



# CONTRA COSTA COUNTY

## AGENDA

### Transitional Community Advisory Board

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Monday, April 13, 2026

5:30 PM

1025 Escobar Street #110, Martinez, CA  
94553 | 3650 Mt. Diablo Blvd, Ste 180 in  
Lafayette, CA 94549 | Contra Costa  
College  
2600 Mission Bell Drive  
San Pablo, CA 94806 |  
[https://cccouny-us.zoom.us/j/828961768](https://cccouny-us.zoom.us/j/82896176897)  
97, Dial in: 1-408-961-3929,  
82896176897#

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Agenda Items: Items may be taken out of order based on the business of the day and preference of the Committee

Roll Call and Introductions

Public comment on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to two minutes).

1. APPROVE Record of Action minutes from March 9, 2026 TCAB meeting [26-1587](#)  
**Attachments:** [TCAB Minutes 03.09.26](#)  
[TCAB Meeting Slides 04.13.26](#)
2. RECEIVE update on Request for Qualifications for the Lead Entity for Federal D. Glover Community Wellness Network [26-1588](#)
3. DISCUSS Request for Proposals development process and RECEIVE Ad Hoc committee assignments [26-1589](#)

4. RECEIVE presentations from Contra Costa Health Services and Employment and Human Services Departments [26-1590](#)

**Attachments:** [1. CCH Behavioral Health A3 Brochure](#)  
[2. CCH Housing Navigation Services](#)  
[3. CCH Maternal and Infant Health](#)  
[4. CCH Preventative Health Care April2026](#)  
[5. CCH Reentry Population Services](#)  
[6. EHSD Resource Navigation for Benefits](#)

The next meeting is currently scheduled for May 11, 2026.

Adjourn

The Committee will provide reasonable accommodations for persons with disabilities planning to attend the Committee meetings. Contact the staff person listed below at least 72 hours before the meeting. Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Committee less than 96 hours prior to that meeting are available for public inspection at 1026 Escobar St., #2B, Martinez, CA 94553, during normal business hours. Staff reports related to items on the agenda are also accessible online at [www.contracosta.ca.gov](http://www.contracosta.ca.gov). If the Zoom connection malfunctions for any reason, the meeting may be paused while a fix is attempted. If the connection is not reestablished, the committee will continue the meeting in person without remote access. Public comment may be submitted via electronic mail on agenda items at least one full work day prior to the published meeting time.

For Additional Information Contact: Jessica Travenia, [jessica.travenia@oresj.cccounty.us](mailto:jessica.travenia@oresj.cccounty.us).



# CONTRA COSTA COUNTY

1025 ESCOBAR STREET  
MARTINEZ, CA 94553

## Staff Report

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**File #:** 26-1587

**Agenda Date:** 4/13/2026

**Agenda #:** 1.

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**Advisory Board:** Transitional Community Advisory Board  
**Date:** April 13, 2026  
**Subject:** Record of Action  
**Presenter:** Jessica Travenia  
**Contact:** Jessica Travenia, [jessica.travenia@oresj.cccounty.us](mailto:jessica.travenia@oresj.cccounty.us)

### Information

The TCAB will review and approve the Record of Action from the March 9, 2026 meeting.

### Referral History and Update

Standing action item to ensure accuracy of official records.

### Recommendation(s) / Next Step(s)

Approve as submitted or with amendments.

### Motion / Vote Required

**Transitional Community Advisory Body  
Meeting Minutes and Record of Action  
March 9, 2026**

**I. Roll Call and Introductions**

Quorum at 5:38 PM

*Present for quorum:* Dr. Mariah Bruce, Rachel Corona, Loren Dalbert, Chair Edward Harris, Bianca LaChaux, Walter McMath, Willie Robinson, Kim Jones (alternate), Antwanisha Hicks (alternate)

*Present (on-line, exercising Just Cause for voting purposes):* Walter McMath, Vice Chair Dr. Jalaima Nichols, Patt Young (alternate)

*Present post quorum:* Leslie Brown, Angela Butler-Owens, Dr. Fredrick Lee, Nnedi Obembe

*Absent:* Dr. LéJon Payne

**II. APPROVE February 9, 2026 TCAB Record of Action / Minutes**

Motion by Member Dr. Mariah Bruce, second by Member Loren Dalbert to approve February 9, 2026 Record of Action / Minutes.

Ayes: Unanimous

*Public comment:* None

Group also agreed to continue current meeting process agreements.

**III. REVIEW TCAB Scope of Work / Workplan**

RFQ submitted for TCAB approval	03/09/26
RFQ Outreach strategy discussion	03/09/26
RFQ submitted for Equity committee approval	03/16/26
RFQ submitted for BOS approval	03/31/26

*Public comment:* None

Roll call for TCAB members who joined post quorum: Members Angela Butler-Owens, Nnedi Obembe, Dr. Fredrick Lee and Leslie Brown.

**IV. REVIEW and APPROVE Request for Qualifications (RFQ) for Wellness Network Lead Entity**

Motion by Member Willie Robinson, second by Member Dr. Mariah Bruce to move approval of RFQ for Wellness Network Lead Entity.

*Public comment:* None

**Transitional Community Advisory Body  
Meeting Minutes and Record of Action  
March 9, 2026**

Roll call vote in favor: Leslie Brown, Dr. Mariah Bruce, Angela Butler-Owens, Rachel Corona, Loren Dalbert, Pastor Ed Harris, Bianca LaChaux, Dr. Fredrick Lee, Walter McMath, Dr. Jalaima Nichols, Nnedi Obembe, Willie Robinson

Opposed: None

Motion passes.

Discussed RFQ awareness outreach strategy to broaden public awareness of RFQ availability.

List includes:

- Black led nonprofits
- Community-rooted providers
- Healing, Reentry, Housing and Health Networks
- Organizations in East, Central, and West County
- All leaders known to the network, including former Steering Committee

Discussion ensued about media outreach. Director Carr suggested a press release can be disseminated. Vice Chair Nichols asked if TCAB could see existing distribution list. Director Kim indicated that over 5,000 emails are in ORESJ distribution lists. Director Carr asked that TCAB members would assist by advertising to their networks.

Outreach channels include community networks, faith and cultural organizations provider coalitions, county and philanthropy partners, direct outreach of TCAB.

Outreach channels to reach audiences include:

- Community networks
- Faith and cultural organizations
- Provider coalitions
- County and philanthropy partners
- Direct outreach by TCAB members

Member Walter McMath suggested social media outreach including TikTok. Also utilize BOS social media pages. Member Butler-Owens suggested development of a Frequently Asked Questions (FAQ) document to also help increase clarity and understanding.

Target audience for RFQ includes:

- Black-led non-profit agencies
- Community-rooted providers
- Healing, reentry, housing, and health networks
- Organizations in East, Central and West County
- All leaders known to the network, former steering committee

Chair Ed Harris asked if other target audiences should be reached. Member Willie Robinson suggested outreach to Black news outlets in the Bay Area. He will share the information with Staff Jessica Travenia.

**Transitional Community Advisory Body  
Meeting Minutes and Record of Action  
March 9, 2026**

*Public comment:* None

**V. RECEIVE Data Presentation**

Staff Jessica Travenia introduced Staff Emaan Ahmed who assisted in developing the Data Presentation. Delivered slide presentation (included in 03/09/26 meeting agenda packet).

Data presentation introductory statement:

1. The feasibility study and data show that African American harm, disinvestment, and unmet need are concentrated in specific places and driven by specific systems - policing, housing, healthcare, and economic exclusion. Because of that, the County is not just funding programs. It is building a new, Black-led safety net network with shared governance.
2. The feasibility study and data show that Black residents in Contra Costa County are facing overlapping crises in health, housing, reentry, and safety - concentrated in specific neighborhoods and shaped by systemic inequities. This means the people chosen to lead this initiative must be capable of addressing trauma, distrust, and structural barriers, not just managing programs.

Data presentation concluding statement:

This data requires leaders who:

- Are trusted by Black communities in Antioch, Pittsburg, Richmond, and North Richmond
- Have lived or deeply embedded experience navigating systems that have harmed Black families
- Can bridge community wisdom with public systems
- Can lead healing, not just service delivery

TCAB's role is to ensure leadership eligibility criteria reflect these realities - not just professional credentials. It is to ensure that the people and organizations chosen to run this system actually reflect the communities, the trauma, and the solutions described in this data. Further, TCAB's role is to shape eligibility and selection criteria for RFQ and RFP processes so governance is in congruence with data in terms of geography (East, Central and West County), lived experience, community trust, equity and accountability.

*Public comment:* None

Member Willie Robinson noted that census tract of North Richmond has changed drastically. Director Kim stated that services are targeted for African American/Black residents but open to all. Robinson asked, if you design a program to focus on Blacks in community who are most harmed, how do we contend with the changing demographics in a community to ensure that the target population is served? Staff Jessica Travenia noted that even if there are population changes the most harmed population, which historically has been Black residents, will be served. Director Kim added that this initiative has always, and will continue to, prioritize the Black community.

**Transitional Community Advisory Body  
Meeting Minutes and Record of Action  
March 9, 2026**

Director Kim stated that the Request for Proposals (RFP) questions should explore how applicants demonstrate competency, experience and accessibility in effectively engaging the target population.

RFP will be for community-based Service Providers. In addition, existing County services will also be provided through the network.

Staff Jessica Travenia shared priority areas as identified in data studies and community input:

1. Behavioral Health Services
2. Housing Navigation
3. Preventative Health Care
4. Infant and Maternal Health
5. Resource Navigation
6. Reentry Support and Restorative Alternatives

RFP will be discussed at the April meeting along with presentations being made by County providers. The Network will include providers identified via the RFP as well as County providers.

Member Loren Dalbert asked if homeless services include black-led providers. County homeless program will make a presentation at a future TCAB meeting.

Alternate Member Antwanisha Hicks noted that Healthy Places Index (HPI) spoke to education deficits that does not seem to be captured in this initiative. Director Carr shared Phase One does not cover education needs but future phases may do so.

Chair Ed Harris suggested a TCAB running “parking lot” to capture these ideas.

Member Dr. Mariah Bruce stated that her purpose in joining TCAB was to assist this endeavor to partner with education, particularly Contra Costa Community College district.

Chair Ed Harris asked if there could be ORESJ office hours to help provide clarity on TCAB subjects. Staff Jessica Travenia stated yes.

Chair Harris asked for an additional ten (10) minutes added to meeting to cover final agenda items. Member Walter McMath made motion to extend meeting by ten (10) minutes, second by Member Angela Butler-Owens. Motion passes unanimously.

**VI. RECEIVE TCAB Updates and Announcements**

1. TCAB approved RFQ at tonight’s meeting.
2. TCAB discussed RFQ outreach strategy at tonight’s meeting.
3. TCAB received data presentation at tonight’s meeting.
4. TCAB will receive the draft RFP for review and discussion at the April meeting.
5. TCAB will receive presentations from African American focused specialized programs in Contra Costa County at the April meeting.

**Transitional Community Advisory Body  
Meeting Minutes and Record of Action  
March 9, 2026**

**VII. DISCUSS Next Steps**

Chair Ed Harris asked each person to share one word that describes how each person feels about tonight's meeting.

Motion to adjourn meeting made by Member Dr. Mariah Bruce, second by Member Angela Owens-Butler. Unanimous approval.

Meeting adjourned at 7:36 PM

The next meeting is currently scheduled for April 13, 2026 at 1025 Escobar Street, Room 110, Martinez, CA 94553.

# Federal D. Glover Community Wellness Network Transitional Community Advisory Board

Office of Racial Equity and  
Social Justice (ORESJ)  
Contra Costa County  
April 13th, 2026



**5:30 – 5:35 PM**

- **Welcome & Living Community Agreements**
- public comment

**5:35 – 5:40 PM**

- **Action Item: Approve Record of Action**
- public comment

**5:40 – 5:45 PM**

- **Review Scope of Work / Workplan**
- public comment

**5:45 – 5:50 PM**

- **RFQ Revision and Process Update**
- public comment

**5:50 – 5:55 PM**

- **Ad Hoc Committee Assignments**

**5:55 – 6:00 PM**

**Framing: Purpose of Presentations**

**6:00 – 8:00 PM**

- **Contra Costa Health Presentations + TCAB Q&A:**

**8:00 – 8:10 PM**

- **Updates, Announcements & Closing**

**Get to the point, stick to the point**

# T-CAB COMMUNITY AGREEMENTS

CENTER ONE ANOTHER'S WELLBEING AND GROUP WELLNESS

BE THE EXAMPLE

SHOW RESPECT  
RESPECT FELLOW MEMBERS TIME, ENERGY, LABOR, DIFFERENCES

Be Positive

No Hidden Agendas

STEP UP/STEP BACK; TAKE SPACE/MAKE SPACE

TAKE CARE OF YOUR NEEDS, ASK FOR SUPPORT

Unified Purpose

LISTEN TO UNDERSTAND, NOT TO RESPOND

PAUSE FOR QUESTION'S

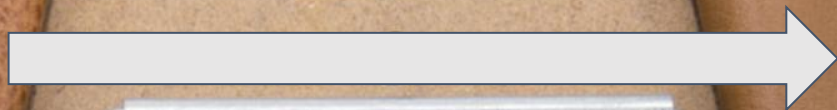
ASSUME GOOD INTENTIONS

STAY SOLUTION-FOCUSED

ASK QUESTIONS



# Action Item



Approve TCAB record of action from 3/9

## Meeting Minutes

Subject		Date	
Facilitator		Time	
Location		Scribe	
Attendees			
Key Points Discussed			

# Work Plan Snapshot: Where we are now??

Who	What	When	Progress
Contra Costa Health	Presentations	Tonight	
ORESJ Staff	RFP Draft	Before May Mtg	
Ad Hoc Groups	RFP edits & funding strategy	Before May Mtg	

# RFQ Update

**Guest: Supervisor Scales- Preston  
Vice-Chair, Equity Committee**



# Ad Hoc Group Assignments

## Qualifications, Eligibility & Geographic Focus

- **Dr. Jalaima Nichols**
- **Walter McMath**
- **Bianca LaChaux**
- **Frederick Lee**
- **Willie Robinson**
- **Rachel Corona**

## Funding Distribution & Service Categories

- **Angela Butler-Owens**
- **Dr. LéJon Payne**
- **Loren Dalbert**
- **Leslie Brown**
- **Patt Young**

## Collaboration Requirements / Network Design

- **Edward Harris**
- **Kim Jones**
- **Dr. Mariah Bruce**
- **Nnedi Obembe**
- **Antwanisha Hicks**

