Program Improvements for Valued Outpatient Treatment (PIVOT) Innovation Project
Contra Costa Behavioral Health Services
2025

Abstract: The PIVOT Innovation Project reimagines behavioral health in Contra Costa County by enhancing care coordination, expanding evidence-based practices, strengthening the workforce, integrating technology, and improving housing solutions. Aligned with CalAIM, BH-CONNECT, and the Behavioral Health Services Act, this initiative streamlines services and ensures seamless transitions. PIVOT builds a more connected, effective, and inclusive system for the future.

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COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☐ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors.
☒ Local Behavioral Health Board approval Approval Date: 5/21/2025
☐ Completed 30-day public comment period Comment Period: 3/20/2025 – 4/20/2025
☒ BOS approval date: Approval Date: 6/24/2025 If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: _____ *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: _____ ***Note: Date requested above is not guaranteed until MHSOAC staff verifies <u>all requirements</u> have been met.***

County Information

County Name: Contra Costa County

Date submitted: TBD

Project Title: Program Improvements for Valued Outpatient Treatment (PIVOT) Innovation Project

Total amount requested: $8,885,824

Duration of project: 7/1/2025 through 6/30/2029

Background and Purpose

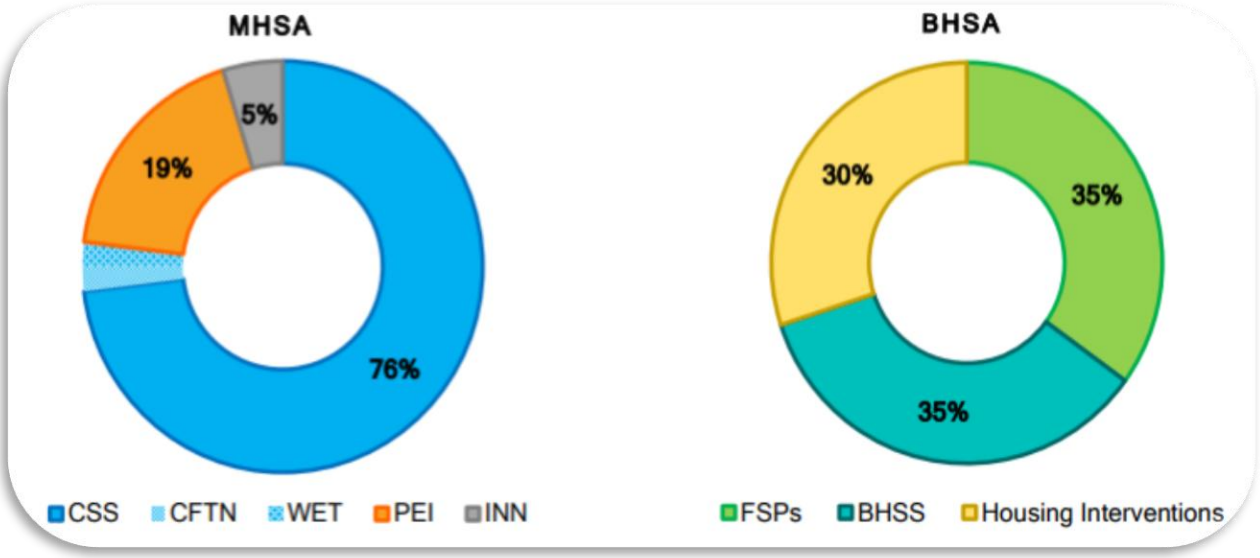
In March 2024, California voters approved Proposition 1, which introduces significant changes to the Mental Health Services Act (MHSA) and transforms it to the Behavioral Health Services Act (BHSA). Under the BHSA, there are significant adjustments to the funding allocations and regulatory requirements.

The BHSA restructures the five historical MHSA components of Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities and Technological Needs, and Innovation into three components. Those three components are:

- Full-Service Partnership (FSP) Programs with 35% of funds aimed at providing comprehensive care for individuals with the most complex needs
- Housing Interventions (HI) with 30% of funds designated for rental subsidies, operational support, shared housing, family housing for youth, and covering non-federal portions of transitional rental assistance
- Behavioral Health Services and Supports (BHSS) with 35% of funds, focused on general behavioral health programs

The BHSA shift also reduces the amount of funding allocated to each county, whereas previously 5% of funds were reserved for State-level administrative initiatives, under new BHSA requirements a total of 10% is reserved for State-level administrative initiatives. These initiatives include Population-based prevention (4%), Workforce infrastructure (3%), and Statewide oversight and monitoring (3%). This shift reduces the amount allocated to counties, as well as the number of components and funding allocations (see Figure 1).

Figure 1. Restructuring of MHSA to BHSA



Each component also holds specific requirements. HI requires that at least half of HI funds be directed to support housing interventions for the chronically homeless, and up to 25% may be used for capital development. FSP requires funding to support intensive community-based care

for people with complex behavioral health needs; and also expands services to include treatment for Substance Use Disorder (SUD). The regulations also require services be provided through Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), High Fidelity Wraparound, Intensive Case Management (ICM), and Individual Placement and Support (IPS) models. Under BHSS, there is a requirement to fund Early Intervention (EI). At least 51% of the BHSS funds must be directed to EI programs to address early signs of mental illness and also under new BHSA regulations expand EI services to include early intervention for SUD. Of the 51% of funds allocated to EI, at least 51% must be directed to children and youth under the age of 25. The remaining 49% of funds under BHSS may be used for Children's, Adult and Older Adult Systems of Care, Outreach and Engagement, Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN).

Counties retain flexibility, allowing up to 7% of funds to be shifted between categories, enabling a maximum of 14% to be added to any single category. However, although previously under MHSA there were funding requirements; there was still much more flexibility to allocate services based on system needs and community feedback. Under new BHSA regulatory requirements, there is much more structured and regulatory requirements both in funding allocations and programming. The BHSA expands its focus to include individuals with substance use disorders and prioritizes those at risk of or experiencing homelessness, justice involvement, child welfare system involvement, or institutionalization/conservatorship. Other requirements will mandate that Contra Costa Behavioral Health Services (CCBHS) achieve full administrative integration of Mental Health and Alcohol and Other Drug Services. The anticipated year for Costa Behavioral Health Services (CCBHS)to achieve full administrative integration of is by 2029.

Given the transformative nature of many behavioral health initiatives under the larger Behavioral Health Transformation[1] effort which includes Proposition 1 or BHSA[2], California Advancing and Innovating Medi-Cal (CalAIM[3]), and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT[4]), CCBHS requires additional support to design, plan, implement, and evaluate ongoing changes. The scope of the changes is far reaching and will have enormous impacts on the overall system. These major transformational changes impacting the way services are reimbursed; new funding priorities are mandated by the Department of Health Care Services (DHCS) and require new metrics for evaluation through National Committee for Quality Assurance (NCQA) accreditation; which is a new External Quality Review (EQR) organization. These initiatives also require CCBHS to work much more closely with the managed care plans and local health jurisdictions for coordinated behavioral health services. In Contra Costa County, this includes Contra Costa Public Health and the Contra Costa Health Plan. Funding

[1] Department of Health Care Services (DHCS) - Behavioral Health Transformation. https://www.dhcs.ca.gov/BHT/Pages/home.aspx

[2] Governor Newsom's Transformation Of Mental Health Services. https://www.gov.ca.gov/wp-content/uploads/2023/09/FACT-SHEET-Transforming-Mental-Health-Services.pdf

[3] Department of Health Care Services (DHCS) - CalAIM Behavioral Health Initiative. https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx

[4] Department of Health Care Services (DHCS) - Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative. https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx

priorities and scope of services will transform the MHSA drastically starting on July 1, 2026. Therefore, CCBHS is proposing to launch the Program Improvements for Valued Outpatient Treatment (PIVOT) Innovation Project.

Innovation Project Defined

As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community. The PIVOT Innovation Project will allocate up to an estimated $8.9 million in time-limited funding (up to five years) to support various areas needed to implement BHSA. CCBHS intends to start PIVOT activities during Fiscal Year (FY) 2025 – 2026, once approved by the BHSOAC, and received local approval by the Contra Costa Board of Supervisors. CCBHS anticipates the PIVOT Innovation Project to run through until June 30, 2029, to coordinate transition under the Behavioral Health Transformation requirements.

This proposed Innovation project is requested to augment existing infrastructure support for CCBHS to successfully plan, implement, and coordinate evaluation for the Behavioral Health Transformation. The project will focus on:

1. Streamlining capacity for specialty mental health services with focus on supporting services to diverse communities and implementing Community Defined Evidence Practices or CDEPs
2. Supporting a reboot of Full-Service Partnership (FSP) programs
3. Implementing structural processes needed for Housing and CCBHS regulatory needs
4. Integration of BH-CONNECT and required Evidence Based Practices (EBPs)
5. Evaluation and support for Workforce Education and Training (WET) programming
6. Enhancement of Technological Needs (TN) and coordination of care
7. Evaluation, initiative alignment and expansion of services and requirements necessary under BHSA

The PIVOT Innovation Project will allow CCBHS to utilize innovation dollars to evaluate and identify successful strategies needed to prepare for the transition to BHSA, as well as share lessons learned. There are other counties which are also participating in the PIVOT Innovation Project to strengthen integration both administratively and in delivery of services, as necessary to meet compliance with regulatory updates under Behavioral Health Transformation. Per BHSA regulations, approved innovation projects can continue on after July 1, 2026, as long as approval has been received from the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) and implementation has started prior to June 30, 2026.

