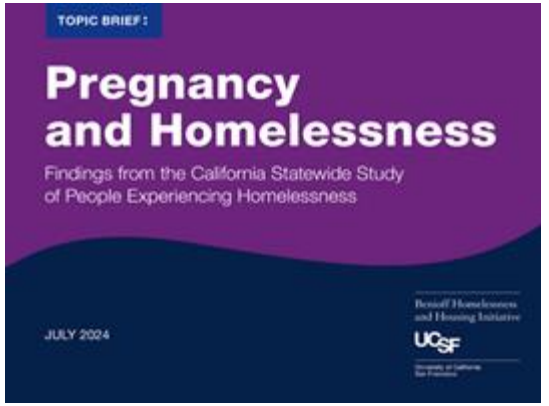
Older Adult Homelessness

- **HOME SAFE:** CDSS
- **HOPE HOME**
- **Advance Care Planning in Permanent Supportive Housing**

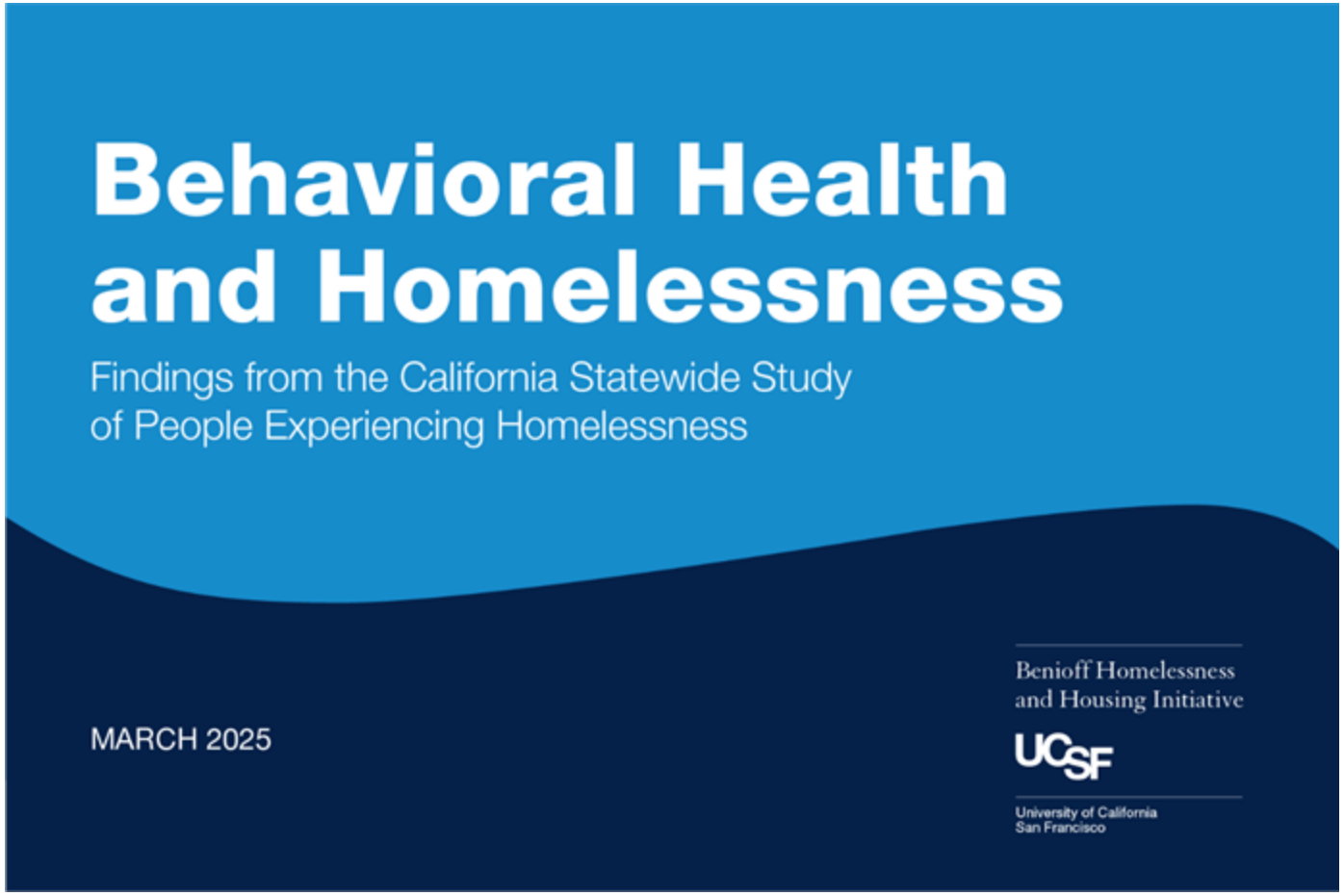
How Data Helps Solve Homelessness

- ✓ Reveals what's really going on
- ✓ Helps prioritize resources & avoid expensive mistakes
- ✓ Strengthens the case for real solutions
- ✓ **Provides a roadmap to more effective policies**





Homelessness.ucsf.edu



Access the report here

@UCSFBHHI | @MKushel | @Margot Kushel

Email

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margot.kushel@ucsf.edu

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UCSF

University of California San Francisco

homelessness.ucsf.edu/CASPEH

BHHI Newsletter

BHHI Webinars

Behavioral Health Task Force

August 13, 2025

By: Glenn Tsang, Policy Advisor for Homelessness and Housing

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

CalAIM – Transitional Rent

Housing Efforts as Part of DHCS' Medi-Cal Transformation

California is transforming Medi-Cal to improve health care quality, access, and outcomes for Medi-Cal Members.

» In 2022, California Advancing and Innovating Medi-Cal (CalAIM) introduced:

- The **Enhanced Care Management (ECM) benefit**, for the highest-risk, highest-need Members; and
- A menu of **14 Community Supports**, which are services that help improve the health and well-being of Medi-Cal managed care plan (MCP) Members by addressing their health-related social needs, supporting healthier lives, and avoiding higher, costlier levels of care.

» **Transitional Rent is the newest Community Support and will go live across California in 2026**. Transitional Rent was authorized under the BH-CONNECT* Section 1115 demonstration waiver. With this launch, California joins a number of other states in offering up to 6 months of rental assistance through Medicaid.

*BH-CONNECT = Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment

The Newest Community Supports Service: Transitional Rent

Under Transitional Rent, MCPs will cover up to six months of rental assistance for Members who are experiencing or at risk of homelessness and meet certain additional eligibility criteria.

The policies governing Transitional Rent are driven by three key objectives:

1) **Ensure a connection to long-term housing supports**, such as rental subsidies, for Members receiving Transitional Rent to provide a pathway to housing stability and prevent a return to homelessness.
2) Use the temporary housing stability afforded by Transitional Rent as an opportunity to **help Members connect to needed health care services**.
3) Minimize administrative barriers (without compromising program integrity), so that Members experiencing or at risk of homelessness can readily access Transitional Rent.

Reminder: Transitional Rent Eligibility Criteria

Eligible high-need members enrolled in a MCP may be eligible for up to 6 months of Transitional Rent if they meet the following criteria:

1

MEET CLINICAL RISK FACTORS

- Meet the access criteria for Medi-Cal Specialty Mental Health Services (SMHS), *or*
- Meet the access criteria for Drug Medi-Cal (DMC), *or*
- Meet the access criteria for Drug Medi-Cal Organized Delivery Systems (DMC-ODS) services, *or*
- Have one or more serious chronic physical health conditions, *or*
- Pregnant to 12-months postpartum, *or*
- Have physical, intellectual, *or* developmental disabilities

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2

EXPERIENCING OR AT RISK OF HOMELESSNESS (SOCIAL RISK FACTOR)

- As defined by US Department of Housing and Urban Development's (HUD's) current definition as codified at 24 CFR part 91.5, with certain modifications

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3

MEET CRITERIA FOR SPECIFIED "TRANSITIONING POPULATIONS"

- Transitioning out of an institutional or congregate residential setting, *or*
- Transitioning out of a carceral setting, *or*
- Transitioning out of interim setting, *or*
- Transitioning out of recuperative care or short-term post-hospitalization housing, *or*
- Transitioning out of foster care, *or*
- Unsheltered homeless, *or*
- Eligible for Full Service Partnership (FSP)

Transitional Rent Populations of Focus (POFs)

Under both start dates, MCPs have the option to go live with additional POFs under Transitional Rent, beyond the required BH POF for the January 1, 2026 launch.