Presentations are for **investment decision-making**

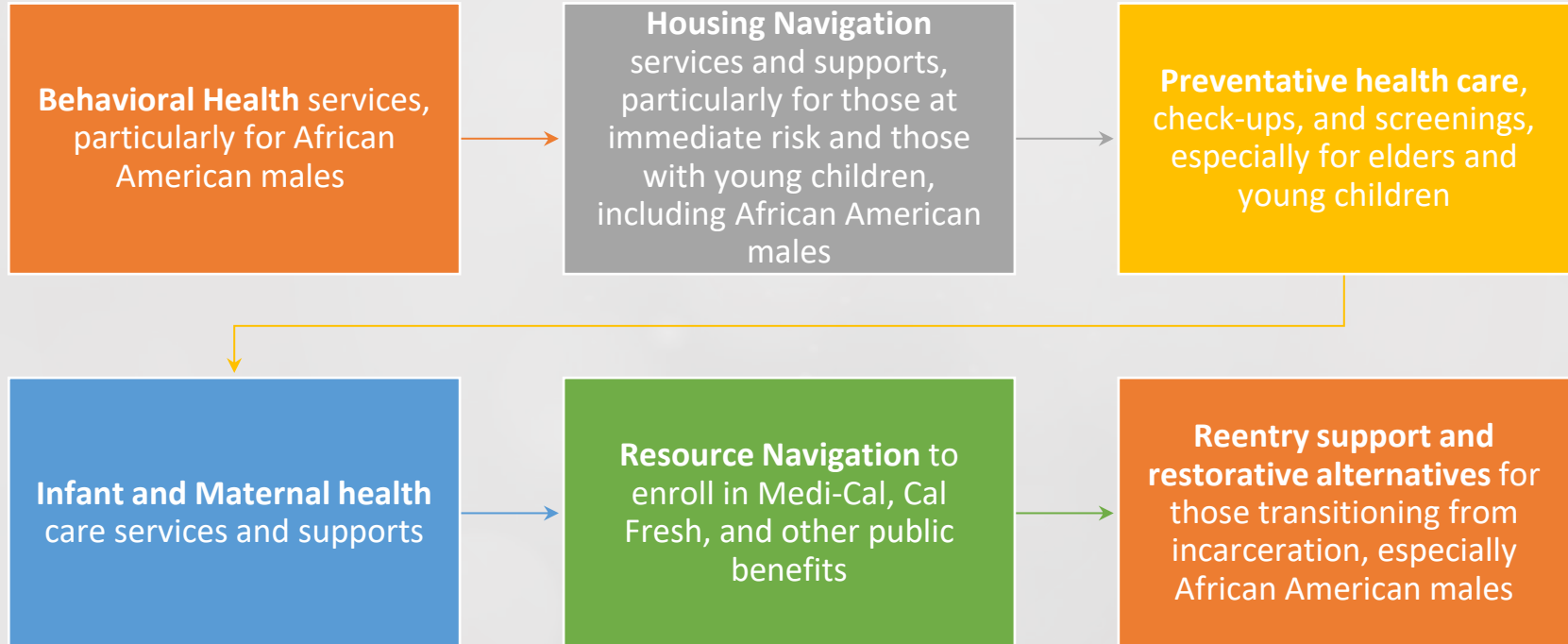
*“Where will investment change outcomes and not just expand services*

### Priority Service Areas

- Behavioral Health
- Housing Navigation
- Preventative Care
- Maternal & Infant Health
- Resource Navigation
- Reentry Support

# Priority Service Categories

## County-Community Partnership



# Updates and Reminders



Who?  
What?  
When?

<b>CCH Staff</b>	Presentation from African American-focused Specialized Programs in County	<b>April TCAB Mtg- 4/13</b>
TCAB	Approval of the Request for Qualifications (RFQ) for Lead Entity	April
TCAB	Outreach Strategy Design	April/May
TCAB	Populate & Identify Invitees to Lead Entity Application Process	April/May
TCAB	Review & edit the Request for Proposals for Service Providers	April/May

# THANK YOU

## for serving on the TCAB!

**Office of Racial Equity and Social Justice**  
1026 Escobar Street, Suite 2B  
Martinez, CA 94553

Kendra Carr, Co-Director

- [kendra.carr@oresj.cccounty.us](mailto:kendra.carr@oresj.cccounty.us)
- (925) 655-4642

Peter Kim, Co-Director

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- (925) 655-4641

Jessica Travenia, Budget & Policy

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- (925) 655-4644



# CONTRA COSTA COUNTY

1025 ESCOBAR STREET  
MARTINEZ, CA 94553

## Staff Report

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**File #:** 26-1588

**Agenda Date:** 4/13/2026

**Agenda #:** 2.

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**Advisory Board:** Transitional Community Action Board  
**Date:** April 13, 2026  
**Subject:** Request for Qualifications update  
**Presenter:** Jessica Travenia  
**Contact:** Jessica Travenia, [jessica.travenia@oresj.cccounty.us](mailto:jessica.travenia@oresj.cccounty.us)

### Information

Supervisor Shanelle Scales-Preston and the Equity Committee Vice Chair will provide an update on the RFQ process, including timeline, milestones, and decision-making framework.

### Referral History and Update

Builds on prior TCAB review and approval of RFQ revisions.

### Recommendation(s) / Next Step(s)

Provide direction and identify any clarifications needed for implementation.



# CONTRA COSTA COUNTY

1025 ESCOBAR STREET  
MARTINEZ, CA 94553

## Staff Report

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**File #:** 26-1589

**Agenda Date:** 4/13/2026

**Agenda #:** 3.

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**Advisory Board:** Transitional Community Advisory Board  
**Date:** April 13, 2026  
**Subject:** Request for Proposals update and Ad Hoc assignments  
**Presenter:** Jessica Travenia  
**Contact:** Jessica Travenia, [jessica.travenia@oresj.cccounty.us](mailto:jessica.travenia@oresj.cccounty.us)

### Information

The TCAB will identify and confirm Ad Hoc Committees aligned to priority service areas to support focused review, input, and recommendations for the RFP process.

### Referral History and Update

Ad Hoc structure previously discussed as part of TCAB governance and implementation support.

### Recommendation(s) / Next Step(s)

Approve committee structure, membership, and scope.



# CONTRA COSTA COUNTY

1025 ESCOBAR STREET  
MARTINEZ, CA 94553

## Staff Report

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**File #:** 26-1590

**Agenda Date:** 4/13/2026

**Agenda #:** 4.

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**Advisory Board:** Transitional Community Advisory Board  
**Date:** April 13, 2026  
**Subject:** Presentations from county departments on priority service areas  
**Presenter:** Jessica Travenia  
**Contact:** Jessica Travenia, [jessica.travenia@oresj.cccounty.us](mailto:jessica.travenia@oresj.cccounty.us)

### Information

Contra Costa Health Services and Employment and Human Services Department representatives will present the specific programs and services provided across six (6) priority service areas: Behavioral Health, Housing Navigation, Preventative Health Care, Infant & Maternal Health, Resource Navigation, and Reentry Services.

Each presentation will include:

- Overview of services
- Populations served
- Current reach within African American communities
- Identified gaps and unmet needs
- Opportunities for investment

Each presentation will be followed by TCAB questions and discussion.

### Referral History and Update

Presentations respond to findings from the feasibility study and prior TCAB Data Dive identifying

priority service areas.

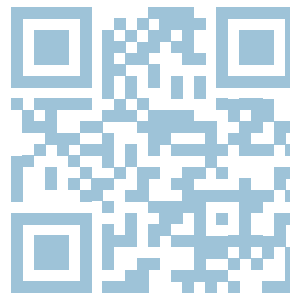
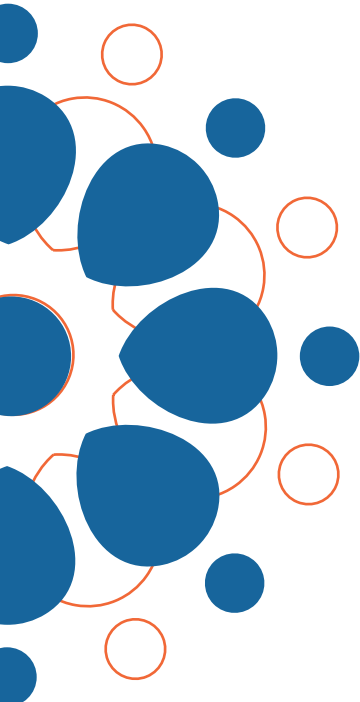
**Recommendation(s) / Next Step(s)**

Provide feedback to inform funding priorities, RFP design, and service alignment.

If you or someone you know is experiencing a mental health crisis, help is available.

 **Call 844-844-5544**

We're here if you need us. If you're unsure about reaching out, don't hesitate to call A3. Our team is ready to offer assistance and support.



*Learn more at*  
[cchealth.org/a3](https://cchealth.org/a3)



## About A3

A3 provides mental and behavioral health crisis support to **anyone, anywhere** at **anytime** in Contra Costa County.

## Who We Are

A3 is a team of behavioral health professionals who are experts in mental health, substance use counseling, peer support and social needs.

## What We Offer

- Help over the phone
- In-person care, if necessary
- Connection to services countywide
- Follow-up care



## Mental Health Crisis Support

### A Need for Help

There are several ways to connect with the A3 Miles Hall Crisis Call Center, including options like 911, 988 and community health providers. However, the direct number is **844-844-5544**.

### Someone to Talk To

Care begins as soon as a call to the call center is answered. Trained staff provide support over the phone, triage presenting issues and determine when an in-person response is necessary.

### Someone to Respond

Specially trained teams are dispatched to the person in need to address the crisis and provide care.

### A Place to Go

The team may determine the person in crisis needs a place to go to get more support, and can connect them to services countywide.

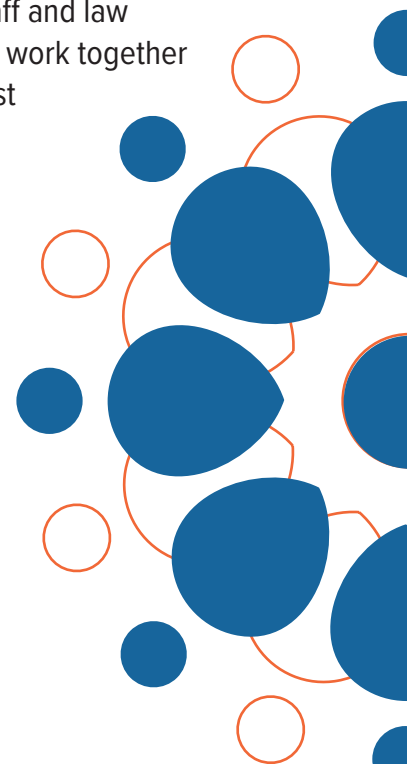
### Follow-Up Care

A3 provides ongoing support through regular follow-up and connection to services.

## What to Expect

After calls to the A3 Miles Hall Crisis Call Center are answered, trained staff will provide care over the phone and assess if an in-person response would be beneficial. Staff will keep callers informed about the estimated time a response team will arrive at the location of the individual experiencing a crisis.

A3 prioritizes safety through ongoing collaboration with local law enforcement. In certain situations, based on careful evaluation, A3 staff and law enforcement may work together to provide the best possible support.



CONTRA COSTA  
**HEALTH**



[cchealth.org](http://cchealth.org)

# Contra Costa Health – Health, Housing and Homeless Services

**Jamie Schecter,  
Homeless Services  
Chief**

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Contra Costa Health and the  
Continuum of Care

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Data Snapshot

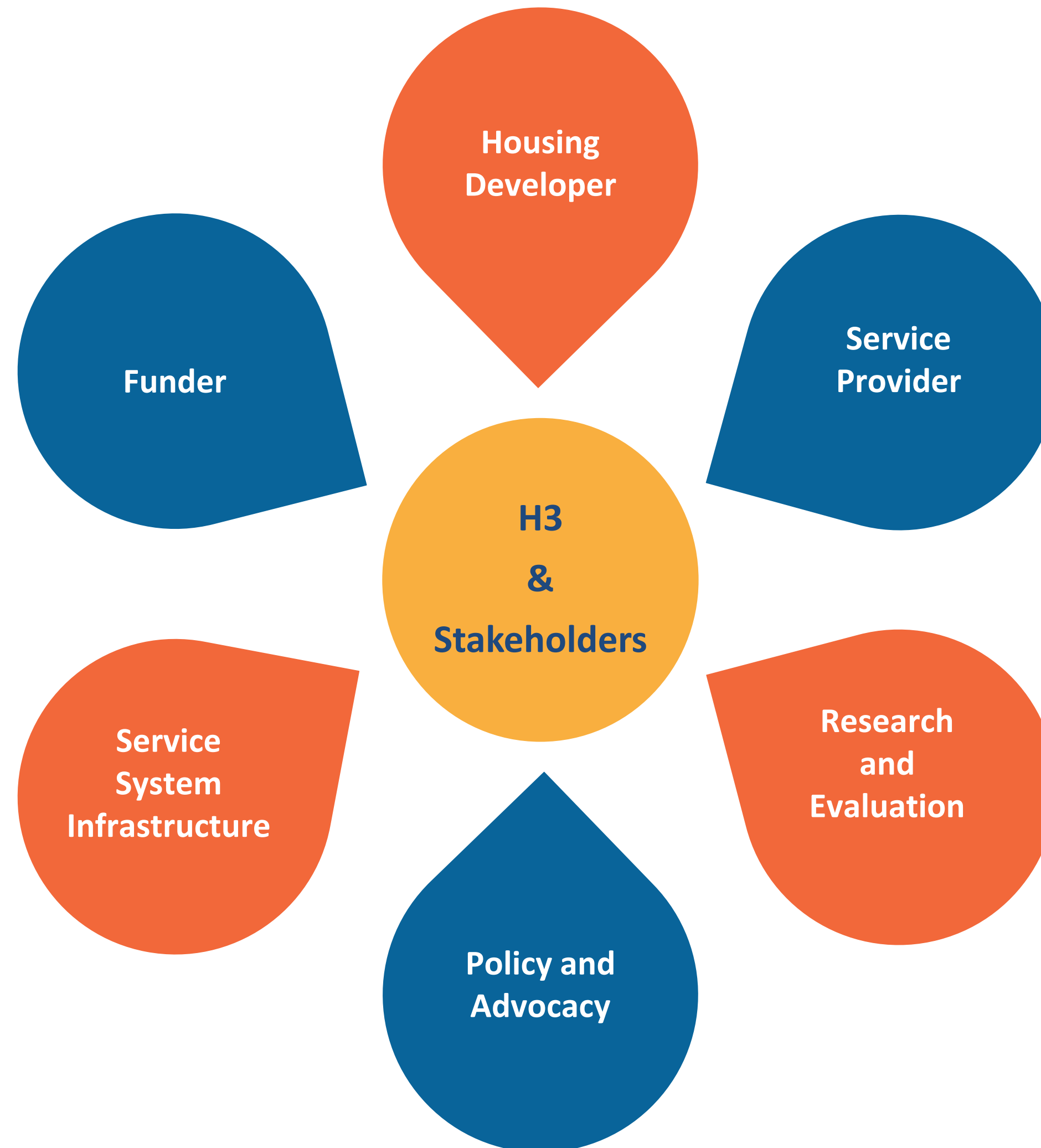
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Services and How to Connect