1. Innovation Regulations Requirement Categories

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☒ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☒ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☒ Increases access to mental health services to underserved groups
- ☒ Increases the quality of mental health services, including measured outcomes
- ☒ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☒ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

2. Project Overview

Primary Problem

After review of currently known BHSA regulatory requirements and changes to funding structure, it is evident that CCBHS must re-organize and focus concurrently on multiple efforts to meet new requirements and implementation dates. Aside from the BHSA allocating less funding to counties across the board, there are also several new requirements where it is necessary to modify current programming and prepare for expansion of services to support Substance Use Disorder (SUD) treatment. BHSA will also impact workflow and require training on billing, reporting, defining new outcome measurements, and overall changes in delivery of services. Detailed changes have been identified further in the following areas:

Full-Service Partnerships (FSP)

Under WIC Section 5887, FSP programming updates will require mental health services, supportive services, Substance Use Disorder (SUD) services, assertive field-based initiation for SUD treatment, outpatient behavioral health services for evaluation and stabilization, ongoing engagement services, service planning for housing interventions, and Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) services to fidelity. This will require significant evaluation to existing FSP programming to better understand if current services will need to be revamped. Additionally, with the expansion for SUD treatment services, FSP programming will need to build further infrastructure to meet these obligations. Other requirements under the FSP component mandate Intensive Case Management (ICM), High-Fidelity Wraparound (HFW), and Individual Placement and Support (IPS) Model of Supported Employment. ICM service expansion is focused on the goal of better supporting client functioning, employment, housing outcomes, and reduce length of hospital stays. HFW will focus on team-based and family-centered evidence-based practices as an approach to care for children/youth

living with the most intensive mental health or behavioral challenges as an alternative to out-of-home placement for those with complex needs. The focus of IPS will be to assist clients to find and maintain employment.

Housing Interventions (HI)
30% of funds will now be allocated to HI. HI regulations requires that 50% of funds must be used for persons who are chronically homeless, homeless or at risk of homelessness. Additionally, up to 25% of the HI funds may be used for capital development projects. HI funding may be used for rental subsidies, operating subsidies, shared housing (including recovery housing), family housing, non-federal share for transitional rent, other housing supports, as defined by DHCS, including the community supports, capital development projects, and project-based housing assistance, including master leasing. Additionally, the target populations under HI are defined below:

Eligible children and youth who meet one of the following conditions:
- Are chronically homeless or experiencing homelessness or are 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 pursuant to Section 300, 601, or 602
- Are at risk of institutionalization

Eligible adults and older adults who meet one of the following conditions:
- Are chronically homeless or experiencing homelessness or are at risk of homelessness
- Are in, or are at risk of being in, the justice system
- Are reentering the community from prison or jail
- Are at risk of conservatorship pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5
- Are at risk of institutionalization

Behavioral Health Services and Supports (BHSS)
Under MHSA, 20% of funds were directed to the Prevention and Early Intervention (PEI) component, however under BHSA, Prevention is moved to State-level initiatives, and 17.85% of funds remain for Early Intervention (EI). EI funding must be prioritized for services for youth and young adults which have a primary focus on childhood trauma, addressing root causes of Adverse Childhood Experiences (ACEs) or other social determinants of health that contribute to early origins of Mental Health (MH) and expand these services to include EI services for SUD. Additionally under WIC Section 5840(d), EI programs must focus on reducing likelihood of certain adverse outcomes specific to early childhood (ages 0-5), children from ages between Transitional Kindergarten (TK) through 12th grade, as well as young adults in higher education with programming goals focused on EI for the following:
- Suicide and self-harm
- Incarceration
- School suspension, expulsion, referral to an alternative or community school, or failure to complete

- Unemployment
- Prolonged suffering
- Homelessness
- Overdose
- Removal of children from homes
- Mental illness in children and youth from social, emotional, developmental, and behavioral needs in early childhood

Under MHSA requirements, CCBHS contractors currently under the component of PEI were not required to provide the types of services outlined under EI and did not contain services for SUD. New requirements will oblige CCBHS to release RFPs that comply with the defined programming. Additionally, a momentous change is the expansion of services to include early intervention for SUD; as well as several other types of services such as:

- Scaling of and referral to Early Psychosis Intervention (EPI) Plus Programs
- Scaling of and referral to Coordinated Specialty Care
- Scaling of and referral to other similar Evidence Based Practices (EBPs) and Community Defined Evidence Based Practices (CDEPs) for early psychosis, mood disorder detection and intervention programs
- Services and activities with a primary focus on screening, assessment, and referral
- Telephone help lines
- Mobile response services

The bulk of these services delineated under EI will require services which meet Medi-Cal billable criteria. This significantly impacts most programs currently in the category of PEI as many do not currently offer these types of services. This will require significant staff support both from CCBHS and contractors to ensure services are structured under new programming mandates.

The remaining 17.15% of funds under the BHSS component may be utilized under the new categories of Children's, Adult, and Older Adult Systems of Care, Outreach and Engagement, but also are inclusive of Workforce Education and Training (WET) and Capital Facilities/Technological Needs (CFTN) which previously were their own component under the MHSA. The updated funding requirements and modification of programming under the BHSS component will have a substantial impact on utilization of services, processes, and evaluation of outcomes.

Coordination and Technological Needs

There will be a significant need, based off of the changes from MHSA to BHSA to coordinate care, especially with the expansion for SUD treatment services. Furthermore, there will be a need to re-evaluate and learn new processes, and reporting requirements while working to coordinate services, housing, and additional EBPs and CDEPs into the system of care. This influx will require additional staff capacity to support this coordination to identify the appropriate services needed for clients. Additionally, coordination and integration of systems that support the needs of both providers of mental health and substance use treatment services is part of the goal in integration.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)

There will be requirements that must also be implemented through BH-CONNECT which overlap with the BHSA transition and delivery of services. This includes utilization review processes involving pre-discharge coordination and follow-up requirements for clients, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for children and youth, Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT), Initial Child Welfare/Specialty Mental Health Assessments, and the alignment of Child and Adolescent Needs and Strengths (CANS) tools; amongst other system requirements.

Evidence Based Practices (EBPs) and Community-Defined Evidence Practices (CDEPs)

As part of new requirements, both under transition to BHSA and BH-CONNECT, there will be a requisite to provide additional EBPS and CDEPs. DHCS will develop a biennial non-exhaustive list that will also now be required as part of service delivery. This will require that CCBHS implement new or expand on existing training that aligns with the EBP and CDEP identified. DHCS has indicated the list will be a reference tool for counties to determine which best are suited for implementation and needs. Under WIC Section 5840 (c)(5), DHCS may require counties to implement particular EBPs and CDEPs if they are demonstrating gaps in services or struggling to meet performance measures.

Administrative Needs

There will be a significant increase for administrative support, to uplift and meet all regulatory requirements under BHSA. Under MHSA, only a Three-Year Plan which included description of only County funded MHSA programs and expenditures was necessary. However, under BHSA the reporting mandates are expanded. Counties must now complete an Integrated Plan (IP) to be completed every three years, along with annual updates. The IP requires that counties report out on all local, state, and federal programming, funding and related outcomes connected to the public behavioral health system. Additionally, counties are to submit the report via an electronic reporting portal to DHCS. It is estimated that MHSA funds in Contra Costa represent about 25% of the behavioral health budget, therefore this new requirement is anticipated to require reporting and program description, expenditures, and outcomes from any funding source used in the public behavioral health system.

There are also significant changes to the Community Program Planning Process (CPPP). Counties are to demonstrate meaningful stakeholder involvement for both mental health and SUD policy, program planning, implementation, evaluation, workforce efforts, quality improvement, health equity, and budget allocations. Under WIC 5963.03, the stakeholder list of individuals that must be involved in the CPP expands from usual stakeholder involvement of peers, consumers, families, and providers, to add requirements around more formalized engagement of individuals or agencies also representing:

- Youths or youth mental health or substance use disorder organizations
- Public safety partners, including county juvenile justice agencies
- Higher education partners
- Early childhood organizations

- Local public health jurisdictions
- County social services and child welfare agencies
- Labor representative organizations
- Health care organizations, including hospitals
- Health care service plans, including Medi-Cal managed care plans as defined in subdivision (j) of Section 14184.101
- Disability insurers
- Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- The five most populous cities in counties which have a population greater than 200,000
- Local agencies on aging
- Independent living centers
- Continuum of care, including representatives from the homeless service provider community
- Regional centers
- Emergency medical services
- Community-based organizations serving culturally and linguistically diverse constituents
- Individuals representing viewpoints of victims of domestic violence and sexual abuse
- People with lived experience of homelessness
- Health Plans and Housing Services

This creates a much more robust list of stakeholders and efforts needed to engage such individuals or agencies; further requiring staff support to support this process.