POF 1	**Behavioral Health POF *(mandatory starting 1/1/2026)***
POF 2	Pregnant and postpartum (up to 12 months)
POF 3	Transitioning out of an institutional or congregate residential setting
POF 4	Transitioning out of a carceral setting
POF 5	Transitioning out of an interim setting
POF 6	Transitioning out of recuperative care or short-term post-hospitalization housing
POF 7	Transitioning out of foster care
POF 8	Experiencing unsheltered homelessness

Note: **Individuals who qualify for the BH POF** must meet the access criteria for Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), or Drug Medi-Cal Organized Delivery System (DMC-ODS), be experiencing or at risk of homelessness and be within a specified transitioning population OR unsheltered OR Full Service Partnership (FSP) eligible.

Behavioral Health Transformation

Behavioral Health Transformation – Prop 1

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 Bond (AB 531)

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

Behavioral Health Services Act (SB 326)

- 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

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Behavioral Health Infrastructure Bond Act

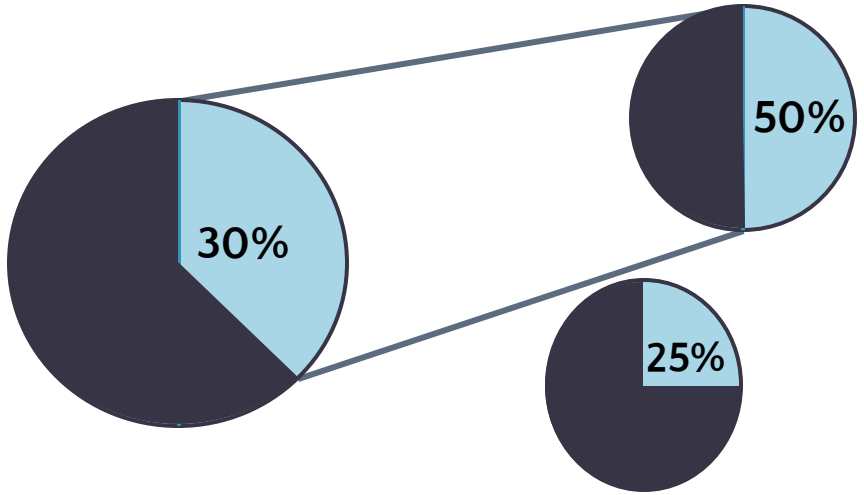
$6.38B — **Behavioral Health Bond**

$4.4B	Up to $4.4 billion for **competitive grants to build, enhance, and expand behavioral health treatment settings**.
$1.065B	Up to $1.065 billion for **housing investments for veterans** experiencing or at risk of homelessness who have behavioral health conditions
$922M	Up to $922 million for housing investments for **persons at risk of homelessness** who have behavioral health conditions

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

Housing Interventions Legislative Funding Requirements

30% of the funds distributed to counties must be used for Housing Interventions



50% of the Housing Intervention funds must be used for persons who are **chronically homeless**, with a **focus on individuals living in encampments**

Up to 25% of the Housing Intervention funds may be used for **Capital Development projects**

- Counties have the flexibility to move 7% of funds to/from Housing Interventions into another category (Full Service Partnership (FSP) or Behavioral Health Services Supports)
- Counties with a population of less than 200,000 may request an exemption from the required 30% allocation of Behavioral Health Services Act funds for Housing Interventions* (*Note: exemption process under development*

*(Section 95(1)(B)) of SB 326, Section 5892 of the WIC

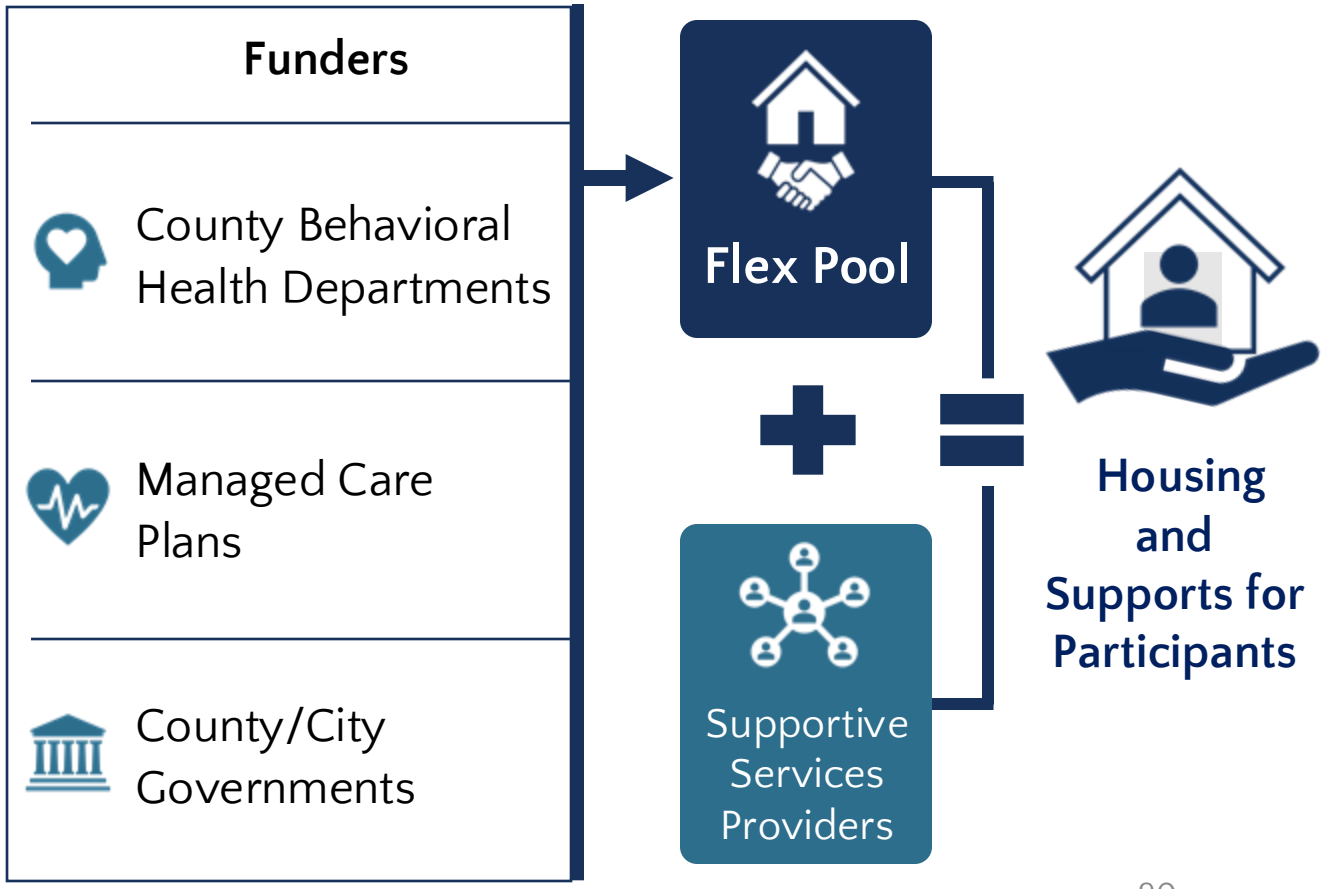
DHCS

Flexible Housing Subsidy Pools (“Flex Pools”)

New! Flexible Housing Subsidy Pools Request for Applications

DHCS encourages the development of Flexible Housing Subsidy Pools ("Flex Pools") as an effective model to streamline and simplify administering Transitional Rent and coordinating related housing supports.

- Flex Pools are a locally designed model for streamlining provision of housing supports and engaging landlords.
- **The Flex Pools RFA**, invited applicants for two opportunities in support of Flex Pools:
  1. **Participation in the Flex Pools Academy,** which offers individualized technical assistance.
  2. **$150k Planning Grants** for county behavioral health agencies and/or tribal entities to launch and operationalize a Flex Pool.
- The RFA closed on **Friday, June 13, 2025**.