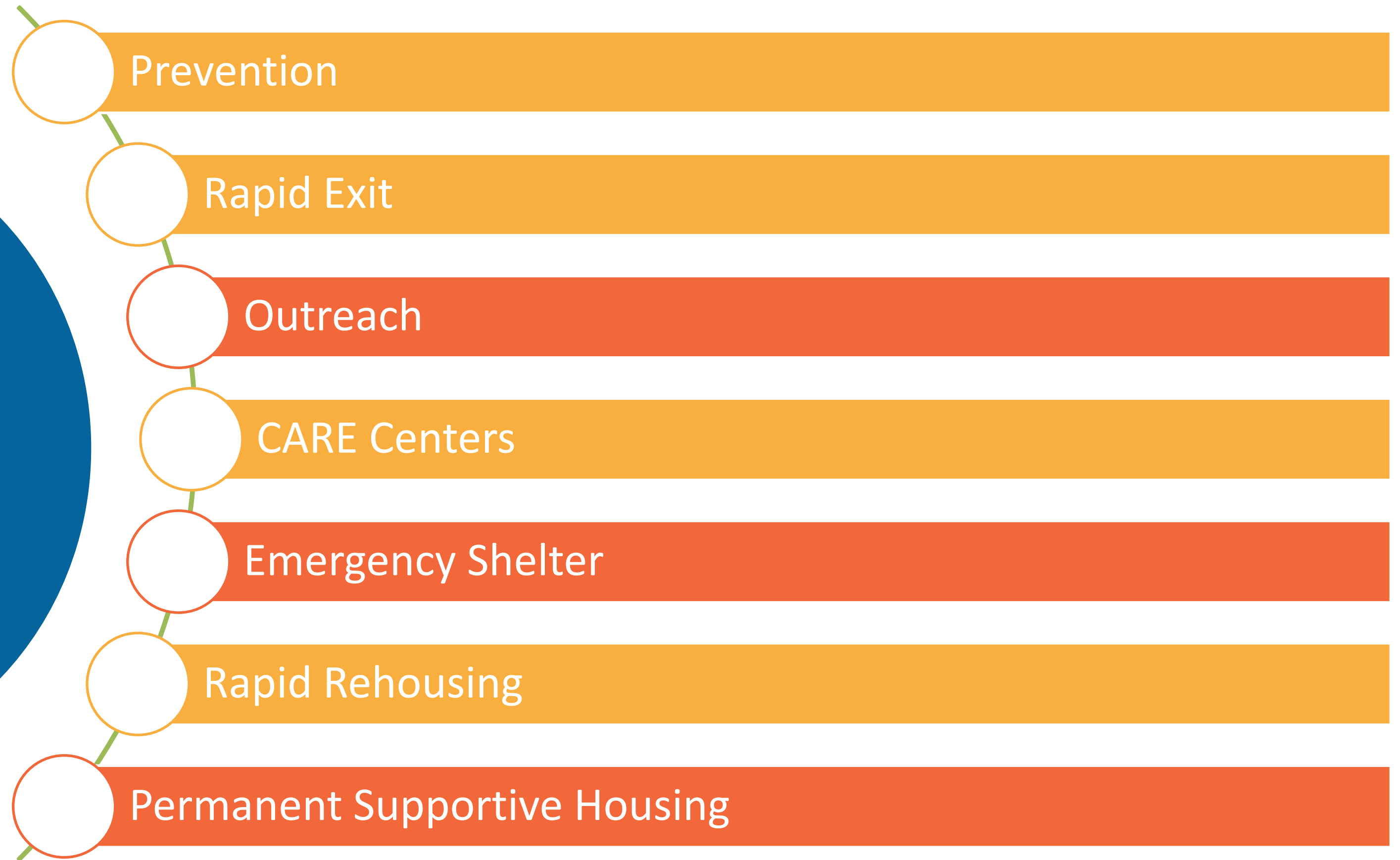
Contra Costa Health - Health, Housing and Homeless Services (H3) is committed to making homelessness short-lived and non-recurring by ensuring an integrated system of housing and support services for persons experiencing homelessness in Contra Costa County.



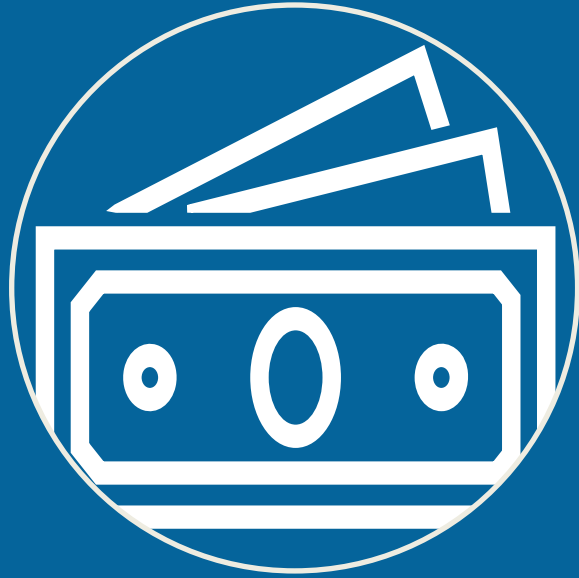
## Roles of H3



<b>LEADERSHIP</b>	CoC Governing Board (appointed by Board of Supervisors)		<b>Contra Costa Council on Homelessness (CoH)</b>					
	CoC Lead Agency HMIS Lead Agency Administrative Entity		<b>Contra Costa Health: Health, Housing &amp; Homeless Services (H3)</b>					
<b>PROVIDERS</b>	Prevention	Rapid Exit	Outreach	Interim Housing/ Emergency Shelter	Transitional Housing	Rapid Rehousing	Permanent Supportive Housing	Permanent Housing
<b>PARTNERS</b>	Health Care (Physical and Mental)	Veterans Affairs	Criminal Justice & Legal Services	Domestic Violence	School Districts	Workforce	Public Safety	People With Lived Experience
<b>STAKEHOLDERS</b>	Cities	County	Community Members	Community Orgs	Funders	And more!		



# Data Snapshot



Workers need to earn **\$45.50/hour** to afford a 2-bedroom apartment in Contra Costa

[Contra-Costa\\_Housing\\_Report-2.pdf](#)



**Cost of housing** is the biggest factor in a community's rate of homelessness

[Colburn, G., & Aldern, C. P. \(2022\). Homelessness is a housing problem: How structural factors explain U.S. patterns. University of California Press](#)

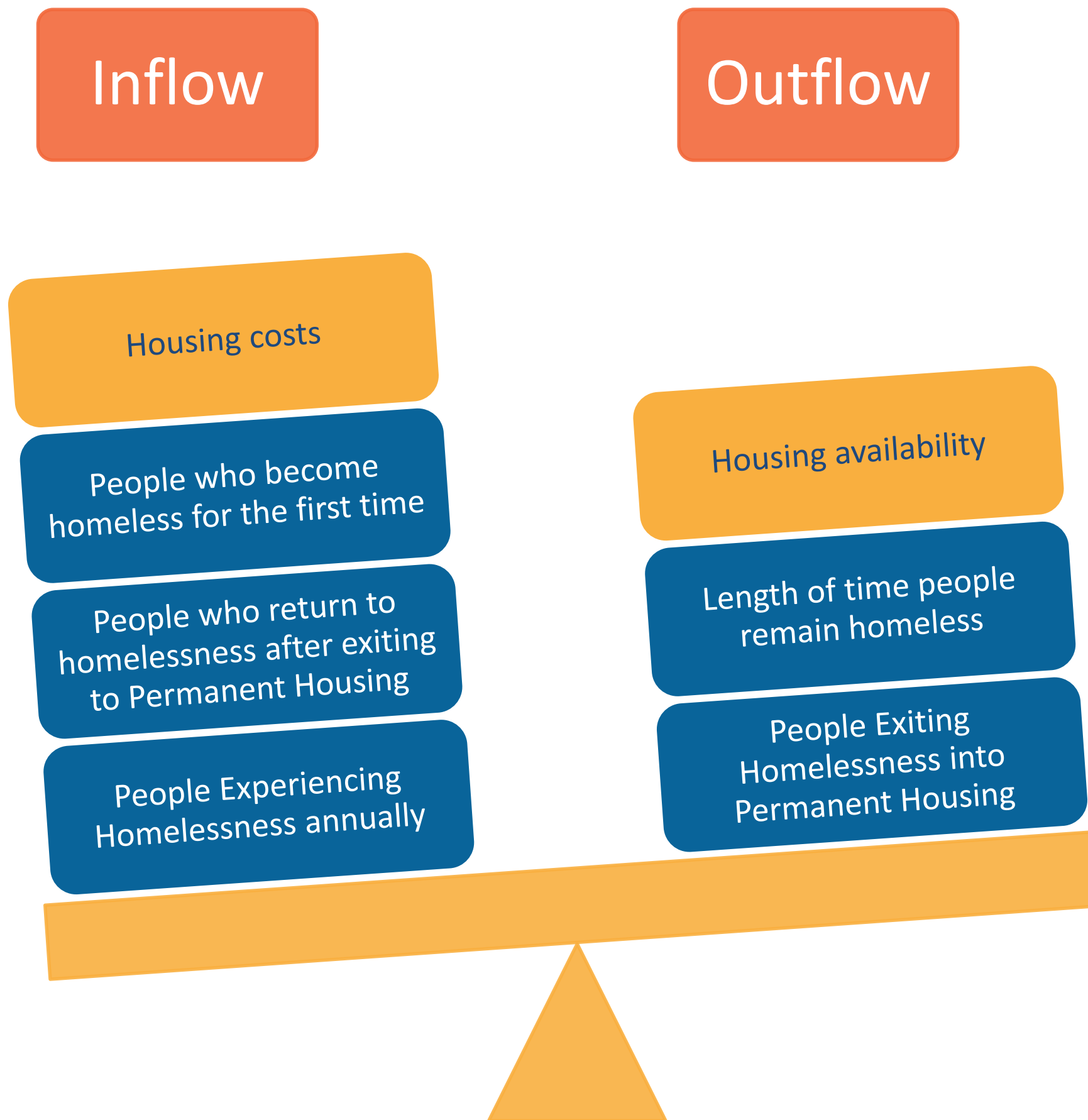


Contra Costa CoC served 14,245 people in 2024, a 40% increase since 2020

2024 Contra Costa HMIS Data



# Key Indicators



9,995 households served (14,245 people)  
**40% increase since 2020<sup>1</sup>**

Black/African American people  
overrepresented 4x<sup>1</sup>

Increased temporary and permanent housing beds by 34% since 2023<sup>2</sup>

79% of people receiving homeless crisis response services\* have a disabling condition

97% of households receiving prevention services retained or exited to permanent housing<sup>1</sup>

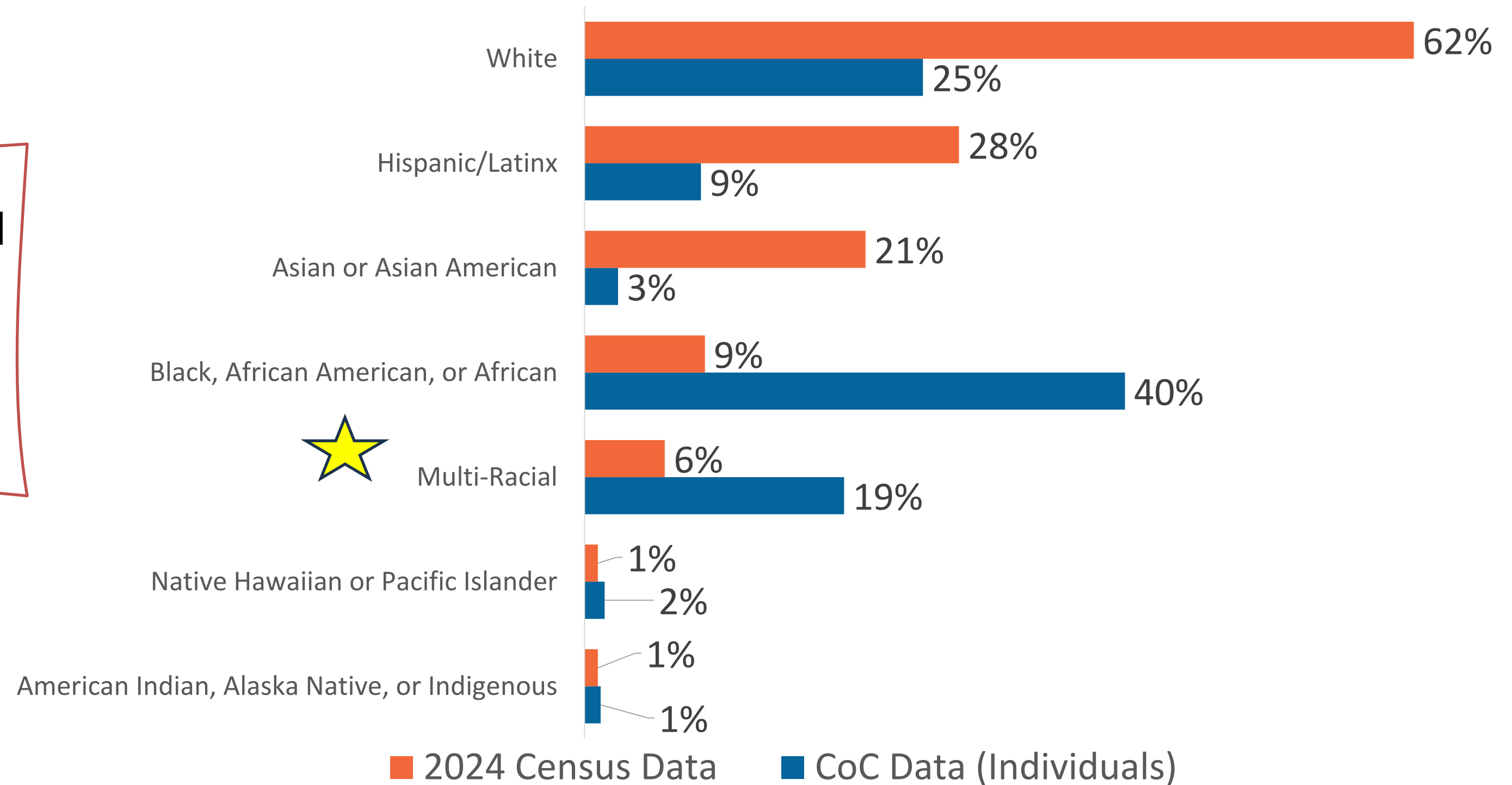
98% of the 1,316 households served in permanent housing programs retained housing<sup>1</sup>