Evaluation, Initiative Alignment and Regulatory Requirements Under BHSA
Subsequently, all previously listed impacts and requirements under the IP, as well as changes in coordination of care will require CCBHS to develop tailored framework for evaluation and assessment for items such as:

- Client outcomes and service utilization
- Effectiveness of administrative process changes
- Workforce development impact and strategies
- Housing and/or service access improvements
- Alignment of BHSA funding priorities and regulatory requirements
- Behavioral Health Transformation and integration goals
- Community collaboration
- A continued focus on wellness, recovery, and resilience while working to prioritize needs of clients, consumers and peers

Proposed Project
The proposed PIVOT Innovation Project will allow CCBHS to utilize identified strategies to reduce the impacts of the adaptation of the BHSA into public behavioral health system.

Reboot of Full-Service Partnership (FSP) Programs
CCBHS has the following FSP programs: three FSP programs for children, two FSP programs for transition age youth, and five FSP programs for adults providing services as such:

- Children's FSP: Provides clients with personal service coordinators, multi-dimensional family therapy for co-occurring disorders, and services provided by county-operated children's clinic staff
- Transition Age Youth (TAY) FSP: Supports youth who experience challenges such as homelessness, substance abuse, trauma, school failure, multiple foster care placements, and juvenile justice involvement with targeted services to address their specific challenges
- Adult and Older Adult FSP: Provides comprehensive support to adults (18+) with who are uninsured or receive Medi-Cal benefits and earn at or below 200% of the federal poverty level

To meet FSP regulatory requirements and enhance FSP services, CCBHS must coordinate additional support for:

- Mental Health Clinic Support
- Assisted Outpatient Treatment
- Wellness and Recovery Centers
- Hope House – Crisis Residential Center
- MHSA - Funded Housing Services

CCBHS has provided FSP services through contracted provider agencies and County clinics. These programs are rooted in a "no-fail" philosophy, ensuring clients receive the support they need through 24/7 field-based wraparound care. Two of the children's FSP programs have specific focuses: one on Multidimensional Family Therapy (MDFT) and one on Multi-systemic Therapy (MST). Additionally, one TAY program and four adult programs focus on the adoption of Assertive Community Treatment (ACT). Meanwhile, one children's program, one TAY program, and one adult program do not have a specific focus but utilize various aspects of the full spectrum of community services to support their clients.

FSP Preliminary Data

Preliminary data suggest that the FSP model has been successful in Contra Costa and demonstrated reductions in homelessness, incarceration, and psychiatric emergency services (PES) visits. Data from FY 2021-2022 found:

- 61.2% decrease in PES episodes
- 69.9% decrease in inpatient psychiatric hospitalizations
- 47.8% decrease in inpatient psychiatric hospitalization days
- 19.7% decrease in productive meaningful activity (average hours per week), impacted by the COVID-19 pandemic
- 55.5% decrease in the number of unhoused individuals

However, it must be acknowledged that those analyses are based on a small sample, with no statistical significance testing performed. Overall, CCBHS lacks a robust data infrastructure for reliably tracking FSP client outcomes. CCBHS intends to build infrastructure through the Innovation project.

The BHSA requirement for counties to allocate 35% of the total budget to FSP programs, has led CCBHS to evaluate its existing FSP services to ensure successful enhancement and expansion of FSPs under BHSA. CCBHS's October through December 2024 evaluation identified the following areas targeted for improvement:

- Enhancing fidelity in treating co-occurring disorders (inclusive of mental health and SUD services)
- Expanding specialty staff within FSP teams
- Strengthening collaboration with psychiatric hospitals
- Improving interdisciplinary team coordination
- Promoting retention of both clients and FSP staff

To address these identified areas for improvement and need to comply with new requirements under BHSA, the Innovation project will be crucial to support the transformation of its FSPs. CCBHS plans to meet new BHSA mandates with modifications to its FSP programs which include:

- Implementation of EBPs - Streamline adoption of Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Individual Placement and Support (IPS) model of supported employment, and high-fidelity wraparound care
- Defined Levels of Care - Establish clear criteria for step-down services to ensure smooth client transitions
- Comprehensive Outpatient Behavioral Health Services - Enhance evaluation and stabilization services
- Sustained Client Engagement - Ensure ongoing participation in treatment and housing support
- Integration of SUD Services - Embed SUD services within all FSP programs, including co-located services and dual certification for services under the Drug Medi-Cal Organized Delivery System (DMC-ODS)

Infrastructure and Administrative Process Improvements

To successfully transition and expand FSP programs, Contra Costa County must develop:

- Local technical and data infrastructure
- Align county data systems with state and federal standards
- Implement real-time tracking tools for client care levels and transitions
- Improve data security and quality
- Update to administrative processes
- Defined step-down criteria and workflows
- Services which ensure continuity during client transitions
- Training for providers on new FSP structures and performance-based contracting

Transition to Performance-Based Contracting

To prepare for the shift toward outcome-based reimbursement models, CCBHS will need to:

- Develop infrastructure for value-based contracting
- Provide technical assistance for data collection and exchange
- Update criteria and establish new funding opportunities that align with service requirements

- Establish contractor incentives for participation
- Create systems to monitor program fidelity and performance
- Design tools to track client and program outcomes
- Work with contractors to coordinate reporting under new contracting requirements

CCBHS will leverage insights from its FSP evaluation and multi-county initiatives to sustain a successful transition under BHSA. CCBHS recognizes the need for enhanced data infrastructure and administrative processes to support this transformation. The PIVOT Innovation Project will be critical to implementing these changes and ensuring the continued success of its FSP programs under the Behavioral Health Transformation and beyond.

Integrate Evidence-Based Practices

In pivoting from MHSA to BHSA, CCBHS will be transforming its systems to comply with new BH-Connect initiatives, some of which are in direct alignment with BHSA, and other elements, that are unique to BH-Connect. BH-Connect is designed to increase access and strengthen the continuum of community-based behavioral health services for Medi-Cal members living with significant behavioral health needs. The program is comprised of a 5-year Medicaid section 1115 demonstration, State Plan Amendments to expand coverage of EBPs available under Medi-Cal, and complementary guidance and policies to strengthen behavioral health services statewide.

The objectives of BH-Connect are to:
1) Reduce reliance on facility-based care and strengthen community support, and
2) Bridge gaps to care for those with significant behavioral health needs

These populations of focus include children and youth involved in child welfare; individuals and families experiencing or at risk of homelessness; and justice-involved individuals. A major initiative designed to expand the care continuum is the addition of EBPs under BH-Connect. The new EBPs include:

Assertive Community Treatment (ACT)	Intensive, team-based support for individuals with serious mental illness to promote community living and recovery.
Forensic ACT (FACT)	A specialized ACT model that supports individuals with mental illness who are involved in the criminal justice system.
Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)	Early intervention program designed to provide comprehensive, team-based care for individuals experiencing their first episode of psychosis.
Individual Placement and Support (IPS) Supported Employment Model	Evidence-based employment program that helps individuals with mental health conditions find and maintain competitive jobs.
Enhanced Community Health Worker (CHW) Services	Expanded CHW support to enhance outreach, engagement, and care coordination for individuals with complex behavioral health needs.

Peers with Justice Involved Specialization	Peer support specialists with lived experience in the justice system, providing mentorship and guidance for justice-involved individuals with mental health conditions.
Clubhouse Services	Community-based psychosocial rehabilitation programs that offer peer support, employment, education, and social opportunities for individuals with mental health conditions.

The additional EBPs targeted for children and youth include; Parent-Child Interaction Therapy (PCIT), Multi-systemic Therapy (MST), and Functional Family Therapy (FFT). In addition, under BHSA and EPSDT, High Fidelity Wraparound will be required, serving as the children's FSP under the former program. To assist counties with implementing these EBPs to fidelity, Centers of Excellence will provide training, technical assistance, and support to assist counties with gaining the skills and creating the infrastructure to implement these practices with fidelity.

Achieving and maintaining compliance with BHSA and BH-Connect EBPs and beyond, will necessitate development of new processes, policies, procedures, trainings, and systems, which will require substantial staff time to develop, implement, and sustain. To ensure successful system transformation, this proposed Innovation project will be aimed to support significant system changes that will benefit clients who are most at risk for negative outcomes.

For counties to successfully implement all BH-Connect components designed to support the most at-risk clients, and implement EBPs with fidelity, there will be a need to further support a robust workforce equipped to provide culturally and linguistically appropriate care. Approaches that will support current workforce shortages under BH-Connect entail a two-pronged approach which is both long-term and short-term investments designed to support identification, training, and retention of staff providing services across the continuum. A key focus is providing culturally and linguistically diverse care for various populations; engaging individuals with lived experience in the workforce; and addressing acute shortages in health professionals working with children and youth, and justice-involved individuals.