California Health and Human Services Agency Behavioral Health Task Force

Jonathan Russell | Director, Housing and Homelessness, Alameda County

August 13, 2025

Alameda County Health

Alameda County Landscape

Alameda County Health
Housing and Homelessness Services

- Tenth largest CoC in the country by Point-In-Time Count
- Housing and Homelessness Services (H&H)
  - *Countywide strategic/operational and Continuum of Care lead agency/Collaborative Applicant*
  - *Situated within health agency (alongside Behavioral Health Dept.)*
  - *Close coordination with county HCD as development/capital lead*
- H&H administers MHSA-funded housing resources
  - *$22M of MHSA annually on various housing*
- Close coordination w/ local Managed Care Plan as the CalAIM intermediary for Housing Community Supports
  - *24 providers serving 2,800 people per month with CalAIM funded housing services*

Longer Stays and More Complex Needs – Unsheltered Data

- 60% of individuals reported one or more disabling condition
- 59% of individuals reported their current episode of homelessness being 36 months or more
- Housing Queue Snapshot:

Alameda County Health

Structural Drivers of Compounding Needs

System Response:
Accelerate PSH Development

System Need:
Diversify the Continuum of Housing Types

Alameda County Health

Enhanced Permanent Supportive Housing ("PSH+")

Clients must meet **both** of the following program eligibility criteria to be considered:

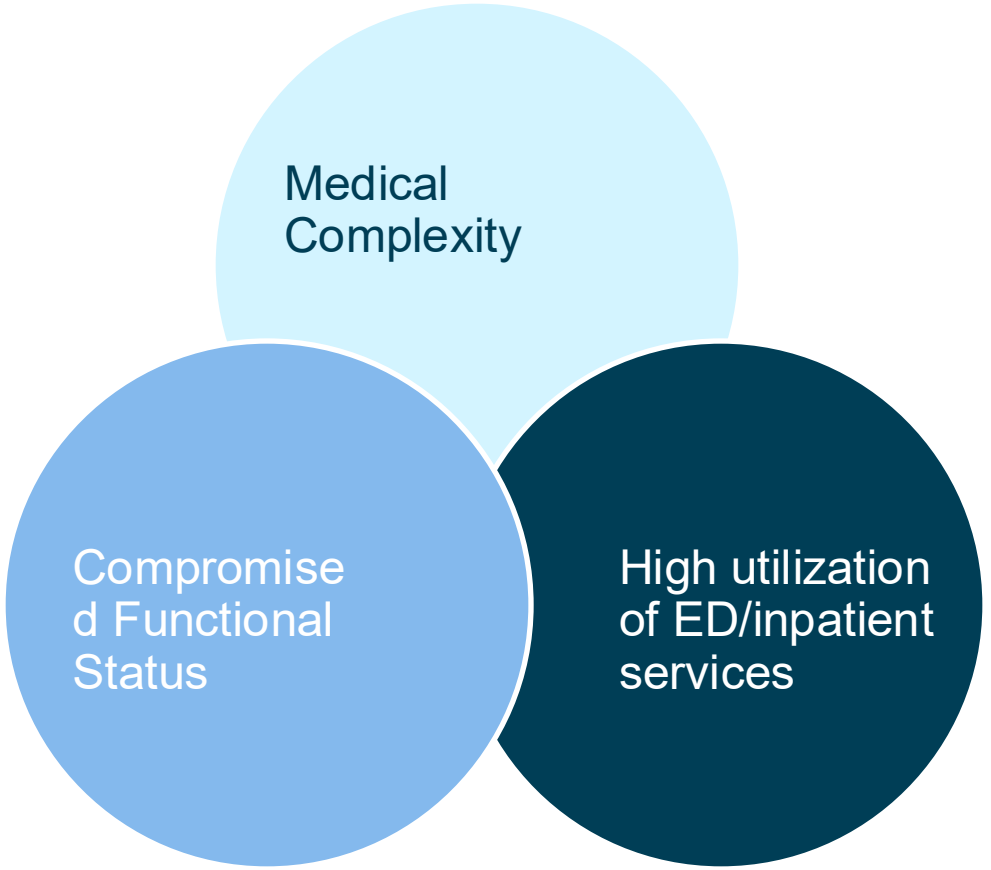
1) Homeless

2) Qualifying health condition that meets:

a) Frequent utilization of (or unmet need for) health care services, **AND**

b) Significant functional limitations, **AND**

c) Medical Complexity/Complex Chronic Illness



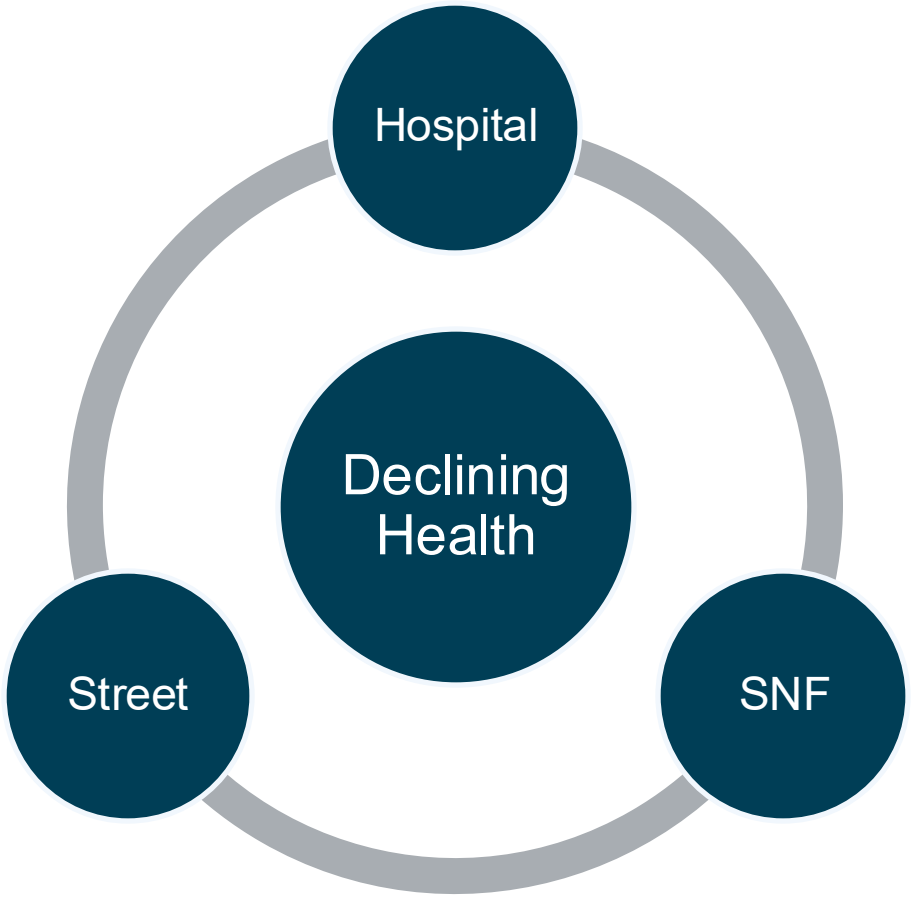
CARDEA HEALTH

Alameda County Health

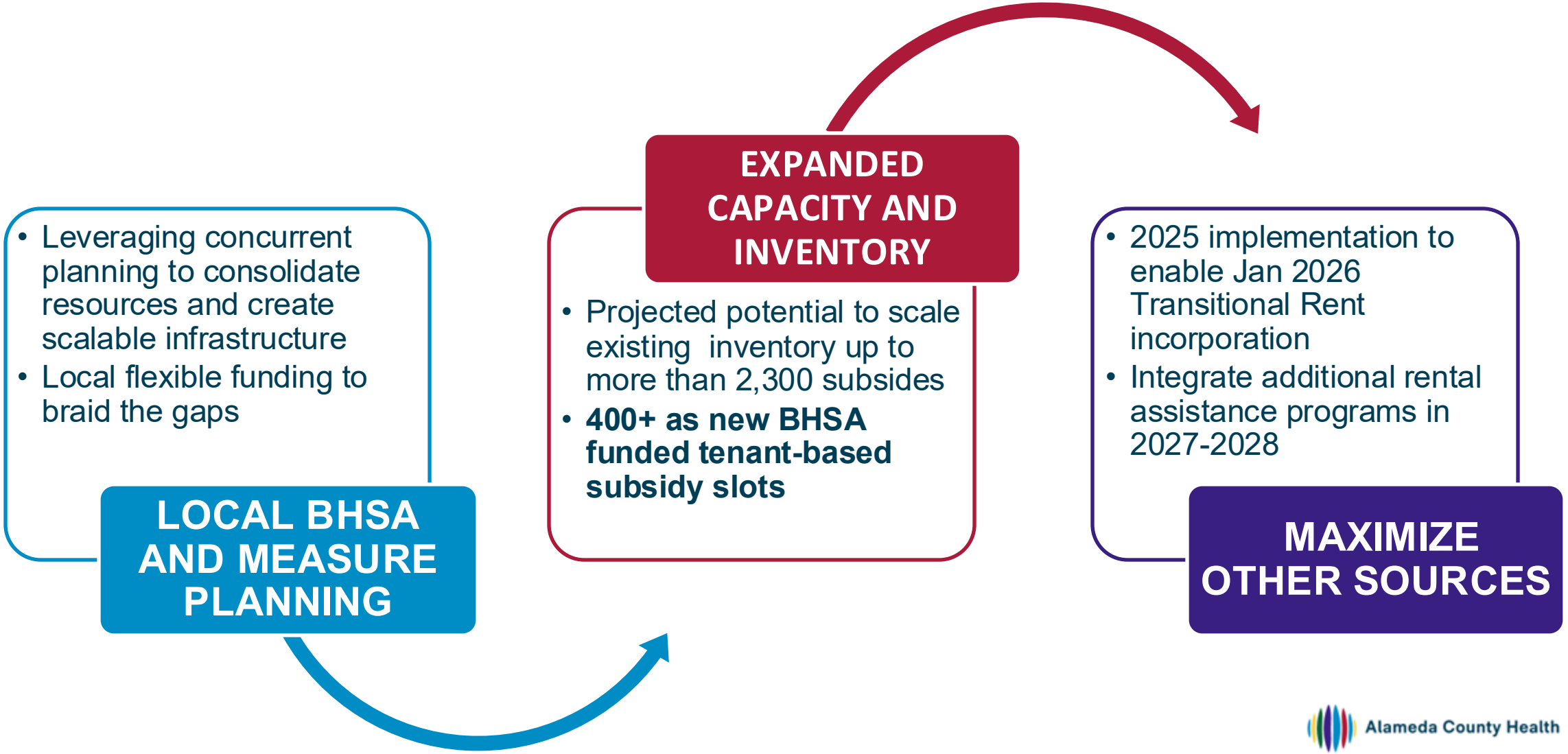
Who is this PSH+ Designed For?

Individuals with Significant Functional Limitation:

- ❑ Inability to complete Activities of Daily Living (ADLs) independently.
- ❑ Rely on assistive devices including a walker or wheelchair or are bedbound by illness or disability.
- ❑ Severe mental illness, traumatic brain injury or other cognitive disability



Housing Interventions Planning – Flex Pool



Alameda County Health

Health and Housing – The Pain and The Promise

TRANSLATION TABLES

- Health, housing, and homelessness are different languages with often exceedingly technical subdialects

FUNDAMENTAL FRAMEWORKS

- Orientations between health plans, safety nets, and housing providers potentially at odds

DIFFERENT DELIVERABLES

- Systems driven by *different needs which are met in different ways*

Alameda County Health

Nevada County Behavioral Health

Making the most of new housing resources: A small county perspective

NEVADA COUNTY
CALIFORNIA

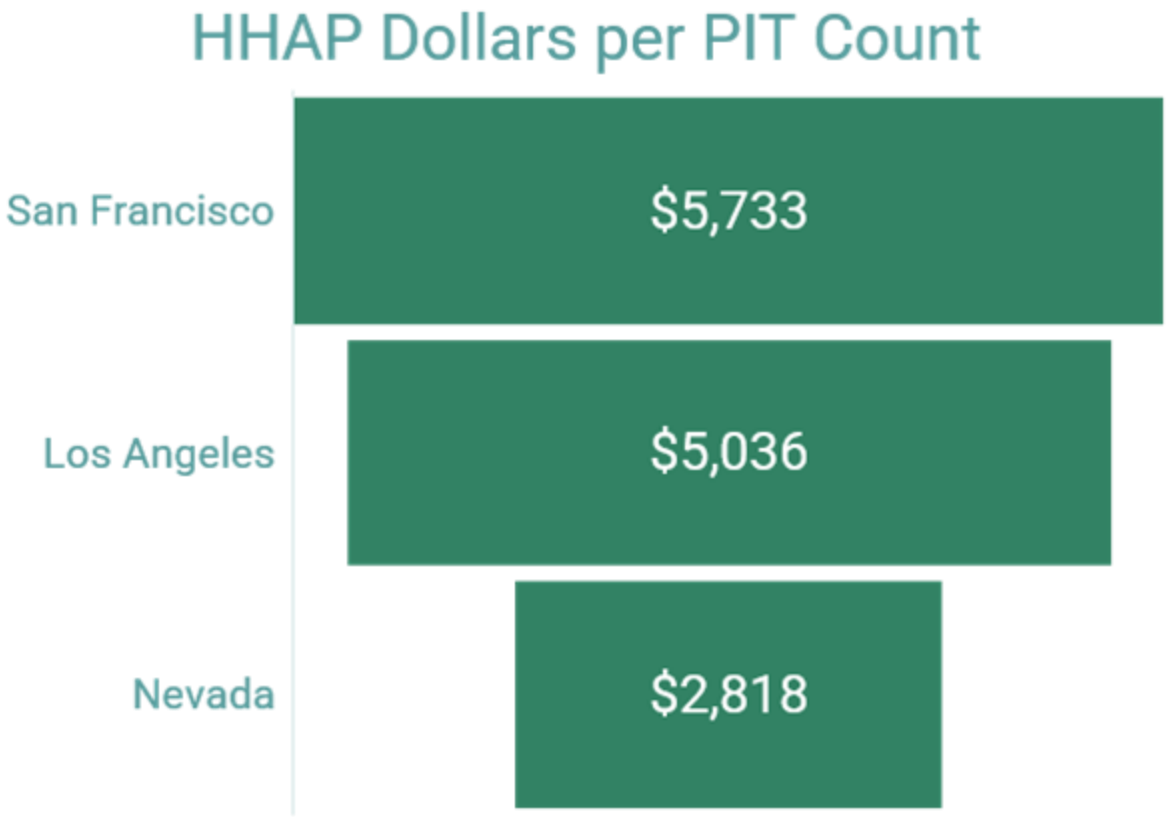
The opportunity in front of us

- Housing is critical!
- The need is unimaginable
- Treatment without housing is nearly futile
- Unprecedented resources available

Homelessness looks different in rural counties

- Less visible
- Fire risk is top concern
- More conservative communities

In addition to higher rates of homelessness, small counties get less funding



- **Significant allocations for the Big 13 cities**
- **This creates a clear role for cities that is very hard to establish in small counties**
- **Sets up significant challenges around land use and permitting issues**

Integrating homeless services, housing and behavioral health is hard!!

Different approaches	• Treatment focus versus housing focus • Risk tolerance
Different knowledge bases, data systems	• EHR versus HMIS and CES
Different funding streams	• Grants versus billable services • HCD versus DHCS

What we have been doing in Nevada County?

Type of Housing/Shelter	17/18 beds	25/26 beds (projected)
Shelter (motels)		4
Interim	4	51
Recovery residence	7	41
Respite	4	5
Permanent Supportive Housing	42	130
Other (Board and Care, etc)	2	6
Odyssey House	10	16
Total	**69**	**253**

NEVADA COUNTY CALIFORNIA | Behavioral Health

Every county is different: Evaluate specific needs and resources

- How does homelessness look in your county? Creates different pressures
- Do you have partners who can build/buy/renovate housing?
- Do you have political will and practical capacity for the county to own housing?
- What type of housing or buildable lots are available in your county?