Source: 2024 Contra Costa Continuum of Care Annual Report and [2. 2025 Homeless Point In Time Count - 2025 PIT Count Infographic](#)

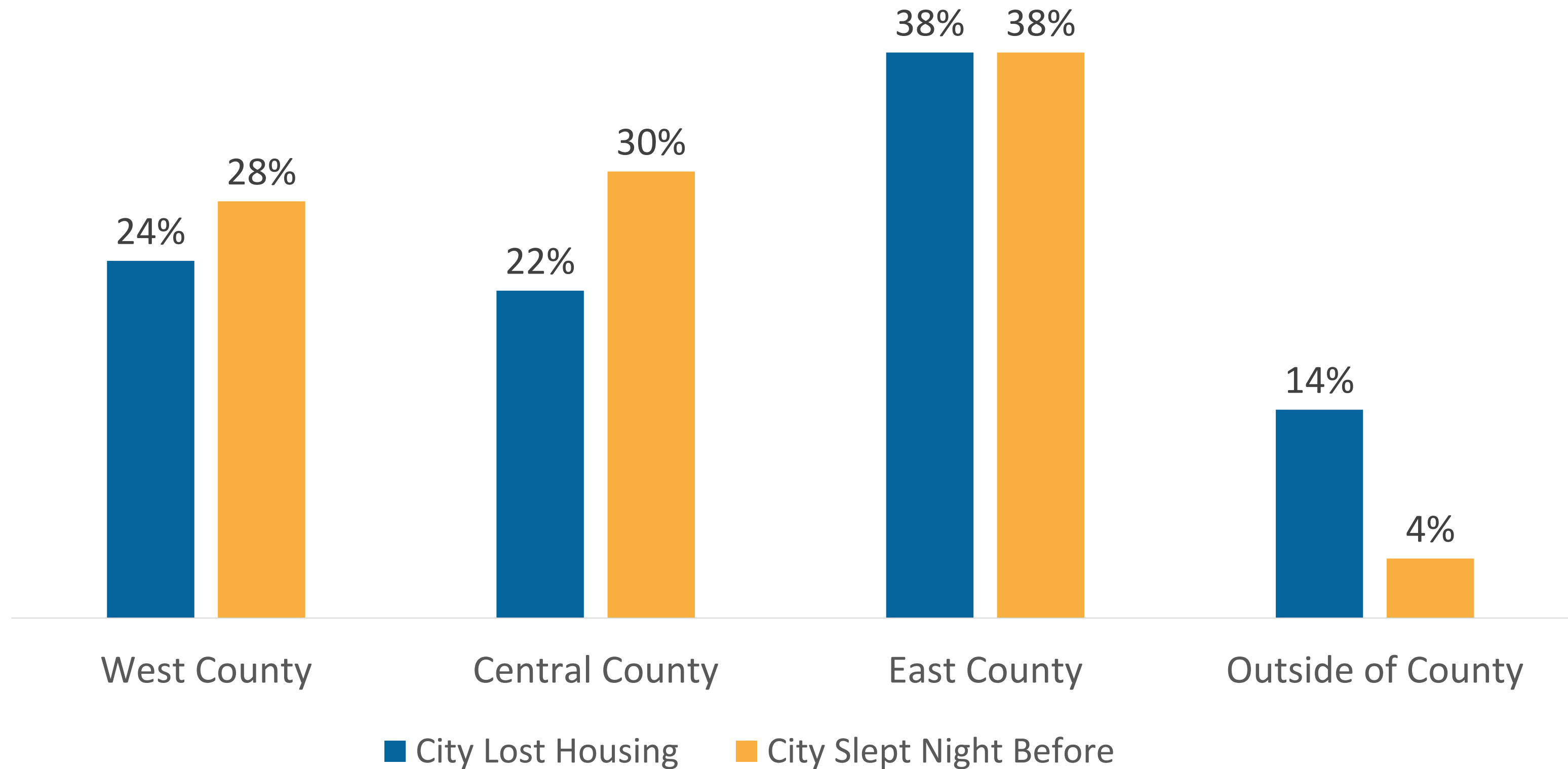
\*Homeless crisis response services include homeless outreach, emergency or interim shelter, basic needs, case management, referrals to financial and social benefits, housing navigation, and linkages to health and housing services.

## Race Distribution in the CoC Compared to 2024 County Census Data Estimates

Black/African American/African and Multi-Racial over-represented relative to County census



## Where Households Lost Housing and City Where Slept Before Enrollment, by Region, 2024



## Black/African American/African Households in the CoC Demographics

Households are more likely to be families with minor children (28% served compared to 18% of CoC overall)

More likely to be women (53% compared to 49% of CoC overall)

Younger (38% under 24 compared to 30% CoC overall)

Fewer older adults (17% compared to 22% of the CoC overall)

Similar rates of exits to Permanent Housing (within 1% of overall exit rate)

# Black/African American/African Households in the CoC – Programs Utilization

## Most Utilized Programs



- CORE Mobile Outreach
- Prevention – Non-Coordinated Entry
- VASH – Veteran Administration Supportive Housing
- Prevention – Coordinated Entry
- CARE Centers and Concord Service Center

## Most Utilized Services



- Outreach – Housing Coordination
- Outreach – Emergency Supplies/Meals
- Service Planning and Delivery Assistance
- Outreach – Coordinated Entry Assessment
- CalAIM Housing Navigation Service

# Black/African American/African Households in the CoC – Geography

## Of the Top 5 Cities where people lost housing in the CoC



More likely to be Black/African American/African

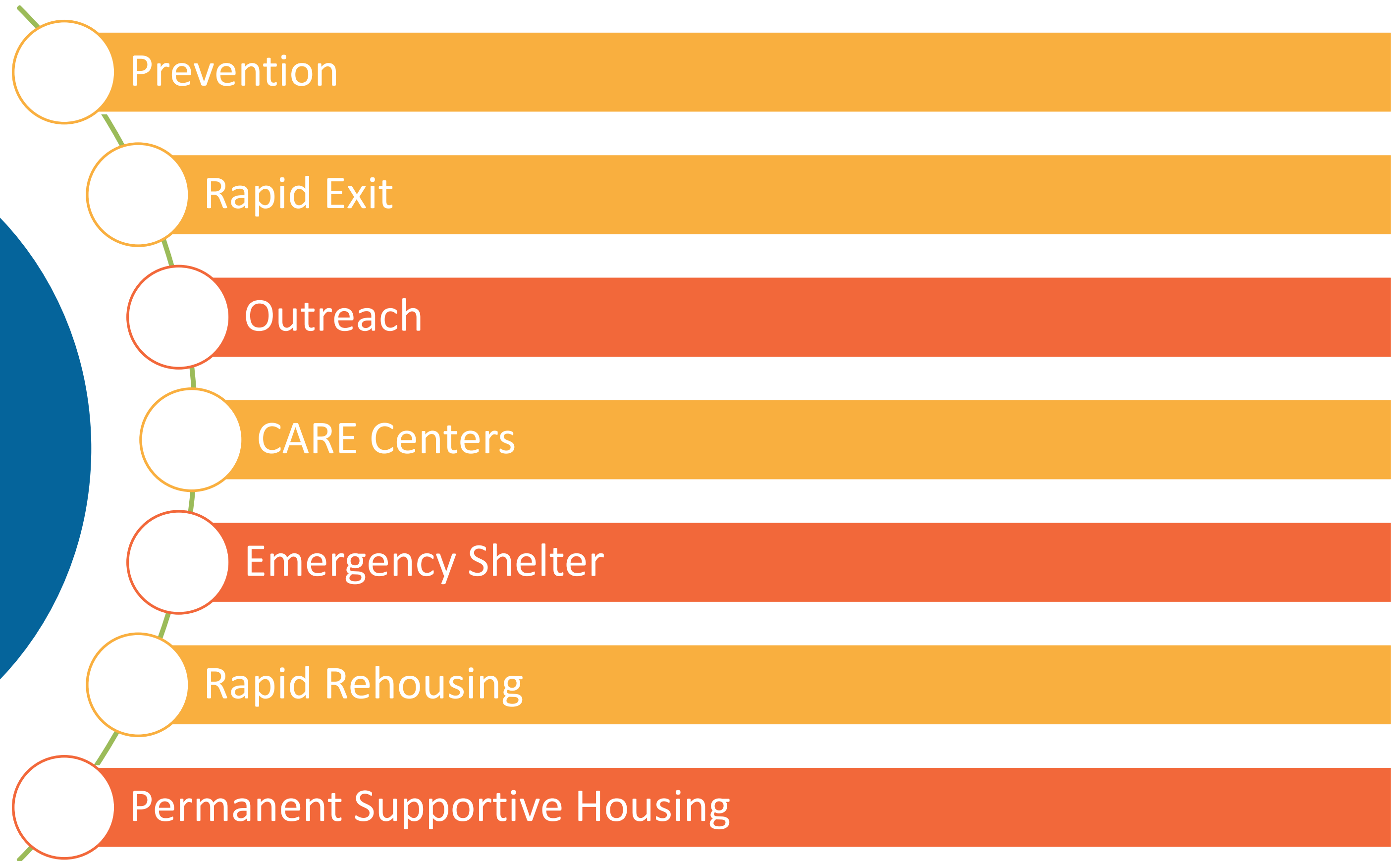
- Antioch
- Richmond
- Pittsburg



Less likely to be Black/African American/African

- Concord
- Martinez

# Services and How to Connect



## Coordinated Entry

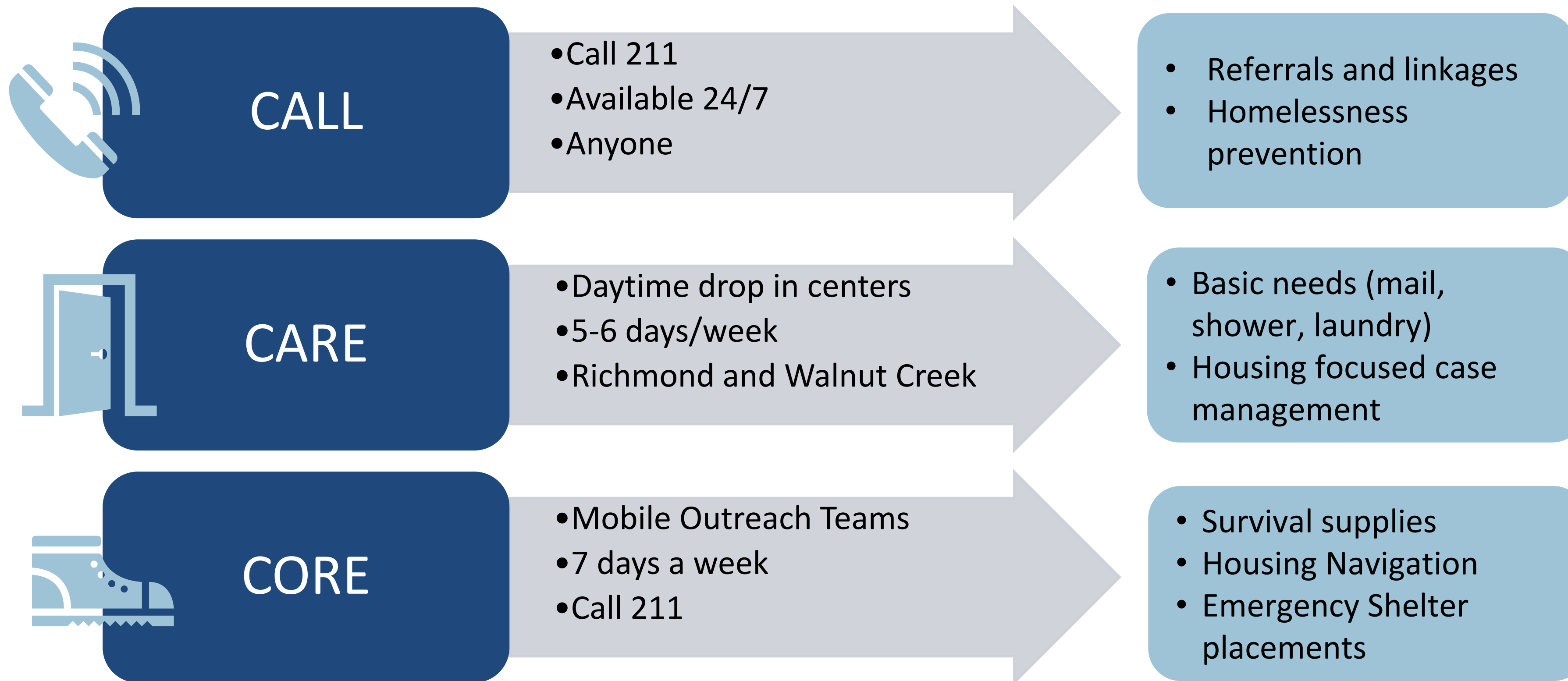
A system to ensure all people experiencing a housing crisis have easy access to homeless services

Individuals and families experiencing homelessness are quickly identified, assessed and connected to the most appropriate available resource

Prioritizes the most vulnerable for limited resources



## How to Connect



## Emergency Shelters

- Some County funded, some privately operated
- Lower barriers as much as possible
  - Non-congregate
  - No set-length of stays
  - Pet friendly

## Warming Centers

- Night-by-night placements

## Safe Parking

- Monitored locations where people can sleep in their vehicles

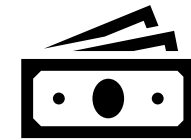
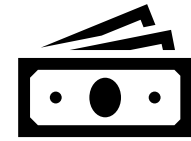
## Transitional Housing Programs

- Typically population specific – veterans, transition aged youth, survivors of domestic violence
- Time-limited programs



Get Help

Coordinated Entry



## Market Rate

- Pay own rent
- No support services

## Vouchers (multiple types)

- Some are just for low-income (Housing Choice Vouchers/Section 8) and some are for people experiencing homelessness (EHV/Mainstream)
- No supportive services
- Only “SOMETIMES” part of homeless system

## Rapid Rehousing

- Time limited (6-18 months)
- Must be homeless
- Rental support & Supportive services

## Permanent Supportive Housing

- NOT time limited
- Rental support & Supportive services
- Must be disabled and homeless

# Questions + Answers

CONTRA COSTA  
**HEALTH**



[cchealth.org](https://cchealth.org)

# Jamie Schecter

Homeless Services Chief,  
Contra Costa Health: Health, Housing  
and Homeless Services

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[cchealth.org/h3](https://cchealth.org/h3)



Get Help

CONTRA COSTA  
HEALTH



[cchealth.org](https://cchealth.org)

[Family, Maternal & Child Health \(FMCH\) | Contra Costa Health](#)

## BLACK INFANT HEALTH & PERINATAL EQUITY INITIATIVE

Natalie Berbick, MSW

Family Maternal and Child Health Director

Adiam Mengis, MPH, LLB

Perinatal Services Program Coordinator

Jarah Crowner, MPH

Black Infant Health Coordinator

Monday, April 13<sup>th</sup>, 2026

# Objectives

- Overview of FMCH Programs
- Maternal and Infant Health Indicators Data
- Black Infant Health (BIH) Program overview
- PEI Initiative and Key interventions
- PEI/BIH Community Advisory Board
- #Deliver Birth Justice Campaign
- Calls to Action
- Referral pathways
- Questions & Comments



# Black Maternal Health Week April 11th-17th 2026

- What is Black Maternal Health Week?
- #BMHW26 celebrates the leadership and expertise of Black community-based organizations as the foundation for advancing equity and ensuring transformative, sustainable improvements in Black Maternal Health. Advancing collective action highlights the essential role of collaboration between Black-led organizations, advocates, and communities to lead advocacy efforts, shape policies, and amplify solutions.