Long-term investments will be structured to expand the pipeline of behavioral health staff to provide services to clients with significant behavioral health needs; specifically services to clients with co-occurring challenges both in mental health and SUD. Further efforts will be made to build upon investments in peer providers, community health workers, and SUD counselors. These investments may take form in loan repayment programs, or other types of financial incentive programs, expansion of behavioral health career pathway programs, residency or internship programs, or training and delivery of EBPs and CDEPs. Due to this changing landscape, CCBHS will revise its workforce initiatives established under MHSA, as needed to account for changes in funding allocation under BHSA, and State initiatives, as well as requirements under BH-Connect in order to successfully support implementation of the system transformation.

Coordination of Care and Access for Specialty Mental Health Services

CCBHS has long been committed to addressing the challenges in providing mental health treatment to traditionally underserved populations. CCBHS calculates the penetration rates for

its client population on an annual basis. Penetration rates are calculated by dividing the number of unduplicated beneficiaries served by the total number of people eligible for Medi-Cal. Overall, CCBHS's penetration rates have consistently been higher in comparison to other large counties and the state as a whole. However, there has been longstanding data showing gaps in services for some communities through a comparison of Medi-Cal beneficiary demographics and penetration rates.

To address ongoing challenges in reaching its diverse communities, CCBHS must continue to make larger system changes to ensure the needs of these underserved populations living with serious behavioral health conditions are met. One area CCBHS would like to further assess as a potential implementation with BHSA is working to further build on the relationships between CBOs and the communities served by assessing and helping CBOs develop capacity to further serve individuals living with serious behavioral health challenges and identify the minimum capacity to become a Specialty Mental Health Services contracted provider.

Component activities and objectives will include but not be limited to:

- Assessing what it takes for a CBO to become a Medi-Cal/Drug Medi-Cal provider
- Identifying the type of technical assistance needed to support this initiative
- Determining if embedding culturally based approaches for specialty mental health services improve penetration rates and outcome
- Identifying CDEPs that can generate revenue and be recognized by the State

The activities in this component will draw upon recommendations and lessons learned from Solano County's Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM) INN Project. These include:

- Staffing Considerations
  - A variety of staff may participate over the duration of the project
  - Contra Costa will call upon staff from its Quality Improvement/Quality Assurance unit to support activities related to Medi-Cal requirements
  - Involvement of the Ethnic Services Manager (ESM) or team member so that efforts correspond with other cultural competence efforts and can be communicated to relevant stakeholders

- Budget and Financial Planning
  - Track staff costs over the course of the project to inform the cost analysis in the final evaluation
  - Contra Costa will help CBOs identify and track the costs for staffing, program costs and other expenses necessary for Medi-Cal certification

- Community Partnerships & Engagement
  - Engaging community members who are cultural brokers and persons with lived experiences will be important for community outreach early in the project

- Contra Costa will engage with community members to elicit their feedback and experiences when identifying successful CDEPs

The ability to determine the necessary steps for CBOs to become specialty mental health providers will have lasting benefits to the public behavioral health system of care. It will improve access for Contra Costa County's most underserved populations and help close the gap in penetration rates. It will also help identify CDEPs that can generate revenue for the County and CBOs serving these populations, creating a sustainable system of care. Lastly, this component will help build the capacity for CBOs to provide a broader range of services, strengthening their role in the system of care. Supporting contracted CCBHS CBOs in becoming specialty mental health providers through Medi-Cal certification will allow these CBOs to bill for a more expanded range of services that they otherwise currently are unable to bill.

Expand Technology and Coordination: Re-imagining Service Flow of Operations and Information Exchanged to Promote Quality Care and Improve Client Outcomes with Investments in Interoperability

CCBHS will need to increase client access to health information exchange in real time, which promotes more effective health services for the client and better outcomes. Health information interoperability is the ability of different healthcare systems to share and use client data allowing one system to send data to another. This also enables more accurate diagnoses and treatments allowing providers to easily exchange medical records between different electronic health record systems. This may look like further identification of electronic health records that can support health information exchange for both mental health services and SUD treatment services, or further coordination between CCBHS and contracted CBOs which support this exchange, as well as better communication between data collected by CCBHS and the larger Contra Costa Health system. Benefits include improved client care allowing providers to access more information about clients resulting in better care and treatment plans. It also allows data analysts and behavioral health managers the ability to access and report on client data to improve community health and reporting for State efforts. Furthermore, it gives clients more control over their health information, which can lead to better adherence to treatment plans.

Workflow Changes with Contract Agencies Through Data Exchange

When contract health agencies implement data exchange, their workflows significantly change by allowing for real-time access to client information across different healthcare systems, streamlining care coordination, reducing administrative burdens, improving decision-making, and enabling proactive interventions, ultimately leading to more efficient and client-centered care delivery. This workflow change requires technology, resources and training. Instead of manually entering client information from paper records or phone calls, healthcare providers can directly access updated data from the client's electronic health record through the data exchange platform, saving time and furthering system progress.

With access to a comprehensive view of a client's medical history across different platforms, providers can better coordinate care, identify potential issues early, and avoid unnecessary duplication of treatment. Data exchange enables near-instantaneous updates to client records, ensuring clinicians have the most recent information at the point of care, leading to more

informed decisions. Streamlined referrals can be initiated electronically through the data exchange platform, including necessary client details, which reduces administrative tasks and expedites the referral process. Secure messaging capabilities within the data exchange platform facilitate better communication between providers, including specialists, primary care physicians, and contracted health agencies, improving continuity of care. Clients can access their health information through secure client portals, allowing them to actively participate in their care, communicate with providers more effectively, and aid in their recovery.

Improving Database and Reporting Infrastructure to Promote Operational and Financial Transparency

It will be necessary to manage and replace healthcare legacy systems to maintain large data sets and healthcare needs. This includes improving health information databases and reporting infrastructures. There is a growing need across all aspects of healthcare where clients expect real-time access to their medical records, treatment plans, testing results, billing, etc. When it comes to financial transparency, there will also be a need to define all behavioral health funding sources as part of the Implementation Plan. Additionally, as more providers; such as peer providers and community health workers have entered the healthcare payment space, and regulations continue to update over the recent years; the pricing models have grown in complexity. By analyzing large datasets, viewing assessments, and medical and pharmaceutical information, healthcare providers can identify risk factors and make better client predictions. This allows for earlier interventions ultimately reducing healthcare costs and improving client care and quality of life. There are large amounts of information in client records and streamlining computerized summaries also makes client care easier and more efficient with improved data systems.

Health information technology upgrades present numerous opportunities for improving and transforming healthcare which includes reducing oversight, improving clinical outcomes, facilitating care coordination, improving practice efficiencies, and tracking data over time. High-quality data supports healthcare providers in accurate diagnoses, offering effective treatments, and minimizing inaccuracies. It supports informed decision-making, enhances client care, and increases client satisfaction.

- CCBHS will need adequate resources to understand and perform the implementation of new technologies, including testing and report writing
- CCBHS would like to further invest in training, technical support and processes that improve the ability to connect with our contracted providers and data exchange
- Additionally, it is anticipated the influx of new reporting and technological requirements will intensify in upcoming years; which will require systems and increased workforce to support organizational needs

Unite Housing and Care

California counties, including Contra Costa face significant challenges in addressing the intertwined needs of housing and behavioral health. Stable housing is crucial for mental health as well as substance use recovery, and untreated behavioral health conditions can be a major barrier to housing stability. This complex relationship requires a multifaceted approach. To

address these challenges and ensure the successful implementation of the Behavioral Health Transformation, CCBHS will need to:

- Assess the current state of housing availability for behavioral health clients to better identify and understand gaps and needed resource development
- Develop financial and technological infrastructure (including administrative staff) to better manage housing and treatment needs
- Analyze and develop funding strategies to maximize resources for housing supports
- Develop a strategy to expand transitional and permanent supportive housing
- Strengthen partnerships with local housing agencies and community organizations

A comprehensive assessment of the current state of housing availability for CCBHS clients is paramount. This assessment would delve into specific types of housing available, their accessibility, and their suitability for individuals with diverse behavioral health needs. By thoroughly identifying and understanding the gaps in current resources, CCBHS can better direct future resource development and tailor solutions to the unique needs of this vulnerable population. To effectively manage the complex intersection of housing and treatment, CCBHS will develop robust financial and technological infrastructure. This includes investing in sophisticated data management systems to track client needs, housing availability, and treatment outcomes. Furthermore, adequate administrative staffing is essential to ensure efficient coordination between housing providers, behavioral health services, and other relevant agencies such as the Continuum of Care and local managed care plans. This investment in infrastructure will streamline processes, improve data-driven decision-making, and ultimately enhance the quality of care for individuals with behavioral health needs.

