WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

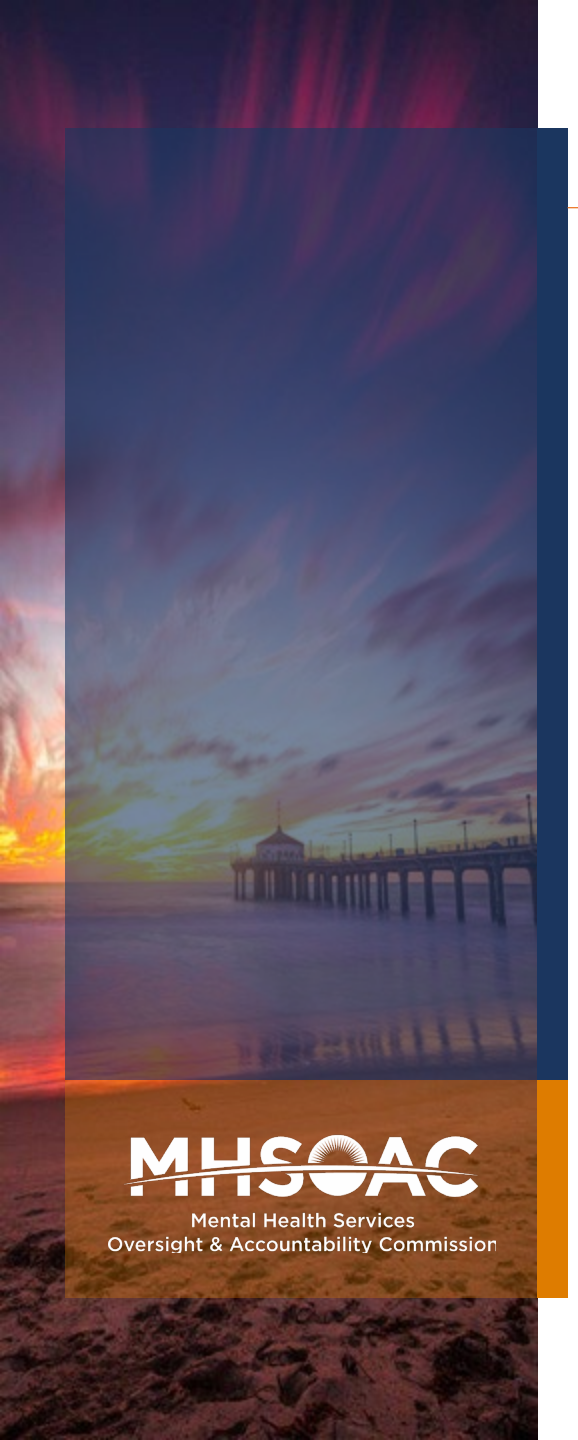
Commission Meeting
July 25, 2024
Presentations and Handouts

Agenda Item 6:	•Presentation:	California's FY 2024-25 State Budget Overview
Agenda Item 7:	•Presentation:	Robust Data Systems Needed for California's Child Behavioral Health
	•Presentation:	Behavioral Health Transformation Transparency and Accountability
	•Presentation:	Transformational Change in Behavioral Health: Listening and Building Trust and Creating Trustworthiness are Front and Center
Agenda Item 9:	•Presentation:	Proposition 1 Implementation: Exploring Commission Opportunities
	•Handout:	MHSOAC Proposition 1 Implementation: Exploring Commission Opportunities - Reference Guide

MHSOAC
Mental Health Services
Oversight & Accountability Commission

California's FY 2024-25 State Budget Overview

July 25, 2024



Enacted California State Budget FY 2024-25

Budget solutions for 2024-25 include:

- **$16 billion** in spending reductions.
- **$13.6 billion** from additional revenue (mostly temporary) and internal borrowing.
- **$6 billion** in fund shifts, which move general fund costs to other state funds.
- **Nearly $6 billion** in withdrawals from the Budget Stabilization Account (rainy day fund) and Safety Net Reserve.
- **3.1 billion in funding delays.** Food assistance for undocumented Californians is being delayed for two years, as well as a wage increase for people who provide disabilities services for six months.
- **$2 billion in deferrals.** One month of state employee payroll costs will be shifted from June 2025 (the last month of the 2024-25 fiscal year) to July 2025 (the first month of the 2025-26 fiscal year).

Enacted California State Budget FY 2024-25

Revenue Solutions

- Budget solutions include a temporary increase in state revenues, which helps to avoid more harmful service cuts, but will also reduce revenues in the future.

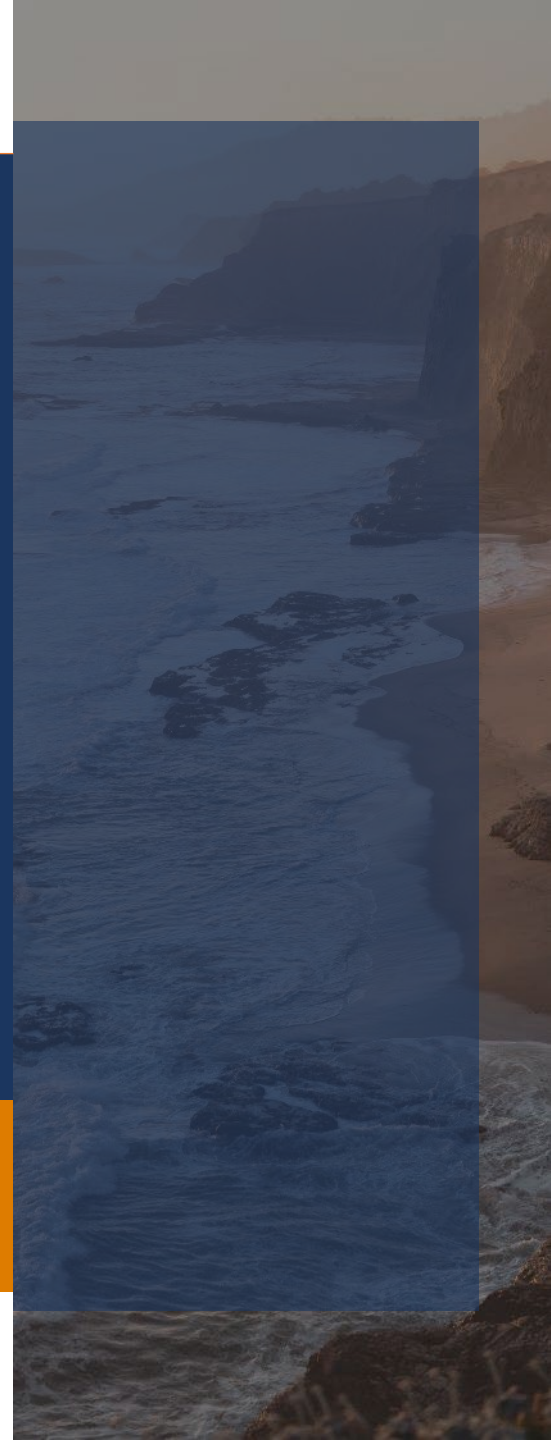
State Operations

- Reducing state operations spending tied to vacant positions, for General Fund savings of $762 million in 2024-25. As part of his state budget for 2025-26, the governor must propose permanent elimination of vacant positions, cutting state operations spending by up to an additional 7.95%, for general fund savings of $2.2 billion in 2025-26. Savings will be achieved through operational efficiencies and other cost-reduction measures on top of the cut to vacant positions. These reductions would equal roughly 10% of total

Impact on critical programs and services

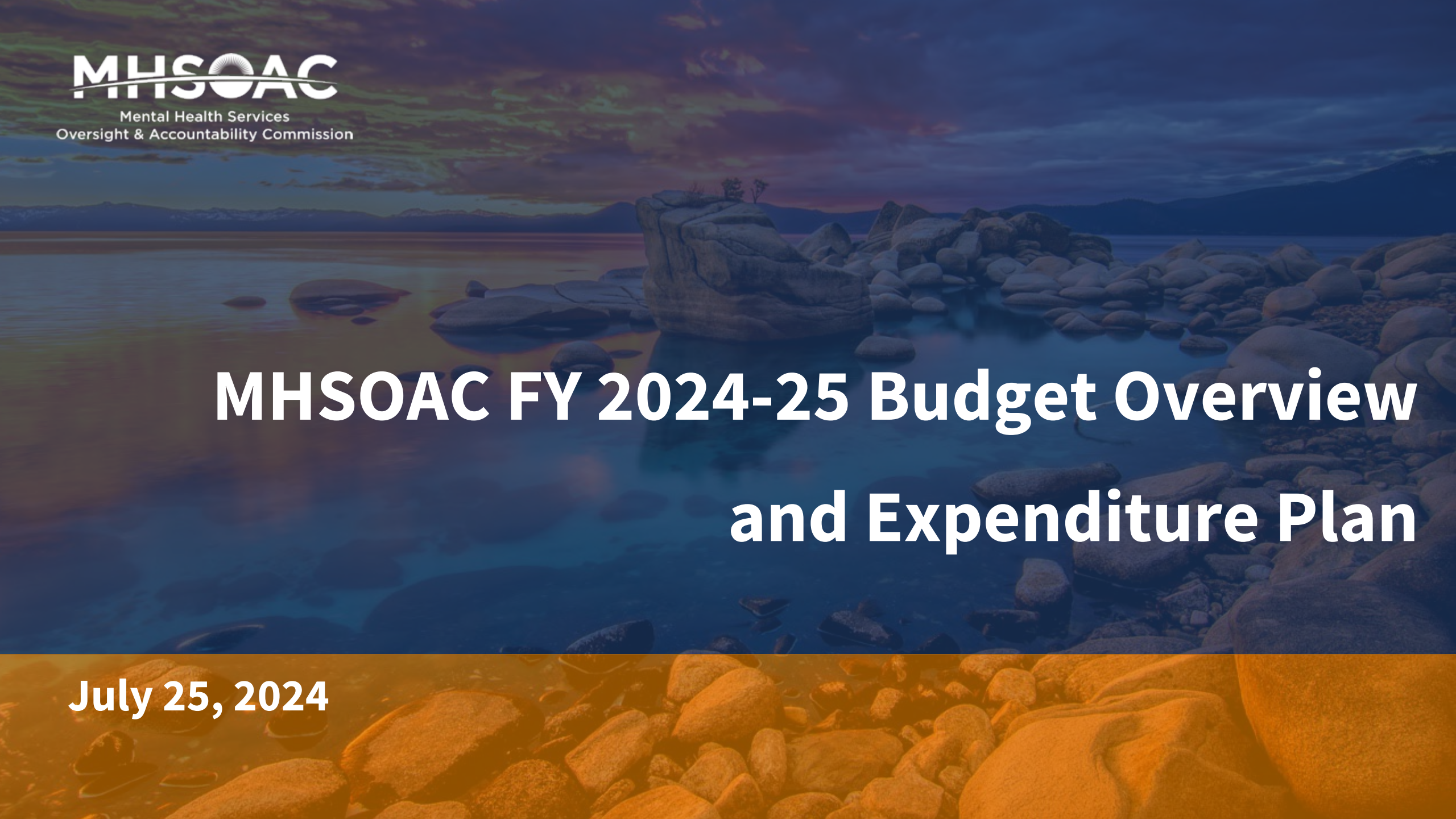
Budget agreement rejects many harmful cuts to critical programs.

- The budget agreement preserves the expansion of Medi-Cal eligibility for undocumented adults ages 26 to 49 as well as In-Home Supportive Services (IHSS) for undocumented Californians.



What happens next?

- Budget decisions are made all year round, not just during the month of June. As part of the 2024-25 budget package, the governor and legislative leaders will pass additional trailer bills in August and possibly amend the 2024 Budget Act.