Policy Page - Black Mamas Matter Alliance



## 2026 BLACK MATERNAL HEALTH WEEK *TOOLKIT*

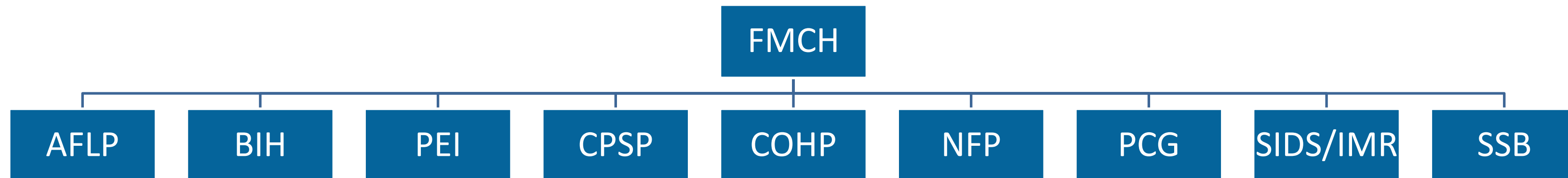
This official toolkit contains key messaging, social shareables, and other materials related to **BMHW26**.



VISIT [BLKMATERNALHEALTHWEEK.COM](https://BLKMATERNALHEALTHWEEK.COM) FOR MORE INFO

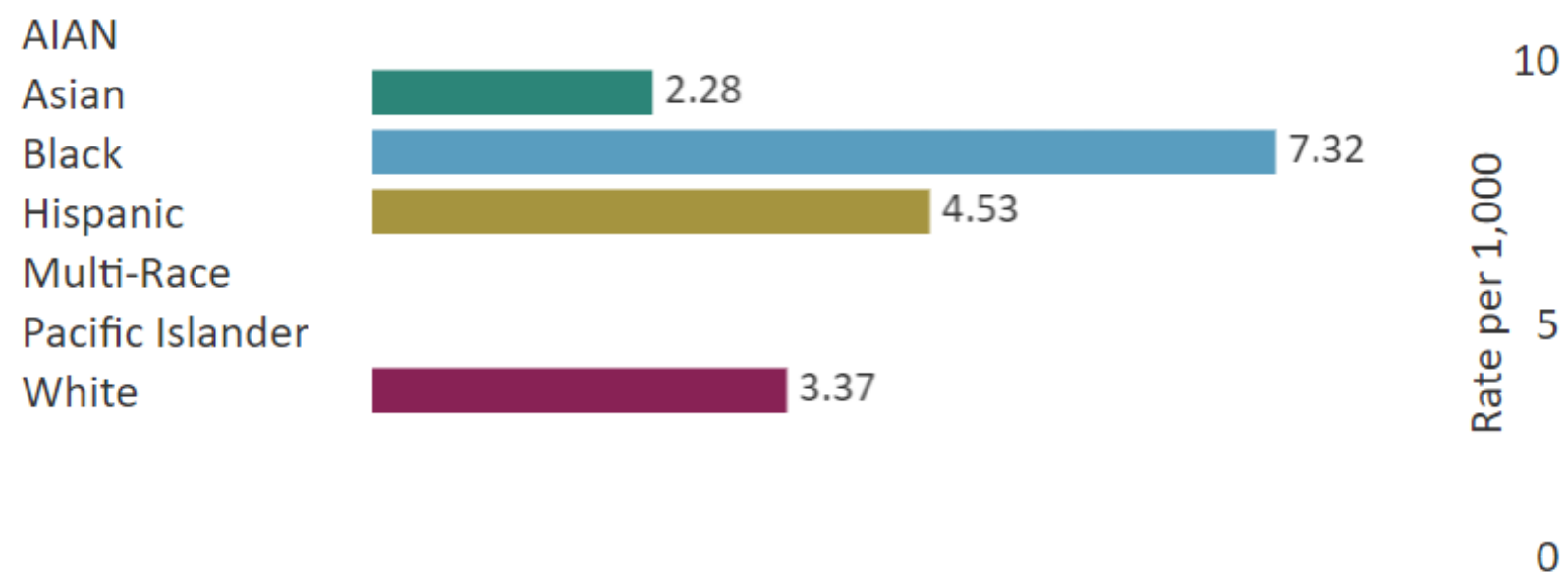
# Contra Costa Health Family, Maternal, and Child Health Programs

- The FMCH Program provides premiere prevention and intervention services for Contra Costa families in supportive, culturally driven, strength-based, affirming and innovative ways!
- **Vision:** A community where all individuals reach their optimal level of health and well-being.
- **Mission:** Family, Maternal and Child Health Programs, in partnership with community members, county programs, and community organizations, provide support, resources and services to eliminate health inequities and improve the quality of life for all children, youth and families.



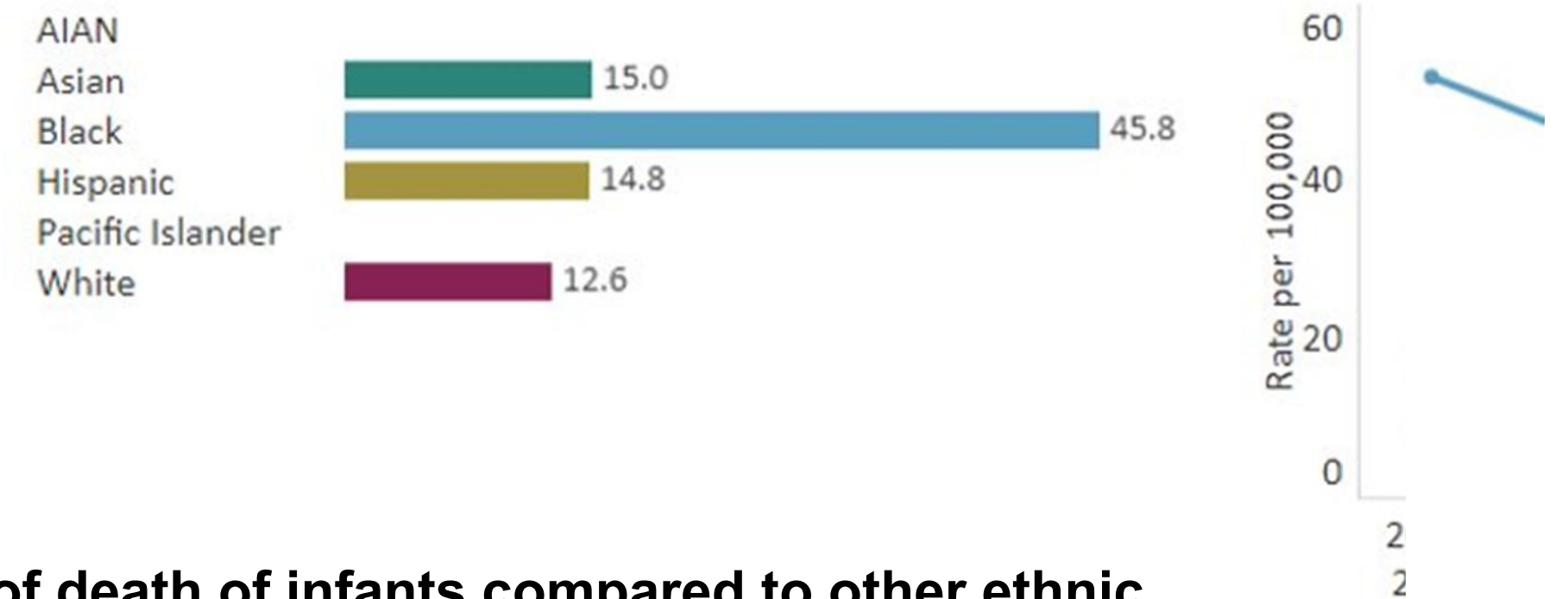
## Local Contra Costa County Maternal and Infant Indicators (Cont.)

Infant Mortality by Race/Ethnicity, Contra Costa County, 2019-2021



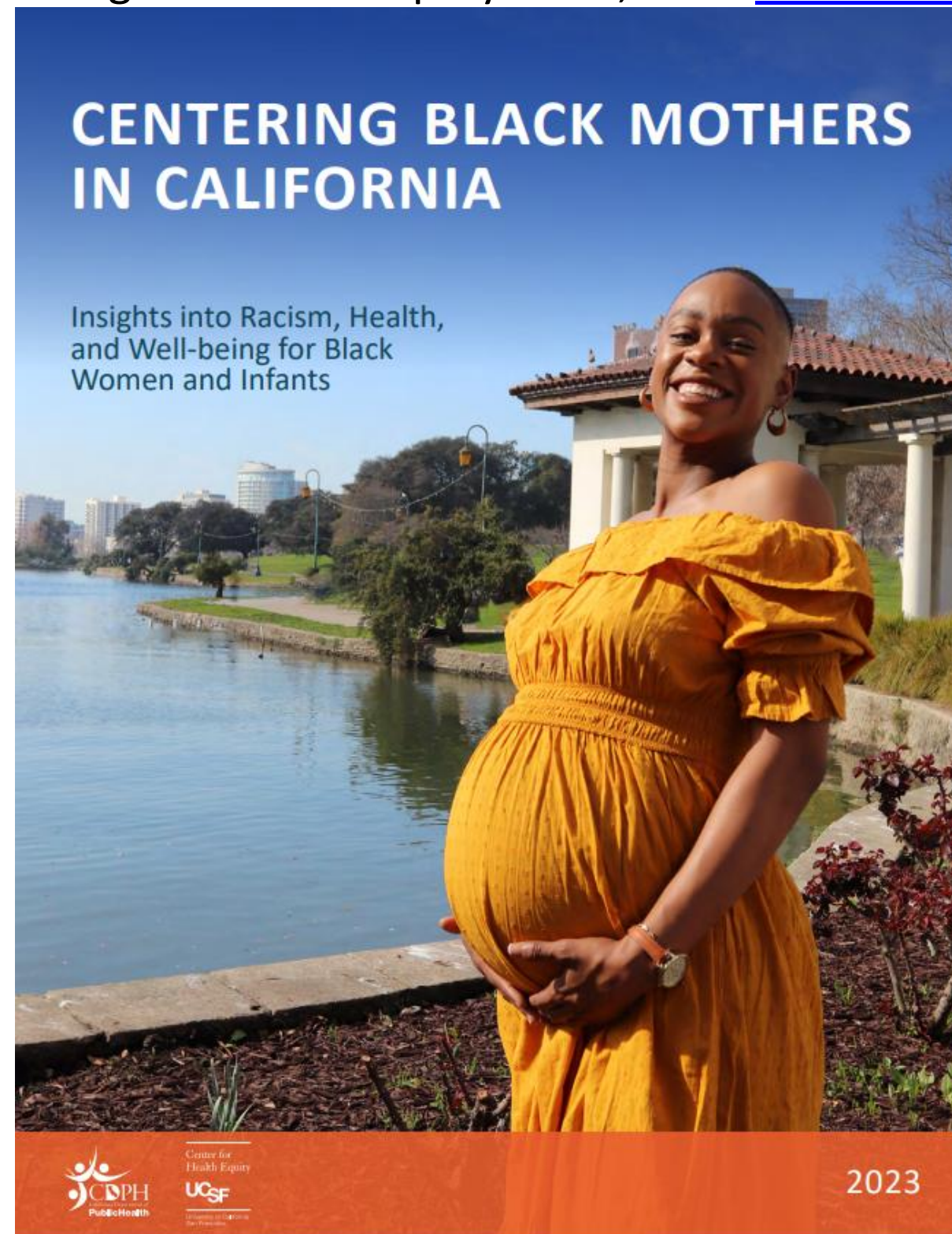
## California Maternal Related Mortality Indicator

Pregnancy-Related Mortality Ratio by Race/Ethnicity, California, 2018-2020



**In Contra Costa, Black infants have nearly 2-3 times the rate of death of infants compared to other ethnic groups. In CA, Black mothers have 3-4 times the rate of death when compared to other ethnic groups.**

Centering Black Mothers Report, 2023 [Centering Black Mothers](#)  
Advancing Black Birth Equity in CA, 2026 [Black Birth Equity](#)



# CDPH Resources



## Program Information

**Our Goal:** To advance the long-term goal of achieving healthy pregnancy and birthing outcomes for Black infants, women, and birthing people.

**We Serve:** Black (self-identified) women and birthing people who are 16 years or older, pregnant, or up to six months postpartum at the time of enrollment (regardless of income) in Contra Costa county.

