Behavioral Health Services Act (BHSA) Educational Session

Session Overview

- Welcome & Introductions
- History of Prop 1
- BHSA Goals & Priority Populations
- Fiscal Restructuring & BHSA Funding Categories
- Planning & Reporting
- Oversight & Accountability
- Opportunities to Participate

History of Prop 1

Legislative Background of Prop 1

- The Mental Health Services Act, MHSA, was passed by California voters in November 2004 and went into effect in January 2005.
- In March of 2024, California voters approved Proposition 1, authorizing a general bond measure to address homelessness and to reform the MHSA with a goal to transform and modernize California's behavioral health system.

Legislative Background of Prop 1 (con't)

Prop 1 was a two-part measure based on two bills introduced to the California Legislature in February of 2023 which included:

- **Assembly Bill (AB) 531 (Irwin)** Creation of a $6.38 billion general obligation bond to fund behavioral health treatment and residential facilities with an emphasis on veterans and individuals with behavioral health needs experiencing homelessness.
- **Senate Bill (SB) 326 (Eggman)** Reform of the Mental Health Services Act (MHSA), as well as the county behavioral health children and adult systems of care and reporting processes.
- **Prop 1, was placed on the ballot for the 2024 primary election and was passed by California voters in March of 2024.**

AB 531 (Irwin)-General Bond Allocations

Types of housing the bond can fund includes:

- Short-term Crisis Stabilization
- Acute & Subacute Care
- Crisis Residential
- Community-based Mental Health Residential
- Substance Use Disorder Residential
- Peer Respite
- Community & Outpatient Behavioral Health Service
- Other Clinically Enriched Longer-term Treatment & Rehabilitation Facilities

High Level Overview of SB 326 (Eggman)

Restructured the Funding Categories

Created a ***New*** Housing Category

Eliminated County-Based Prevention Funding

Eliminated Requirement for Separate Innovation Plans & Created a ***New*** Innovation Fund Overseen by the BHSOAC

Established BHSA as a ***New*** Source of Funding for Substance Use Disorder (SUD) Services

Doubled the State's Allocation of the Tax from **5% to 10%** to Fund ***New*** Workforce & Population-Based Prevention Initiatives

Created ***New*** Priority Populations

Changes to the Community Program Planning (CPP) Process & Expanded Stakeholders

Created ***New*** Structure for Planning, Data Gathering, Reporting, & Accountability Across **ALL** County Behavioral Health Funding Streams

Increased Focus on Maximizing Medi-Cal Billing

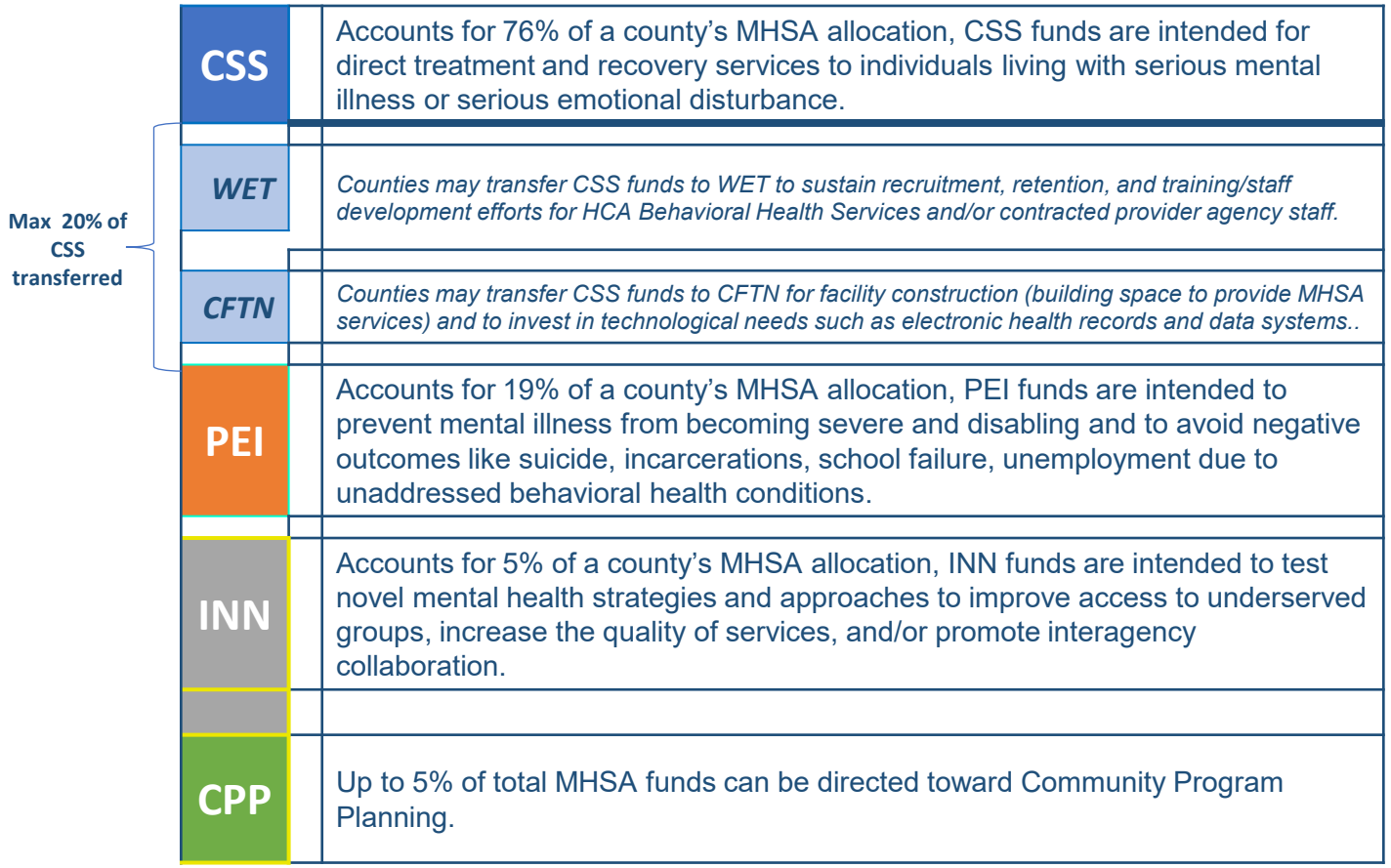
Changed Role & Responsibilities of State Partners