Securing sustainable funding is also crucial for expanding and maintaining housing supports for behavioral health clients. A thorough analysis of existing funding streams is necessary to identify opportunities for maximization and strategic reallocation. Additional analysis will also be required to effectively blend traditional Medi-Cal revenues as well as newly implemented State funding resources. Simultaneously, CCBHS plans to explore and develop new funding strategies, including continuing pursuit of state and federal grants, leveraging partnerships with philanthropic organizations, and exploring innovative financing models. This proactive approach to funding will ensure the long-term viability of housing initiatives and support the development of a comprehensive network of services.

Another critical component of addressing the housing crisis for behavioral health clients is the development of a comprehensive strategy to expand transitional and permanent supportive housing. Transitional housing provides a steppingstone for individuals moving from institutional settings or homelessness, offering temporary shelter and support services to facilitate their transition to independent living. Permanent supportive housing, on the other hand, provides long-term housing coupled with ongoing support services for individuals with chronic behavioral health conditions. This strategic expansion would prioritize the creation of housing options that are integrated within the community, promote social inclusion, and offer tailored support services to meet the diverse needs of residents.

Finally, strengthening partnerships with local housing agencies and community organizations is essential for creating a coordinated and effective system of care. This should also include strengthening collaboration and coordination with other county departments which provide housing related services, such as Health Housing and Homeless Services (H3), the Connect to Coordinated Outreach Referral and Engagement (CORE) team, the Contra Costa Continuum of Care, etc. Collaborative efforts will ensure resources are utilized efficiently, duplication of services is minimized, and clients receive seamless support across multiple agencies. By fostering strong relationships with stakeholders, CCBHS can build a robust network of support which empowers individuals with behavioral health needs to achieve housing stability and their overall well-being.

Prioritization will be placed on a thorough assessment of existing housing availability, robust infrastructure development, strategic funding, expansion of supportive housing options, and strengthened community partnerships. CCBHS intends to utilize the PIVOT Innovation Project to create a more equitable and supportive environment for its most vulnerable residents. These combined efforts will both improve housing stability and enhance access to vital behavioral health services, ultimately fostering greater well-being and community health.

Prepare a Strong Workforce

Historically, California's public behavioral health system has experienced a shortage of behavioral health workers, specifically underrepresentation of diverse professionals with consumer and family member experience. To support challenges faced by the public behavioral health workforce, the MHSA included a component for Workforce Education and Training (WET) programs with the intent to support workforce development and retention efforts and increase a culturally and linguistically diverse workforce. In Contra Costa County, WET has been used to support a financial incentive program which prioritizes hard-to-fill and hard-to-retain positions, with an emphasis on prioritizing a culturally and linguistically diverse workforce, as well as supporting a clinical paid internship program both within CCBHS's County system of care, and through contracted CBOs. WET has also been used to uplift the peer voice and grow peer providers by what is known today as the Service Provider Individualized Recovery Intensive Training or SPIRIT program. This program has elevated the peer voice in Contra Costa which today supports over 60 peer providers within the CCBHS County system of Care and numerous other peer providers working in CCBHS contracted CBOs. SPIRIT is also one of the longest running programs for peer development in California, which serves to boost consumer and family members with lived experience in gaining education and skills to enter into the behavioral health workforce. WET has also been used to provide training relevant to client and staff needs.

Despite these workforce efforts, CCBHS continues to have staffing challenges. Several factors contribute to these challenges, including limited flexibility in work schedule; non-competitive pay in comparison to surrounding counties; minimal pay differential for specialty skills (e.g., language competency); and slow hiring and human resources processes for potential candidates. In the most recent Medi-Cal Specialty Behavioral Health External Quality Review for the Contra Costa Mental Health Plan for FY 2023-24, the top recommendation from Behavioral Health Concepts, the agency contracted by DHCS to conduct CCBHS's External Quality Review Organization, was to implement recruitment and retention strategies for both clinical and quality positions – a

carryover recommendation from the two prior external reviews, demonstrating the enduring nature of the hiring challenges facing CCBHS.

CCBHS has had a longstanding history of offering internship programs in the mental health field, however it has yet to build capacity for internships focused on treatment of SUD. A goal for CCBHS would be to expand its paid internship program as well as behavioral health career pathway program to further support career pathway development under this area. Despite existing programming, barriers exist that challenges successes and include but are not limited to:

- Competition amongst systems - For example, hospitals, education, criminal justice, and managed care plans all compete for the same qualified staff and interns, not only in the County, but within the Bay Area
- In addition, there would need to be capacity to explore how the career pathway model could be expanded to support workforce needs of SUD counselors or clinicians with experience in co-occurring disorders.

These challenges are not limited to CCBHS. The State continues to seek solutions to address this challenge with its recent behavioral health reform efforts. One of the tenets of BHSA is increasing access by building workforce infrastructure. State efforts under BHSA will be to utilize 3% of funds to support workforce investments to expand a culturally competent and well-trained behavioral health workforce to mitigate capacity shortages and expand access to services.

CCBHS seeks to assess and evaluate its workforce development strategies to align with the needs of its changing system of care. Furthermore, recent efforts proposed by the California Department of Health Care Access and Information (HCAI) have outlined plans for developing a data-driven statewide strategy to expand and diversify California's behavioral health workforce. The strategy will explore innovative solutions to improve financial incentives, compensation, recruitment, and retention. HCAI will also explore the ability to offer flexible work schedules, develop career pathways, and reduce administrative barriers. Where possible, CCBHS will partner with/and or align its efforts with HCAI's approach and draw upon shared learning.

Research on Innovation Component

Based on the 2020 United States Census estimates, the population size in Contra Costa County is about 1.2 million.[5] In addition, its estimated that 23% of the population are children, 77% are 18 or older, and about a quarter of residents are foreign born.[6] It is also estimated that 8% of people in Contra Costa are living in poverty and about 33% of the residents have public health coverage.[7]

[5] State of California Department of Finance. (2021, December 15). Projections- Household Projections for California Counties. http://www.dof.ca.gov/Forecasting/Demographics/projections/

[6] United States Census Bureau. (2021, December 15). Contra Costa County, California. https://data.census.gov/cedsci/profile?g=0500000US06013

[7] United States Census Bureau. (2021, December 15). Selected Economic Characteristics. https://data.census.gov/cedsci/table?q=contra%20costa%20county%20data&t=Health%20Insurance&g=05US&tid=ACSDP1Y2019.DP03

The population size is expected to grow.[8] According to Covered California, for a person to be considered at 200% Federal Poverty Level in 2020, an individual's income would be at or below $24,980.[9] This is the primary population intended to be served through Contra Costa Health and CCBHS.

Furthermore, CCBHS has historically had challenges in reaching the Latino/a/X/Hispanic and Asian/Pacific Islander populations. For example:

- A report comparing the number of clients targeted versus the number served by race/ethnicity is reviewed. This report has shown Latino/a/X/Hispanic and Asian/Pacific Islander (API) populations as underserved. The Mental Health Plan has identified disparities such as API populations that represent 10% of eligibles, but only 6% of beneficiaries served. Latino/a/X/Hispanic populations represent 38.3% of eligible beneficiaries, but only 17.9% of beneficiaries served, according to the EQRO Final Report FY2010-2011.
- To address disparities, CCBHS implemented a number of strategies. Annual penetration rate analyses have informed various access building strategies for such groups as API and have set the QI work plan goal of increasing the penetration rates of that group by 1 percent by the end of 2012; as identified in the EQRO Final Report FY2011-2012.
- It was also noted the Mental Health Plan's Latino/a/X/Hispanic penetration had declined very slightly from Calendar Year 2015…[10]
- The Latino/a/X/Hispanic penetration rate has been declining for the last three years.[11]
- Latino/a/X/Hispanic and API individuals are disproportionately less likely to access Specialty Mental Health Services in Contra Costa County. In Calendar Year 2020, Latino/a/X/Hispanic individuals represented 34.1% of the total Medi-Cal eligible population yet comprised only 25% of beneficiaries served. In the same time period, API beneficiaries represented 10.9% of

[8] State of California Department of Finance. (2021, December 15). Projections- Household Projections for California Counties. http://www.dof.ca.gov/Forecasting/Demographics/projections/

[9] Covered California. (2020, March). Program Eligibility by Federal Poverty Level for 2020 https://www.coveredca.com/pdfs/FPL-chart2020.pdf

[10] FY 17-18 Medi-Cal Specialty Mental Health External Quality Review – Contra Costa Mental Health Plan (MHP) Final Report. https://www.calegro.com/data/MH/Reports%20and%20Summaries/Prior%20Years%20Reports%20and%20Summaries/Fiscal%20Year%202017-2018%20Reports/MHP%20Reports/Contra%20Costa%20MHP%20EQRO%20Final%20Report%20FY17-18%20RW%20v5.pdf