Participants enrolled in our program are **followed up to 1 year postpartum.**

**Service Delivery:** Services are free and provided by **Family Health Advocates, Group Facilitators, Public Health Nurses, and Medical Social Workers.**

blackinfanthealth.org



### Parenting or Pregnant?

*Black Infant Health (BIH) aims to improve health among African American mothers and babies by empowering pregnant and mothering African American women to make healthy choices for a brighter future.*

#### PROGRAM GOALS

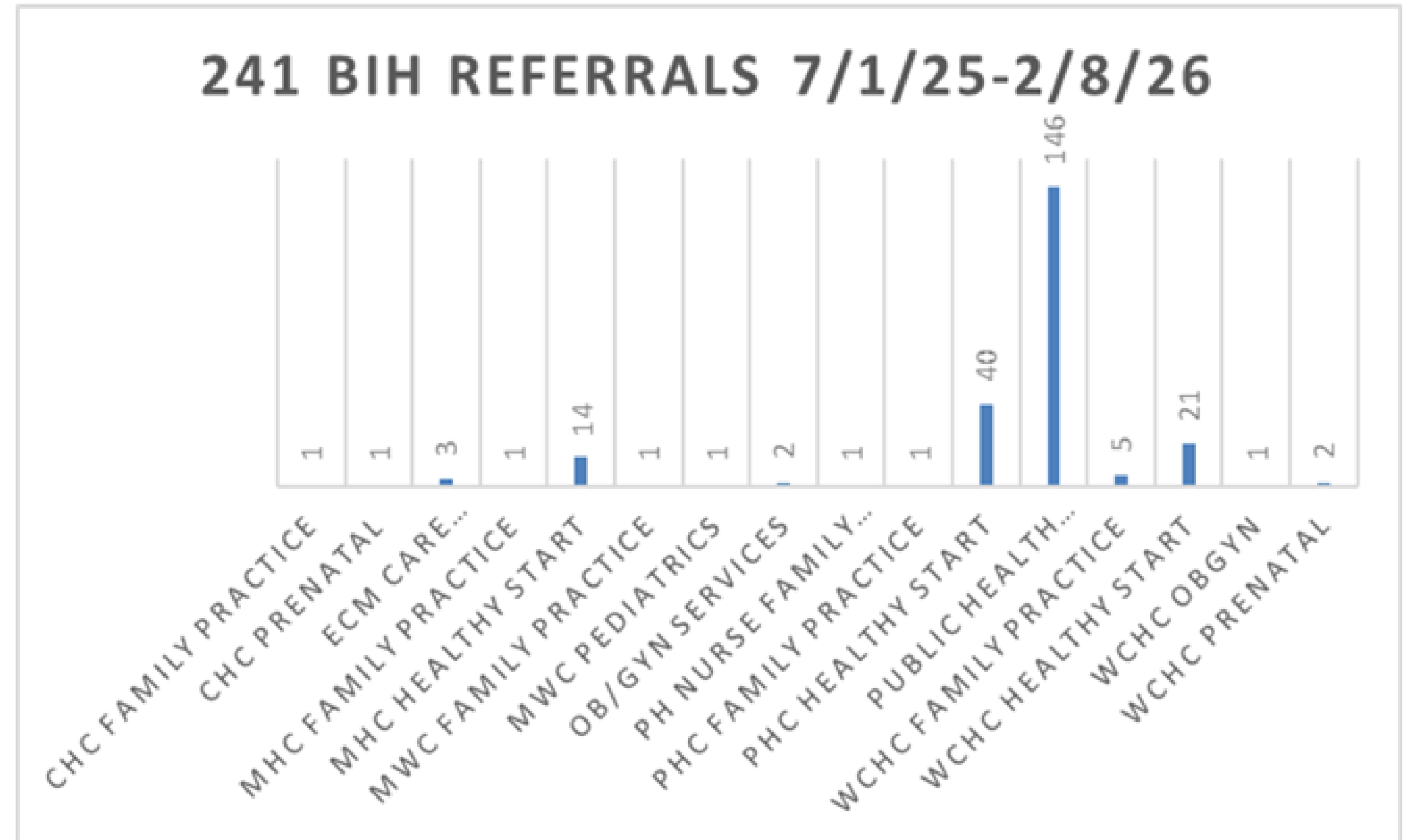
- EMPOWER** women, build resilience, and reduce stress.
- CONNECT** women with medical, social, and mental health services.
- ENGAGE** communities and raise awareness about Black Infant Health.
- PROMOTE** healthy behaviors to support health and wellness.
- IMPROVE** outcomes for African American women and their families.
- SUPPORT** healthy relationships and enhance bonding and parenting skills.

#### SERVICES

- VIRTUAL SESSIONS** for prenatal (10 sessions) & postpartum (10 sessions)
- TRANSPORTATION** to and from Doctor's office
- INDIVIDUAL LIFE COACHING** and case management
- HEALTH AND FAMILY** support referrals
- SUPPORT SERVICES** from a public health nurse and social worker
- SPECIALTY CLASSES** in breastfeeding, nutrition, parent education and more

## BIH Program Data

- FY 25 - 26 Data [Q1&2] :
- Clients served: **168**  
[52.5% of annual target]
- 
- Referrals so far: **241**
- Group Series started this year
- Three Prenatal groups
- Four Postpartum groups



## Additional Information

- BIH has served Black women throughout California Local Health Jurisdictions for over 30 yrs.
- Follows the Life Course Perspective.
- Program model has changed based on social needs of participants.
- Utilize health education, life planning and motivational interviewing techniques.
- No income, insurance or education requirements as the effects of RACISM affects all socio-economic demographics of pregnant Black women.

blackinfanthealth.org



### PROGRAM GOALS

- EMPOWER** women, build resilience, and reduce stress.
- CONNECT** women with medical, social, and mental health services.
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### SERVICES

#### Parenting or Pregnant?

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- TRANSPORTATION** to and from Doctor's office
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- HEALTH AND FAMILY** support referrals
- SUPPORT SERVICES** from a public health nurse and social worker
- SPECIALTY CLASSES** in breastfeeding, nutrition, parent education and more

# Program Model

## Group Sessions

BIH provides 10 prenatal and 10 postpartum sessions designed to empower and support participants. Group sessions are led by culturally supportive staff who reflect the target population served and provide attendees with the opportunity to bond and support other pregnant women. Sessions cover many topics, including:

- Cultural heritage as a source of pride
- Healthy pregnancy, labor & delivery
- Nurturing ourselves & our babies
- Prenatal, postnatal & newborn care
- Stress management
- Healthy relationships

*Complemented by 1:1 support*

## 1:1 Support Case Management

Participants also have 1:1 sessions, which are intended to support participants in making healthy choices.

Topics covered include:

- Referrals for identified services (e.g., medical, dental, social)
- Guidance on family planning
- Identification of strengths and problem-solving skills
- Assistance with setting short and long-term goals

*1:1 support is available to 16- and 17-year-old participants and those who are unable to attend group sessions.*

# Black Infant Health Eligibility



## Prenatal Group

**30 weeks or less**  
**10 weekly groups**

- Life Planning & Goal Setting
- One-On-One Support
- Birth Planning
- Safety Review (including Safe Sleep)
- Referrals & Linkages
- Raffles
- Sisterhood
- Empowerment and Confidence



## Case Management ONLY

**Pregnant, baby less than**  
**6 mo., 16yrs and older**

- Life Planning & Goal Setting
- One-On-One Support
- Birth Planning
- Safety Review (including Safe Sleep)
- Postpartum Mood Assessment (EPDS)
- Community Resources
- Referrals & Linkages

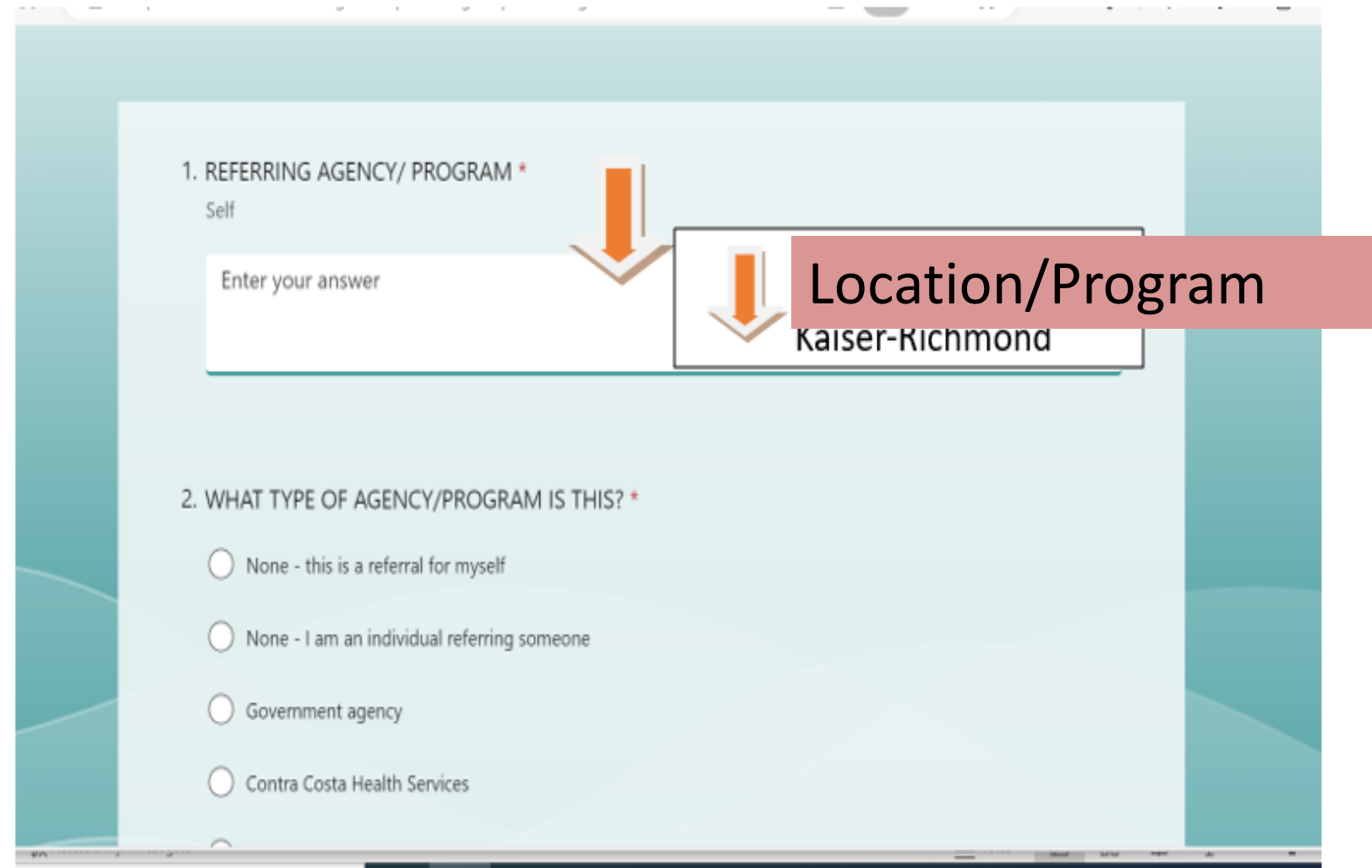


## Postpartum Group

**Up to 6mo. Postpartum**  
**10 weekly groups**

- Life Planning & Goal Setting
- One-On-One Support
- Safety Review (including Safe Sleep)
- Postpartum Mood Assessment (EPDS)
- Community Resources
- Referrals & Linkages
- Raffles
- Sisterhood
- Empowerment and Confidence