Challenges we face as we become “housers”

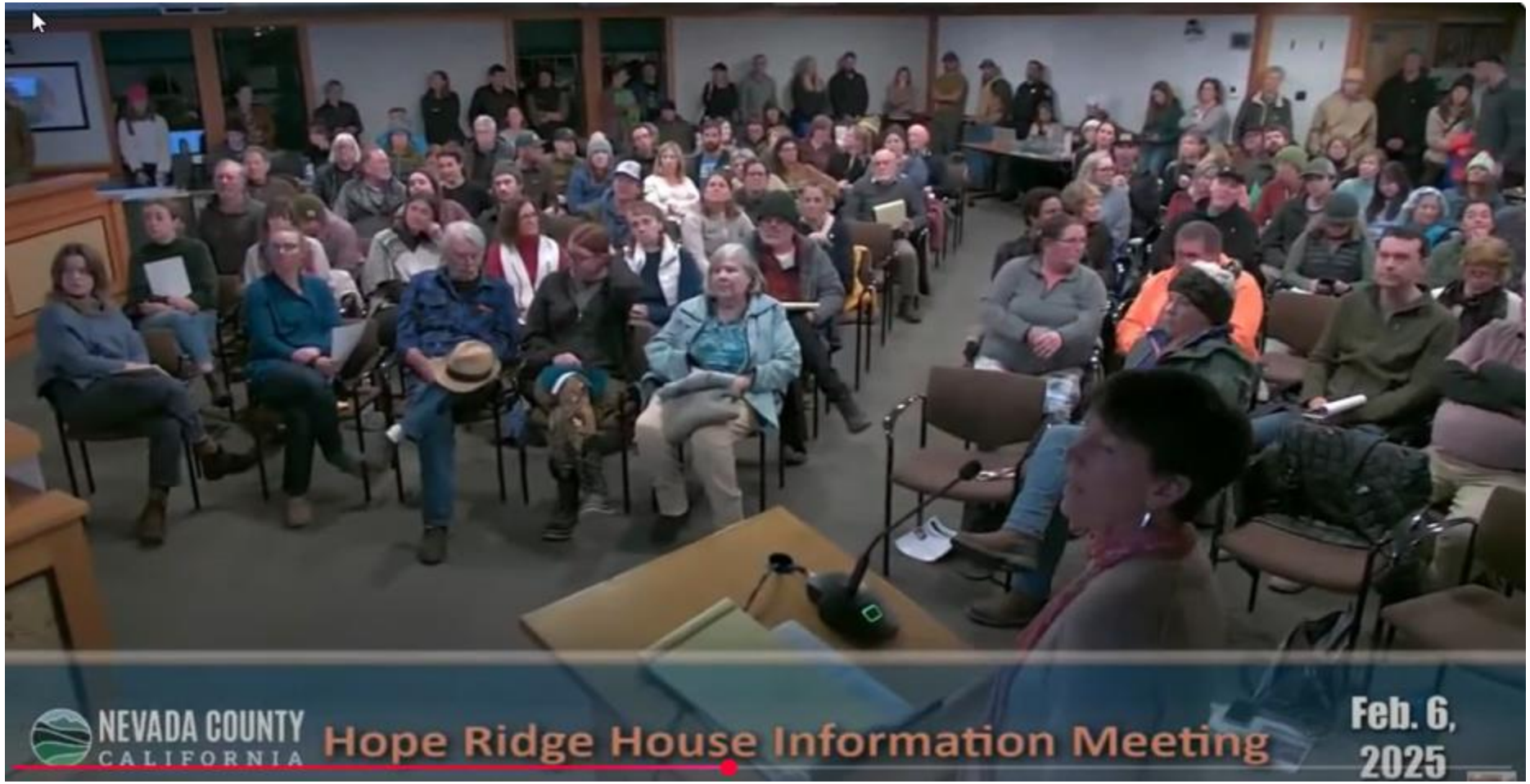
Purchasing, renovating, owning and managing a ton of facilities is hard!

- So many things we do not know!
- Lack of expertise is painful sometimes
- Capacity needed in our other departments – county counsel, facilities, purchasing etc

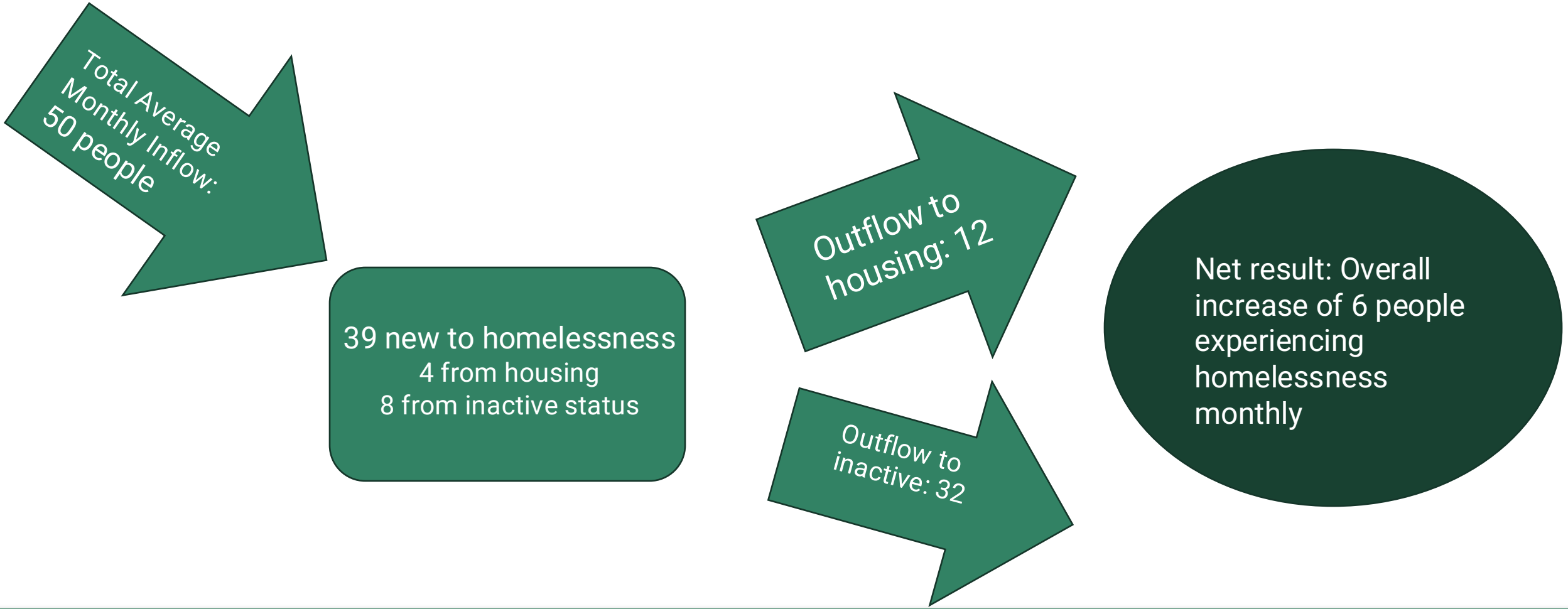
Paying for housing for the long term is expensive

- We run about $15k per year per bed overall
- Costs are offset due to vouchers in our system; unsubsidized beds cost more
- Project based vouchers are fully spent for 5+ years out
- Affording rent without subsidy is impossible for low-income people

NIMBYism is real – and in a small county, everyone knows everyone



Despite all of this work, the numbers keep rising



What does the money look like for us?