[11] FY 2018-19 Medi-Cal Specialty Mental Health External Quality Review – Contra Costa Mental Health Plan (MHP) Final Report. https://www.calegro.com/data/MH/Reports%20and%20Summaries/Prior%20Years%20Reports%20and%20Summaries/Fiscal%20Year%202018-2019%20Reports/MHP%20Reports/Contra%20Costa%20MHP%20EQRO%20Final%20Report%20FY%202018-19%20CL%20v16.pdf

the total Medi-Cal eligible population, yet they represented only 4.8% of beneficiaries served.[12]

- Commonalities between the Mental Health Plan and Statewide county comparison is that the Latino/a/X/Hispanic and API groups are underrepresented. The Latino/a/X/Hispanic penetration rates have taken a downward trend the last three years. The penetration rates of the API population is also on a slight downward trend.[13]
- Commonalities between the Mental Health Plan and Statewide county comparison is that the Latino/a/X/Hispanic and API groups are underrepresented. The Latino/a/X/Hispanic penetration rates have taken a downward trend the last three years. The API penetration rates have consistently been the lowest in the Mental Health Plan. The Average Approved Claims per Member (AACM) for the API community has decreased 20% from Calendar Year 2020 to Calendar Year 2022. The last two years they have remained lower than other large counties and statewide.[14]

Two additional priority populations identified by CCBHS are the African American/Black and the LGBTQI+ communities. For example, marginalized populations identified both in quantitative and qualitative data in the CCBHS Cultural Humility Plan are listed below:

- Latina/Latino/LatinX/ Hispanic
- Asian communities
- LGBTQI+ youth
- African American/ Black Communities - although penetration rates show to be serving at minimum or higher rates in this population, stakeholders have voiced the need for more culturally appropriate services and early intervention targeted for the specific needs identified by African American/ Black communities.[15]

These deficiencies have not gone ignored over the past ten years. CCBHS's Quality Improvement Work Plan has had goals and objectives to engage some of these underserved populations since Calendar Year 2012. For example, some of the Work Plan efforts have been:

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[12] FY 2021-22 Medi-Cal Specialty Behavioral Health External Quality Review – Contra Costa Final Report. https://www.caleqro.com/data/MH/Reports%20and%20Summaries/Prior%20Years%20Reports%20and%20Summaries/Fiscal%20Year%202021-2022%20Reports/MHP%20Reports/Contra%20Costa%20MHP%20EQRO%20Final%20Report%20FY21-22.pdf

[13] FY 2022-23 Medi-Cal Specialty Behavioral Health External Quality Review – Contra Costa Final Report Revised August 2023. https://www.caleqro.com/data/MH/Reports%20and%20Summaries/Prior%20Years%20Reports%20and%20Summaries/Fiscal%20Year%202022-2023%20Reports/MHP%20Reports/Contra%20Costa%20MHP%20EQR%20Revised%20Final%20Report%20FY22-23%20RW%2004.17.23%20rev%208.23.23.pdf

[14] FY 2023-24 Medi-Cal Specialty Behavioral Health External Quality Review – Contra Costa Final Report. https://www.caleqro.com/data/MH/Reports%20and%20Summaries/Fiscal%20Year%202023-2024%20Reports/MHP%20Reports/Contra%20Costa%20MHP%20FY%202023-24%20Final%20Report%20CMH%20040524.pdf

[15] 2024 Cultural Humility Plan Update. Contra Costa Behavioral Health Services. https://www.cchealth.org/home/showpublisheddocument/31276/638701358315970000

- By end of year (2012) increase the penetration rate for the Latino/a/X/Hispanic and API, population(s) by 0.5% (using the APS procedure for calculating Medi-Cal eligibles), per the Contra Costa Quality Improvement Workplan, 2012.

One of the challenges in reaching these underserved groups may include limitations in the county workforce demographics and ability to provide linguistically appropriate services by providers. Individuals are likely to seek support from Community-Based Organizations (CBOs) that may be able to better serve cultural groups. CBOs are also more likely to integrate CDEPs into their services that look beyond traditional empirical based models to emphasize behavioral health practices that a community considers culturally relevant and healing. Additionally, due to the political climate, some groups are weary of engaging in county services.

Recognizing this, CCBHS has historically used Prevention and Early Intervention funds under MHSA to contract with CBOs that served specific cultural populations (e.g., La Clinica de La Raza, Community Health for Asian Americans, the Center for Human Development, and the Rainbow Community Center) to assist in reaching our goals. The 2013 Quality Improvement Work Plan stated CCBHS was to:

- Track outreach of PEI programs by end of year (2013) and increase the penetration rates by 0.5% for the following populations: Latina/Latino/LatinX/ Hispanic and API.

More recently (2023) the Contra Costa Quality Improvement Work Plan included the goal to:

- Increase penetration rates for underserved populations from previous years for:
  - Latina/Latino/LatinX/ Hispanic by 3.6%
  - API by 2.2%

CCBHS also launched an MHSA Innovation Project for Community Defined Practices (CDP). This CDP Innovation Project is aimed to support equitable access to behavioral health supports and wellness for underserved and unserved communities including Asian American/Pacific Islander (AAPI), Latino/a/x, Black/African American, LGBTQI+ and others. CCBHS awarded an estimated $5,516,875 to 17 agencies through June 30, 2026, through a competitive process to support community-defined practices and other forms of outreach, engagement not offered in the existing CCBHS System of Care.[16] CCBHS plans to utilize information learned from the CDP Innovation Project to analyze methods that CDEP programming can support services for diverse populations.

Learning Goals and Project Aims

This PIVOT Innovation Project proposal identifies learning objectives under each component and will require its own evaluation plan and team to track lessons learned. Upon approval of this project, CCBHS plans to work with planner/evaluators to support evaluation efforts. Learning questions will be explored that add to and align with the goal or mission of these components.

[16] Mental Health Services Act (MHSA). Contra Costa Behavioral Health Three Year Program and Expenditure Plan. FY 2024-25. Annual Update. https://www.cchealth.org/home/showpublisheddocument/30878/638636498732900000

Planner/evaluators from each component will gather data and information to tell a cohesive story of successes and lessons learned. The planner/evaluators will identify an evaluation plan for each component, identifying the methodology for data collection and tracking to address learning questions. Planner/evaluators for each component will be responsible for developing an annual narrative report of lessons learned and recommendations across all components.

Reports will be directly shared with the BHSOAC and local stakeholders as part of the annual PIVOT Innovation Project Report and included in the future Integrated Plan and annual updates under BHSA. Based on the activities and objectives of each component, CCBHS has drafted the following preliminary learning questions:

Evaluation for Reboot of Full-Service Partnerships

- How can the different FSP levels be operationalized to support timely and appropriate transitions in level of care?
- What administrative processes and program operations ensure that members experience seamless continuity of care during transitions between FSP levels?
- For contracted programs, what changes are needed in the contract language to incorporate the different levels of care?
- Are the existing data systems adequate for providing real time tracking of client progress?
- What are the standards for fidelity monitoring?

Evaluation for Housing Interventions (HI) which Promote Unity and Coordinate Care

- What gaps exist in the current array of housing options?
- What are the most successful strategies for identifying the most at-risk target population?
- What are the viable funding structures that can support this integrated model of care?
- What housing models would best support the needs of the target population?

Evaluation for Streamline Capacity to Service Diverse Communities

- What are the minimum requirements for a CBO to become a Medi-Cal/Drug Medi-Cal Organized Delivery System provider?
- What type and level of technical assistance are needed to support CBOs?
- Does embedding culturally based approaches for specialty mental health care improve penetration rates and client outcomes?
- Which Community Defined Evidence Practices (CDEPs) are most effective?
- How can CDEPs be utilized to generate revenue?
- Do services under this component lead to more culturally and linguistically appropriate services?

Evaluation for Workforce Development

- Which incentives increase the likelihood of filling hard-to-fill and hard-to-retain positions?
- How can workforce strategies be directed to support a workforce that is more culturally and linguistically diverse?
- Do these workforce initiatives place the County in a better position to apply and qualify for grants to sustain/expand workforce initiatives?

Evaluation for Integration of Evidence Based Practices (EBPs)

- Have the required initiatives under BH-Connect been implemented properly and in a timely manner?
- Have the EBPs been integrated into service delivery?
- What additional training is required to support the successful implementation of BH-Connect?

Evaluation for Enhancement for Technological Needs and Coordination of Care

- Has our interoperability and data exchange infrastructure been substantially improved?
- Has improved data sharing with contract agencies resulted in increased coordination of care?
- Have enhanced databases and reporting systems led to greater financial transparency?

Each area of the proposal will have a tailored evaluation framework assessing client outcomes, service utilization, the effectiveness of administrative process changes, the impact on workforce, and housing and/or service access improvements.

3. Additional Information for Regulatory Requirements

Contracting

If approved, CCBHS will either build off its existing network of consultants and contractors, or engage in an RFP process to identify consultants, contractors and Subject Matter Experts (SMEs) with the knowledge, skills and abilities needed to support listed activities throughout this innovation proposal. Per Contra Costa County requirements, all consultants or contractors must meet outlined standards before any contractual agreement can be established for services.