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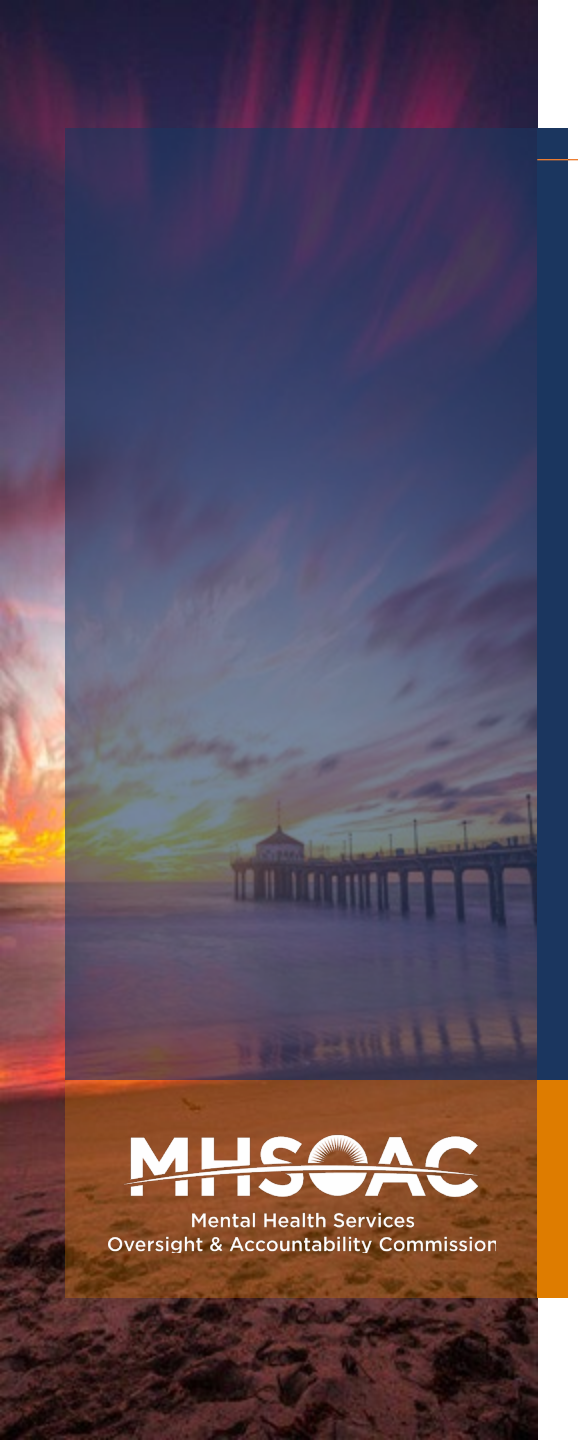
MHSOAC FY 2024-25 Budget Overview and Expenditure Plan

July 25, 2024



MHSOAC Budget Overview

2023-24	2024-25
$118.6 Million	$48.8 Million

August 24, 2023
- Budget Approved

January 25, 2024
- Mid-Year Update

July 25, 2024
- Final report

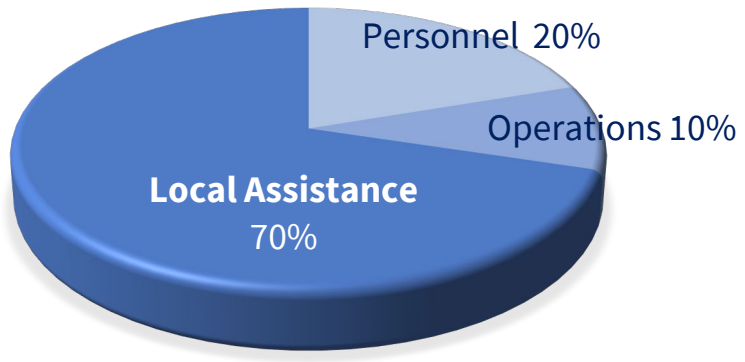
July 25, 2024
- Presented for Approval

January 23, 2025
- Mid-Year Update

July 24, 2025
- Final report

MHSOAC Current Year Budget Expenditure Plan

Fiscal Year 2024-2025	Proposed Budget
Operations	
Personnel	$9,697,000
Core Operations	$2,910,000
Commission Priorities	
Communications	$60,000
Research	$1,075,000
Budget Directed	
Evaluation of FSP Outcomes (SB 465)	$400,000
Prop 1 Implementation	$100,000
Local Assistance	
Mental Health Wellness Act	$20,000,000
Mental Health Student Services Act	$7,606,000
Community Advocacy	$6,700,000
Held for Reserve	$250,000
TOTAL	**$48,798,000**

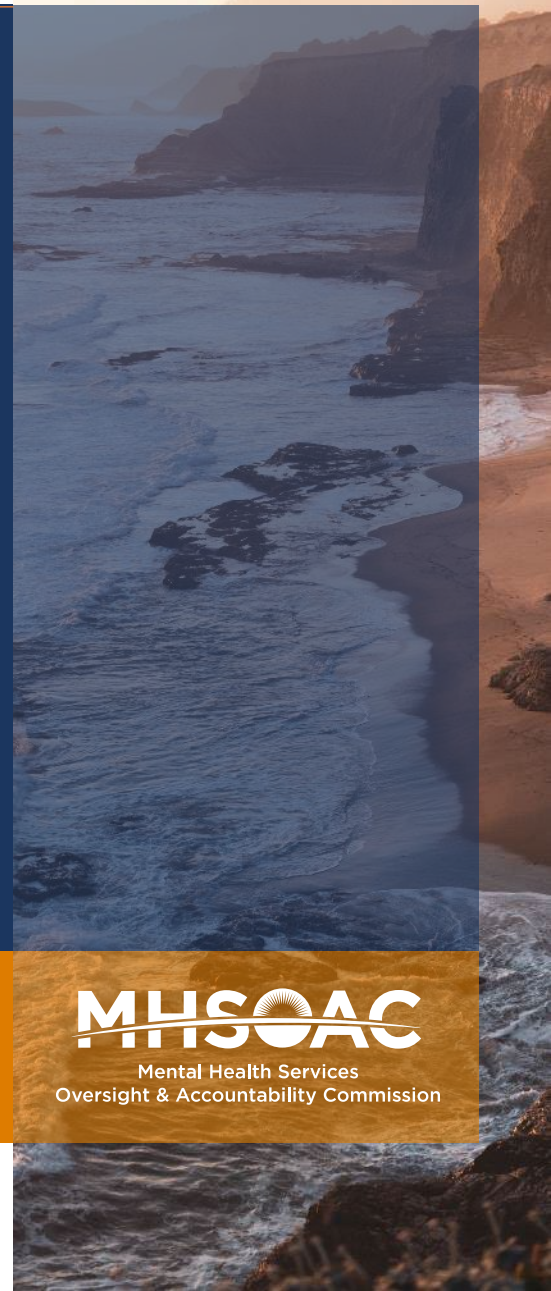


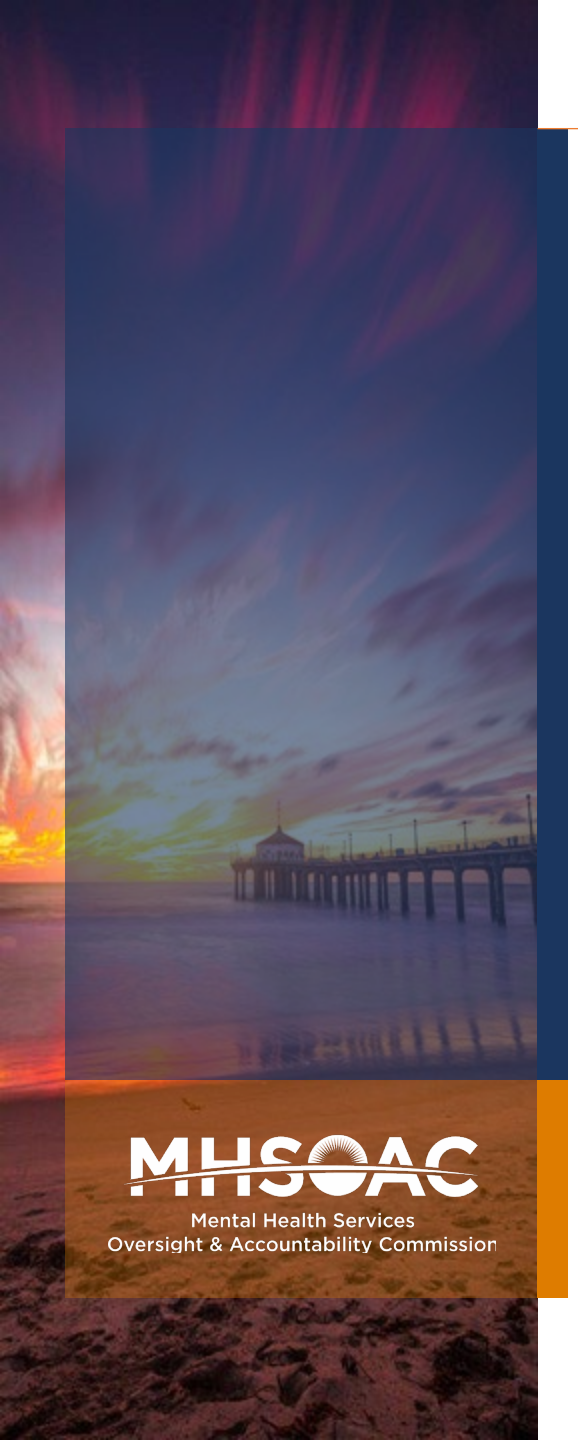
Operations
Core Operations, Communications, Research, FSP Eval, Prop 1 Implementation, Reserve

Local Assistance
Mental Health Wellness Act, Mental Health Student Services Act, Community Advocacy

FY 2024-25 Procurements

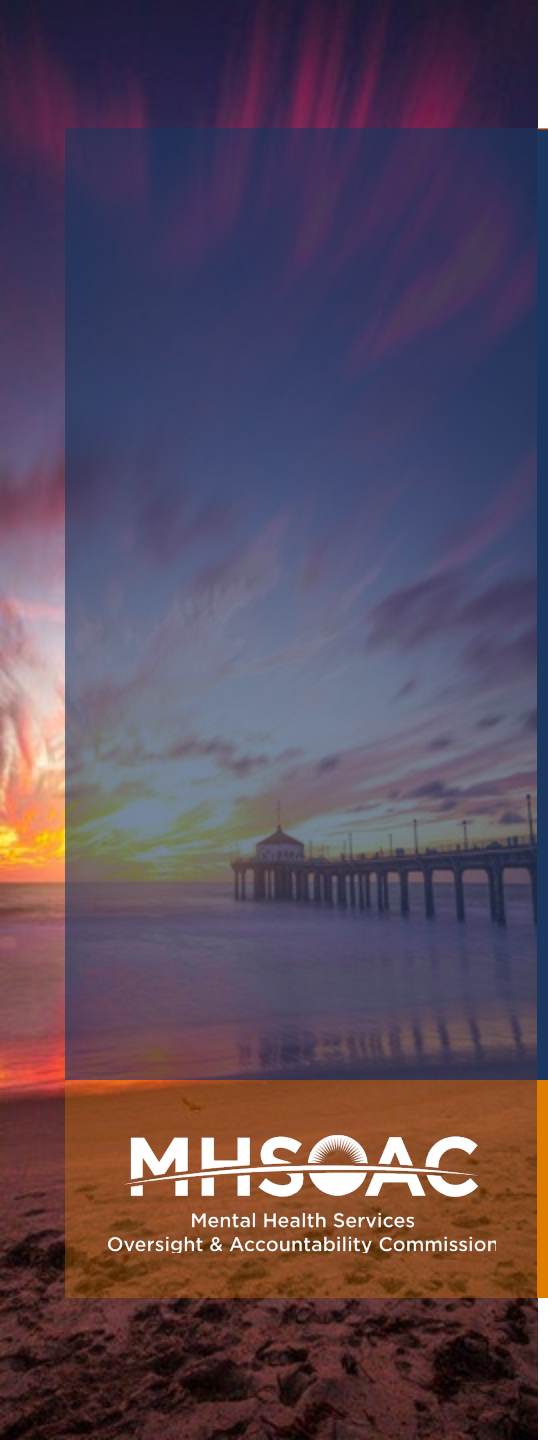
- Mental Health Student Services Act - Round 4
- Mental Health Wellness Act - Maternal Mental Health
- Mental Health Student Services Act – Statewide Technical Assistance Coordinator
- K-12 Advocacy
- Immigrants and Refugees Advocacy





Expenditure Authorization

- $200,000 contract with Public Works Alliance to design a strategy for building a financially sustainable network model for allcove sites
- $150,000 Stanford contract for a Research and Evaluation consultant



Motion

- That the Commission approves the Fiscal Year 2024-25 expenditure plan and associated contracts.