High Level Overview of Changes

MHSA Plan Structure

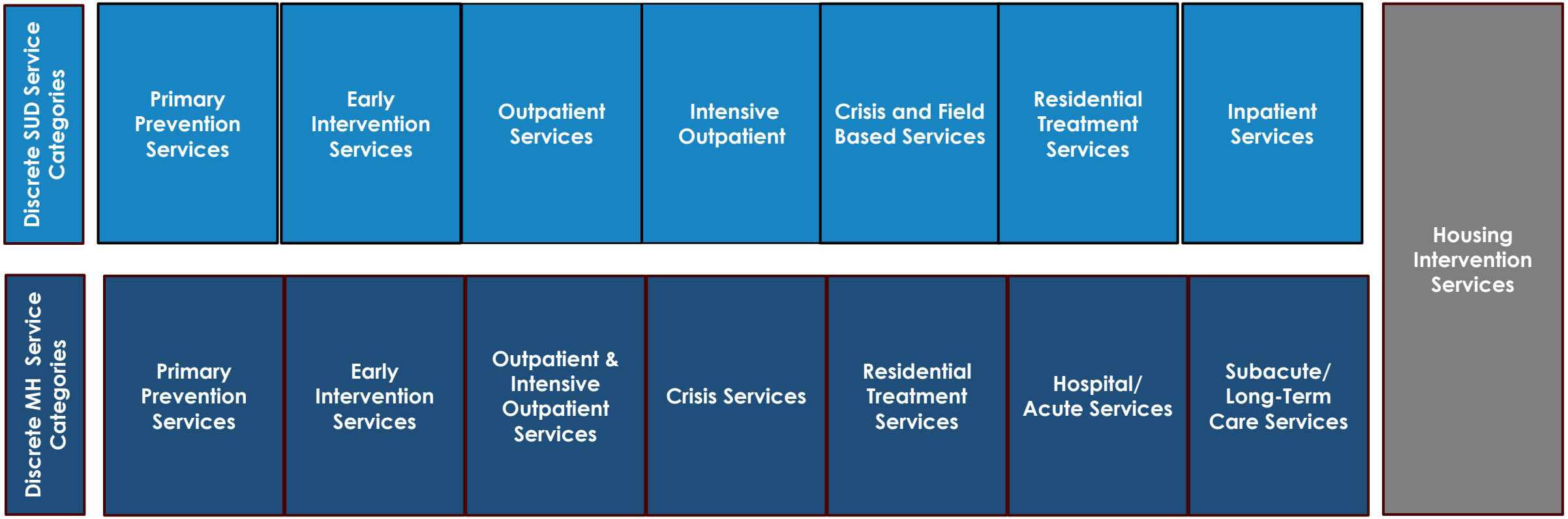
The MHSA Plan is structured according to each component and includes:

- Overview of Community Program Planning Process.
- Description of Component Programs, services, numbers to be served, and populations.
- MHSA Component Funding Summary
- Results (outcomes/outputs) from previous full fiscal year of data.
- Required certifications.



Behavioral Health Care Continuum

3-Year Integrated Plans (IPs) structure for **ALL** county behavioral health funding sources, not just the BHSA, reported in a Behavioral Health Care Continuum.



Source: BHSA County Policy Manual Version 1 2.2 – April 2025

BHSA Goals & Priority Population

Behavioral Health Transformation Initiatives

Builds upon and aligns with other major behavioral health initiatives in California including:

- California Advancing and Innovating Medi-Cal (CalAIM) Initiative
- California Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT) Initiative
- Children and Youth Behavioral Health Initiative (CYBHI)
- Medi-Cal Mobile Crisis services
- Behavioral Health Bridge Housing Program
- Community Assistance, Recovery, and Empowerment (CARE) Act, Lanterman-Petris-Short Conservatorship Reforms
- 988 Expansion
- Behavioral Health Continuum Infrastructure Program (BHCIP)

Overarching BHSA Goals

- **Reduce homelessness**
- Focus on “vulnerable populations” with emphasis on the **unhoused and children/youth**
- Requires evidence-based practices (EBPs) and community-defined evidence practices (CDEPs) **across all funding categories**
- Whole person approach that is **trauma-informed**
- Emphasis on **reducing disparities**
- Increased transparency and accountability through **state goals**
- **Alignment** of state behavioral health initiatives

Statewide Population Behavioral Health Goals

Health equity will be incorporated in each of the BH Goals

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

BHSA Priority Populations

***Individuals living with serious mental illness and individuals living with substance use disorders who qualify for specialty mental health services:**

Eligible Children and Youth who:
Are chronically homeless or experiencing homelessness or at risk of homelessness
Are in, or at risk of being in, the juvenile justice system
Are reentering the community from a youth correctional facility
Are in the child welfare system
Are at risk of institutionalization

Eligible Adults and Older Adults who:
Are chronically homeless or experiencing homelessness or at risk of homelessness
Are in, or at risk of being in, the justice system
Are reentering the community from state prison or county jail
Are at risk of conservatorship
Are at risk of institutionalization

Source: BHSA County Policy Manual Version 1 2.2 – April 2025 and new BHSA language W&I Code section 5892 subdivision (d)

BHSA Eligible Populations

Eligible children and youth means persons who are 25 years of age or under who meet either of the following:
Meet SMHS access criteria specified in subdivision (d) of W&I Code section 14184.402 and implemented in SMHS guidance 11 (includes individuals 21-25 years of age who meet this criteria) OR
Have at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders.
Eligible adults and older adults means persons who are 26 years of age or older who meet either of the following:
Meet SMHS access criteria specified in W&I Code section 14184.402, subdivision (c) and implemented in DHCS guidance 13 (only applies to individuals 26 years of age and older) OR
Have at least one diagnosis of a moderate or severe substance use disorder from the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of tobacco-related disorders and non-substance-related disorders.