We will have about $2m per year of BHSA to spend on housing

Already fully allocated if all current projects come online

We already braid funding in our housing system, so unlikely to use flex pool approach

We are planning to become a Transitional Rent provider but only for people moving into our system of housing; we cannot guarantee month 7 for anyone else

Despite the challenges, we must aggressively pursue housing wherever we can

Transforming Behavioral Health – Housing is Health

QUESTIONS & DISCUSSION

CalHHS
California Health & Human Services Agency

LUNCH BREAK

30 Minutes

CalHHS
California Health & Human Services Agency

Proposition 1 / BHSA Implementation: Department Updates

PRESENTATION AND MEMBER DISCUSSION

CalHHS
California Health & Human Services Agency

Proposition 1/ BHSA Implementation
Topics & Speakers

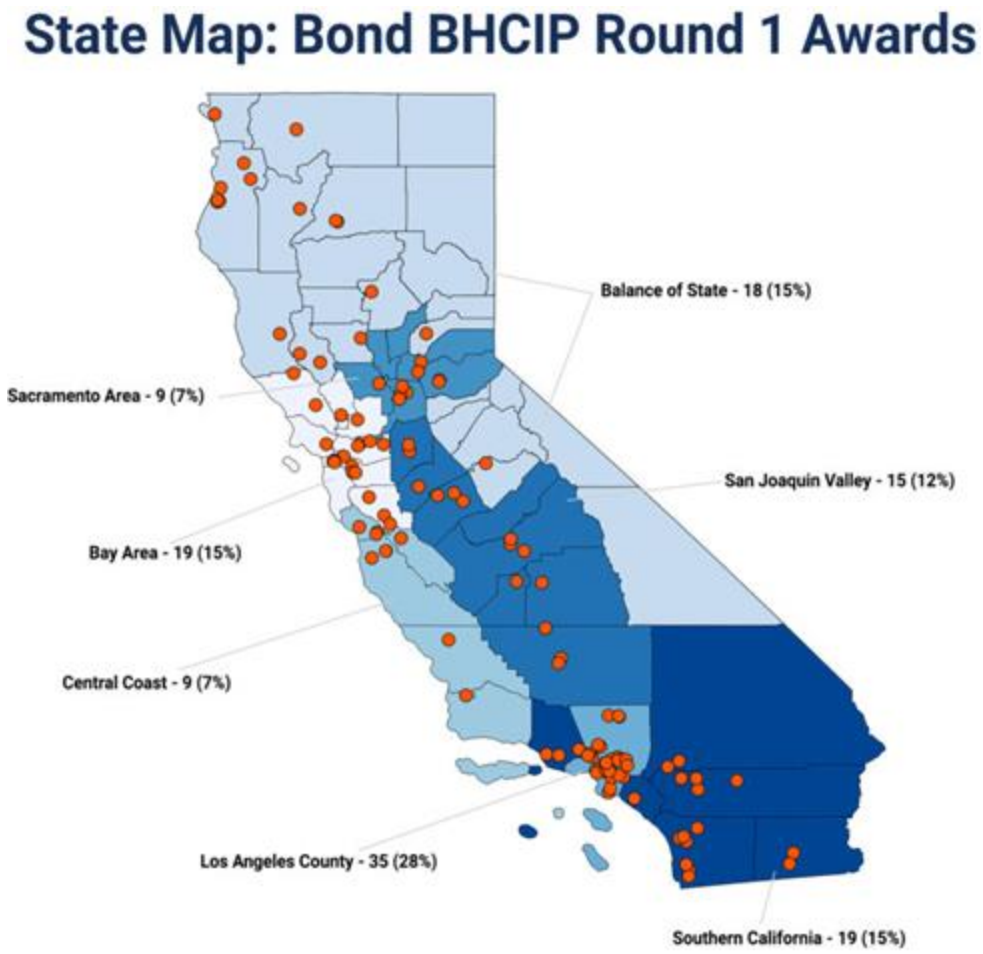
- Department of Health Care Services
- Department of Health Care Access and Information
- California Department of Public Health

CalHHS
California Health & Human Services Agency

The State's Behavioral Health Transformation –Implementation and Planning Updates

BHTF
August 2025

Behavioral Health Bond Milestones



Bond Behavioral Health Continuum Infrastructure Program (BHCIP) Round 1: Launch Ready awards released in May 2025:

- Up to $3.3 billion in grant funding
- Creates 5,077 new residential/inpatient treatment beds for mental health and substance use disorders and 21,882 new outpatient slots
- Funds 122 projects accounting for 209 mental health and/or substance use disorders facilities

Bond BHCIP Round 2: Unmet Needs (over $800 million) Request for Applications released May 30, 2025

- Applications due October 28, 2025
- Award announcements anticipated spring 2026
- Deadline to request a Pre-Application Consultation (PAC) is August 29, 2025

BHSA County Policy Manual

- Provides counties and partner organizations with **guidance necessary to implement** Behavioral Health Transformation requirements as detailed in the Behavioral Health Services Act (BHSA), **including developing draft and final County Integrated Plans.**
- Released for public comment in smaller, more manageable parts, called "**modules**"
  - Modules provide **focused, detailed guidance** on specific aspects of the overall policy, allowing stakeholders to thoroughly review and provide feedback on each section.
- Since California voters passed Prop 1, DHCS has been facilitating stakeholder engagement opportunities which inform the development of the Policy Manual and products.

Module 1

- Public comment period: Nov 8 – Dec 2
- Received 773 comments
- **Final version released February 2025**

Module 2

- Public comment period: Dec 3 – Dec 23
- Received 669 comments
- **Final version released April 2025**

Module 3

- Module 3 released for public comment on April 7-25, 2025
- Received over 1,100 comments
- **Final version released June 2025**

Module 4

- In development
- Continuing Stakeholder Engagement including Public Listening Session on Oversight and Monitoring, EBP

Final guidance available here

DHCS Quality and Equity Advisory Committee (QEAC)

Purpose: Provide DHCS with guidance and recommendations on proposed statewide population behavioral health goals (BH goals)

PHASE 1:

- Informs planning for the first Integrated Plan (IP)
- Population-level behavioral health measurement
- System planning and resource allocation
- Transparency

Measures have been **finalized** in the Policy Manual

Focus:
Resource planning and leveraged publicly available measures

PHASE 2:

- Informs planning for the Annual Updates, BH Outcomes Accountability and Transparency Report, and future IPs
- Performance measurement
- Accountability
- System planning and resource allocation
- Transparency

DHCS **began work in Q1 2025**

Focus:
Aspirational measures and blue-sky metrics that will evaluate systems-level change

Quality and Equity Advisory Committee (QEAC)

Statewide Behavioral Health Goals

- In the IPs due June 2026, counties are required to complete planning on all six priority goals and one additional goal. Each goal has 1 primary measure and 2–3 supplemental measures.

Planning and progress on these goals will require coordination across multiple service delivery systems.

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

Health equity will be incorporated in each of the BH Goals

The next QEAC meeting is on **August 19th**– you can register here

Major Milestones: Jan 2025–July 2026

2025 Q1

- DHCS released updates to the BHSA County Policy Manual.

2025 Q2

- **Bond BHCIP Round 1 awards announced** (May 2025).
- Bond BHCIP **Round 2 RFA released** (May 2025).
- DHCS released updates to the BHSA County Policy Manual, including the **Integrated Plan template.**

2025 Q3

- DHCS released the **County Portal (digital solution)** for counties to complete their Integrated Plans (August 2025).
- DHCS to launch **Training and Technical assistance (TTA)** to support counties in leveraging the County Portal to complete their draft and final Integrated Plans.

2025 Q4

- Bond BHCIP **Round 2 applications are due** to DHCS (October 28).

2026 Q1

- Counties to **submit their draft Integrated Plan** to DHCS no later than March 31, 2026.

2026 Q2

- Counties to **submit their final Integrated Plan** to DHCS no later than June 30, 2026.
- Bond BHCIP **Round 2 Award Announcements** (Spring 2026)

2026 Q3

BH-CONNECT Workforce Initiative

$1.9B in funding

The Workforce Initiative will support the training, recruitment and retention of behavioral health practitioners to provide services across the continuum of care. Updates provided on the 5 programs:

- **Medi-Cal Behavioral Health Student Loan Repayment (MBH-SLRP, LRP)**
  - Program launched successfully on **July 1**
  - HCAI hosted launch webinars on July 9 and July 10 with overwhelming interest and enrollment of 1000 people in each webinar.
  - Since the launch, HCAI has received **1,803** submitted applications with **2,067** in progress
- **Medi-Cal Behavioral Health Residency Training Program (MBH-RTP)**
  - Program launched successfully on **July 15**
    - Multiple programs are actively working on their applications
  - HCAI will host a launch webinar on July 22

BH-CONNECT Workforce Initiative

BH-CONNECT Updates

- **Medi-Cal Behavioral Health Community-Based Provider Training Program (MBH-CBPTP)**
  - Mid-July through mid-August, HCAI has hosted in-person and online stakeholder engagement sessions for training organizations of AOD Counselors (July 14,July 22) CHW/P/Rs (August 5, August 11) and Peer Support Specialists (August 4). The purpose of these engagements was to share program information and allow space for stakeholder feedback and Q&A.
  - Internal program design work has begun as of Aug 1.
- **Medi-Cal Behavioral Health Scholarship Program (MBH-SP)**
  - In Early August, HCAI will begin engaging with Institutes of Higher Education to provide program awareness and to discuss marketing amplification and payment logistics.
  - Internal program design work had begun as of July 15.
- **Medi-Cal Behavioral Health Recruitment and Retention Program (MBH-RRP)**
  - Provides bonuses, supervision support for pre-licensure and pre-certification practitioners, backfill costs for personnel in training, and certification/licensure costs aimed at personnel working in Medi-Cal safety net settings.
  - Program expected to launch Q3 2026

BHSA Funding Breakdown- Workforce

10% of total funding allocated for statewide investments. Of this amount:

Annual Funding ≈ $100M

3%

Workforce

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

BHSA Workforce- 3%

2026-2030 Workforce Education and Training (WET) Five-Year Plan

HCAI has **launched the development process for the 2026–2030 Five-Year Workforce Education and Training (WET) Plan** which identifies behavioral health workforce needs across California and informs the strategic use of funds from the Behavioral Health Services Act (BHSA) to support workforce development initiatives.