Thank You
MHSOAC
Mental Health Services
Oversight & Accountability Commission

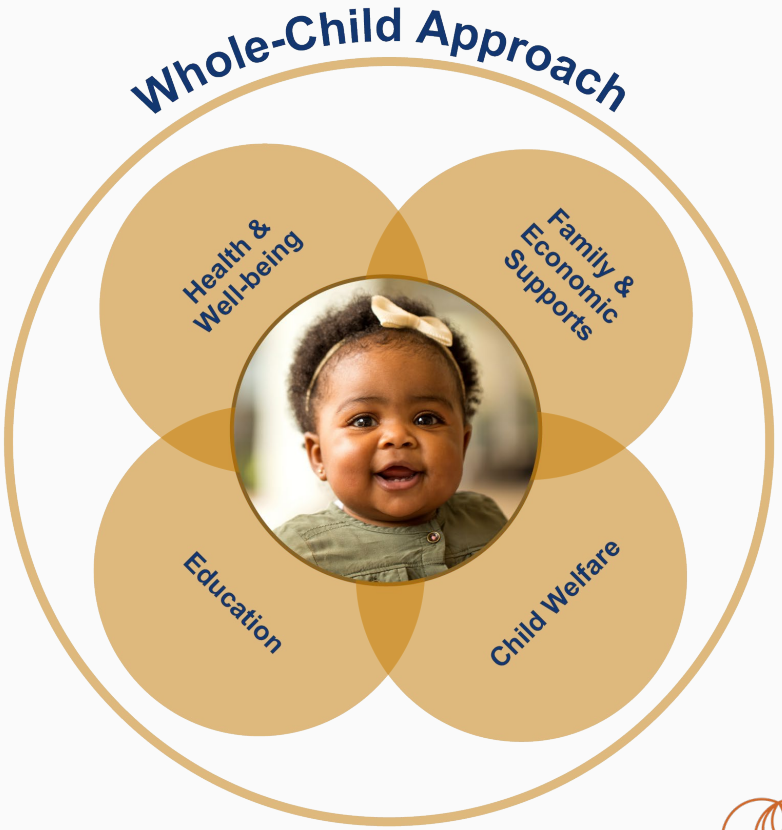
Children Now®

Robust Data Systems Needed for California's Child Behavioral Health

Children Now

Research, policy development and advocacy dedicated to promoting children's health, education and well-being in California.

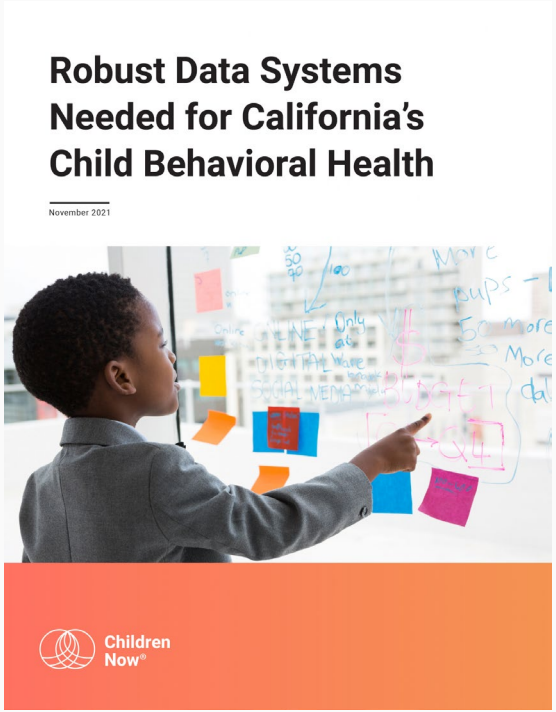
Leads The Children's Movement of California, a unique network of more than 4,600 diverse organizations.



Children Now

Purpose

- Identify publicly reported metrics on children's mental health and substance use from various state agencies
- Identify data gaps and recommend ways California can improve data collection efforts and leverage existing/new data to promote better outcomes for children and youth



Source: https://www.childrennow.org/portfolio-posts/robust-data-systems-needed-for-californias-child-behavioral-health/

Methodology

Source: https://www.childrennow.org/portfolio-posts/robust-data-systems-needed-for-californias-child-behavioral-health/

Children Now

Methodology

80 Metrics		
Group	**Type of Domain**	**Number of Measures***
Population Indicators describe characteristics of the child population regarding behavioral health	Known Prevalence	15
	System Use	24
	Outcomes	6
	Early Identification	39
System Performance Indicators describe how the child behavioral health care system is functioning	Access	18
	Quality	4
	Consumer Satisfaction	0

Source: https://www.childrennow.org/portfolio-posts/robust-data-systems-needed-for-californias-child-behavioral-health/

Findings

State data reports fail to provide a comprehensive view of the behavioral health needs and outcomes of children and youth:

- Significant gaps in disaggregated demographic data (i.e. age, race, ethnicity, sexual orientation, gender identity, geography, etc.)
- Lack of data on non-clinical settings (i.e. at home, in community, at school)
- No consistent data across delivery systems (i.e. private, public coverage)

Source: https://www.childrennow.org/portfolio-posts/robust-data-systems-needed-for-californias-child-behavioral-health/

Data Sources and Limitations

Source	Type of Data Available	Data Limitations
DHCS	Utilization of mental health services, most common diagnoses, health plan quality measures, timely access to mental health providers, mental health provider network availability.	Lack of consumer satisfaction, quality, and outcomes data, inconsistent race/ethnicity and geographic stratifications across all reports and data sets; Lack of disaggregated data on children and youth in foster care, children and youth with child welfare involvement, and children and youth with juvenile justice involvement, and very young children (ages 0-5) across all reports and data sets.
DSS (Continuum of Care Reform Dashboard)	Number/percentage of youth in foster care or with child welfare involvement who received a specialty mental health service. Number/percentage of children in foster care for whom a child welfare worker completed a required mental health screening. Data on psychotropic medication usage	Lack of consumer satisfaction, quality, timely access, and outcomes data. Lack of data on mental health services across delivery systems or payors. Specialty mental health utilization data lacks disaggregation for certain service types. Lags in data availability. Lack of consistent data on outcome, follow up, or service receipt after a mental health screening.

For full list of data sources and limitations see: https://www.childrennow.org/portfolio-posts/robust-data-systems-needed-for-californias-child-behavioral-health/

Statewide Opportunities for Better Data

- Proposition 1 (new)
- Transitional Kindergarten (new)
- CYBHI
- CalAIM
- Cradle-2-Career

Source: https://www.childrennow.org/portfolio-posts/robust-data-systems-needed-for-californias-child-behavioral-health/

Changes Needed

- Improve demographic data collection
- Provide Disaggregated Data for Special Populations (i.e. young children, children and youth with child welfare, foster care, and/or juvenile justice involvement)
- Use Existing Data to Prevent and Treat Trauma
- Gather consumer experiences and satisfaction
- Focus on quality
- Focus on Outcomes

Source: https://www.childrennow.org/portfolio-posts/robust-data-systems-needed-for-californias-child-behavioral-health/

Suggested New Metrics

Measure	Type of Domain
Percent of children 0 -5 receiving support for identified developmental or behavioral health challenge	Access
Number/percent of children who want mental health services but have not been able to obtain any	Consumer Experience/Access
Number/percent of youth who want substance use disorder services but have not been able to obtain any	Consumer Experience/Access
Percent of youth satisfied with provider	Consumer Experience/Access
Percent of youth satisfied with the frequency and type of services received	Consumer Experience/Quality
Reason for satisfaction/dissatisfaction with services or provider	Consumer Experience/Quality
Percent of parents reporting concerns about their child's development	Early Identification
Percent of parents reporting need for support for their children's behavioral health but not finding it	Early Identification/Access
Percent of children 0 -5 identified with a developmental or behavioral health challenge	Early Identification/Known Prevalence
Percent of children/youth with a co-occurring diagnosis of mental health and substance use disorder	Known Prevalence
Percent of children/youth screened for substance abuse	Known Prevalence
Percent of children suspended with a mental health/substance use disorder need	Outcome/Early Identification
Number/percent of young children suspended and/or expelled from child care programs due to behavioral issues	Outcome/Early Identification
Number/percent of missed school days due to mental health related issues	Outcome/Early Identification
Percent and outcome of developmental and social emotional screenings for young children	Outcome/Known Prevalence
Percent of juvenile justice-involved youth with a mental health/substance use disorder need	Outcome/Known Prevalence

Thank you!

Lishaun Francis

Senior Director, Behavioral Health

lfrancis@childrennow.org

Children Now

Learn more about Children Now:

www.childrennow.org

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Read our blog:

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Children Now

Behavioral Health Transformation Transparency and Accountability

Mental Health Services Oversight and Accountability Commission

Stephanie Welch
California Health and Human Services Agency

MENTAL HEALTH FOR ALL

CalHHS

July 25, 2024

Behavioral Health Services Act (BHSA)

Behavioral health services in California are now funded by a mix of insurance, county funds, and the MHSA/BHSA.

The BHSA is the first major structural reform of the Mental Health Services Act since 2004. It expands and increases the types of supports available to Californians in need by focusing on gaps and priorities.

- Focuses on the most vulnerable and at-risk, including set-asides for children and youth.
- Broadens the target population to include individuals with substance use disorder.
- Updates allocations for local services and state directed funding categories, including housing supports.
- Clearly advances community-defined practices as a key strategy of reducing health disparities and increasing community representation.
- Revises county processes for planning and reporting.
- Improves transparency and accountability.

MENTAL HEALTH FOR ALL

CalHHS

Behavioral Health Services Oversight and Accountability Commission (BHSOAC)

- **DHCS will consult with BHSOAC on:**
  - Development of biennial list of Early Intervention evidence-based practices.
  - Building FSP levels of care.
  - Developing statewide outcome metrics.
  - Determining statewide BH goals and outcome measures.
- **CDPH will consult with BHSOAC** and DHCS on population-based mental health and SUD prevention programs
- **BHSOAC will consult with:**
  - CalHHS and DHCS to determine allowable uses of funds for the BHSA Innovation Partnership Fund.
  - CDPH for population-based prevention innovations.
  - HCAI for workforce innovations.
  - CalHHS regarding funding allocations created by the Investment in MH Wellness Act.
- **BHSOAC will collaborate with:**
  - CalHHS to promote transformational change through research, evaluation, and tracking outcomes.
  - DHCS and the California Behavioral Health Planning Council (CBHPC) to write a report with recommendations for improving/standardizing BHSA promising practices.