# Referral Pathways – FMCH Referral Form

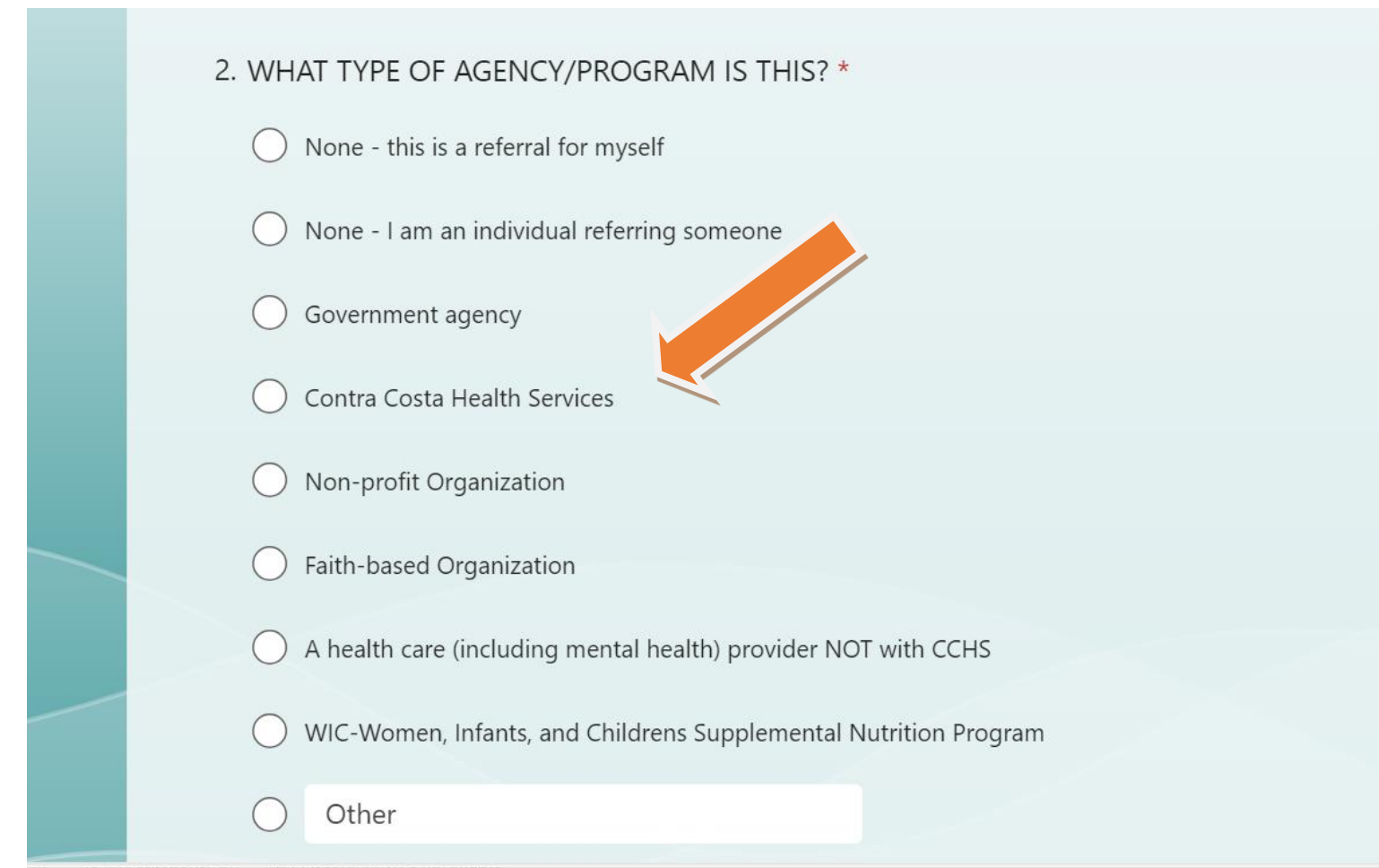


1. REFERRING AGENCY/ PROGRAM \*

Self

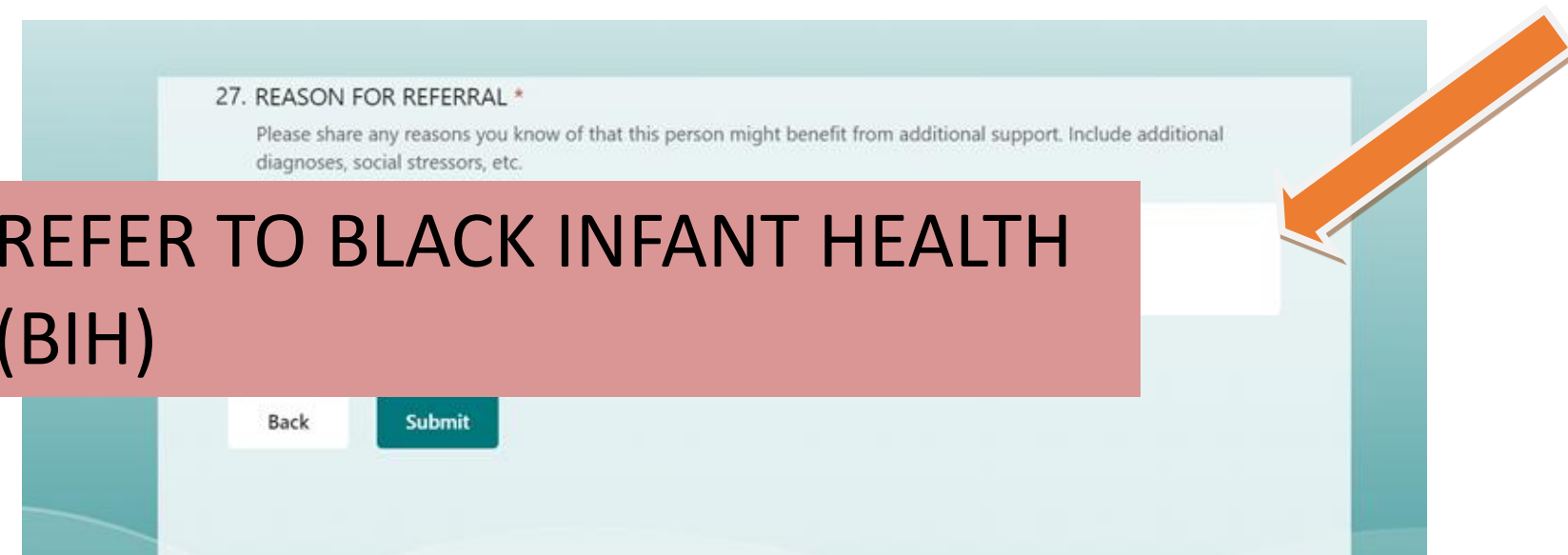
Enter your answer

Location/Program  
Kaiser-Richmond



2. WHAT TYPE OF AGENCY/PROGRAM IS THIS? \*

- None - this is a referral for myself
- None - I am an individual referring someone
- Government agency
- Contra Costa Health Services
- Non-profit Organization
- Faith-based Organization
- A health care (including mental health) provider NOT with CCHS
- WIC-Women, Infants, and Childrens Supplemental Nutrition Program
- Other



27. REASON FOR REFERRAL \*

Please share any reasons you know of that this person might benefit from additional support. Include additional diagnoses, social stressors, etc.

REFER TO BLACK INFANT HEALTH (BIH)

Back Submit

TO ACCESS THIS REFERRAL, SUBMIT THROUGH MS FORMS PORTAL.

PATIENT WILL RECEIVE CALL BY BIH OUTREACH LIASION.

OUTREACH: 3 ATTEMPTS IN 30 DAYS

OFFERED GROUP, 1:1 SUPPORT, ASSESSED BY BIH MENTAL HEALTH PROFESSIONAL FOR IMMEDIATE STRESSORS AND COMMUNITY RESOURCES.

LINK: [FMCH Online Referral Form](#)

## Gaps/Unmet Needs

- Limited Donations from outside partners
  - Strollers
  - Bassinets
  - Diapers
- Program offers support up to 1 year postpartum
  - Some moms have expressed interest in continued engagement w/ other participants and their case managers
  - Not a dedicated space for Black Moms only in CCC who offer services and guidance beyond year 1
- Targeted Education
  - Lactation Support
  - Midwifery
  - Healthy Relationships
  - Sexual & Reproductive Health





# Interventions for the Perinatal Equity Initiative

# Contra Costa County PEI/BIH Community Advisory Board

- An active board that meets quarterly
- Advises our PEI team about needs of the community and services that should be reinforced in Contra Costa Team
- Bring awareness about the need for health equity where they live, work, play and pray
- Diverse group: Black parents, doulas, health care professionals, PH professionals, community leaders, policy makers, faith-based organizations, and more.



\*\*\*Anyone is welcome to join 😊\*\*\*

## Program Accomplishments

- CoCo Doula **5** Year Anniversary!
- Successfully hosted **4** doula trainings and launching our **4<sup>th</sup>** training this May
- **60** doulas graduated from the Doula Training.
- Served more than **300** families.
- More than **250** CoCo Doula babies born.
- In-house therapist & lactation consultants
- Families expressed excited to be in the program, and sad to leave program.

## CoCo Doula Program

The Doula program services Black birthing women by providing care, advocacy, and emotional support for improved birthing outcomes.

Support provided for at least 7 prenatal visits, L&D and up to 6 weeks postpartum visits featuring breastfeeding, infant care, depression screening, birth planning, linkage and referrals and much more.



**FREE services funded by the State and provided by CBO – FIERCE Advocates**

# Partners in Pregnancy: Fatherhood Program



**Objective:** To provide fatherhood support services for partners of Black mothers in order to enhance the protective factors and stability for the infant.

## **FREE Fatherhood Services in Contra Costa County**

12 sessions in a group or one-on-one setting focusing on fatherhood skills, parenting and relationship skills, self-awareness, and self-care.

Additional sessions for new, expectant, and non-custodial fathers on workforce development, rights and responsibilities, child support, and money management.

Support with health, relationship, and financial goals as you grow your family.

# PEI Nutrition Support Program

Serving East and West County

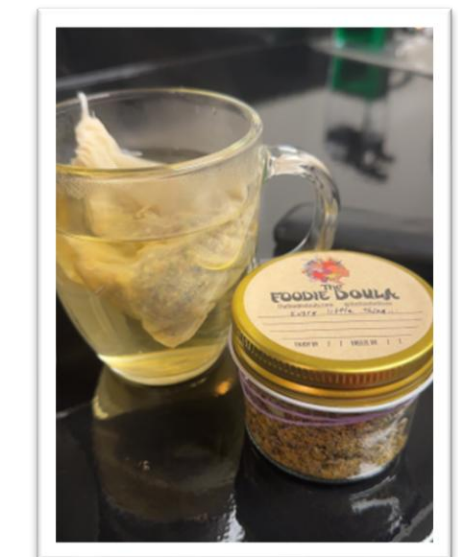
- East: Mother for mothers Postpartum Justice (MPJ)
- West: 18 Reasons

The Program is a home-delivered meal service to provide Black mothers/birthing persons healthy food and nutrition during the immediate postpartum period

- *Receive 3 meals per week for 12 weeks after childbirth, for FREE!*

*Eligibility Criteria:*

- You are a Black Infant Health or Coco Doula client, or partner of a Fatherhood Program participant
- You're a resident of Contra Costa County



## Client Satisfaction Survey Quotes for PEI Interventions

- **CoCo Doula Program:** “I am so thankful to CoCo Doulas for introducing me to my doula. This was my second pregnancy and I had many concerns after experiencing complications with my first child. My doula was not only knowledgeable and experienced, but kind and reassuring. Her support was a major contribution to my success in having a VBAC. I cannot thank CCD and Fierce Advocates enough!”
- **CoCo Doula Program:** “Doula was on personal level loved talking with her, answerig all questions, very supportive the whole time!”
- **Nutrition Support Services:** “I’m glad the meals were available when I don’t have enough food or enery to cook”
- **Nutrition Support Services:** “Glad the food has changed. The portions are bigger and have a bit more flavor. The fact that I don’t have to think about certain meals”
- **Partners In Pregnancy Fatherhood Program:** “I learned a lot on the importance of communication and slowing down with my girl in handling different situations.”

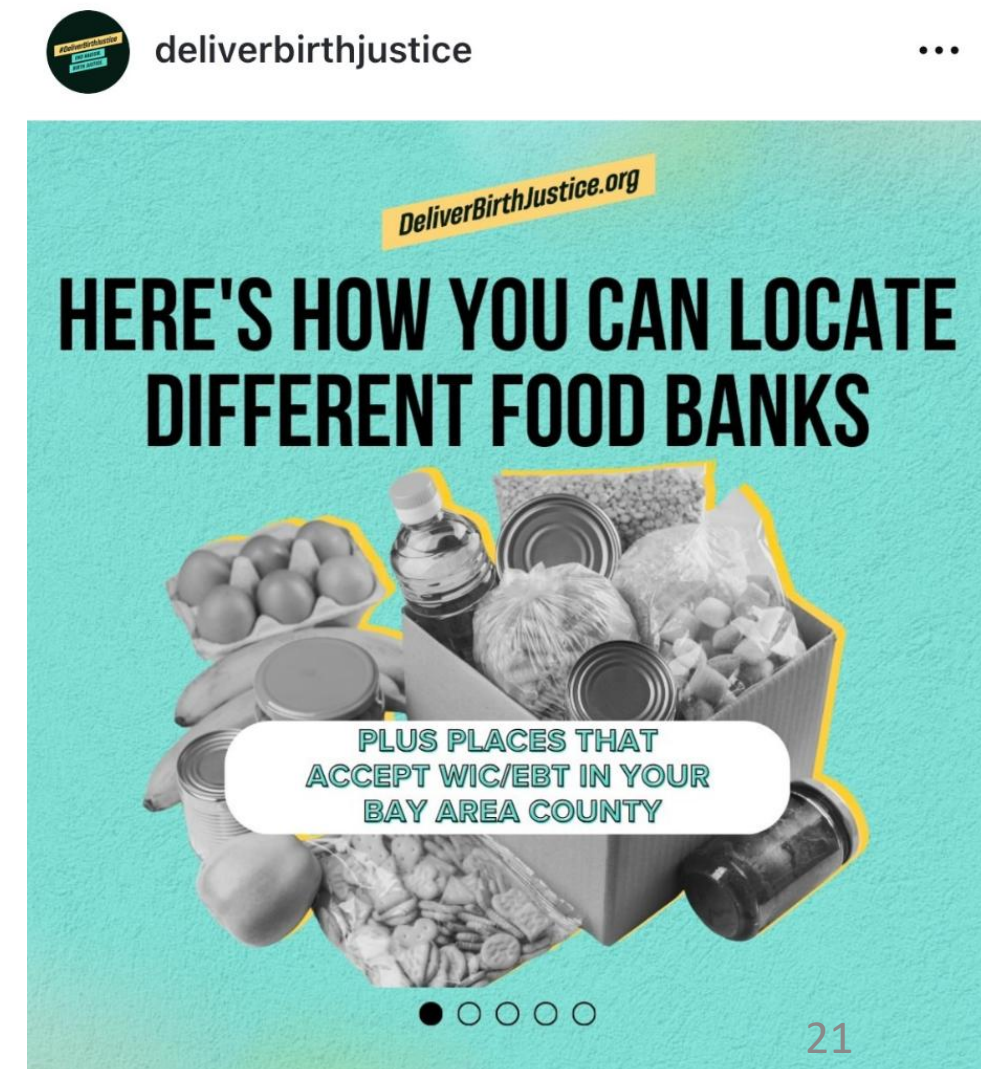
**#DeliverBirthJustice**  
**END RACISM.**  
**BIRTH JUSTICE.**

# Deliver Birth Justice Campaign Updates



This campaign aims to mobilize all corners of the Bay Area – from health professionals to policy makers to community members to end racism and deliver birth justice for Black families.

Continue to attend events and be present on Digital Media: Website and Social Media platforms



# # Deliverbirthjustice Calls to Action

- Learn how racism and bias harm Black mothers and babies
- Listen, trust and respond
- Be an advocate
- Become an ambassador for birth justice
- Welcome doulas and midwives to your institutions
- Refer clients to CoCo Doula and Fatherhood Programs
- Take anti-racist/implicit bias training and incorporate it into practice
- Create a system for reporting and addressing incidents of racism and bias within your institution
- Hire and retain birthing providers of color
- Organize listening sessions on birth justice with community partners and Black mothers and families
- Enforce robust policies to evaluate and effectively address potential inequities and racial biases in administering Adverse Childhood Experiences (ACEs) screenings.
- Share our #DeliverBirthJustice campaign



**Bay Area #DeliverBirthJustice  
Public Awareness Campaign (PAC)  
Community Advisory Board (CAB)**

April 15 | 2:30 p.m. – 4:00 p.m. – BMHW 2026  
*Register Here:*






**CALLING ALL BAY AREA  
CAB Members!**

Alameda • Contra Costa • San Francisco • Santa Clara • Solano

*This #BlackMaternalHealthWeek, we're inviting you to share your feedback on our regional media campaign. #DeliverBirthJustice brings awareness of how anti-Black racism impacts our birth outcomes, and with your help, we want to maximize our reach!*

**#DeliverBirthJustice**  
END RACISM.  
BIRTH JUSTICE.

**WEDNESDAY, APRIL 15**  
2:30PM - 4:00PM via zoom

Scan or tap the QR code to register





Follow us on social media!