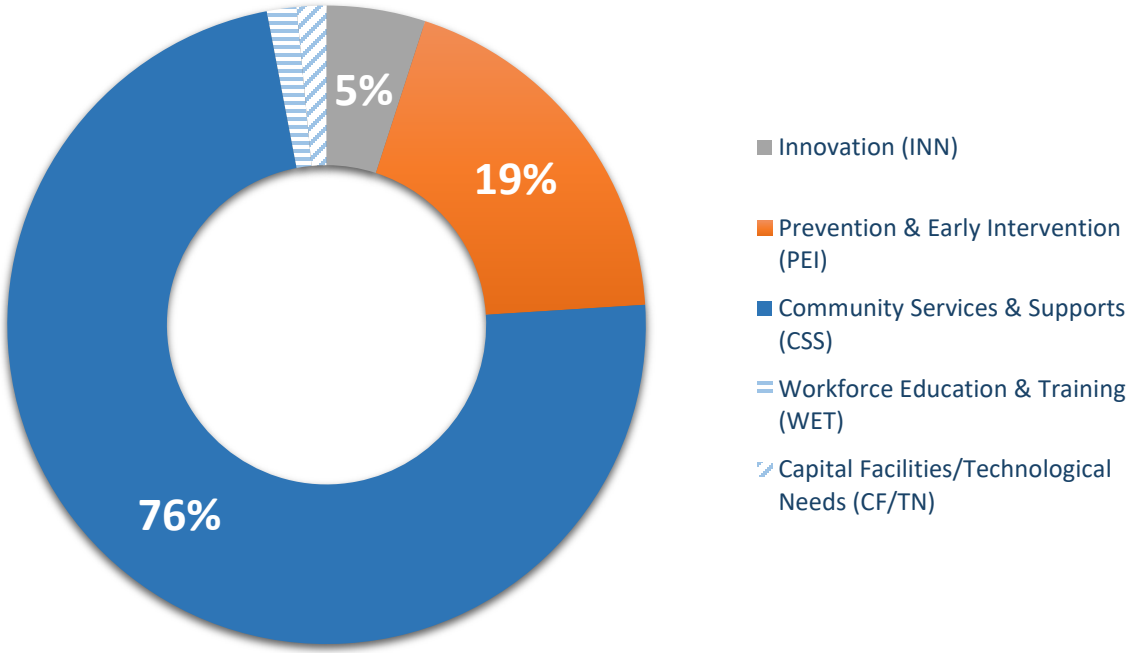
Source: BHSA County Policy Manual Version 1 2.2 – April 2025 and W&I Code section 14184.402 subdivisions (c) and (d)

Fiscal Restructuring and BHSA Funding Categories

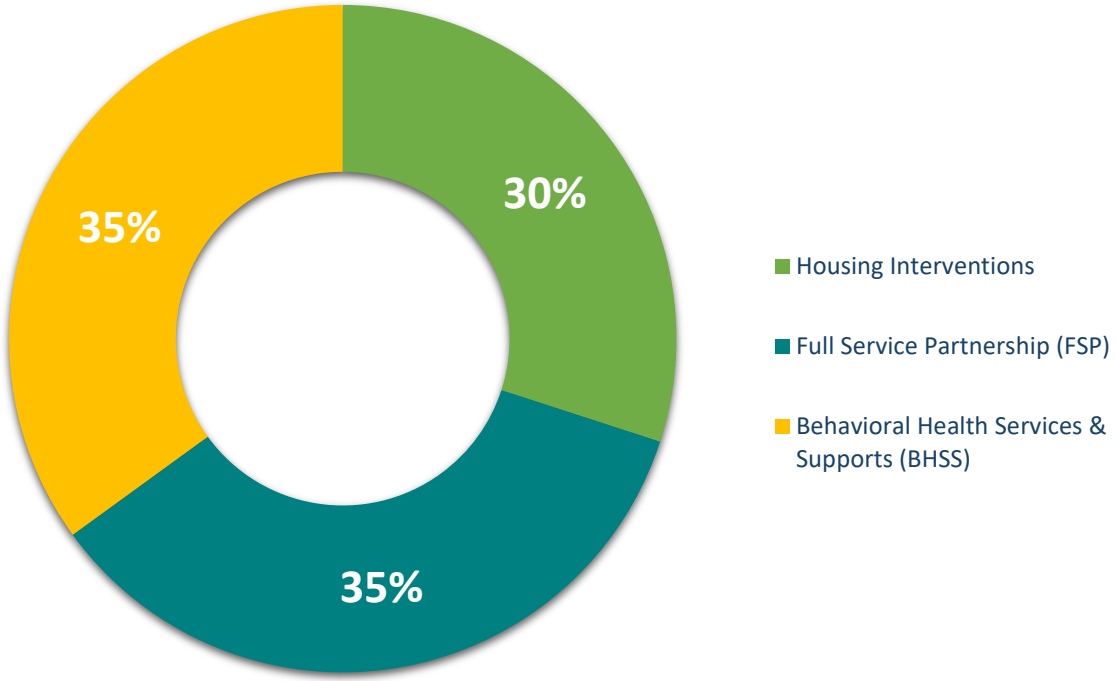
Modernization: MHSA to BHSA

Modified from 5 Funding Components to 3 Funding Categories

Current MHSA Funding Components



BHSA Funding Categories



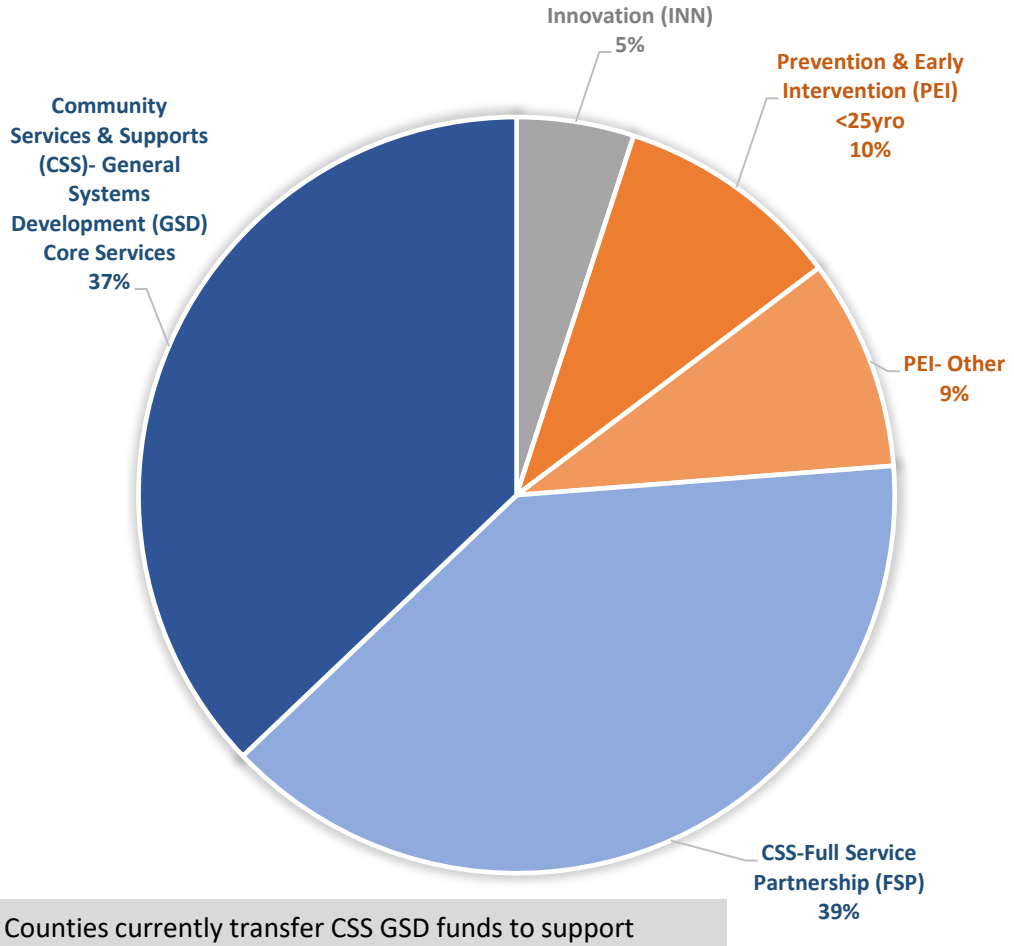
Source: Current MHSA language W&I Code section 5892 subdivision (a)

