REVISED VERSION FOR 12/19/2025 submission to DHCS based on State's feedback

BEHAVIORAL HEALTH SERVICES ACT INTEGRATED PLAN TEMPLATE VERSION 1

June 30, 2025

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Introduction

The Behavioral Health Services Act (BHSA) (Senate Bill (SB) 326, Chapter 90, Statutes of 2023) requires all county Behavioral Health Departments to submit a three-year Integrated Plan for Behavioral Health Services and Outcomes outlining intended use of funds and a budget for behavioral health programs administered, beginning with Fiscal Years (FY) 2026-2029 (July 1, 2026 – June 30, 2029). The Department of Health Care Services (DHCS) is developing a portal where counties will enter their Integrated Plans and updates (herein referred to as the "county portal").

This document is the template for the Three-Year Integrated Plan. The final release of the Integrated Plan will be available on the county portal and questions will be formatted to collect information in a streamlined manner. The county portal will include web form elements such as dropdown menus and text fields. Throughout this template, bracketed text represents planned user interface elements for the county portal. Additional information on standards for completing and submitting the
Integrated Plan is provided in the Behavioral Health Services Act County Policy Manual (herein referred to as the "Policy Manual") Chapter 3.

Figure 1. Integrated Plan Submission Workflow

*Recommended sequence. See details on the exemption submission process in the Integrated Plan Submission section (Policy Manual Chapter 3, Section E.4).

General Information

1. County, City, Joint Powers, or Joint Submission: **County**
2. Entity Name: **Contra Costa County**
3. Behavioral Health Agency Name: **Contra Costa County Behavioral Health Services**

4. Behavioral Health Agency Mailing Address: **1340 Arnold Drive, Suite 200 Martinez, CA 94553**
5. Primary Mental Health Contact
    a. Name: **Suzanne Tavano**
    b. Email: **suzanne.tavano@cchealth.org**
    c. Phone: **925-957-5169**
6. Secondary Mental Health Contact
    a. Name: **Steve Hahn-Smith**
    b. Email: **steve.hahn-smith@cchealth.org**
    c. Phone: **925-957-5130**
7. Primary Substance Use Disorder Contact
    a. Name: **Fatima Matal Sol**
    b. Email: **fatima.matalsol@cchealth.org**
    c. Phone: **925-348-3279**
8. Secondary Substance Use Disorder Contact
    a. Name: **Mark Messerer**
    b. Email: **mark.messerer@cchealth.org**
    c. Phone: **925-335-3326**
9. Primary Housing Interventions Contact
    a. Name: **Adam Down**
    b. Email: **adam.down@cchealth.org**
    c. Phone: **925-348-6839**
10. Compliance Officer for Specialty Mental Health Services (SMHS)
    a. Name: **Priscilla Aguirre**
    b. Email: **priscilla.aguirre@cchealth.org**
11. Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
    a. Name: **Mark Messerer**
    b. Email: **mark.messerer@cchealth.org**
12. Behavioral Health Services Act (BHSA) Coordinator

Name	Email Address
Windy Murphy Taylor	**windy.taylor@cchealth.org**

13. Substance Abuse and Mental Health Services Administration (SAMHSA) liaison

Name	Email Address
Paul Reyes	**paul.reyes@cchealth.org**

14. Quality Assurance or Quality Improvement (QA/QI) lead

Name	Email Address
Steve Hahn-Smith	**steve.hahn-smith@cchealth.org**

15. Medical Director

Name	Email Address
Stephen Field	**stephen.field@cchealth.org**

Exemption Requests

Please complete the following section if the county is requesting a Housing Interventions exemption for the Integrated Plan (IP) covering Fiscal Years (FY) 2026-2029. Only counties with a population of less than 200,000 may request a Housing Interventions exemption for the FY 2026-2029 IP. Counties must submit their exemption request by March 31 of the fiscal year prior to the fiscal year covered in the IP (i.e., exemption requests for the FY 2026-2029 IP must be submitted to DHCS by March 31, 2026) to facilitate timely review and approval.