- The requirement continues under the BHSA and now includes addressing workforce needs/shortages around serving people with chronic substance use disorders.
- The **BHSA provides a 3% set-aside** to fund workforce development.

Community Engagement Plan

- HCAI has begun **hosting a series of engagement sessions** to gather insights on the behavioral health needs of vulnerable populations, including issues related to individuals with Limited English Proficiency. These sessions will also explore key workforce development topics and challenges.

The 2026–2030 Five-Year WET Plan is scheduled for publication in **Q2 2026**.

Major Milestones: Jan 2025–July 2026

2025 Q1

- HCAI held Behavioral Health Workforce Advisory Group and Health Workforce Education & Training Council to discuss BH-CONNECT and engagement.

2025 Q2

- HCAI announced CMS approval of making **Certified Wellness Coaches Medi-Cal reimbursable**

2025 Q3

- HCAI launched the **first two BH-CONNECT Workforce Initiatives**: the Medi-Cal Behavioral Health Student Loan Repayment Program and the Medi-Cal Behavioral Health Residency Training Program (July 2025)
- **HCAI** initiated **stakeholder engagement for WET Planning** that will inform the uses of Prop 1 funding

2025 Q4

- HCAI to award first cycle of **Medi-Cal Behavioral Health Student Loan Repayment Program**
- HCAI to award the first cycle of the **Medi-Cal Behavioral Health Residency Training Program**

2026 Q1

HCAI to launch **two additional BH-CONNECT Workforce Initiatives**: the Medi-Cal Behavioral Health Scholarship Program and the Medi-Cal Behavioral Health Community-Based Provider Training Program

2026 Q2

HCAI to publish final **Workforce Education and Training (WET) Plan**

2026 Q3

BHSA Funding Breakdown- Prevention

10% of total funding allocated for statewide investments. Of this amount:

Annual Funding ≈ $120-$140M

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.

At least 51% of Population-Based Prevention funds must be used for populations who are 25 years old or younger

BHSA Population-Based Prevention- 4%

Population-based prevention programs must:

- Incorporate **evidence-based practices** or promising **community defined evidence practices**
- Meet one or more of the following:
  1. Benefit the entire population of the state, county, or particular community
  2. Serve identified populations at elevated risk for a mental health or substance use disorder
  3. Aim to reduce stigma associated with seeking help for mental health challenges and substance use disorders
  4. Serve populations disproportionately impacted by systemic racism and discrimination
  5. Prevent suicide, self-harm, or overdose
- **Strengthen population-based strategies led by CDPH**

Prevention funding **cannot** be used for early intervention, diagnostic services, or treatment for individuals

Confidential - Low

BHSA Population-Based Prevention- 4%

BHSA Population-Based Prevention Program Guide

Phase 1: Provides information about the BHSA, Population-Based Prevention Program statutory requirements, statewide goals, and state level leadership and alignment activities.

- The development of Phase 1 is rooted in community input including 12 listening sessions and feedback regarding the priority goals and populations of focus reflected in the statewide prevention strategies.

Phase 2: Following a public comment process on Phase 1, Phase 2 guidance will address the operational and administrative components to execute activities to achieve intended objectives, goals, outcomes.

- Phase 2 will also be guided by community input and will include specific funding levels and implementation activities per strategy.

Confidential - Low

BHSA Population-Based Prevention- 4%

BHSA Population-Based Prevention Program Guide

Phase I and II will comprise the **Final Plan**.

- To cover the period beginning July 2026 for a three-year period (Fiscal Years 2026-2029).
- This timeline is intended to align with the 3-year County Integrated Planning effort to facilitate cross systems collaboration and supporting strategic alignment, as needed, for coordinated and complementary approaches.

The Plan will be updated regularly to clarify and provide details on the implementation of the Statewide Population-Based Prevention Program. This Plan may also be updated based on outcomes of prevention efforts or as emerging needs and issues arise.

Confidential - Low

BHSA Population-Based Prevention- 4%

Next Steps- BHSA Guide

- **By mid-July 2025**: Synthesize the outputs of a multi-stakeholder feedback process into updated BHSA prevention guidance.
- **By August 2025:** Release DRAFT Phase 2 of the CDPH BHSA Guidance for public comment.
- **By October 2025:** Finalize and release Final Plan (Phase 1 and 2).
- For ongoing stakeholder engagement after release of Final Plan:
  - Development of a formal advisory committee to support/inform continuous planning and improvement

Confidential - Low

Major Milestones: Jan 2025–July 2026

2025 Q1

- **CDPH** completed extensive planning efforts (landscape analysis, review of existing plans, listening sessions)
- **CDPH will continue community engagement** through active listening sessions, webinars and public comment through **Q4 2025**

2025 Q2

- **CDPH** released draft **Phase 1 Guide** on Prop 1 **prevention activities** (June 2025) – including webinar and public comment opportunity

2025 Q3

- **CDPH** to release draft **Phase 2 guidance** on Prop 1 **prevention activities** – to include webinar and public comment opportunity
- **CDPH** to begin planning efforts to establish formal Advisory Council (with inaugural meeting in **Q3 2026**)

2025 Q4

- **CDPH** to release final Phase 1 and 2 **Guides** on Prop 1 **prevention activities**

2026 Q1

- **CDPH** to release requirements to execute grant/funding agreements with anticipated **July 1, 2026 start date**