MENTAL HEALTH FOR ALL

CalHHS

Overview of BHT Legislative Requirements Related to Quality Measurement and Disparities

Establish behavioral health performance and quality metrics in consultation with counties, stakeholders, and the Behavioral Health Services Oversight and Accountability Commission (BHSOAC)

Measure and evaluate the quality and efficacy of behavioral health services across California

Identify demographic and geographic disparities in the quality and efficacy of behavioral health services and programs

SB326: SEC. 109. 5963.04 (b)

County Integrated Plan for Behavioral Health Services and Outcomes

Three-year plans **must** include:

- All local, state, and federal behavioral health funding (e.g., BHSA, opioid settlement funds, SAMHSA and PATH grants, realignment funding, federal financial participation) and behavioral health services, including Medi-Cal.
- A budget of planned expenditures, reserves, and adjustments.
- Alignment with statewide and local goals and outcomes measures.
- Workforce strategies.

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County Integrated Plan for Behavioral Health Services and Outcomes Ctd.

- Plans **must** be developed with consideration of the population needs assessments of each Medi-Cal Managed Care Plan and in collaboration with local health jurisdictions on community health improvement plans.
- Plans **must** be informed by local stakeholder input, including additional voices on the local behavioral health advisory boards.
- Performance outcomes will be developed by DHCS in consultation with counties and stakeholders.

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County 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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County Behavioral Health Outcomes, Accountability, and Transparency Report Ctd.

- The plans and reports is **shall** include data through the lens of health equity to identify racial, ethnic, age, gender, and other demographic disparities and inform disparity reduction efforts.
  - Other data and information may include the number of people who are eligible adults and older adults, who are incarcerated, experiencing homelessness, inclusive of the availability of housing, the number of eligible children and youth.
- The metrics **shall** be used to identify demographic and geographic disparities in the quality and efficacy of behavioral health services and programs.

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State Auditor Report

- The State Auditor shall issue a comprehensive report on the progress and effectiveness of implementation of BHSA by December 31, 2029 and every 3 years thereafter until 2035.
- **Shall** include:
  - BHSA policy impact
  - Timeliness of guidance and technical assistance
  - Progress toward goals and outcomes
  - Gaps in service and trends in unmet needs
  - Inclusion and impact of SUD services and personnel
  - Effectiveness of reporting requirements
  - DHCS oversight of plans and reports
  - Coordination and collaboration areas of improvement
  - Recommendations of changes or improvements

MENTAL HEALTH FOR ALL

CalHHS

Update: Characteristics of the DHCS BHT IT Platform

Web Based

The platform is web-based. and easily accessible

Centrally Managed

The platform is managed by DHCS.

Provides Data

The platform provides real-time access and data to make collaboration easier.

What does this mean for me?

Easy Access

Real-time access to data

Continuous Iteration

Changes are implemented quickly

Ability to Shift

We shift as priorities shift

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

How We Are Doing Things Differently

An iterative, incremental approach allows us to develop better products faster

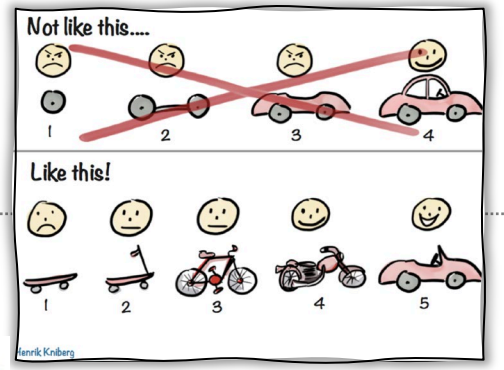
- Define **key outcomes and results** and measure through iterative and frequent check-ins with future end users
- Regularly **add functionality** to the tool
- **Fast delivery** by prioritizing rapid delivery of products to gain quick feedback and continuous improvement

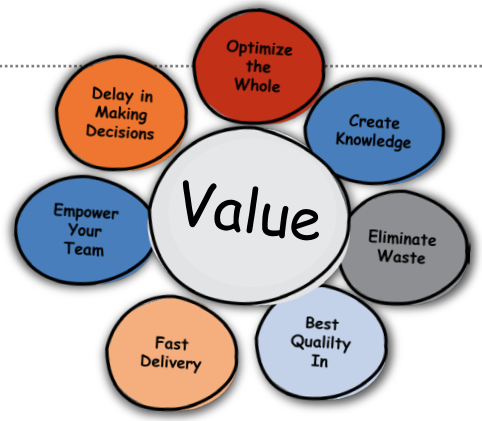
Growth mindset focused on learning what works well and doesn't

- **Foster collaborative solutions** through human-centered design so that solutions are tailored to meet users' needs.
- **Dedicate efforts to deeply understand pain points and preferences**, using these insights to drive the development of more effective and personalized strategies.
- Work closely with counties to envision 'the art of the possible,' **leveraging technology** to deliver innovative solutions that exceed expectations.

Relentless focus on achieving outcomes

- **Eliminate waste** by reducing any activity that does not add value to the outcome, such as unnecessary code, redundant processes, excessive meetings, and wait times
- **Collect feedback to refine processes**, fostering a growth mindset that embraces continuous improvement and innovative thinking.





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

For more information:

- The Governor's Mental Health for All Webpage linked here
- CalHHS Behavioral Health Transformation Webpage linked here
- DHCS Behavioral Health Transformation Webpage linked here

Transformational Change in Behavioral Health: Listening and Building Trust and Creating Trustworthiness are Front and Center

MHSOAC Meeting Prop 1

Sergio Aguilar-Gaxiola, MD, PhD
Professor of Clinical Internal Medicine
Director, Center for Reducing Health Disparities
UC Davis School of Medicine

July 25, 2024

UCDAVIS HEALTH | Center for Reducing Health Disparities

Summer, 2004
Prop 63 rally at the Fresno State campus

If Transforming the Behavioral Health System of Care is the Goal

Listening and Building Trust and Creating Trustworthiness with those we intend to serve are Front and Center

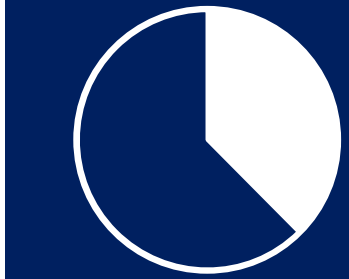
The Bottom Line

Enhancing the mental health of our communities through improving care and reducing mental health disparities

A critical ingredient:

Meaningful Community Engagement

Few Mexican American and Mexican origin adults, utilize behavioral health care services when needed



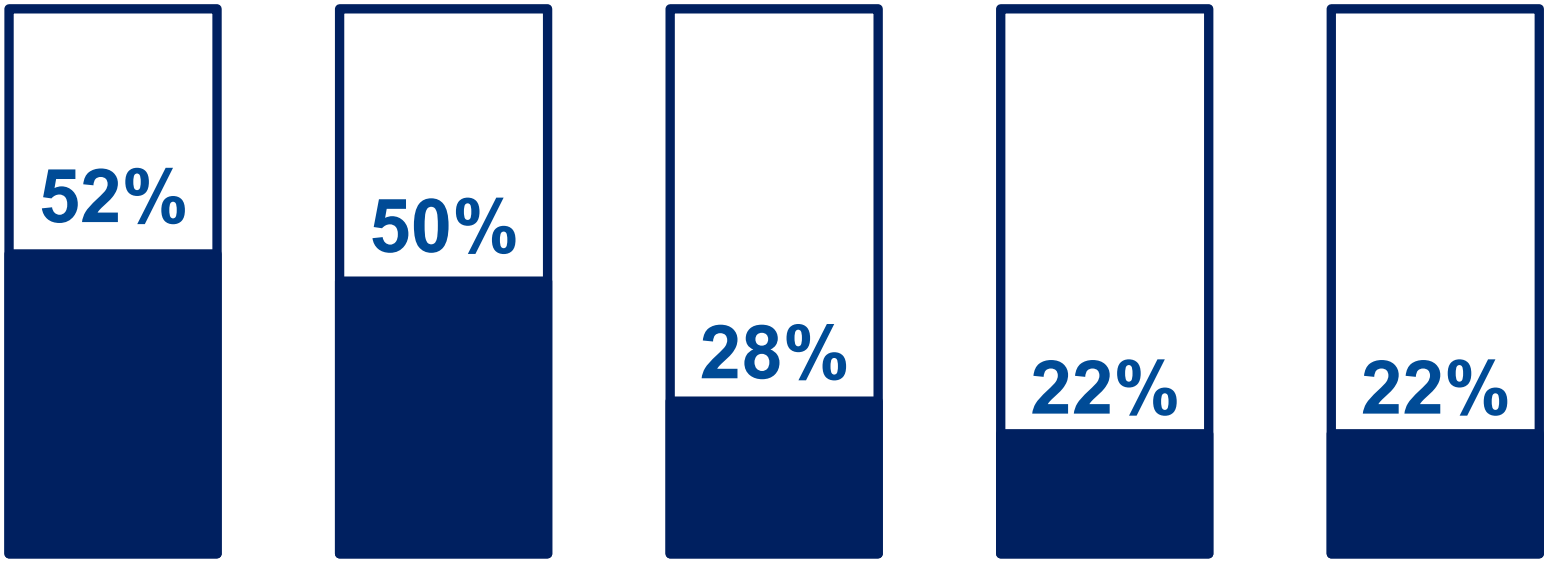
38%
U.S. Born Residents

15%
Immigrants

9%
Farmworkers

"Mexican American Prevalence and Services Survey" (MAPSS, 2000) study of 4,013 rural and urban Mexican American and Mexican origin adults. *Aguilar-Gaxiola, et al. Translating research into action: Reducing disparities in mental health care for Mexican Americans, Psychiatric Services, 2000*

Institutional Barriers



“Mexican American Prevalence and Services Survey” (MAPSS 2000). **Individuals with Severe and Persistent Mental Disorders**

What is your North Star in Transforming Behavioral Health?

The Road(s) Ahead: Outcomes that Matter

If You Build It, Will They Come?

It depends on:

- Who builds it
- How it’s built
- Where it’s built

Advancing Health Equity and Systems Transformation through Community Engagement

SCAN ME

NATIONAL ACADEMY OF MEDICINE

NAM Leadership Consortium

7 Impact Stories

Title	Geography	Community	Health Focus
1. The Walkability Project	Roseville, CA	Low-income	Healthy built environment
2. The Faith-Based Organization Network	North Carolina	African-American, faith-based	Partnership development across health issues
3. Health Equity Zones	Rhode Island	Communities at highest risk of adverse health outcomes	Community-identified: teen pregnancy, lead poisoning, food access, etc.
4. IT MATTTRS Colorado	Central Plains	Rural	Substance abuse treatment
5. Native Wellness Network	Native Wellness Network	American Indian/Alaskan native communities	Community-identified: healthy kids, healthy weight, diabetes prevention, breast feeding, suicide prevention
6. Act Now Against Meth	Los Angeles, CA	LGBTQ, LatinX, the recently incarcerated, and sex workers	Substance abuse (methamphetamines) & HIV
7. AltaMed's HEAL through PCOR	Los Angeles, CA	Multi-ethnic community, primarily LatinX	Strengthening patient and community engagement within an FQHC

The Walkability Project

Watch Debra Oto-Kent, HEC Founder and Executive Director, describe the Walkability Project and its sustained community impact.

National Academy of Medicine's Assessing Meaningful Community Engagement

We did kitchen table discussions, we met in people's backyards. We engaged with parents after school. We cast a very wide net when talking to people...and based on that input, we pivoted and changed our approach.

Debra Oto-Kent
HEC Founder and Executive Director

KEY ENGAGEMENT ACTIVITIES

To align the project with community priorities, HEC pursued a series of engagement strategies to incorporate community members into all aspects of the work.