If the county has a population of less than 200,000, according to the Department of Finance Population and Housing Estimates, the county is able to request a Housing Intervention exemption. To apply, select which Housing Intervention Exemption you would like to request (counties are able to request more than one exemption): **N/A**

☐ Behavioral Health Services Fund Housing Intervention Component Exemption
☐ Housing Intervention Funds for Chronically Homeless Exemption
☐ Housing Intervention Funds for Capital Development Exemption

Behavioral Health Services Fund (BHSF) Housing Interventions Component Exemption Request

1. **Behavioral Health Services Fund Housing Intervention Component:** For counties seeking an exemption to the requirement to allocate 30 percent of the BHSA funds (beyond transfer allowance) distributed to the county for Housing Intervention services. **N/A**

    a. What percentage of funds is the county requesting to utilize for the Housing Intervention Component?

    b. Of the percentage of funds above or below the required 30 percent being utilized for Housing Interventions, identify which allocation components and the percentage the funding will transfer from or into.

        i. Full-Service Partnerships

ii. Behavioral Health Services and Supports

c. Please select which Housing Interventions exemptions criteria the county meets.

☐ Very significant or very limited need

☐ Sufficient/insufficient funding from other sources to address housing needs

☐ Other considerations

d. Please provide justification for this Housing Interventions exemption request

Supporting Data #1

e. Please upload supporting data

f. Please select the data source

☐ Claims Data

☐ Coordinated Entry System Data

☐ Housing Inventory Count

☐ Homeless Management Information System Data

☐ Point in Time Count

☐ Other

Housing Intervention Funds for Chronically Homeless Exemption Request

1. **Housing Intervention Funds for Chronically Homeless:** For counties seeking an exemption to the requirement to use 50 percent of Housing Intervention Component allocation for individuals who are chronically homeless. What percentage of Housing Intervention Component allocation is the county requesting to use for those who are chronically homeless?
   N/A

   Please select which Housing Interventions exemptions criteria the county meets:

   ☐ Very limited need

   ☐ Sufficient funding from other sources to address housing needs

   ☐ Other considerations

   a. Please provide justification for this Housing Interventions exemptions request.

   Supporting Data #1

   d. Please upload supporting data.

   e. Please select the data source:

   ☐ Claims Data

   ☐ Coordinated Entry System Data

☐ Housing Inventory Count

☐ Homeless Management Information System Data

☐ Point in Time Count

☐ Other

Housing Intervention Funds for Capital Development Exemption Request

1. **Housing Interventions Funds for Capital Development:** For counties seeking an exemption to the requirement that no more than 25 percent of Housing Intervention Component allocation can be spent on capital development. **N/A**
    a. What percentage of Housing Intervention Component allocation is the county requesting to use for capital development projects?

    b. Please select which Housing Intervention exemptions criteria the county meets:

    ☐ Significant capital development required to meet housing needs of eligible population

    ☐ Other funding sources insufficient to address need

    ☐ Costs of accessibility improvements exceed 25 percent capital improvement limits

    ☐ Other

    c. Please provide justification for this Housing Interventions exemptions request.

Supporting Data #1

    d. Please upload supporting data.

    e. Please select the data source:

    ☐ Evidence of need for housing production

    ☐ Partnership agreements/letters of support

    ☐ Project budget with funding breakdown

    ☐ Other

Funding Transfer Requests

If the county aims to submit a funding transfer request for the Fiscal Years (FY) 2026-2029 Integrated Plan (IP) period, please complete the questions below. Counties must submit their request by March 31 of the FY prior to the FY covered in the IP (i.e., exemption requests for the FY 2026-2029 IP must be submitted to DHCS by March 31, 2026) to facilitate timely review and approval.

Counties with populations under 200,000 can assume that their request to reduce Housing Intervention Component funds from the required 30 percent is approved when completing the table below.