Community Program Planning

The idea for this project developed through ongoing discussions with stakeholders regarding the Behavioral Health Transformation. CCBHS has incorporated this item as part of standing agenda items to cover through the Behavioral Health Director's Report. The discussions have revolved around Senate Bill 326 (SB326), Proposition 1, and eventually the passing of the BHSA. All stakeholder meetings are open to the public and publicized through a broad email distribution list of over 1,000 recipients and growing. The public is able to self-register to receive automated meeting notices. Agendas, meeting information, or Community Program Planning (CPP) events are posted in public view on-site and on-line. The stakeholder bodies included in these meetings represent:

- Peers (consumers / clients and those with lived experience)
- Peer providers
- Family members
- Family partners
- Mental Health Commission (Board Members)
- Community Based Organization staff
- Behavioral health providers
- Underserved populations
- Faith-based organizations
- Criminal justice

- Alcohol and Other Drug Services (AODS) representatives
- Veteran representatives

Stakeholder meeting groups have allowed for ongoing discussions as part of CCBHS's Behavioral Health Director updates regarding the transition of MHSA to BHSA. CCBHS has been keeping the community apprised of information as learned and has considered input and needs regarding the BHSA transformation. Below are the meeting groups and dates where the BHSA transition was discussed.

Mental Health Commission - Meeting Dates
- October 4, 2023
- November 1, 2023
- February 7, 2024
- March 6, 2024
- April 3, 2024
- May 1, 2024
- June 5, 2024
- August 7, 2024
- September 4, 2024
- November 6, 2024

Mental Health Services Act Advisory Council (MHSA AC) - Meetings Dates:
- January 5, 2023
- April 6, 2023
- June 11, 2023
- September 7, 2023
- October 5, 2023
- April 4, 2024
- June 6, 2024
- August 1, 2024
- October 3, 2024

Presentation to the Service Provider Individualized Recovery Intensive Training (SPIRIT) Course at Contra Costa College:
- January 31, 2024

Mental Health Services Act Advisory Council Community Forum – Understanding Proposition 1:
- February 22, 2024

Additionally, CCBHS held a special Community Program Planning Process stakeholder meeting on February 13, 2025, to share and review its plan to propose the Program Improvements for Valued Outpatient Treatment (PIVOT) Innovation Project. Members of the community were able to provide input after the presentation through a Question-and-Answer section, as well as Public Comment. Apart from the meeting group, a survey was released from February 19th, 2025,

through February 25, 2025, that was sent out to the distribution list of over 1,000 people. The community input received to date has been incorporated into the proposal.

CCBHS will continue to update stakeholders as more concrete information is released by DHCS. Additionally, similar Innovation projects in other counties have been reviewed to help CCBHS in better gaining insight in developing this project. Other proposals examined which are variations of this proposal Innovation Project include Orange and San Mateo County's Program Improvements for Valued Outpatient Treatment (PIVOT) and Nevada County's BHSA Implementation Plan. All projects have a similar goal of facilitating the implementation strategies in preparation of the BHSA transition.

MHSA General Standards

The project was developed through a community planning process that included discussions and presentations and multiple stakeholder meetings from 2023 to present day. On-going community collaboration will be supported through stakeholder meetings and sharing of annual reports. There has been ongoing concern about how services and supports will continue to prioritize all, especially marginalized and underserved community groups. Formal discussion has and continues to be held at stakeholder meetings and feedback continues to be elicited for project roll-out.

Although MHSA will be transitioning to BHSA, the PIVOT Innovation Project focuses on services that are client and family driven; where clients and family members are encouraged to provide feedback on the quality and effectiveness of the project via surveys and monitoring of outcome reports. Programming will continue to strive for the golden standard of being wellness, recovery and resilience-focused, recognizing the importance of community-driven cultural practices and working to uplift any CDEPs and EBPs in programming which support mental health and wellness, as well as further expansion and integration of services; with a focus on expansion of SUD treatment. This will be done in consideration of efforts listed for reboot of Full-Service Partnership (FSP) programs, building a system to better coordinate housing interventions and work with CBOs to streamline capacity for Specialty Mental health Services with an emphasis on services to diverse communities, and continuing to develop workforce efforts that will support services to vulnerable communities as well as building infrastructure needed for enhancement of technological needs, data tracking, outcome reporting, and fiscal transparency.

Cultural Competence and Stakeholder Involvement in Evaluation

The concept for this proposal was introduced after much discussion about SB326, Proposition 1, BHSA, and Behavioral Transformation with community stakeholders. It is evident that there will be significant impacts to current programming under MHSA. CCBHS has identified the PIVOT Innovation Project as a method to mitigate the impact of changes under BHSA and support the most vulnerable populations.

Innovation Project Sustainability, Proposition 1 Alignment, and Continuity of Care

This project aligns with BHSA funding priorities and regulatory requirements under the Behavioral Health Transformation, as well as integration goals, and Statewide workforce development

strategies. The project also meets BHSA and current MHSA regulatory requirements, ensuring community collaboration, and a focus on wellness, recovery, and resiliency for clients, consumers and peers.

The overarching goal of this Innovation Project is to help Contra Costa County, and other counties, prepare for the upcoming changes under the new legislation. As such, this project aligns with the tenets of BHSA and the three new components under FSP, HI and BHSS.

BHSA mandates 35% of funds for FSP programs, requiring administrative and data infrastructure improvements. The FSP Reboot focuses on streamlining processes and ensuring compliance and expansion of services under new requirements. Additionally, with 30% of funds allocated to housing programs, this component aims to enhance equitable access to housing and care, emphasizing culturally responsive services. Key initiatives include:

- Assessing housing gaps and resources
- Developing financial/technological infrastructure for housing management
- Expanding transitional and permanent supportive housing
- Strengthening partnerships with housing agencies

The 30% of funds and programming which will be allocated to the HI component aims to enhance equitable access to housing and care. Key initiatives include:

- Assessing housing gaps and resources
- Developing financial/technological infrastructure for housing management
- Expanding transitional and permanent supportive housing
- Strengthening partnerships with housing agencies

The remaining 35% of funds are to be allocated to the BHSS component; which would require several new and/or expansion of programming that would strive to support access of services and develop the capacity of CBOs to serve the County's diverse community; both through specialty mental health service providers and beyond. If successful; this would increase access of care and further identify EBPs and CDEPs that also generate revenue for services and could overlap with mandates under BH-Connect. Initiatives could include, but are not limited to:

- Integration of Evidence-Based Practices (EBPs) and Community Defined Evidence-Practices (CDEPs) that would support Early Intervention Programming
- Expansion of services in all areas focused on SUD treatment
- Workforce development via training and implementation of EBPs and CDEPs
- Maintain or build off of existing behavioral health workforce programs with State-backed initiatives
- Enhancement of technology and coordination of services through investment in interoperability and data exchange
- Improvement of data sharing and reporting systems
- Coordinating care between CCBHS, contracted providers, and the larger public health system
- Prepare a strong workforce via explored expansion of internship programs and behavioral health career pathways

- Evaluate ability to scale out workforce retention and recruitment incentives
- Strengthen WET programs to enhance cultural competency and linguistic diversity

The goal for CCBHS, would be to adopt successes identified; wherever possible and adopt under BHSA, or other areas of the Behavioral Health Transformation.

Communication and Dissemination Plan

Communication and dissemination regarding the project will continue to be addressed through the MHSA Advisory Council meetings, where on-going updates are provided until further notice. There will also be ongoing communication notices via email, public posting and circulation amongst any other stakeholder groups as necessary. Any RFPs released as a result of this Innovation Project shall be communicated at stakeholder meetings, and through our broad email distribution lists, as well as posting on the CCBHS website and through social media platforms. A Bidder's Conference will be held to provide interested parties the opportunity to ask questions and receive support in their application process.

Timeline

The proposed project timeline is as follows, with a starting date to follow project approval:

Month	Task(s) / Objective(s)
Months 1 - 3	• Post staff positions, release funding opportunities to identify consultants and contractors in order to build capacity and infrastructure to support the PIVOT Innovation Project and the Behavioral Health Transformation • Create and post Request for Proposal for contractors and consultants • Engage in ongoing community planning for FSP programs. • Evaluate FSP structure and baseline of services to identify areas that will need restructuring
Months 3 - 6	• Select and award contractors and consultants that will support PIVOT Innovation Project • Draft more formalized evaluation plan for each area identified in PIVOT Innovation Project • Start onboarding staff that will support PIVOT Innovation Project
Months 6 - 9	• Continue to onboard staff that will support PIVOT Innovation Project • Establish and execute contracts with contractors and consultants
Months 9 – 48	• Staff, consultants and contractors support implementation of BHSA and Behavioral Health Transformation • Specialize implementation for each BHSA component, activities, services, identified outcomes, evaluation, as needed.
Months 54 – 48	• Prepare for transition and sustainability of successful efforts of PIVOT Innovation Project into system of care
Annually	• Create and post annual Innovation Project report for public comment and viewing • Submit report annually to BHSOAC
Final Year	• Create and post final Innovation Project report of results and lessons learned for public comment and viewing and submit to BHSOAC

1. Innovation Project Budget and Source of Expenditures

Budget Narrative

CCBHS is requesting approval to utilize a total of $8,885,824 in MHSA Innovation funds to implement this four-year project. Descriptions of the expenses are included, and all costs are estimates per Fiscal Year (FY), as appropriate. CCBHS plans to allocate funding for county staff, subject matter experts, consultants and contractors to support the activities of each component.