Built a mechanism for broad community inclusion throughout the project. A five-member, cross-sector team and advisory committee of community-based organizations and residents were assembled to confirm project goals with the community. This was important because other neighborhoods in the city had neighborhood associations that could advocate for their needs; this community did not.

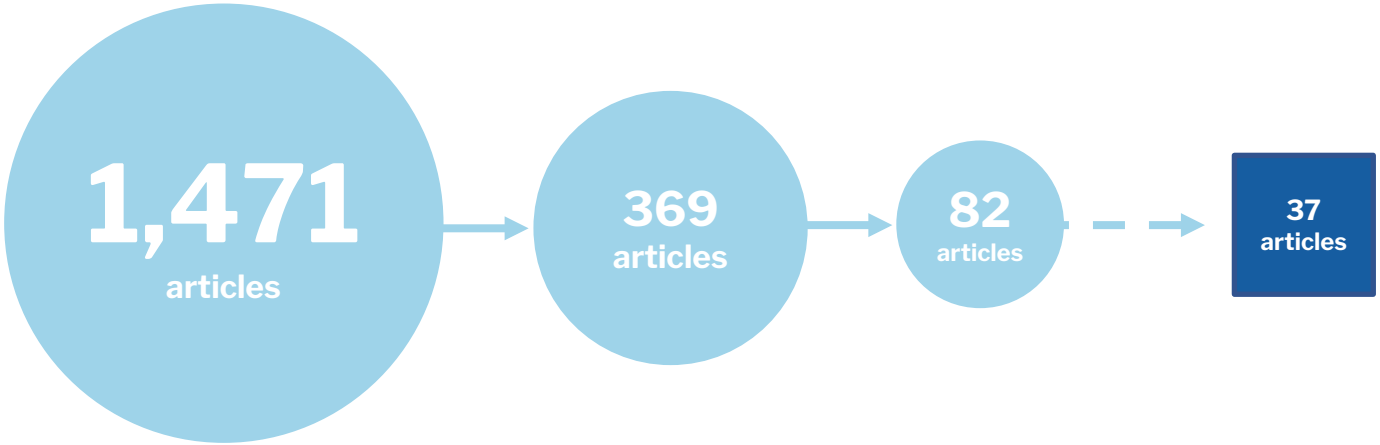
Engaged as many stakeholders as possible, and met them where they lived and worked. The advisory committee sought input from diverse stakeholders with everyday experience of the community. These included residents in core neighborhoods, neighborhood associations, city officials, hospitals, health and social service agencies, faith organizations, and law enforcement. To do so, the advisory committee held key informant interviews, backyard chats, after-school engagement with parents, and focus groups. Notably, they reached out to people who had not been involved and did not know who to turn to in order to make their voices heard.

NIH National Center for Advancing Translational Sciences

https://nam.edu/programs/value-science-driven-health-care/assessing-meaningful-community-engagement/the-walkability-project/; Rutter, May 2023

Assessment instruments

Development process at-a-glance: comprehensive literature review



Total articles from literature search & grey literature

Total that met inclusion criteria after reviewing abstracts

Total that met inclusion criteria after full-text review

112 instruments represented

Total that met prioritization criteria

28 instruments represented

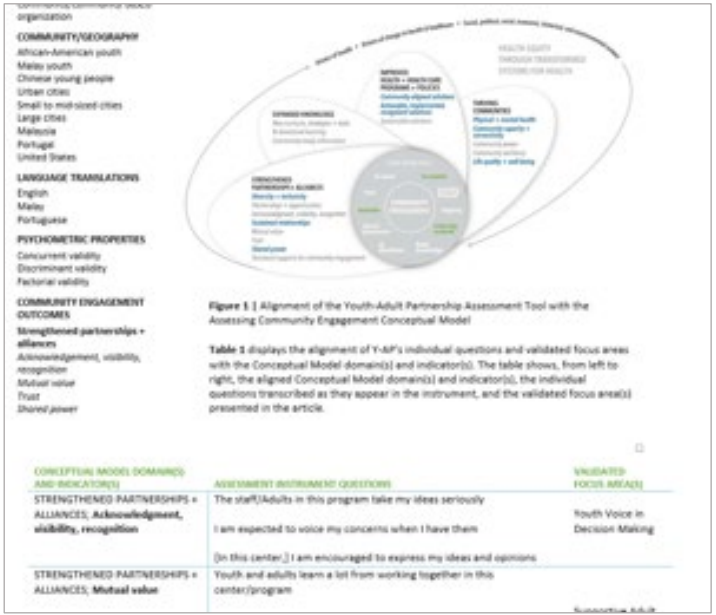
NATIONAL ACADEMY OF MEDICINE

NAM Leadership Consortium

Assessment instruments

Toolkit: 28 instruments to support assessing community engagement

Each instrument and its questions are mapped to the conceptual model



organization

COMMUNITY/GEOGRAPHY
African-American youth
Malay youth
Chinese young people
Urban cities
Small to mid-sized cities
Large cities
Malaysia
Portugal
United States

LANGUAGE TRANSLATIONS
English
Malay
Portuguese

PSYCHOMETRIC PROPERTIES
Concurrent validity
Discriminant validity
Factorial validity

COMMUNITY ENGAGEMENT OUTCOMES
Strengthened partnerships + alliances
Acknowledgement, visibility, recognition
Mutual value
Trust
Shared power

Figure 1 | Alignment of the Youth-Adult Partnership Assessment Tool with the Assessing Community Engagement Conceptual Model

Table 1 displays the alignment of Y-AP's individual questions and validated focus areas with the Conceptual Model domain(s) and indicator(s). The table shows, from left to right, the aligned Conceptual Model domain(s) and indicator(s), the individual questions transcribed as they appear in the instrument, and the validated focus area(s) presented in the article.

CONCEPTUAL MODEL DOMAIN(S) AND INDICATOR(S)	ASSESSMENT INSTRUMENT QUESTIONS	VALIDATED FOCUS AREA(S)
STRENGTHENED PARTNERSHIPS + ALLIANCES; **Acknowledgment, visibility, recognition**	The staff/Adults in this program take my ideas seriously I am expected to voice my concerns when I have them [In this center,] I am encouraged to express my ideas and opinions	Youth Voice in Decision Making
STRENGTHENED PARTNERSHIPS + ALLIANCES; **Mutual value**	Youth and adults learn a lot from working together in this center/program	

Each instrument is presented with summary information

ASSESSMENT INSTRUMENT BACKGROUND

Context of instrument development/use

The study investigated the quality of community programs that self-identified as emphasizing positive youth development, effective citizenry participation, and youth voice. Services provided in the programs addressed social, recreation, health, and academic support. The article focused on the importance of measuring one effective type of youth participation, youth-adult partnership, which is characterized by youth voice in decision making and supportive adult relationships.

Instrument description/purpose

Y-AP measures youth-adult partnerships using two validated focus areas:

- Youth voice in decision making
- Supportive adult relationships

The instrument has a total of nine questions that use a five point Likert-type scale ranging from "strongly disagree" to "strongly agree."

This instrument can be accessed online here.

Engagement involved in developing, implementing, or evaluating the assessment instrument

The initial version of the Y-AP was shared with the respective research teams from the United States, Malaysia, and Portugal for feedback. Modifications regarding "cultural relevancy" and appropriate questions were added to the instrument. The instrument also underwent translation and reverse translation processes to ensure accuracy. Y-AP was then piloted with young people in each country and final modifications were made.

Additional information on populations engaged in instrument use

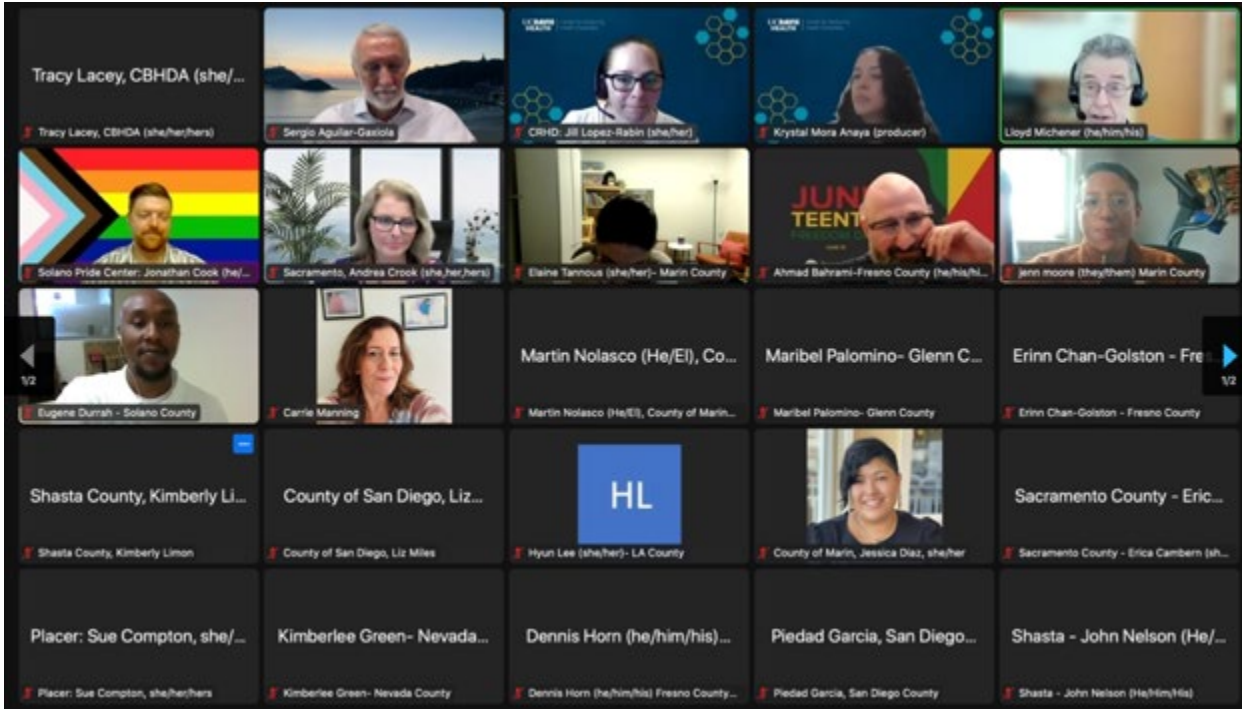
Participants in the programs were African-American youth from across a wide catchment area of urban neighborhoods in the United States, from four state registered after-school programs in a large city in Malaysia serving Malay youth and Chinese young people, and from small to mid-sized cities participating as members of a national youth development organization attending a regional retreat outside of a large city in Portugal.