Note: Up to 5% of the total local millionaire's tax annual revenue can be used to support Community Planning Activities

MHSA Components vs. BHSA Categories

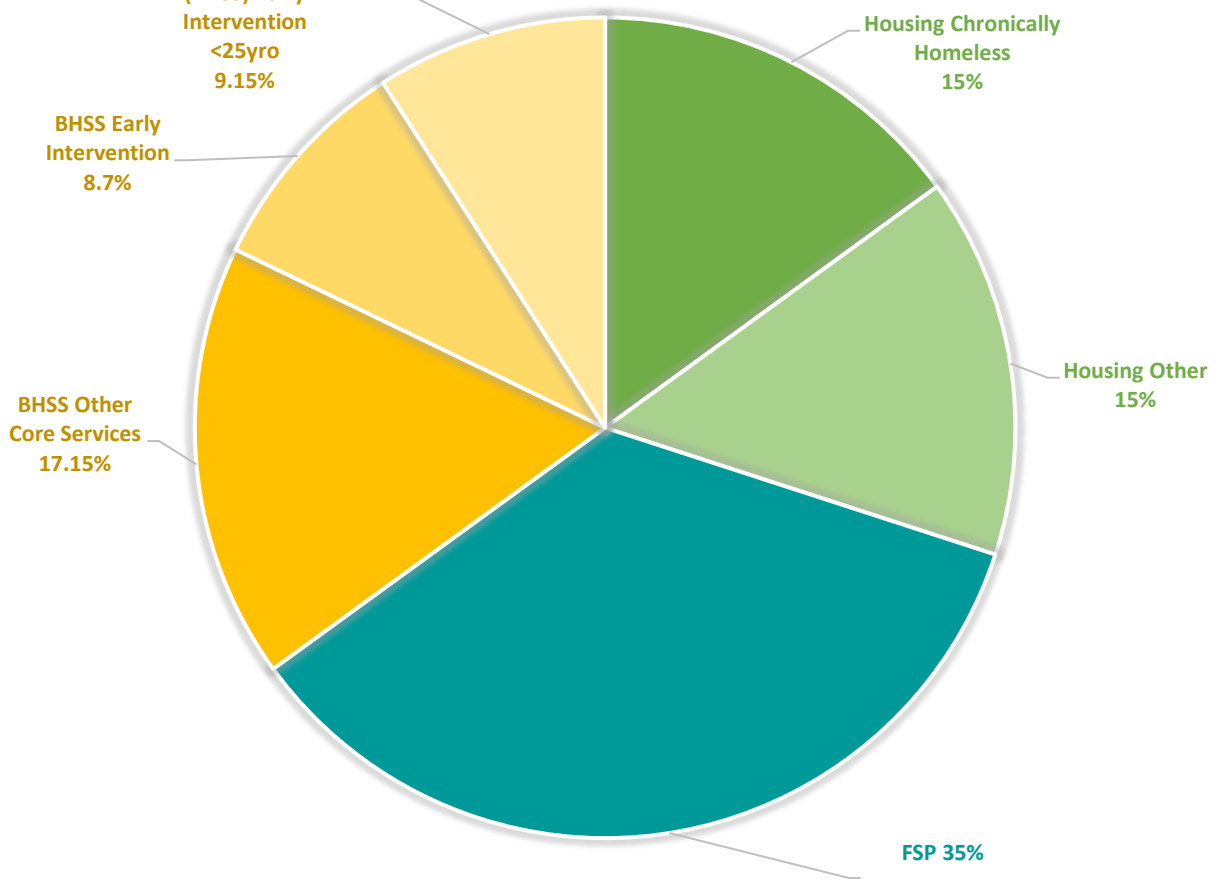
Local Allocations at County Level (% of total County allocation)

Current MHSA Funding Components



Counties currently transfer CSS GSD funds to support Workforce Education and Training (WET) initiatives and Capital Facilities & Technological Needs (CF/TN)

BHSA Funding Categories



BHSA Housing Interventions

Core components of the Housing First Model are required across all Housing Interventions

30% of BHSA Funds: **Housing Interventions** include:

- **Rental Subsidies**:
  - Rental Assistance
  - Project-Based Housing Assistance
  - Master Leasing
- **Operating Subsidies**
- **Allowable Settings**
- **Other Housing Supports:**
  - Landlord Outreach & Mitigation Funds
  - Participant Assistance Funds
  - Housing Transition Navigation Services and Tenancy & Sustaining Services
  - Outreach and Engagement (maximum of up to 7%)
- **Other Housing Intervention Requirements**
- **Capital Development Projects (Max 25% of Housing component funds)**
- **Cannot use BHSA to pay for benefits covered by MCP**

Source: BHSA County Policy Manual Version 1 2.2 – April 2025
Post July 1, 2026, new BHSA language W&I Code section 5830