1. Please enter the proposed allocation adjustments to the tables below.

Table 1. Proposed Allocation Adjustments for Each Funding Component

	Plan Year One	Plan Year Two	Plan Year Three
Behavioral Health Services and Supports	**0%**	**0%**	**0%**
Full Service Partnership	**0%**	**0%**	**0%**
	Plan Year One	**Plan Year Two**	**Plan Year Three**
Housing Interventions	**0%**	**0%**	**0%**
Housing Interventions for Outreach and Engagement	**0%**	**0%**	**0%**

Behavioral Health Services and Supports Transfers

1. Enter the proposed dollars transferred into/from Behavioral Health Services and Supports

Table 2. Behavioral Health Services and Supports Transfers

	Plan Year One	Plan Year Two	Plan Year Three
Dollars transferred **from** Full Service Partnerships	**$0**	**$0**	**$0**
Dollars transferred **from** Housing Interventions	**$0**	**$0**	**$0**

Dollars transferred **into** Full Service Partnerships	**$0**	**$0**	**$0**
Dollars transferred **into** Housing Interventions	**$0**	**$0**	**$0**

2. For Behavioral Health Services and Supports, please include a rationale for the funding allocation transfer request.

Full-Service Partnerships Transfers

1. Enter the proposed dollars transferred into/from Full-Service Partnerships

Table 3. Full-Service Partnerships Transfers

	Plan Year One	Plan Year Two	Plan Year Three
Dollars transferred **from** Behavioral Health Services and Supports	**$0**	**$0**	**$0**
Dollars transferred **from** Housing Interventions	**$0**	**$0**	**$0**
Dollars transferred **into** Behavioral Health Services and Supports	**$0**	**$0**	**$0**
Dollars transferred **into** Housing Interventions	**$0**	**$0**	**$0**

2. For Full-Service Partnerships, please include a rationale for the funding allocation transfer request

Housing Interventions Transfers

1. Enter the proposed dollars transferred into/from Housing Interventions

Table 4. Housing Interventions Transfers

	Plan Year One	Plan Year Two	Plan Year Three

Dollars transferred **from** Behavioral Health Services and Supports	**$0**	**$0**	**$0**
Dollars transferred **from** Full Service Partnerships	**$0**	**$0**	**$0**
Dollars transferred **into** Behavioral Health Services and Support	**$0**	**$0**	**$0**
Dollars transferred **into** Full Service Partnerships	**$0**	**$0**	**$0**

2. For Housing Interventions, please include a rationale for the funding allocation transfer request.

Supporting Information and Data

1. How does this funding transfer request respond to community needs and input?
2. Please include local data supporting the funding transfer request.

County Behavioral Health System Overview

Please provide the city/county behavioral health system (inclusive of mental health and substance use disorder) information listed throughout this section. The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins.

Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook.

Children and Youth

1. In the table below, please report the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row. **Counts may be duplicated as individuals may be included in more than one category.**

Table 5. Number of Children and Youth Served

Criteria	Number of Children and Youth Under 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	**7,130**
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	**1,321**
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	**1,526**
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	**6,561**
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	**43**
Were chronically homeless or experiencing homelessness or at risk of homelessness	**238**
Were in the juvenile justice system	**226**
Have reentered the community from a youth correctional facility	**204**
Criteria	**Number of Children and Youth Under 21**
Were served by the Mental Health Plan and had an open child welfare case	**64**

Were served by the DMC County or DMC-ODS plan and had an open child welfare case	**19**
Have received acute psychiatric care	**1,274**

Adults and Older Adults

1. In the table below, please report the number of adults and older adults (21 and older) served by the county behavioral health system who meet the criteria listed in each row. Counts may be duplicated as individuals may be included in more than one category.