Notes

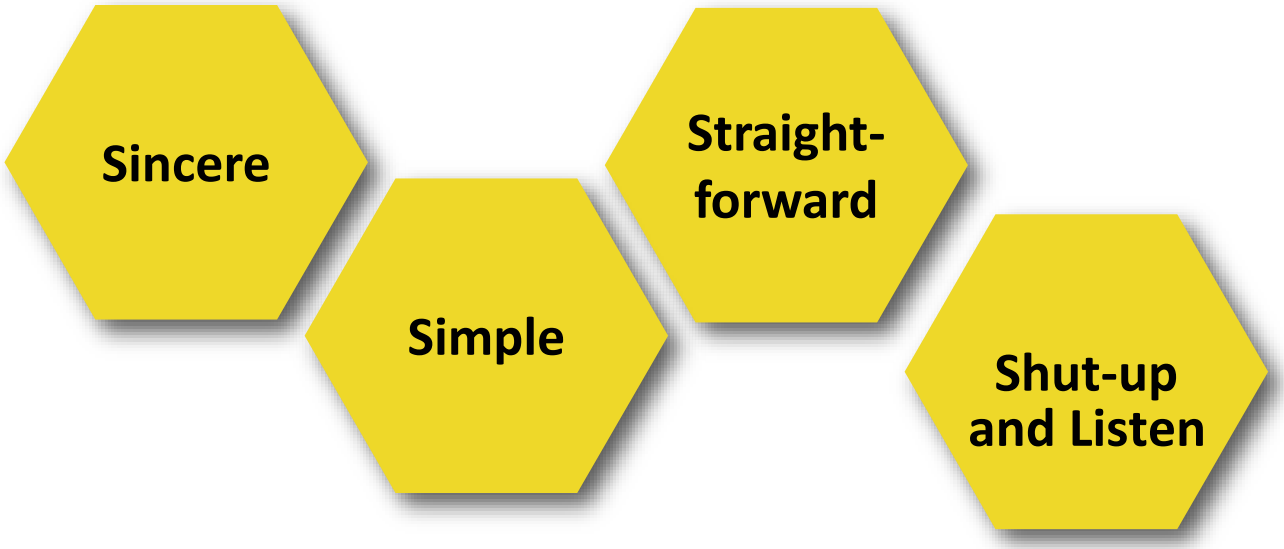
- **Potential limitations:** The identified measures of Y-AP were assessed in the context of youth programs that meet regularly during after-school hours. However, youth-adult partnerships are also implemented in less "structured"

ICCTM Learning Collaborative (1-year Training)

- Trained 161 learners representing 41 CA counties, the Department of Health Care Services, Department of Public Health, the California Behavioral Health Directors' Association, CBOs, etc.
- **Community Engagement Models comprised 3** of the 11 training sessions
- **Building trust and becoming trustworthy organizations** were discussed in-depth



Main Lessons Learned…4 Ss



Recommendations

- **The CA Health and Human Services Agency - Behavioral Health** should co-create an organization-wide **Meaningful Community Engagement framework** that effectively engages All Californians and in particular historically underserved communities and has trust and trustworthiness embedded throughout strategic planning, implementation, evaluation, and dissemination
  a. Support CHHS in co-designing a culturally and linguistically appropriate community engagement framework to effectively engage and serve diverse underserved communities
  b. Provide training to CHHS using relevant and culturally responsive resources, and strategies that translate into meaningful community engagement plans
  c. Provide technical assistance and training with a focus on listening to communities attentively and actively and on building trust and becoming trustworthy

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Proposition 1 Implementation: Exploring Commission Opportunities

Presented by Kendra Zoller, Deputy Director of Legislation

July 25, 2024

July 2024	January 2025	July 2026	December 2029	January 2030
BHSA Revenue Stability Workgroup Begins	Name Change	County Innovation Bucket & Approval Authority Ends	First Report Published by State Auditor	Publishes Report on Promising Practices
	11 New Commissioners	Innovation Partnership Fund Begins		Publishes Report on TA & Community Engagement
	Advises Governor and Legislature on SUD	Consults with DHCS on Early Intervention, FSPs, and Metrics		Publishes Report on Innovation Partnership Fund
	Updates to Data Statute, BHSSA, EPI Advisory Committee, & Fellowship	Consults with CDPH on Population-Based Prevention		
	Consults with CDPH on Stigma and Discrimination	Receives County Integrated Plans		
	Provides TA to Counties	Refers County Performance Issues to DHCS		
	State Audit Authority Begins			
	Report Published by BHSA Revenue Stability Workgroup (June)			

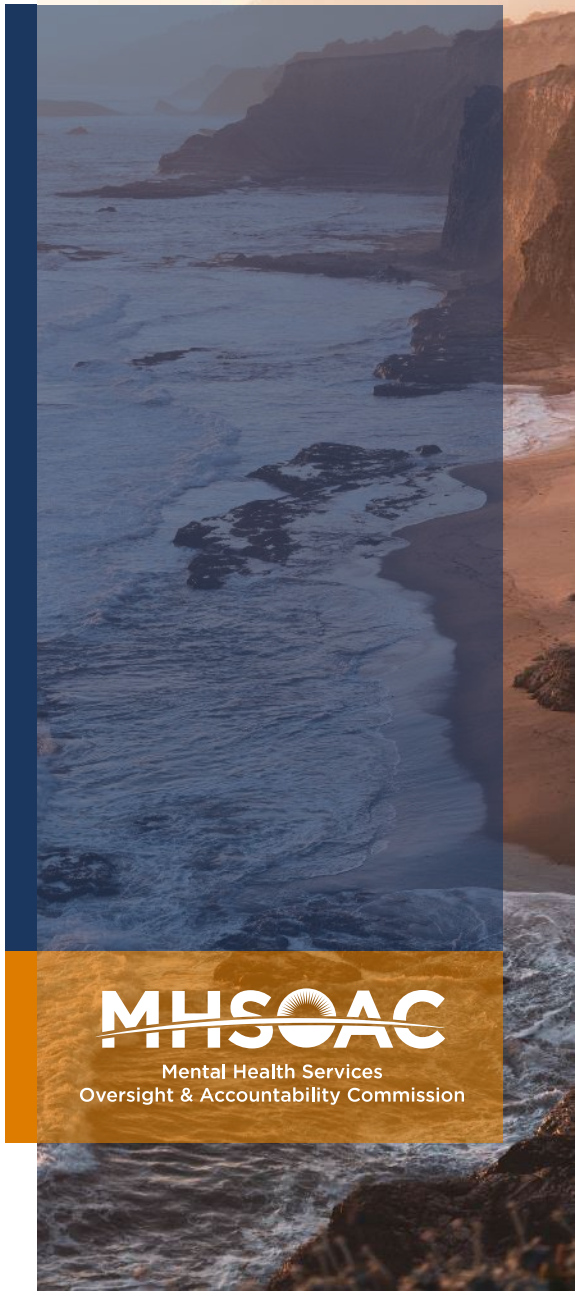
January 1, 2025

Name Change to the Behavioral Health Services Oversight and Accountability Commission

- Should the Commission consider using an informal name, i.e., the “Behavioral Health Commission” ?

- Examples:

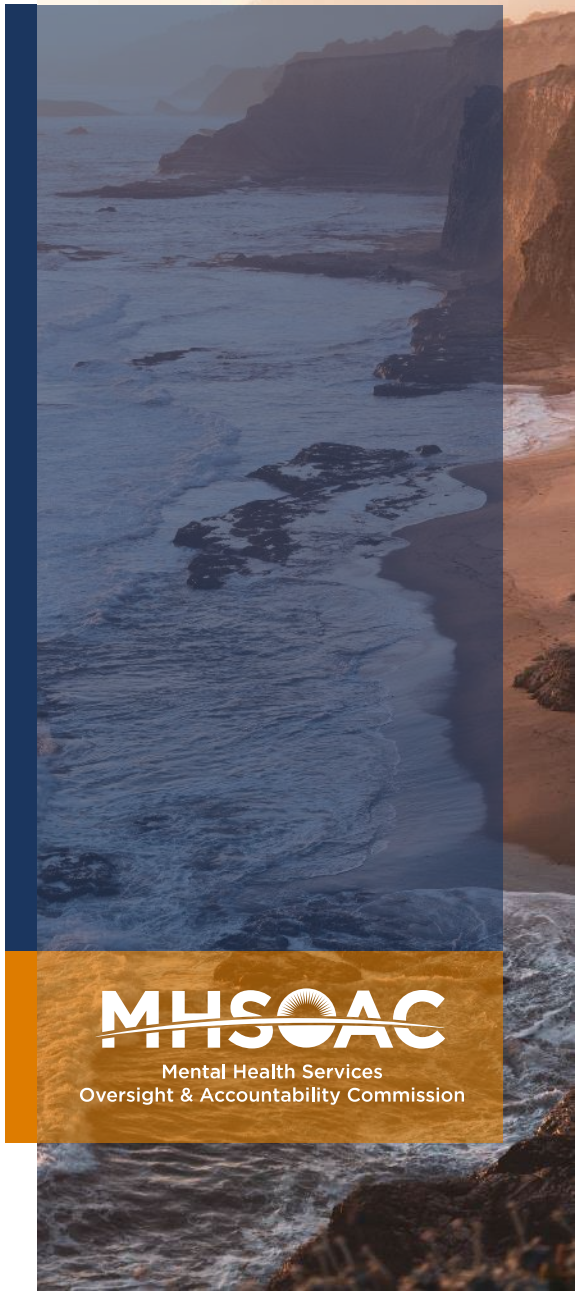
    - First Five Commission
    - Little Hoover Commission



January 1, 2025

Commission Growth with 27 Commissioners

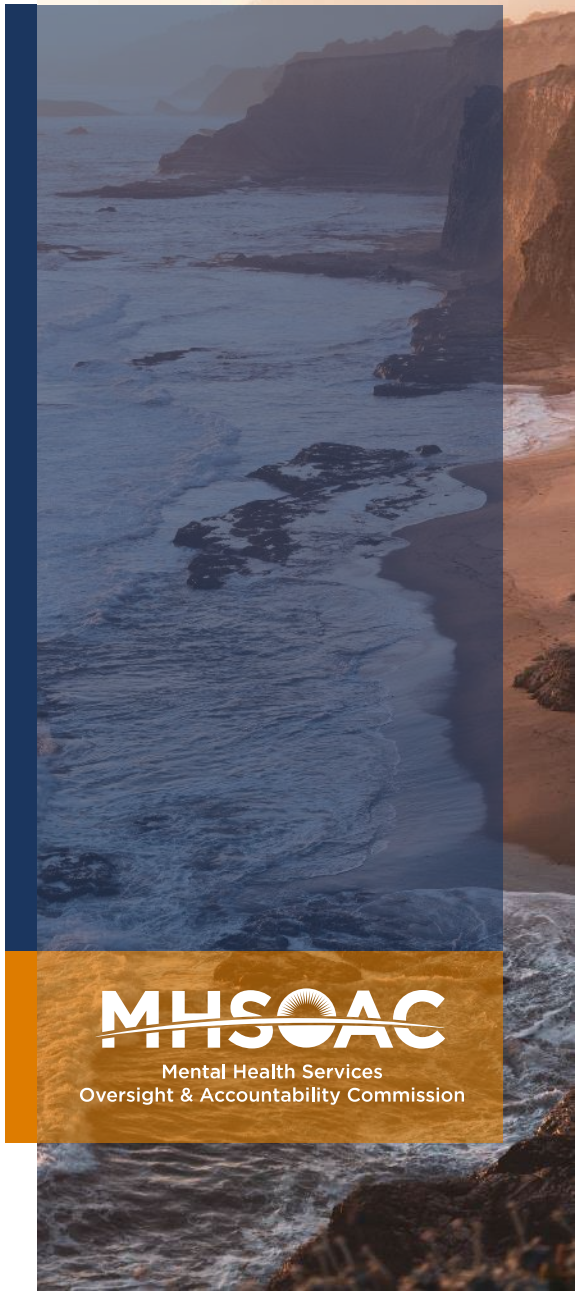
- How can the Commission ensure 14 members are present in-person for a quorum?
- What are the Commission's thoughts on updating the rules and procedures regarding delegated authority?
- How can the Commission improve onboarding?