Allowable Housing Settings

Non-Time Limited Permanent Settings

- Supportive housing
- Apartments, including master-lease apartments
- Single and multi-family homes
- Housing in mobile home communities
- Single room occupancy units
- Accessory dwelling units, including Junior Accessory Dwelling Units
- Tiny Homes
- Shared housing
- Recovery/Sober Living housing, including recovery-oriented housing
- Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
- License-exempt room and board
- Other settings identified under the Transitional Rent benefit

Time Limited Interim Settings

- Hotel and motel stays
- Non-congregate interim housing models
- Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) (does not include behavioral health residential treatment settings)
- Recuperative Care
- Short-Term Post-Hospitalization housing
- Tiny homes, emergency sleeping cabins, emergency stabilization units
- Peer respite
- Other settings identified under the Transitional Rent benefit

Source: BHSA County Policy Manual Version 1 2.2 – April 2025

Full Service Partnership (FSP) Category

35% of BHSA Funding: FSP programs provide individualized intensive recovery-focused, age-appropriate care for individuals with significant behavioral health needs

FSP Eligible

Level 2: Assertive Community Treatment (ACT)
Stand-alone EBP for Highest Need Adults and Older Adults

Level 1: FSP Intensive Case Management (ICM)
Higher Need Adults and Older Adults

BHSS/ Outpatient Eligible

Outpatient MH and SUD Services
Individuals stepping down from FSP ICM who no longer meet the threshold for FSP and should receive outpatient services as needed

High Fidelity Wraparound (HFW) is required for children/youth. BHSA eligible TAY (age 16-25) and younger may receive ACT, FACT, FSP ICM or HCW if determined to be clinically and developmentally appropriate.

Source: BHSA County Policy Manual Version 1 2.2 – April 2025 and new BHSA language W&I Code section 5887

Full Service Partnership (FSP) (con't)

Represents **35%** of the Total Local BHSA Funds

- **FSP programs provide individualized intensive recovery-focused, age-appropriate care for individuals with significant behavioral health needs**
- Services are delivered by multidisciplinary teams in partnership with families or the individual's natural supports and are anchored in a "**whatever it takes**" philosophy
- Counties are required to utilize EBPs and CDEPs
- FSP programs are required to conduct the ASAM screening during the intake assessment
- FSP programs **must** include SUD treatment where appropriate including Medication Assisted Treatment (MAT)
- FSP programs **must** provide ongoing engagement services to include peer support services, transportation and services to support maintaining housing.
- FSP teams are required to coordinate with a FSP participant's primary care provider as appropriate

Source: BHSA County Policy Manual Version 1 2.2 – April 2025 and new BHSA language W&I Code section 5887

FSP Continuum of Care

Treatment Services

- Outpatient behavioral health services for evaluation and stabilization
- Mental health services
- Supportive services
- SUD services
- Ongoing engagement services

EBP Models

- Assertive Community Treatment (ACT)
- Forensic Assertive Community Treatment (FACT)
- Individual Placement and Support (IPS) model of Supported Employment
- FSP Intensive Case Management (ICM)
- High-Fidelity Wraparound (HFW)
- Other EBPs

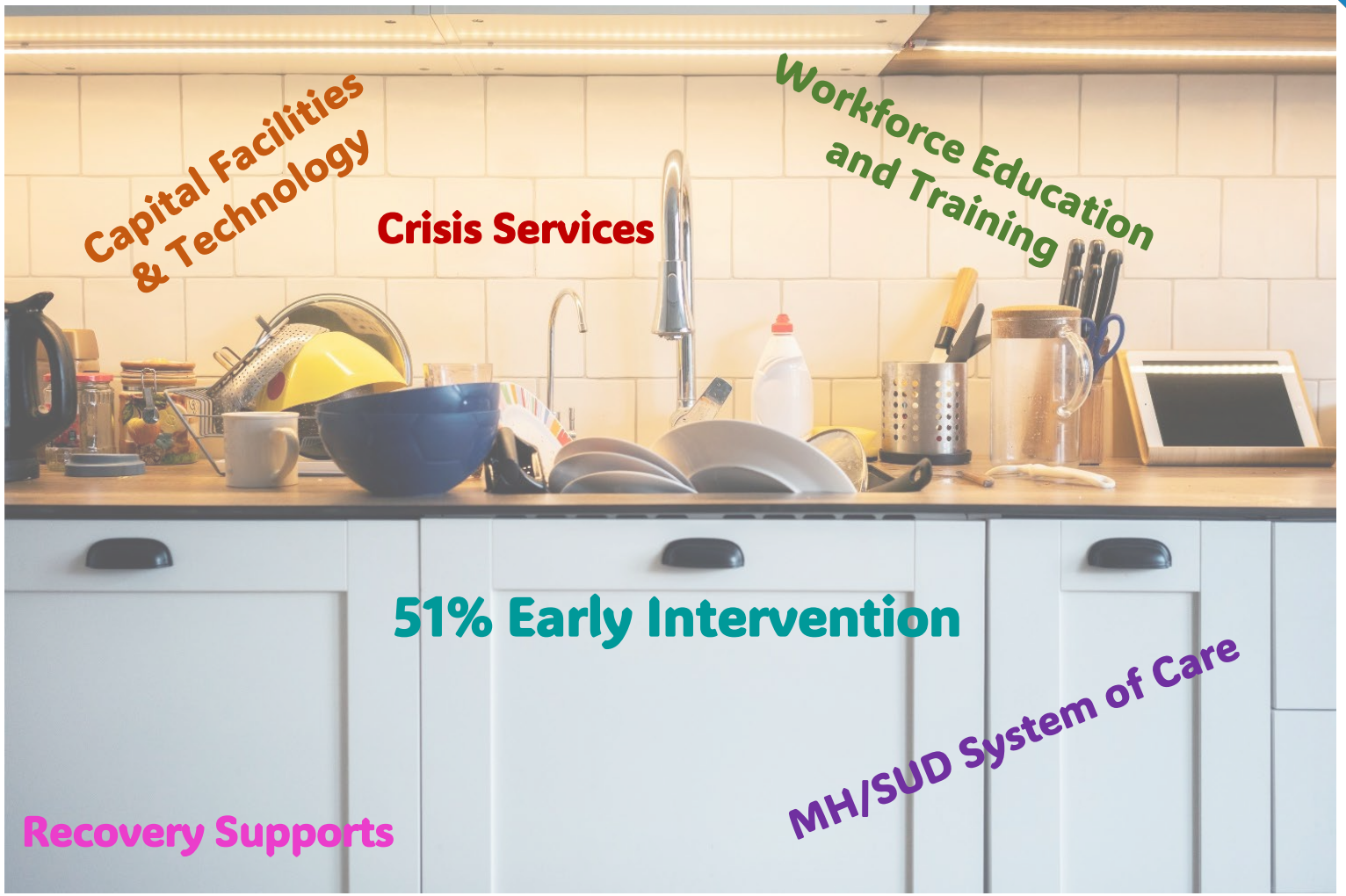
Other Services

- Service planning
- Housing (must be funded under Housing Intervention)
- Outreach
- Recovery-oriented services including peer support services
- Assertive field-based initiation for SUD including mobile teams and street medicine/outreach