Personnel Costs

The proposed budget includes local County staffing costs to support project planning, implementation, data, evaluation, and monitoring activities over four years. The estimated total County staff costs and benefits is $6,885,824. A breakdown of staffing and cost is provided below:

Project Managers: Each BHSA component will have a Project Manager (3 FTEs total) to ensure coordination and alignment of activities throughout the duration of this project. The estimated salary for a Project Manager starting in FY 25 - 26 is $123,213 in addition, benefits are estimated at 60% of salary costs. A 5% Cost of Living Allowance increase is calculated per each FY starting in FY 26 - 27. It should be noted that during the first FY, only 25% of the estimated costs for Project Managers is budgeted due to length of time to onboard staff. This would be a total estimated cost of $2,105,534 over four years.

	FY 25 - 26	FY 26 - 27	FY 27 - 28	FY 28 - 29	Total
Project Manager (3 FTEs)	$92,410	$388,120	$407,526	$427,903	$1,315,958
Estimated Benefits	$55,446	$232,872	$244,516	$256,742	$789,575
Total	$147,855	$620,992	$652,042	$684,644	$2,105,534

Planner/Evaluators: Each BHSA component will have two Planner/Evaluators (6 FTE total) to support data tracking and ensure consistence in reporting and lessons learned throughout the duration of this project. The estimated salary for a Planner/Evaluator starting in FY 25 - 26 is $104,331 in addition, benefits are estimated at 60% of salary costs. A 5% Cost of Living Allowance increase is calculated per each FY starting in FY 26 - 27. It should be noted that during the first FY, only 25% of the estimated costs for Planner/Evaluators is budgeted due to length of time to onboard staff. This would be a total estimated cost of $3,565,741 over four years.

	FY 25 - 26	FY 26 - 27	FY 27 - 28	FY 28 - 29	Total
Planner/Evaluator (6 FTEs)	$156,497	$657,285	$690,150	$724,657	$2,228,588
Estimated Benefits	$93,898	$394,371	$414,090	$434,794	$1,337,153
Total	$250,394	$1,051,656	$1,104,239	$1,159,159	$3,565,741

Administrative Services Assistant III/ Administrative Analyst: There will be 1 FTE Administrative Services Assistant III/Administrative Analyst that will support the PIVOT Innovation Project to establish and monitor contracts, support with releasing necessary funding opportunities, and oversee program tracking for activities resulting throughout the duration of this project and to coordinate any reporting that may need to be submitted to the BHSOAC. The estimated salary for

an Administrative Services Assistant III/Administrative Analyst starting in FY 25 - 26 is $104,292 in addition, benefits are estimated at 60% of salary costs. A 5% Cost of Living Allowance increase is calculated per each FY starting in FY 26 - 27. It should be noted that during the first FY, only 25% of the estimated costs for an Administrative Services Assistant III/Administrative Analyst is budgeted due to length of time to onboard staff. This would be a total estimated cost of $594,068 over four years.

	FY 25 - 26	FY 26 - 27	FY 27 - 28	FY 28 - 29	Total
Admin. Services Assistant III/ Admin. Analyst (1 FTE)	$26,053	$109,507	$114,982	$120,731	$371,293
Estimated Benefits	$15,644	$65,704	$68,989	$72,439	$222,776
Total	$41,717	$175,211	$183,971	$193,170	$594,068

Accountant III: There will be 1 FTE Accountant III position that will support the PIVOT Innovation Project to establish, monitor and provide updates on BHSA budgets, oversee fiscal support, and tracking for activities resulting through the duration of this project. The estimated salary for an Accountant III starting in FY 25 - 26 is $108,929 in addition, benefits are estimated at 60% of salary costs. A 5% Cost of Living Allowance increase is calculated per each FY starting in FY 26 - 27. It should be noted that during the first FY, only 25% of the estimated costs for an Accountant III is budgeted due to length of time to onboard staff. This would be a total estimated cost of $620,481 over four years.

	FY 25 - 26	FY 26 - 27	FY 27 – 28	FY 28 - 29	Total
Accountant III (1 FTE)	$27,232	$114,375	$120,094	$126,099	$387,801
Estimated Benefits	$16,339	$68,625	$72,057	$75,659	$232,681
Total	$43,572	$183,001	$192,151	$201,758	$620,481

Operating Costs

Direct Costs:

Information Technology (IT) systems and support will be needed for tracking, monitoring, and reporting. It will also be necessary to assess for interoperability within the existing system – technology for sharing clinical information, such as between mental health and substance use disorder treatment systems, and with other systems. There will also need to be reporting development of dashboards with multiple data sources. It will also be necessary to identify systems that allow for modifying claiming structures and workflows to adapt to bundled rates and clinical practices. The estimated cost is $300,000 annually, and $1,200,000 over four years.

Consultant Costs / Contracts

Consultant Costs and Contracts:

The proposed budget includes consultants and contractors that will support CCBHS in identification of IT infrastructure and reporting needs over four years. It will be necessary to also consult with Subject Matter Experts (SMEs) for all BHSA components and for expansion of services to include SUD treatment. CCBHS also intends to heavily lean on consultants to support the initial Integrated Plan, specifically the new requirements under the Community Program Planning which

include a much more robust group of stakeholders. The estimated cost is $200,000 annually, for a total of $800,000 over four years.

Budget by Fiscal Year

	PERSONNEL COSTS (salaries, wages, benefits)	FY 25/26	FY 26/27	FY 27/28	FY 28/29	TOTAL
1.	Salaries	**$302,211**	**$1,269,288**	**$1,332,752**	**$1,399,390**	**$4,303,640**
2.	Direct Costs					
3.	Indirect Costs	**$181,327**	**$761,573**	**$799,651**	**$839,634**	**$2,582,184**
4.	**Total Personnel Costs**	**$483,538**	**$2,030,860**	**$2,132,403**	**$2,239,023**	**$6,885,824**
	OPERATING COSTS*					
5.	Direct Costs	**$300,000**	**$300,000**	**$300,000**	**$300,000**	**$1,200,000**
6.	Indirect Costs					
7.	**Total Operating Costs**	**$300,000**	**$300,000**	**$300,000**	**$300,000**	**$1,200,000**
	NON-RECURRING COSTS (equipment, technology)					
8.						
9.						
10.	**Total non-recurring costs**					**$**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)					
11.	Direct Costs	**$200,000**	**$200,000**	**$200,000**	**$200,000**	**$800,000**
12.	Indirect Costs					
13.	**Total Consultant Costs**	**$200,000**	**$200,000**	**$200,000**	**$200,000**	**$800,000**
	OTHER EXPENDITURES (please explain in budget narrative)					
14.						
15.						
16.	**Total Other Expenditures**					**$**
	BUDGET TOTALS					
	Personnel (total of line 1)	**$302,211**	**$1,269,288**	**$1,332,752**	**$1,399,390**	**$4,303,640**
	Direct Costs (add lines 2, 5, and 11 from above)	**$500,000**	**$500,000**	**$500,000**	**$500,000**	**$2,00,000**
	Indirect Costs (add lines 3, 6, and 12 from above)	**$181,327**	**$761,573**	**$799,651**	**$839,634**	**$2,582,184**
	Non-recurring costs (total of line 10)					**$**
	Other Expenditures (total of line 16)					**$**
	TOTAL INNOVATION BUDGET	**$983,538**	**$2,530,860**	**$2,632,403**	**$2,739,023**	**$8,885,824**

Budget Context

ADMINISTRATION:						
A.	**Estimated total mental health expenditures for administration for the entire duration of this INN Project by FY & the following funding sources:**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds	**$983,538**	**$2,530,860**	**$2,632,403**	**$2,739,023**	**$8,885,824**
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding					
6.	**Total Proposed Administration**	**$983,538**	**$2,530,860**	**$2,632,403**	**$2,739,023**	**$8,885,824**
EVALUATION:						
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds					
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding					
6.	**Total Proposed Evaluation**					
TOTALS:						
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 25/26**	**FY 26/27**	**FY 27/28**	**FY 28/29**	**TOTAL**
1.	Innovative MHSA Funds*	**$983,538**	**$2,530,860**	**$2,632,403**	**$2,739,023**	**$8,885,824**
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding**					
6.	**Total Proposed Expenditures**	**$983,538**	**$2,530,860**	**$2,632,403**	**$2,739,023**	**$8,885,824**

*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting**
**** If "other funding" is included, please explain within budget narrative.**