Table 6. Adults and Older Adults Served

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	**3,282**
Received Medi-Cal SMHS	**12,011**
Received DMC or DMC-ODS services	**1,656**
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	**7,876**
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	**1,513**
Experienced unsheltered homelessness	**1,513**
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	**482**
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	**444**
Criteria	**Number of Adults and Older Adults**
Were in the justice system (on parole or probation and not currently incarcerated)	**1,569**
Were incarcerated (including state prison and jail)	**1,570**
Reentered the community from state prison or county jail	**1,509**

Received acute psychiatric services	**2,960**

2. Input the number of persons in designated and approved facilities who were:
    a. Admitted or detained for 72-hour evaluation and treatment rate: **7,009**
    b. Admitted for 14-day and 30-day periods of intensive treatment: **1,114**
    c. Admitted for 180-day post certification intensive treatment: **000**
3. Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs:

    109
4. Please report the total population enrolled in DSH community solution projects:

    68 in MH Diversion
5. Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?

    Yes. For Question 2: One of the designated facilities did not report their hold data for Quarter 1 and Quarter 2. Also, the measure admitted to 180-day post-certification intensive treatment is not a measure that we were required to report on and is not currently being tracked so "000" was recorded as a placeholder value to complete this section of the Plan.
6. Please describe the local data used during the planning process:

    Contra Costa examined a variety of different local data sources to inform its planning efforts for BHSA implementation. In addition to the data fields contained in the data fields for the population served by the behavioral health system and the county's performance on statewide goals, several other data sources were reviewed. Chiefs and Program Managers reviewed local data extracted from Contra Costa Mental Health Plan's EHR that summarized client hospitalizations, psychiatric emergency visits, mobile crisis calls, HEDIS measures, penetration reporting, and open admissions by client diagnoses. In addition to the EHR reporting, an evaluation report summarizing the county's existing FSP programs was reviewed to identify areas of strength and those areas needing enhancement. Reporting discussing estimation of clients eligible for ECM was reviewed to help inform estimates for FSPs and to inform the approach to estimating eligible clients and anticipating needed staffing. Current participation numbers in programs such as CSC FEP, High Fidelity Wraparound, and employment services were pulled to help inform capacity to serve eligible clients, and analysis of the percentage of clients enrolled in FSPs with the desire to work was examined. Referrals to the county's Mental Health Evaluation Team (MHET) were also reviewed. A variety of different data sources were examined specific to children/youth at risk or currently in foster care, including Child Family Services Data, including allegations of abuse by county region and city, and racial identity. Dashboard data related to placement types and number of cases by month, and age categories were also reviewed, as was placement by care provider relationship and home type. Social Determinant of Health

Data, Casey Family Opportunity Maps, and Child Welfare Indications Project data were also reviewed as were data pertaining to domestic violence calls to law enforcement.

7. If desired, provide documentation on the local data used during the planning process.

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

1. Does the county behavioral health system use an Electronic Health Record (EHR)?

   Yes

   a. Please select which of the following EHRs the county uses

   ☐ Altera Digital Health

   ☐ Athena Health

   ☐ Clinicians Gateway

   ☐ CPSI eClinicalWorks

   ☑ **Epic Systems**

   ☐ GE Centricity

   ☐ Greenway Health

   ☐ MEDHOST

   ☐ MediTech

   ☐ Netsmart

   ☐ NextGen Healthcare ☐ Oracle Cerner

   ☐ Practice Fusion

   ☐ Qualifacts Credible

   ☑ **SmartCare**

   ☐ TherapyNotes

   ☐ Other

2. Does the county behavioral health system participate in a Qualified Health Information Organization (QHIO)?

   No

   a. Please select which QHIO the county participates in

☐ Connex

☐ Cozeva

☐ Health Gorilla, Inc.

☐ Long Health, Inc.

☐ Los Angeles Network for Enhanced Services (LANES)

☐ Manifest MedEx

☐ Orange County Partners in Health HIE

☐ Serving Communities Health Information Organization

☒ San Diego Health Connect

☐ SacValley MedShare

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

1. Please provide the link to the county's API endpoint on the county behavioral health plan's website:

   https://icproxy.mycclink.org/proxy-FHIR/api/FHIR/R4/metadata

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?

   Yes

   a. Please describe these challenges and concerns.