Source: BHSA County Policy Manual Version 1 2.2 – April 2025 and new BHSA language W&I Code section 5887

Behavioral Health Services & Supports (BHSS)

Everything else and the kitchen sink!



BHSS Early Intervention (EI) Programming

BHSS EI programs must include outreach, access and linkage to care, MH and SUD early treatment services and supports and must emphasize the reduction of the likelihood of the following adverse outcomes:
Suicide and self harm
Incarcerations
School suspensions, expulsion, referral to an alternative or community school, failure to complete TK-12 or higher education
Unemployment
Prolonged suffering
Homelessness
Removal of children from their homes
Overdose
Mental illness in children/youth

Source: BHSA County Policy Manual Version 1 2.2 – April 2025 and new BHSA language W&I Code section 5840 subdivision (d)

BHSS EI Required Priorities

Current Mandated MHSA PEI Priorities per SB 1004

- Childhood Trauma Prevention & Early Intervention to Deal with Early Origins of Mental Health Needs
- Early Psychosis & Mood Disorder Detection and Intervention, & Mood Disorder and Suicide Prevention Across the Lifespan
- Youth Outreach & Engagement Targeting Secondary Schools &Transition Age Youth both in College or not in College
- Culturally Competent & Linguistically Appropriate Prevention and Intervention including Community Defined Evidence Practices
- Strategies Targeting Mental Health Needs of Older Adults

BHSA Mandated EI Priorities per SB 326

- Childhood Trauma Early Intervention to Deal with Early Origins of Mental Health & Substance Use D/O Needs
- Early Psychosis & Mood Disorder Detection and Intervention & Mood Disorder Programming Across the Lifespan
- Outreach & Engagement Targeting Early Childhood 0-5, inclusive of Out-of-School Youth and Secondary Youth
- Culturally Responsive & Linguistically Appropriate Interventions
- Strategies Targeting Mental Health & Substance Use D/O Needs of Older Adults
- Strategies Targeting MH Needs of Children 0-5 Including Infant & Early Childhood MH Consultation
- Strategies to Advance Equity and Reduce Disparities
- Programs that Include CDEPs and EBPs, and MH and SUD Treatment Services
- Strategies Addressing Needs of Individuals at High Risk of Crisis

Source: BHSA County Policy Manual Version 1 2.2 – April 2025
and new BHSA language W&I Code section 5840.7 subdivision (a)

Additional Funding Considerations

- **Transfers Between Categories**
  - Up to 14% with Max 7% per category
- **Admin Costs**
  - Counties can utilize up to additional 2% (for large counties) of the total annual revenue received to pay administrative costs related to improving plan operations, quality outcomes, fiscal and programmatic data reporting and monitoring of subcontractor compliance for all county behavioral health programs.
- **Prudent Reserve**
  - Max 20% of average of last five years of total

Source: BHSA County Policy Manual Version 1 2.2 – April 2025
and new BHSA language W&I Code section 5892 subdivisions (c) and (e) (2)

State Administered Workforce & Prevention

- **BH Workforce Initiative –** DHCS will administer a portion of the funds, e.g., the **$36M for BH-CONNECT Initiative** and the remaining **ongoing 3%** will be administered by the California Health Care Access & Information (HCAI) department.
  - Workforce funds will be focused on the county behavioral health workforce including county and contractor workforce
  - A portion of the funds can be used to provide technical assistance to support the use of peer support specialists
- **Population-Based Prevention –** CDPH will receive a minimum of 4% of the BHSA funds to administer prevention programming. Focus on stigma reduction and suicide prevention and will target the entire population of the state, a county or a specific community.
  - 51% of the funds **must** be directed to individuals 25 yrs and younger
  - BHSA prohibits use of this funding for 1:1 contacts
  - Allows CDPH to fund the following:
    - School-based health centers, student wellness centers, or student wellbeing centers
    - Group coaching and consultation
    - Student mental health first aid programs
    - Integrated training and support for schools designed to mitigate suspension and expulsion practice
    - Early childhood population-based prevention programs for children 0 to 5 years of age, inclusive, shall be provided in a range of settings

Source: BHSA County Policy Manual Version 1 2.2 – April 2025 and new BHSA language W&I Code section 5892 subdivision (f)

Planning and Reporting

Community Program Planning

Community Program Planning

- Community program planning (CPP) aims to improve the health and well-being of a specific community by identifying community-defined needs, developing strategies, and implementing programs to address those needs.
- Counties may use **up to 5%** of the total annual BHSA revenue received to fund planning costs.

Community Program Planning

Expands list of stakeholders to engage in the community program planning (CPP) process.

- Training for stakeholders is now optional.
- No longer required to engage stakeholders for the annual update or intermittent updates to the IP.