January 1, 2025

Additional 2025 Opportunities

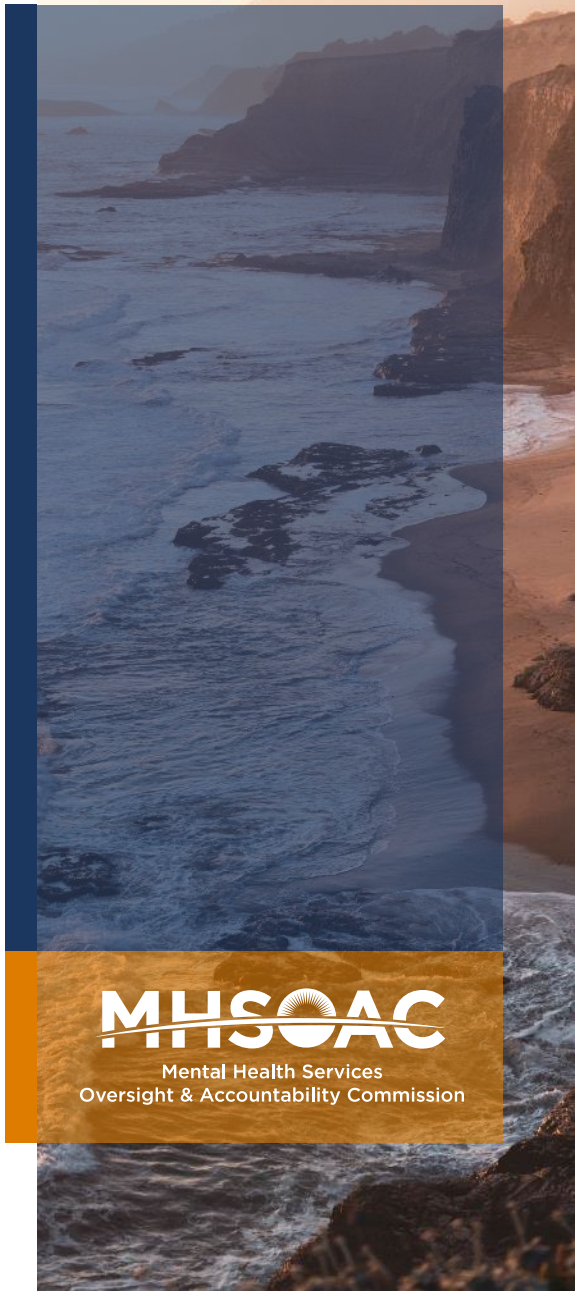
- Advises Governor and Legislature on substance use disorder
- Stronger data statute
- Updates to the BHSSA, EPI Advisory Committee, and Fellowship
- Consults with CDPH on reducing stigma and discrimination
- Provides technical assistance to counties on implementation planning, training, and capacity building investments including on innovative behavioral health models of care and innovative promising practices
- State Audit authority takes effect
- Report published by BHSA Revenue Stability Workgroup (June)



July 1, 2026

Re-envisioning Innovation

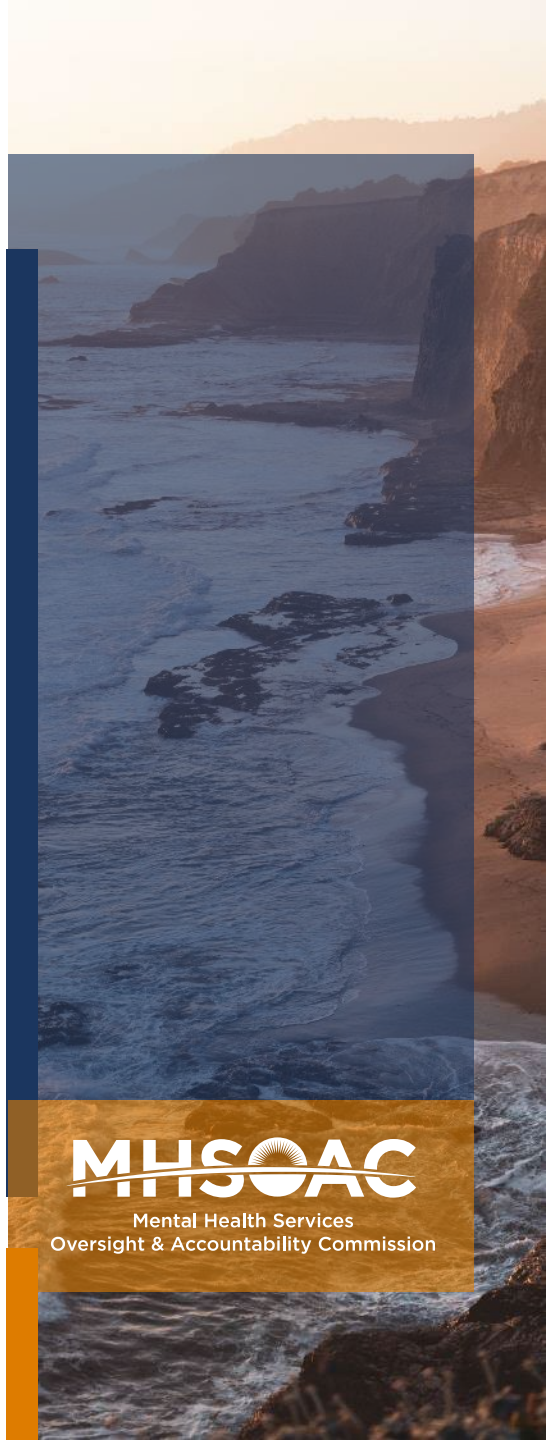
- Current county innovation bucket and approval authority ends
- Innovation Partnership Fund begins
  - $20 million annually for five years
  - Grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and practices
  - Engage private sector for co-investment opportunities



July 1, 2026

Supporting Proposition 1 Priorities

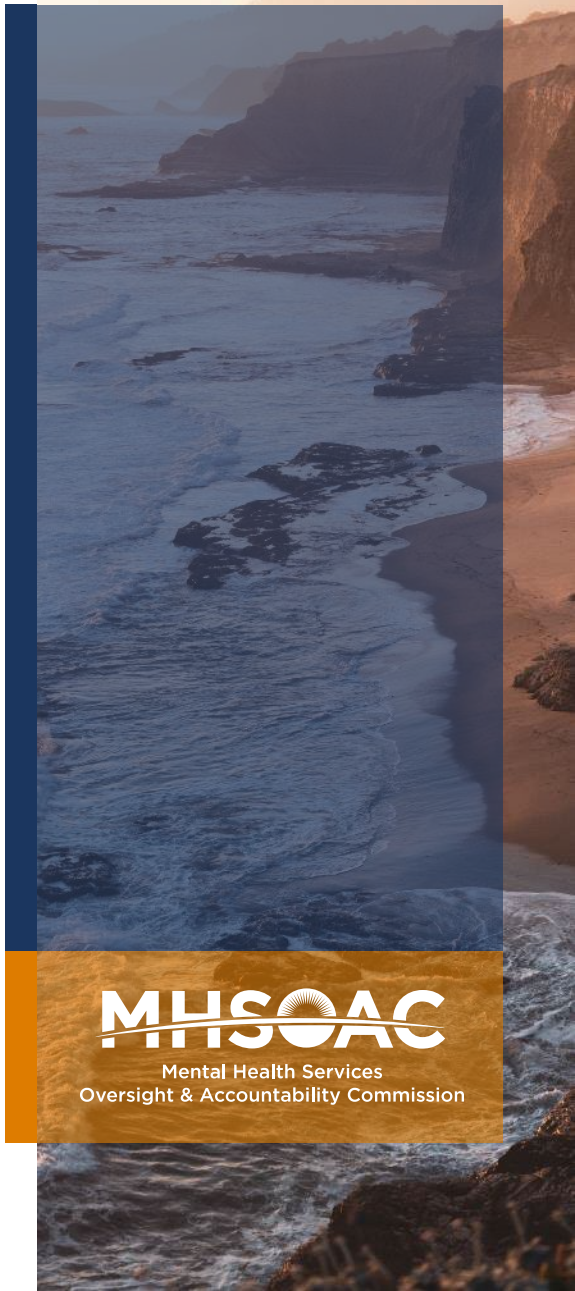
- Early Intervention
  - *Early Psychosis Intervention+, allcove*
- Full-Service Partnerships
  - *Technical assistance, community engagement, data analysis, outcomes reporting*
- Metrics to Measure and Evaluate
  - *Strength-based outcomes*
- Population-Based Prevention
  - *PEI, Suicide Prevention, School Mental Health, Universal Screening, Firearm Violence, Workplace Mental Health, priority populations (0-5, older adults)*
- Housing, Workforce, Accountability, Fiscal Transparency, Community Engagement & Planning



January 2030

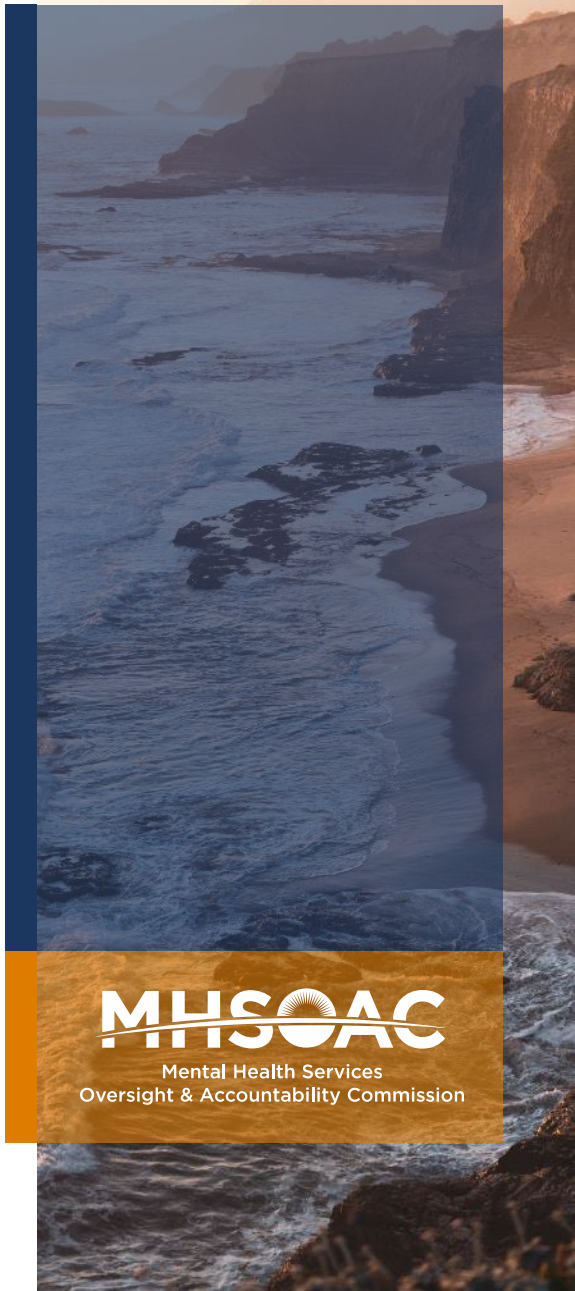
Fostering Knowledge Sharing

- Three Reports:
  - Recommendations for the state based on technical assistance and community engagement
  - Recommendations for improving and standardizing promising practices for BHSA programs
  - Key accomplishments of the Innovation Partnership Fund