      Contra Costa Behavioral Health Services (BHP) and Contra Costa Health Plan (MCP) share similar API requirements and they share an EHR (Epic); however the MCP's All Plan Letters (APLs) and the BHP's Behavioral Health Information Notices (BHINs) are distributed at different times and often contain different requirements which poses a challenge with working with IT vendors and technical teams because implementations have to be staggered and in some cases delayed, to ensure requirements for both entities can be met. Resource planning is also a challenge given the different timelines and requirements. Similarly, due to 42 CFR Part 2 considerations, all substance use disorder programs use SmartCare as the EHR, which involves yet another set of API configurations and this adds financial, resourcing, and additional technical challenges.

3. Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056, 23-057, and 24-016. Does the county wish to disclose any implementation challenges or concerns with these requirements?

   Yes

a. Please describe these challenges and concerns.

One of the challenges for meeting admission, discharge, and transfer data sharing requirements is many contracted providers do not have electronic health records that support ADT data transfer. Similarly, they do not all capture the data in a consistent manner and/or provide the data to us in a timely fashion.

County Behavioral Health System Service Delivery Landscape

Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH) Grant

1. Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?
   No
   a. Please select all services the county behavioral health system plans to provide under the PATH grant.

   ☐ Alcohol or Drug Treatment Services

   ☐ Case Management Services

   ☐ Community Mental Health Services

   ☐ Habilitation and Rehabilitation Services

   ☐ Outreach Services

   ☐ Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services

   ☐ Screening and Diagnostic Treatment Services

   ☐ Staff Training, including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services

   ☐ Supportive and Supervisory Services in Residential Settings

2. Please select the county's referrals for Primary Health Care, Job Training, Educational Services, and Housing Services. **N/A**

   ☐ Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations

   ☐ Improving the Coordination of Housing Services

   ☐ Minor Renovation, Expansion, and Repair of Housing

   ☐ One-time Rental Payments to Prevent Eviction

☐ Planning of Housing

☐ Security Deposits

☐ Technical Assistance in Applying for Housing

3. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

a. Please describe these challenges or concerns.

Community Mental Health Services Block Grant (MHBG)

1. Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period?

Yes

a. Please select all set asides that the county behavioral health system plans to participate in under the MHBG.

☐ Children's System of Care Set-Aside

☑ Discretionary/Base Allocation

☑ Dual Diagnosis Set-Aside

☑ First Episode Psychosis Set-Aside

☐ Integrated Services Agency Set-Aside

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

a. Please describe these challenges or concerns.

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

1. Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period?

Yes

a. Please select all set-asides that the county behavioral health system participates in under SUBG

☑ Adolescent/Youth Set-Aside

☑ Discretionary

☑ Perinatal Set-Aside

☑ Primary Prevention Set-Aside

☐ Syringe Services Program Allowance

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

a. Please describe these challenges or concerns.

Opioid Settlement Funds (OSF)

1. Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?

Yes

a. Please check all set asides the county behavioral health system participates in under OSF Exhibit E.

☑ Address the Needs of Criminal Justice-Involved Persons

☑ Address the Needs of Pregnant or Parenting Women and Their Families, Including Babies with Neonatal Abstinence Syndrome

☑ Connect People Who Need Help to The Help They Need (Connections to Care)

☐ First Responders

☑ Leadership, Planning, and Coordination

☑ Prevent Misuse of Opioids

☑ Prevent Overdose Deaths and Other Harms (Harm Reduction)

☑ Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids

☑ Research

☑ Support People in Treatment and Recovery

☑ Treat Opioid Use Disorder (OUD)

☑ Training

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

a. Please describe these challenges or concerns.

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).

a. Case Management
b. Comprehensive Evaluation and Assessment
c. Group Services
d. Individual Service Plan
e. Medication Education and Management
f. Pre-crisis and Crisis Services
g. Rehabilitation and Support Services
h. Residential Services
i. Services for Homeless Persons
j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

1. In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:

   ☑ **Assertive Community Treatment (ACT)**
   ☑ **Clubhouse Services**
   ☑ **Community Health Worker Services (CHW)**
   ☑ **Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)**
   ☑ **Forensic Assertive Community Treatment (FACT)**
   ☑ **Individual Placement and Support (IPS) Model of Supported Employment**
   ☐ Other Programs and Services
   ☐ Not applicable

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

   No

   a. Please describe these challenges or concerns.