Counties must collaborate with

- Managed Care Plans (Medi-CAL insurance)
- Continuums of care (agency that coordinates homeless services)
- Five most populous cities

Required BHSA Stakeholders

BOLD are new Stakeholders:

- Eligible youth, adults, older adults and families **as defined in Section 5892**
- **Youths or youth mental health/substance use disorder organizations**
- Providers of mental health/substance use disorder treatment services
- Public safety partners including **county juvenile justice agencies**
- Local education agencies
- **Higher education partners**
- **Early childhood organizations**
- **Local public health jurisdictions**
- County social services and child welfare agencies
- **Labor representative organizations**
- Veterans and representatives from veteran organizations
- Health care organizations, **including hospitals**
- **Health care services plans including Medi-Cal managed care plans**
- **Disability insurers**
- **Tribal and Indian Health Program designees**
- **Representatives from the five most populous cities in counties with populations greater than 200,000**
- **Area Agencies on Aging**
- **Independent living centers**
- **Continuum of care including representatives from the homeless services provider community**
- **Regional Centers**
- **Emergency medical services**
- **Community-based organizations serving culturally and linguistically diverse constituents**

Stakeholder representation **must** include individuals representing diverse viewpoints to include but not limited to **youth representatives from historically marginalized communities; representatives from organizations specializing in working with underserved racially and ethnically diverse communities; representatives from LGBTQ+ communities; victims of domestic violence and sexual abuse; people with lived experience of homelessness.**

Source: W&I Code section 5963.03 subdivision (a)

Stakeholder Involvement Requirements
MHSA vs. BHSA

Counties shall demonstrate a partnership with stakeholders throughout the CPP process that includes stakeholder involvement on mental health and substance use disorder:

MHSA
Mental health policy
Program planning and implementation
Monitoring
Quality improvement
Evaluation
Budget allocations

BHSA*
Mental health **and substance use disorder policy**
Program planning and implementation
Monitoring
Workforce
Quality improvement
Health equity
Evaluation
Budget allocations

*Beginning January 1, 2025. **BOLD** is new.

Source: BHSA County Policy Manual Version 1 2.2 – April 2025 and new BHSA language W&I Code section 5963.03 subdivision (a)

Local Review Process

Engage the Community – Listening Sessions, Focus Groups, Community Forums/Townhall Meetings, Workgroups/Committees, Client and/or Family Advisory Meetings/Groups, Surveys, Outreach related to CPP, and Key Informant Interviews

Develop *DRAFT* Integrated Plan/Annual Update Document and DHCS Reviews Prior to Public Hearing

Post Integrated Plan/Annual Update Document for 30-Day Public Comment

Hold Public Hearing at the Behavioral Health Advisory Board Signifies the Closure of the Public Comment Period.

Respond to Public Comments and Finalize the Integrated Plan/Annual Update

Submit to County Board of Supervisors (BOS) for Approval and MUST be approved by the BOS before June 30th

Source: BHSA County Policy Manual Version 1 2.2 – April 2025 and new BHSA language W&I Code section 5963.03

OC's BH Integrated Plan Community Planning Timeline

Jan – March 2025

Plan & Assess

Community planning PAC Kick-Off, listening and data sessions throughout county, co-chair(s) recruitment and selection process

Listening and Data Overview Sessions

April –May 2025

Committees & Focus Group

PAC (April) data summary, committee co-chair selected and announced, committee work begins(May); BHAB CPP report out (April)

Workgroups Start

June – Sept 2025

Program Planning

PAC (July) - Committee Report Outs, review for program/system intersectionality, finalize draft programs, align evaluation plans/metrics with state requirements; BHAB CPP report out (July), Community Forums, and Community Needs Survey

Oct – Dec 2025

Draft Plan Review

Draft Plan finalized, internal review, overview at BHAB, PAC (October) and throughout county; CPP report out at BHAB (October)

Jan – March 2026

Approve & Post

DHCS transfer approval, 30 day posting, continue Plan overview meetings during posting, implementation planning, setting up administrative infrastructure

April – May 2026

Public Hearing

Host Public Hearing, implementation planning, establishing admin infrastructure (RFPs, contract modification development, set up of financial tracking mechanisms, evaluation systems, policies and procedures, etc.)

June 2026

Board Approval

Approval, implementation continues upon approval

BHSA 3-Year Integrated Plan (IP)

Counties will be required to use the IP Template developed by the state submitted via a portal.

- County Demographics & Behavioral Health Needs
- How IP Aligns with Local & State Goals
- CPP Process Including Incorporating Managed Care Plan & Local Health Jurisdiction Community Assessments
- Local Review Process & Planning Costs
- Behavioral Health Care Continuum Capacity
- Prevalence Data Related to Mental Health (MH), SUD and Point in Time Count (Homeless Population)
- How IP Addresses Priority Populations
- Demonstration of How the Funds are Allocated Between MH & SUD
- Description of Each Program, Planned Expenditures, and Program Metrics for **ALL** County Behavioral Health Funding Sources
- Prudent Reserve Account
- Workforce Strategy

Oversight and Accountability

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

Provides greater transparency about county behavioral health spending and administration of behavioral health care.

- Includes annual amount received and spent, unspent state and federal funds and reserves.
- Admin costs and planning costs associated with the CPP process.
- Service utilization including # of people served.
- Data related to statewide goals, local goals, disparities data, etc.
- Data related to the workforce including vacancies and # of county employees providing direct clinical services.

Source: BHSA County Policy Manual Version 1 2.2 – April 2025 and new BHSA language W&I Code section 5963.04

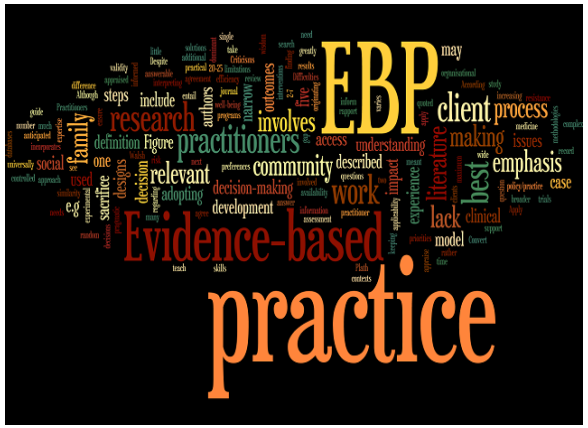
Roles of State Partners

Department of Health Care Services (DHCS)
Determine evidence-based practices (EBPs) and community-defined evidence practices (CDEPs)
Establish statewide goals and metrics
Approval of funding transfer requests
Approval of capital projects funded through the Housing category
Develop FSP levels of care
Review county Integrated Plans and Annual Updates
Impose corrective action plans and monetary sanctions on counties
Provide TA and training to counties

Behavioral Health Services Oversight & Accountability Commission (BHSOAC)
Partner with DHCS to develop a biennial list of EBPs and report on this annually
Participate in the development of statewide metrics and outcomes
Partner with DHCS to develop FSP levels of care
Oversee and administer the new Innovation Partnership Fund
Provide counties with technical assistance related to innovative pilots and projects
Expanded # of commissioners from 16 to 27