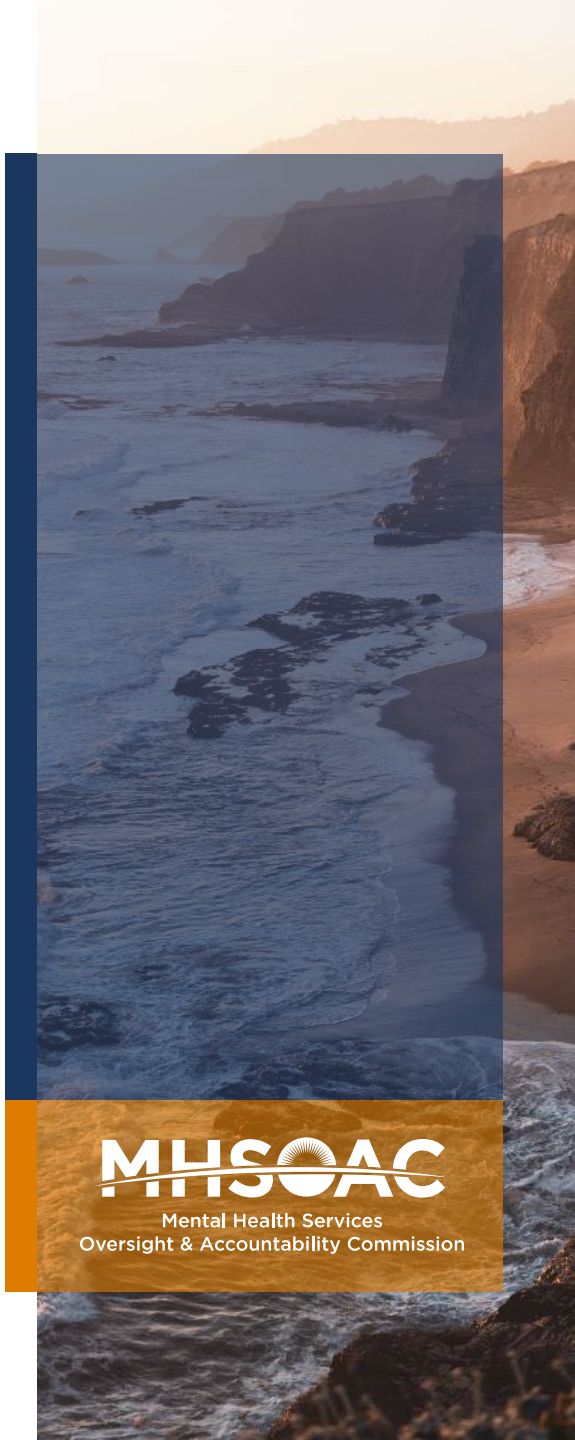
Additional Future Opportunities

- Receives county Integrated Plans (2026)
- Refers county performance issues to DHCS (2026)
- First report published by State Auditor (2028)



Questions for Discussion Today

- Should the Commission consider using an informal name, i.e., the “Behavioral Health Commission” ?
- How can the Commission ensure 14 members are present in-person for a quorum?



MHSOAC Proposition 1 Implementation:
Exploring Commission Opportunities - Reference Guide

Effective January 1, 2025

1. **Name change to the Behavioral Health Services Oversight and Accountability Commission.**

2. **11 New Governor appointed commissioners.**

16 Current Commissions	11 New Commissioners
1. Attorney General 2. Superintendent of Public Instruction 3. Senator 4. Assembly Member 5. A person with a severe mental illness 6. A person with a severe mental illness 7. A family member of an adult or senior with a severe mental illness 8. A family member of a child who has or has had a severe mental illness 9. A physician specializing in alcohol and drug treatment 10. A mental health professional 11. A county sheriff 12. A superintendent of a school district 13. A representative of a labor organization 14. A representative of an employer with less than 500 employees 15. A representative of an employer with more than 500 employees 16. A representative of a health care service plan or insurer	1. A current or former county behavioral health director 2. One person with SUD 3. One person with SUD 4. A peer youth 5. A family member of an adult or older adult with SUD 6. A family member of child or youth with SUD 7. A professional with expertise in housing and homelessness 8. A representative of an aging or disability organization 9. A person with knowledge and experience in community-defined evidence practices and reducing behavioral health disparities 10. A representative of a children and youth organization 11. A veteran or a representative of a veterans' organization ** Assembly and Senate Commissioners may appoint designees*

3. **Advises the Governor on substance use disorder (SUD).**

4. **New and stronger data statute.**

Language Added to Data Statute	Current Data Use Agreements
The Commission may…. make reasonable requests for data and information to the State Department of Health Care Services, the Department of Health Care Access and Information, the State Department of Public Health, or other state and local entities that receive Behavioral Health Services Act funds. ***These entities shall respond in a timely manner and provide information and data in their possession that the commission deems necessary for the purposes of carrying out its responsibilities.***	1. Department of Health Care Services (DHCS) **Medi-Cal data in process* 2. California Employment Development Department (EDD) 3. California Department of Public Health (CDPH) 4. California Department of Education (CDE) 5. California Department of Health Access and Information (HCAI) 6. California Department of Justice **in process*

5. **Expansion of the Behavioral Health Student Services Act to include grants to for outreach to high-risk youth and young adults including victims of domestic violence and sexual abuse.**

6. **Three New Members to the Early Psychosis Intervention (EPI) Advisory Committee: (1) California public school administrator; (2) A representative knowledgeable in community-defined evidence based practices and reducing behavioral health disparities; and (3) A school social worker, school psychologist, or school counselor holding a pupil personnel services credential.**

7. **Expands the commission's fellowship to include substance use disorder consumers and professionals.**

8. **Consults with CDPH on reducing stigma and discrimination.**

9. **Provides technical assistance to counties on implementation planning, training, and capacity building investments including on innovative behavioral health models of care and innovative promising practices.**

10. State Auditor authority takes effect.

Audit Requirements
The State Auditor shall issue a comprehensive report on the progress and effectiveness of implementation of BHSA by December 31, 2029 and every 3 years thereafter until 2035. Shall include: • BHSA policy impact • Timeliness of guidance and technical assistance • Progress toward goals and outcomes • Gaps in service and trends in unmet needs • Inclusion and impact of SUD services and personnel • Effectiveness of reporting requirements • DHCS oversight of plans and reports • Coordination and collaboration areas of improvement • Recommendations of changes or improvements

11. Member of the Behavioral Health Services Act Revenue Stability Workgroup.

Behavioral Health Services Act Revenue Stability Workgroup
• Workgroup to assess year-over-year fluctuations in tax revenues generated by the BHSA and develop and recommend solutions to reduce BHSA revenue volatility and to propose appropriate prudent reserve levels. • CalHHS and DHCS shall jointly convene the workgroup • Shall include representatives from BHSOAC, Legislative Analyst's Office, California Behavioral Health Directors Association, and California State Association of Counties, including both urban and rural county reps. • CalHHS and DHCS shall submit a report that includes its recommendations on or before June 30, 2025

Effective July 1, 2026

1. **Current county innovation bucket and approval authority ends.**

MHSA Buckets	BHSA Buckets
76% Community Services and Supports ○ **38%** Full Service Partnerships ○ Capital Facilities and Technology ○ Workforce Education and Training ○ Prudent Reserve **19% Prevention & Early Intervention** **5% Innovation** **5% State Admin Funds**	**30% Housing Interventions** **35% Full Service Partnerships** **35% Behavioral Health Services and Supports** ○ **51%** Early Intervention ○ ≥ **51%** Children and Youth ○ Outreach and Engagement ○ Workforce Education and Training ○ Capital Facilities and Technology ○ Innovative Pilots and Projects ○ Prudent Reserve **10% State Admin Funds** ○ ≥ **4%** Population-Based Prevention ○ ≥ **3%** Workforce Initiative ○ ≤ **3%** State Admin Funds ○ ≤ **$20 million** annually for the Innovation Partnership Fund

2. **Innovation Partnership Fund begins.**

Innovation Partnership Fund
1. $20 million annually from FY 26-27 to 30-31 and then as determined by the annual budget act ○ May additionally use Mental Health Wellness Act funds 2. Grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and practices which: ○ Improve BHSA programs and practices for underserved populations, low-income populations, communities impacted by other disparities, and other populations ○ Meet statewide BHSA goals and objectives 3. Commission consults with relevant stakeholders o Engage private sector for co-investment opportunities

3. **Consults with DHCS on Early-Intervention, FSP standards of care, and evaluation metrics.**

Early Intervention

Early Intervention programs must:

• Establish and use community-defined evidence practices and evidence-based practices.

• Emphasize the reduction of suicide and self harm, incarceration, school (including early childhood 0-5 age, inclusive, TK-12, and higher education) suspension, expulsion, referral to an alternative or community school, or failure to complete, unemployment, prolonged suffering, homelessness, removal of children from homes, overdose, and mental illness in children and youth from social, emotional, developmental, and behavioral needs in early childhood. Including outreach to education, including early care and learning and TK-12.

• Reduce disparities in behavioral health. Shall include mental health and SUD services that meet the cultural and linguistic needs of diverse communities.

MH and SUD services may be provided to individual children and youth when:

• At high risk for a behavioral health disorder due to trauma, via the ACEs screening tool, involvement in the child welfare system or juvenile justice system, who are experiencing homelessness, or who are in populations with identified disparities in behavioral health outcomes.

Full-Service Partnerships

• Includes mental health, supportive services, and substance use disorder treatment services. Informally referred to as "whatever it takes" model.

• Assertive Community Treatment/Forensic Assertive Community Treatment, Individual Placement and Support model of supported employment, high fidelity wraparound are required. Small county exemptions are subject to DHCS approval.

• Includes Medication-Assisted Treatment, when providing SUD services.

• Establishes standard of care with levels based on criteria for step-down into the least intensive level of care.

• Aligned documentation standards to be consistent with CalAIM.

•Outpatient behavioral health services, either clinic or field based, necessary for the 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.

• Emphasis on employing community-defined evidence practices (CDEP).

Metrics

• DHCS shall establish metrics, in consultation with counties, stakeholders, and the Behavioral Health Services Oversight and Accountability Commission to measure and evaluate the quality and efficacy of the behavioral health services and programs.

• The metrics shall be used to identify demographic and geographic disparities in the quality and efficacy of behavioral health services and programs.

4. Consults with CDPH on Population-Based Prevention.

Population-Based Prevention

Population-based programming on behavioral health and wellness to increase awareness about resources and stop behavioral health problems before they start.

• A majority of Prevention programming (51%) must serve people 25 years and younger. Early childhood population-based prevention programs for 0-5 shall be provided in a range of settings.

• California Department of Public Health is lead, in consultation with DHCS and BHSOAC.

• Provides for school-based prevention supports and programs. Services shall be provided on a schoolwide or classroom basis and may be provided by a community-based organization off campus or on school grounds.

5. Publishes Three New Reports.

Three Reports

1. Recommendations for the state based on technical assistance and community engagement
    - No specific due date
    - In collaboration with DHCS
    - Focused on priority populations and diverse communities
2. Recommendations for improving and standardizing promising practices for BHSA programs
    - Due January 1, 2030 and every three years thereafter
    - In collaboration with DHCS, the Planning Council, and CBHDA
3. Key accomplishments of the Innovation Partnership Fund
    - Due January 1, 2030 and every three years thereafter

4. **Receives county Integrated Plans for Prevention, Innovation, and System of Care Services.**

Integrated Plans
Three-year plans no longer focus on MHSA funds only. Must include: • All local, state, and federal behavioral health funding (e.g., BHSA, opioid settlement funds, SAMHSA and PATH grants, realignment funding, federal financial participation) and behavioral health services, including Medi-Cal. • A budget of planned expenditures, reserves, and adjustments • Alignment with statewide and local goals and outcomes measures • Workforce strategies • Counties plans must be developed with consideration of the population needs assessments of each Medi-Cal Managed Care Plan and in collaboration with local health jurisdictions on community health improvement plans. • County plans must be informed by local stakeholder input, including additional voices on the local behavioral health advisory boards. • Performance outcomes will be developed by DHCS in consultation with counties and stakeholders.

5. **Refers county performance issues to DHCS for the new County Behavioral Health Outcomes, Accountability, and Transparency Report.**

County 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. The plans and reports shall include data through the lens of health equity to identify racial, ethnic, age, gender, and other demographic disparities and inform disparity reduction efforts. • Other data and information may include the number of people who are eligible adults and older adults, who are incarcerated, experiencing homelessness, inclusive of the availability of housing, the number of eligible children and youth. • The metrics shall be used to identify demographic and geographic disparities in the quality and efficacy of behavioral health services and programs.