Deliver Birth Justice



@deliverbirthjustice

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HEALTH



[cchealth.org](http://cchealth.org)

[Family, Maternal & Child Health \(FMCH\) | Contra Costa Health](#)

# Thank You!

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CONTRA COSTA  
**HEALTH**



[cchealth.org](http://cchealth.org)

# CCH Outpatient Services

**Andrea E Sandler MD**  
Assoc Ambulatory Medical Director

4/13/2026

# Overview of Services

- 9 Outpatient Health Centers



- Full Scope Primary Care at all clinics
- Specialty Care Services at the 3 largest clinics – West County, Martinez and Pittsburg
- Approximately 128 Primary Care Providers + 39 Family Medicine Residents
- 229K People empaneled with CCH, 30K identify as Black/African American
- Over 90% of our patients qualify for Medi-Cal

### Primary Care:

- Adult Medicine
- Family Medicine
- Pediatrics
- Women's Health
- Prenatal Care
- Laboratory
- Addiction Medicine



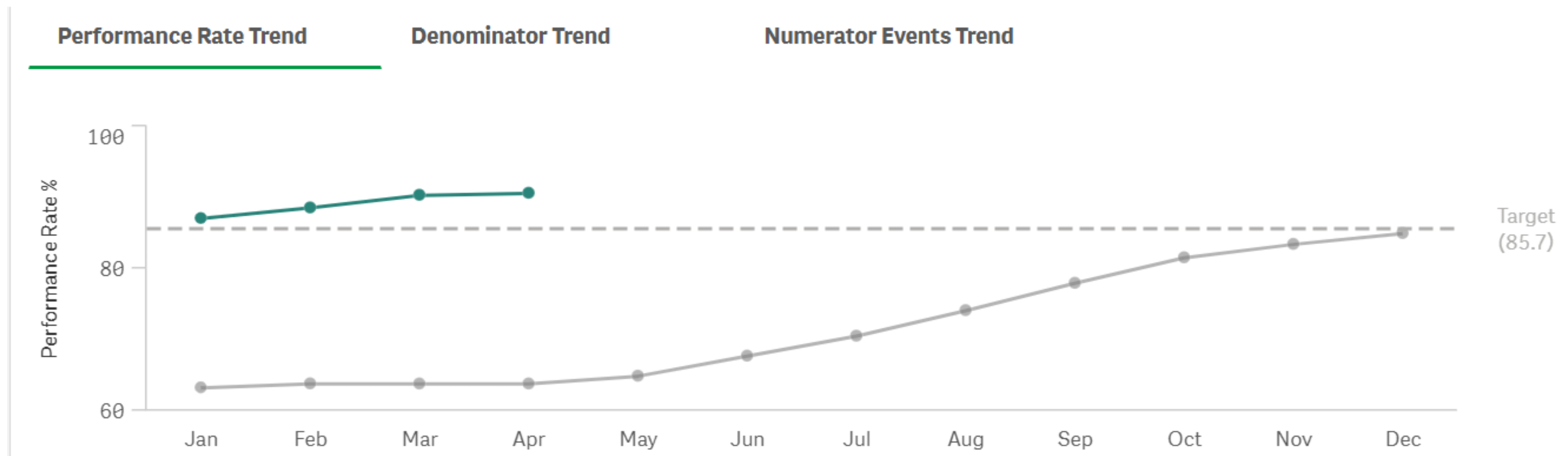
## Examples of Services Offered:

### Specialty Care:

- Audiology
- Cardiology
- Dental
- Dermatology
- Ear Nose Throat
- Gastroenterology
- Gender Clinic for Transgender Patients
- OB/GYN
- Neurology
- Oncology/Hematology
- Ophthalmology
- Orthopedics
- Plastic Surgery
- Podiatry
- Pulmonary/Bronch
- Rehabilitation – Physical and Occupational Therapy
- Renal
- Rheumatology
- Surgery Clinic
- Urology

## QIP – Quality Incentive Program (MediCal Waiver Program)

- Incentive program for California’s public hospital systems
- Numerous measures with a strong outpatient focus
- CCRMC needs to meet targets each year to achieve maximum potential revenue
- This has led to many improvement teams and projects
- This program has led to high level dashboards where we can look at the different measures by clinic, insurance, race, ethnicity, language, etc.



## 2 Strategies to Address Population Health Needs

Inreach – Addressing items at appointments or other points of contact with the health system

- More effective and less resources
- “Care Gaps” are addressed by nursing staff and providers at primary care visits
- Examples: 1. Annual Fall Screening for older adult presenting for a follow up visit for blood pressure  
2. Addressing needed vaccines at a child’s sick visit  
3. Colon Cancer screening discussed at a routine visit for osteoporosis

Outreach – Reaching out to patients to address care needs

- Often very hard to reach people. Takes high person hours to see effective impact.
- Examples:
  1. Mailing FIT (colon cancer screening) tests to patients
  2. Calling people to ask them to come in for blood pressure check
  3. Contacting parents to let them know that their child is overdue for physical or vaccines

## QIP Equity Measures – Defined by the State

- Controlling Blood Pressure – African American/Black Population
- Child and Adolescent Well Care Visits (3-21yo) – African American/Black Population
- Glycemic Status Assessment – African American/Black Population

Have developed many InReach and OutReach over the years to address the above 3 measures.

Able to evaluate ALL of the QIP Measures based on race

## Pediatric Disparities for African American/Black Patients

- Across all ages large gap in Immunizations- especially prenatal, pediatric and adolescent populations
- Large disparity gaps in Pediatric measures – despite efforts to focus on these areas!
- Track these closely and efforts include targeted outreach, contacting “no-shows” and incentive programs

Metric	Total Population	African American	% Disparity Gap
Childhood Immunization	38	18.3	19.7
Adolescent Immunization	60.33	43.2	17.13
WCV* 0-15 Months	80.47	67.4	13.07
WCV* 15-30 Months	80.64	69.6	11.04
Child and Adolescent WCV*	57	52	5
Developmental Screening	80.5	74.9	5.6

\*WCV = Well Child Visit (physical)

# Prenatal Disparities for African American/Black Patients

- Prenatal measures also with disparities especially Immunizations and Prenatal Care
- Prenatal improvement teams very focused on improving experience and outcomes for African American/Black patients

Metric	Total Population	African American	% Disparity Gap
Prenatal Immunization	44.6	20.5	24.1
Prenatal Care	86.16	75.5	10.66
Post Partum Care	88.83	85.8	3.03

## Adult Cancer Screening and Chronic Disease Disparities for African American/Black Population

- **Variable** disparities and success for these areas.
- Cancer screening with less disparities overall.
- Hypertension has been particularly challenging. Previously at 8-9% disparity and then reduced to 0.5%, but lately increased to 4.5%
- Glycemic control for diabetes – currently at 2.65% disparity with total population
- Diabetic retinopathy screening at 8.7% disparity with total population
- Asthma control – 8.4% disparity with total population.

## Opportunities and Conclusions

- 9 Health Centers with full scope Primary Care including geriatric, prenatal, pediatric and adult medicine
- Engaged and interested in reducing health disparities
- Sophisticated data system to track progress
- Areas of particular concern – Pediatric Immunization and Well Visits, Prenatal Immunizations and Visits and Asthma
- Collaboration with more community partners would be welcome and appreciated

CONTRA COSTA  
HEALTH



[cchealth.org](http://cchealth.org)

**Thank you for inviting CCH  
Clinics to present today.**

Special Thank you to Nooshin Abtahi for  
preparing disparity data.


# Forging a Pathway from Prison and Jail to a Health Home



## Contra Costa Health Re-entry Health Conductors Program



# The Re-entry Health Conductor Program Overview



The Re-entry Health Conductor Program is a program of Contra Costa Health and Health Centers. The Re-entry program is a call to action to the county health care system to eliminate health disparities and social inequities among the re-entry population

# Correctional Environments Impacts Health





## Who do we serve:

Returning community members with a chronic illness(es) with special emphasis on those **currently released** from incarceration, adult, men and women, ages 18-100; and those most likely impacted by mass incarceration (African American men).

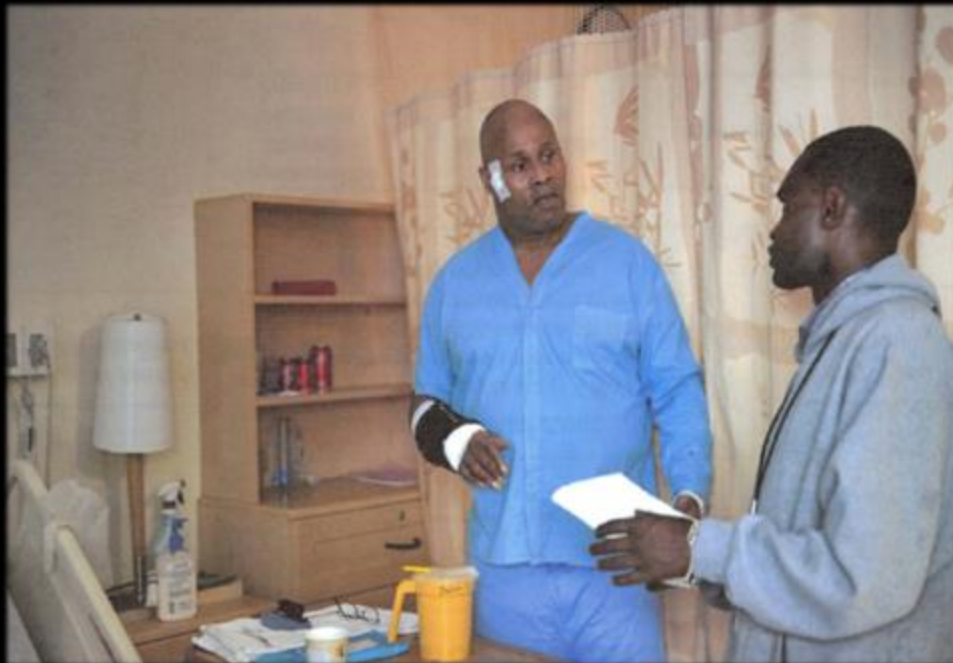
Returning community members who need a health home and intensive support



# Program Services



**Expert Outreach**



**Assistance with Public  
Benefits (Medi-Cal);  
Medical Appointments**



**Emotional Support  
& Mentorship  
(handholding)**

**Health & Social  
Service Navigation &  
Advocacy**





## What is the Transitions Clinic

Transitions Clinics are a network of community medical clinics, with the largest patient pool of returning community members in the nation. Contra Costa Health Transitions Clinic was established in **2012**.

Transitions Clinics provide transitional care within a primary health/medical home tailored for returning community members with chronic medical conditions.

# R.E.M.E.D.Y Support Group

Re  
Entry  
Making  
Every  
Day  
Yours



# The R.E.M.E.D.Y (re-entry making everyday yours) Support Group

- A safe place to fellowship and have healthy snacks
- 12 -week series – co-facilitated by those with a lived experience of incarceration (curriculum based)
- Graduation
- Group topics focus on Cognitive Restructuring, Character Refinement, and Cultural Realignment





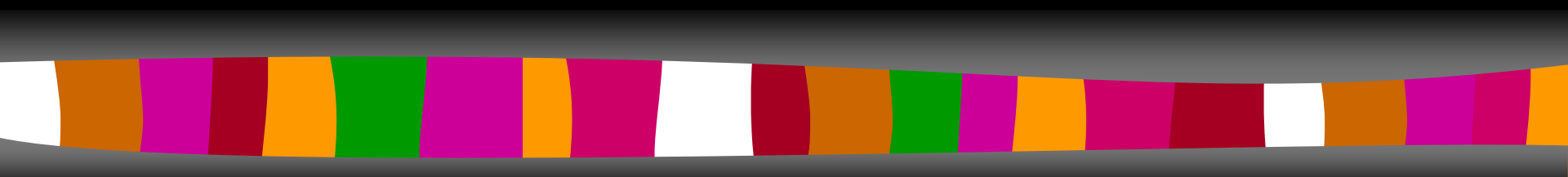
# Program gaps and unmet needs

- 1. Expand the Re-entry Program and Transitions Clinic to other CCH health centers**
- 2. Increase staff with a (lived experience of incarceration) to the County Health Centers/Transitions Clinic/Conductors Program**

# Re-entry Health Conductors Program/Transitions Clinics are located at the following Health Centers:

Pittsburg Health Center, 2311 Loveridge Rd. Pittsburg- 925 -431 - 2792

West County Health Center, 13601 San Pablo, San Pablo -510 – 231 - 8668





# EHSD NAVIGATORS

NAVIGATING TOWARD A  
BETTER, BRIGHTER TODAY

CONTRA COSTA COUNTY

EMPLOYMENT & HUMAN SERVICES

## ***EHSD Navigator Vision Statement***

**“To empower families and individuals to create their own paths to healthy interdependence. Using a “whole person” approach, our Navigators create a warm welcoming environment by streamlining access to resources and enabling participants to be their own advocates moving forward.”**

# Who are EHSD Navigators

Community-based support professionals

Assist individuals and families with access to vital services

Provide guidance and referrals

Located in various community settings

# Objective

- Take a **holistic, participant-driven approach** to community support  
Enable access to services for:
  - Individuals
  - Families
  - Community members
  
- **Partners Involved:**
  - Contra Costa County Employment & Human Services Dept.
  - Community-based organizations
  - Non-profits
  - Faith-based institutions

# *What We do*

- Facilitate clear and consistent communication
- Assist clients with applications and documentation
- Offer in-person support services
- Coordinate distribution of direct aid
- Partner with schools for education and advocacy
- Share resources at public events

# How Navigators Support Participants

- ▶ Personalized assessment of needs
- ▶ Barrier removal
- ▶ Resource navigation
- ▶ Advocacy and emotional support

# Key Barriers We Help Address

Childcare

Transportation

Housing

Digital Access

Legal Support

# Core Resources We Connect To



JOB TRAINING  
PROGRAMS



GED/EDUCATION  
PATHWAYS



FOOD &  
CLOTHING  
ASSISTANCE



EMERGENCY  
FINANCIAL HELP



MENTAL HEALTH  
SUPPORT

# Engagement Strategies



Community presence

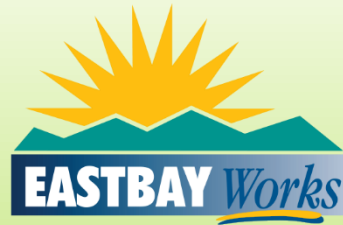


Trust-building



Multilingual support

# Community Partners & Collaborations



# EHSD Navigator Success Story



Sandra Figueroa  
Navigator

# *Referral Process*

- Walk-in to: Designated County Offices, Identified Libraries, Family Justice Centers and selected School District Sites
- Direct referral by County worker or Partner Staff or Community Agency
- Email to [EHSDNavigators@ehsd.cccounty.us](mailto:EHSDNavigators@ehsd.cccounty.us)
- Call the EHSD NAVIGATORS general phone line (925) 608-5979

# Locations

EHSD Antioch- 4545 Delta Fair Blvd.  
EHSD Brentwood -151 Sand Creek Rd.  
SparkPoint Bay Point- 3105 Willow Pass Rd

FJC Richmond- 256 24th Street  
FJC Concord-2151 Salvio Street Ste. 201  
FJC Antioch- 3501 Lone Tree Way Ste. 4  
FJC Danville - 319 Diablo Road, Ste. 103, Danville

Antioch Library – 501 W 18 St. Antioch  
Brentwood Library - 104 Oak St, Brentwood  
Concord Library - 2900 Salvio St, Concord  
San Pablo Library – 13751 San Pablo Avenue.  
DeJean Middle School (District 1) – 3400 Macdonald Ave. Richmond  
Board of Supervisor Office (District 2) – 309 Diablo Rd , Danville  
Board of Supervisor Office (District 3) – 3361 Walnut Blvd, Brentwood  
Oak Grove Middle School (District 4) – 2050 Minert Rd. Concord  
Hillview Junior High (District 5) – 333 Yosemite Dr. Pittsburg

# *EHSD Navigator Contact Information*

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# Questions?



*Building Brighter Futures Together*