DHCS Role & Responsibilities

Determine allowable EBPs and CDEPs



Establish statewide goals and metrics

Approve capital projects and funding transfers

Source: SB 326 bill language

California State Auditor's Role

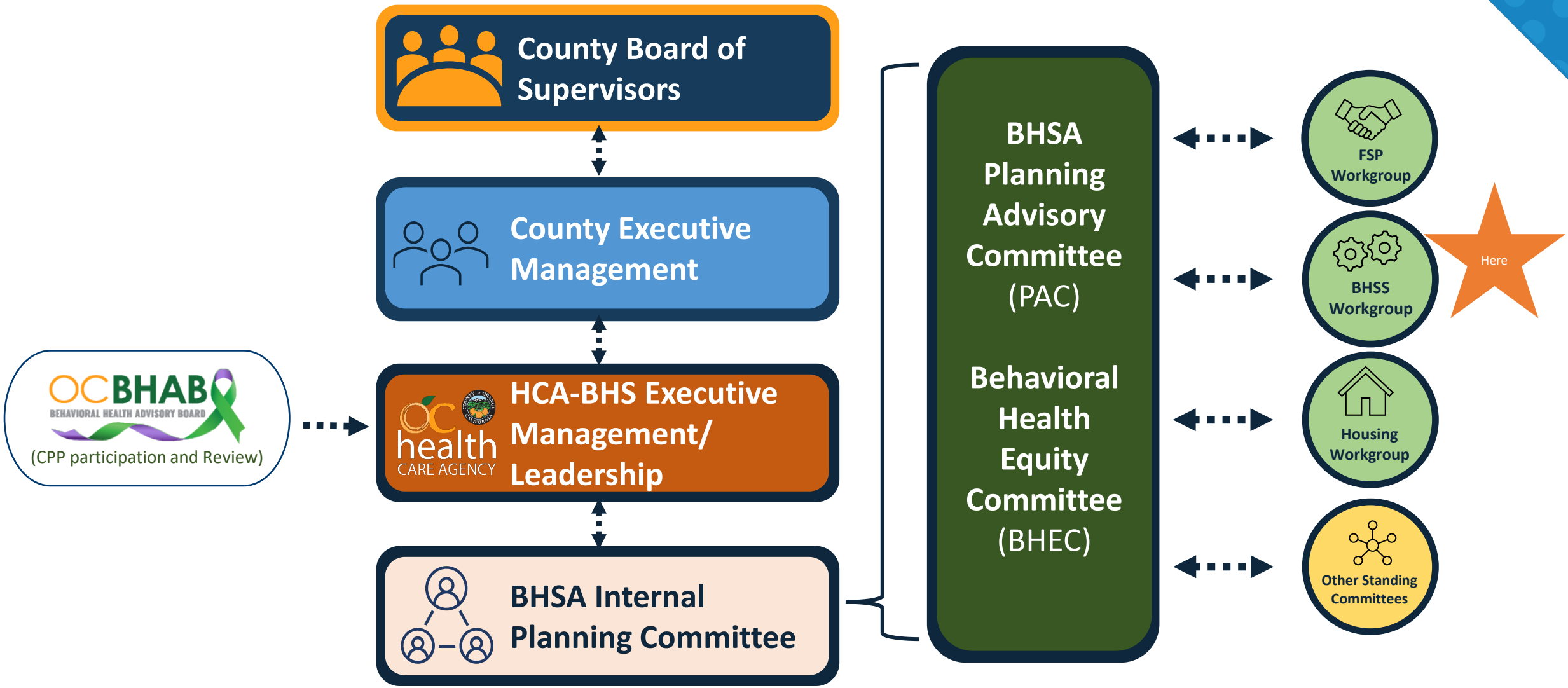
Required to conduct a comprehensive audit and submit a report no later than December 31, 2029, conduct an audit every 3 years thereafter with a final audit due on or before December 31, 2035.

The audit will include:

- Impact of the BHSA including inclusion of SUD for the millionaire's tax
- Timeliness of guidance, training and TA provided by state
- Implementation by all partners
- Revised BHSA allocations, gaps in service and trends in unmet needs
- Outcomes achieved via state administered population-based prevention
- DHCS's oversight of county IPs/AU including use of corrective action, sanctions or both
- Coordination and collaboration occurring during the transition period between state entities and counties
- Recommendations on any changes or improvements indicated by the audit

Opportunities to Participate

Community Program Planning: Framework



BHSA Workgroups

Introduction

Three BHSA Component Workgroups

- ✓ Full-Service Partnership (FSP)
- ✓ Behavioral Health Services and Supports (BHSS)
- ✓ Housing Interventions

Term

One-Year

- ✓ Beginning around May 2025
- ✓ Ending around January 2026
- ✓ No maximum term enforced

Workgroup Makeup

Co-chairs (2)

- ✓ One elected community member
- ✓ One HCA representative

Committee Members

- ✓ Interested community and HCA staff members

Time Commitment

Meetings

- ✓ In-Person or virtually
- ✓ At least 1-2 times/month (TBD by workgroup)

BHSA Workgroups

- This collaborative process will ask consumers, system partners, professionals and other stakeholders to work together to create a more equitable system of care.
- These workgroups will assist with our community program planning to ensure services, treatment and support programs are strategically aligned with community priorities, resources are used effectively, and desired outcomes are attained.

YOU can help to improve the health and well-being of the community.

YOU can help identify community-defined needs.

YOU can help develop strategies to address those needs.

Email bhsa@ochca.com if you are interested in participating!

Focus Groups and Community Forums

Focus Groups

- Currently being scheduled for April-June 2025
- 60-90 minutes
- In person or virtual
- Small groups (10-15 people)
- Short presentation or talking points related to BHSA and pending changes followed by time to ask committee participants pre-defined questions on community gaps and needs.

Community Forums

- Currently being scheduled for June-July 2025
- Date and Time -TBD
- In person
- Large groups (150-200 people)
- Presentation related to BHSA and pending changes followed by an open dialogue and collaboration to share ideas, ask questions or discuss issues affecting the community.

Questions & Discussion

Are there any questions related to Prop 1 and the BHSA?

Are there any questions related to the BHSA Workgroups?

Thank you for your participation.

For questions or to request a meeting, please contact
Michelle Smith at msmith@ochca.com or call (714) 834-3104

For BHSA information
please call (714) 834-3104 or email bhsa@ochca.com

Access QR code for information!

Or access information on the BHSA website

OC Health Care Agency

@ochealthinfo

@ochealth

@oc_hca

@ochealth

www.ochealthinfo.com