2026 Q2

- **July 1, 2026 – Implementation of BHSA Prevention Program**

2026 Q3

- **CDPH** to host inaugural convening of formal **Advisory Council**

Proposition 1 / BHSA Implementation: Department Updates

MEMBER QUESTIONS

CalHHS
California Health & Human Services Agency

Behavioral Health State Governmental Partner Updates

PRESENTATION AND MEMBER DISCUSSION

CalHHS
California Health & Human Services Agency

Behavioral Health State Governmental Partner Updates

Commission for Behavioral Health

Brenda Grealish, Executive Director

California Association of Local Behavioral Health Boards & Commissions

Theresa Comstock, Executive Director

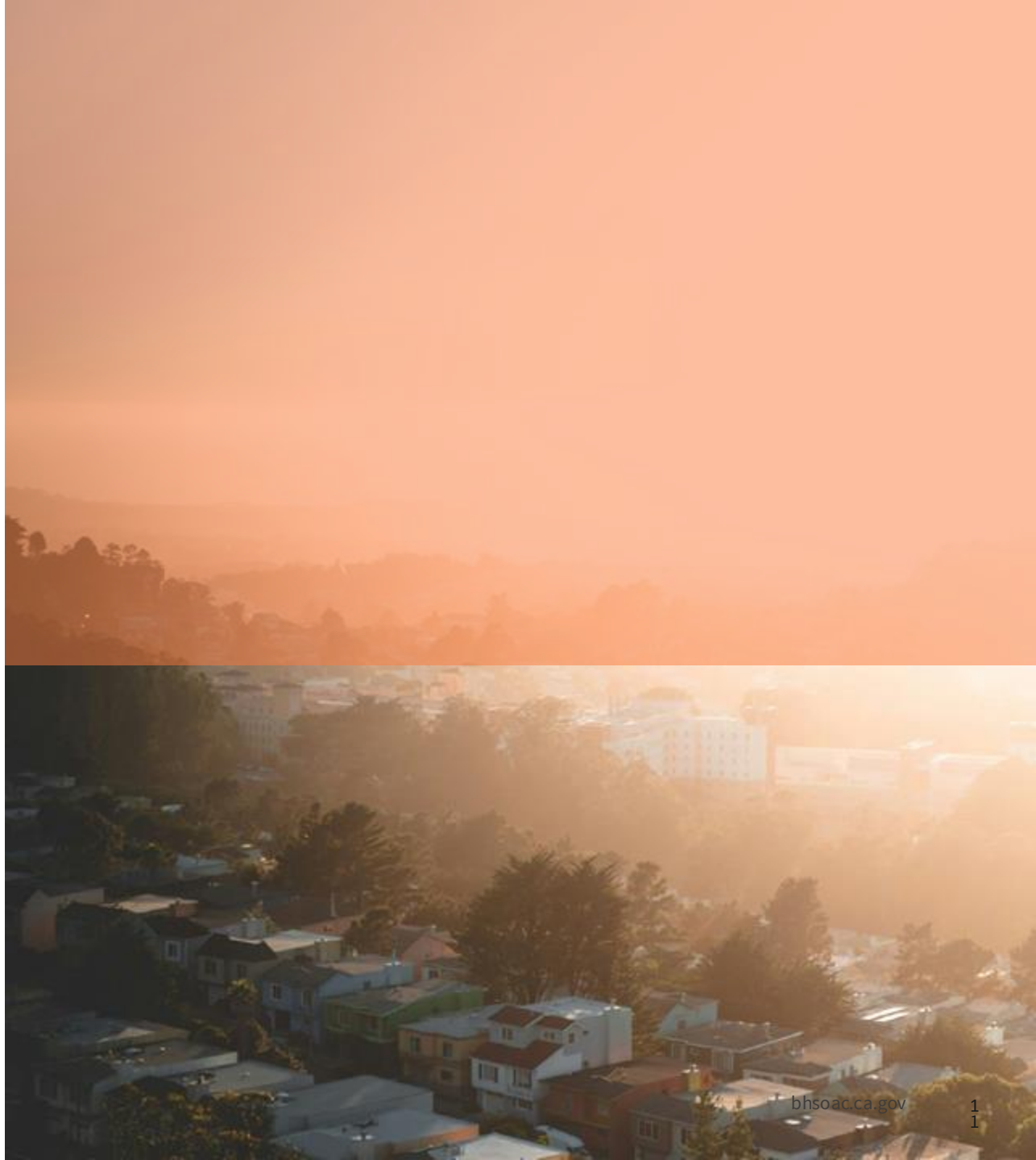
California Behavioral Health Planning Council

Jenny Bayardo, Executive Director

CalHHS
California Health & Human Services Agency

Presentation to the Behavioral Health Task Force

Presented by Brenda Grealish
Executive Director



CBH Advocacy Contracts

- **BHSA State Administrative Cap Funds Include:**

  The costs to assist consumers and family members so that the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services.

- **History of the Nine Populations**
  - 2012:
    - Gained **1) Clients & Consumers, 2) Families, and 3) Parents & Caregivers** from the Department of Mental Health.
    - Legislature added **4) Transition Age Youth.**
  - 2015: Legislature added **5) veterans, and 6) racial and ethnic minorities**.
  - 2016: Legislature added **7) LGBTQ+.**
  - 2018: Legislature added **8) Immigrants and Refugees.**
  - 2022: Legislature added **9) K-12.**

Proposal: A Community Planning Toolkit for Stakeholders

- **Idea:**
  - An accessible, inclusive plain-language guidebook to help community members participate meaningfully in the Community Planning Process in order to help shape the county Behavioral Health Services Act (BHSA) Integrated Plans.

- **Goals:**
  - Help stakeholders understand and engage in the Community Planning Process
  - Support community voice in planning and oversight
  - Promote equity, transparency, and accountability

Key Questions to Guide Development – Part 1

Understanding Barriers & Opportunities

- What challenges do stakeholders face when trying to participate in county planning processes?
- What kinds of information or tools would help your community partners show up more prepared, confident, and effective?

Designing Meaningful & Usable Content

- What information is most critical to help stakeholders understand and engage in this process?
- What formats would be most useful or accessible?
- How do we balance detail and usability?

Key Questions to Guide Development – Part 2

Ensuring Accessibility & Inclusivity

- How do we ensure the toolkit is accessible and easy to understand for all individuals?
- How do stakeholders needs, roles, and level of experience vary?

Implementation & Evolution

- What strategies would help us get this toolkit into the hands of those who need it most?
- How can we make sure the toolkit stays useful over time; what should feedback and update processes look like?

Behavioral Health State Governmental Partner Updates

Theresa Comstock

Executive Director, California Association of Local Behavioral Health Boards & Commissions

CalHHS
California Health & Human Services Agency

BHSA Community Planning

Training	
15 Minute Modules Community Planning Funding Categories	**Presentations** Community Planning Unconscious Bias
Requirements Cultural Requirements Stakeholder Requirements	**Resources** Listening Session Toolkit Tools (DHCS List)

calbhbc.org/training | calbhbc.org/ce

California Association of Local Behavioral Health Boards and Commissions

BHSA Community Planning

Listening Sessions

Recommended Components

Facilitator Guidelines

Conduct & Person-First Language

Form (Sample)

http://www.calbhbc.org/listening-session

California Association of Local Behavioral Health Boards and Commissions

BHSA Community Planning

TOOLKITS

Children & Youth CA Alliance, First 5, Children Now, The Children's Partnership	**Local BH Boards/Commissions** CA Association of Local Behavioral Health Boards/Commissions (CALBHB/C)
County Staff CalMHSA CALBHB/C	**Older Adults** CA Department of Aging Recording | Presentation | Toolkit by County

CCBH | California Coalition for Behavioral Health

www.cabehavioralhealth.org/bhsa

California Behavioral Health Planning Council

ADVOCACY • EVALUATION • INCLUSION

Jenny Bayardo

Executive Officer

ABOUT THE COUNCIL

California Behavioral Health Planning Council
ADVOCACY · EVALUATION · INCLUSION

The California Behavioral Health Planning Council (CBHPC) is a majority Consumer and Family member advisory body to state and local government, the Legislature, and residents of California on mental health services in California.CBHPC consists of thirty-two members appointed by the DHCS including consumers, family members, providers, and eight state department representatives.

Federal Mandates	•Public Law 102-321 re-authorized
State Mandates	•Welfare Institutions Code (WIC) 5772., 5820., 14045.17., 5514.

VISIT OUR WEBSITE

- **Visit the CBHPC Main Page:**
  https://www.dhcs.ca.gov/services/MH/Pages/CBHPC-PlanningCouncilWelcome.aspx

- **Behavioral Health Transformation Webpage:**
  https://www.dhcs.ca.gov/services/MH/Pages/Behavioral-Health-Transformation.aspx

- **Integrated Plans Webpage:**
  https://www.dhcs.ca.gov/services/MH/Pages/Integrated-Plans.aspx

California Behavioral Health Planning Council
ADVOCACY · EVALUATION · INCLUSION

Supporting the Local Planning Process

MEMBER QUESTIONS AND DISCUSSION

BHTF MEMBER UPDATES

DISCUSSION

PUBLIC COMMENTS

CalHHS
California Health & Human Services Agency

CLOSING – REFLECTIONS AND NEXT STEPS

STEPHANIE WELCH, DEPUTY SECRETARY OF BEHAVIORAL HEALTH, CalHHS

ENGAGEMENT OPPORTUNITIES (1/2)

FUTURE 2025 QUARTERLY MEETINGS

All Meetings are hybrid, 10 a.m. to 3 p.m.

- November 12th

Lunch & Learn Presentations between meetings – to be announced

CalHHS
California Health & Human Services Agency

ENGAGEMENT OPPORTUNITIES (2/2)

FOLLOW UP ON BHTF MEETING

- We welcome your feedback in the meeting evaluation!
  - Zoom participants will see a survey
  - Emailed survey for those in-room
- Recording will be posted on the BHTF Website at: Behavioral Health Task Force webpage

CalHHS
California Health & Human Services Agency

Thank you for joining us today!

For information about the Behavioral Health Task Force, please visit the CalHHS website at https://www.chhs.ca.gov/home/committees/behavioral-health-task-force/

CalHHS
California Health & Human Services Agency