Public Safety Realignment (2011 Realignment)

Context text: The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)

a. Drug Courts
b. Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
c. Regular and Perinatal Drug Medi-Cal Services
d. Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
e. Regular and Perinatal Non-Drug Medi-Cal Services

1. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
   No

   a. Please describe these challenges or concerns.

Medi-Cal Specialty Mental Health Services (SMHS)

Context text: The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).

a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services
j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management
m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21
q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21
s. Therapeutic Behavioral Services for individuals under the age of 21
t. Therapeutic Foster Care for individuals under the age of 21
u. All Other Medically Necessary SMHS for individuals under the age of 21

1. Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?

   ☑ ACT

☑ **Clubhouse Services**

☑ **CSC for FEP**

☑ **Enhanced CHW Services**

☑ **FACT**

☑ **IPS Supported Employment**

☑ **Peer Support Services**

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

No

Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS)

1. Select which of the following services the county behavioral health system participates in.

☐ DMC Program

☑ **DMC-ODS Program**

Drug Medi-Cal Program (DMC)

The county behavioral health system is mandated to provide the following services as a part of the DMC Program:

a. All Other Medically Necessary Services for individuals under age 21
b. Intensive Outpatient Treatment Services
c. Medications for Addiction Treatment (including medication, counseling services, and behavioral therapy) (MAT)
d. Mobile Crisis Services
e. Narcotic Treatment Program (NTP) Services
f. Outpatient Treatment Services
g. Perinatal Residential Substance Use Disorder (SUD) Treatment for pregnant women and women in the postpartum period

1. Has the county behavioral health system opted to provide the specific services identified in the list below as of June 30, 2026? **N/A**

    a. Enhanced CHW Services
    b. IPS Supported Employment
    c. Peer Support Services

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **N/A**

    a. Please describe these challenges or concerns

Drug Medi-Cal Organized Delivery System (DMC-ODS)

The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition)

a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment
f. Program (NTP) Services
g. Mobile Crisis Services
h. Recovery Services
i. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
j. Traditional Healers and Natural Helpers
k. Withdrawal Management Services
l. All Other Medically Necessary Services for individuals under age 21
m. Early Intervention for individuals under age 21

1. Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below as of June 30, 2026?

   Yes

   ☐ Enhanced Community Health Worker (CHW) Services

   ☐ Inpatient Services (ASAM Levels 3.7 & 4.0)

   ☐ IPS Supported Employment

   ☐ Partial Hospitalization Services (ASAM Level 2.5)

   ☐ Peer Support Services

   ☑ **Recovery Incentives Program (Contingency Management)**

2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?

   No

   a. Please describe these challenges or concerns.

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs.

Mental Health

- **Assisted Outpatient Treatment (AOT) is funded through MHSA**
- **Mental Health Diversion is funded by the Department of State Hospitals**
- **CalAIM Justice Involved Initiative is partially funded under PATH**
- **CARE is supported by Medi-Cal and private insurance primarily, along with limited services billed directly to the State under State reimbursement rates**
- **Mental Health Evaluation Team (MHET) is not funded by State but receives partial Medi-Cal billing**
- **Mental Health Student Services Act (MHSSA) funded program (Wellness in Schools Program -WISP- located at Contra Costa Office of Education).**
- **Measure X funded Mental Health Services (prevention/early intervention type of services)**
- **Federal Appropriation to build out mobile crisis call center**
- **AB 109 Services: Contra Costa County BHS Forensic MH Services (FMHS) coordinates with the local probation department to provide services to AB 109 and General Supervision probationers.**
- **Mental Health Services funded by school districts for Medi-Cal eligible and uninsured students: Mt Diablo USD, Martinez, USD, Pittsburg USD, Antioch USD.**
- **Probation funded mental health services, incl Wraparound for Probation involved Medi-Cal eligible youth, Functional Family Therapy for Probation involved youth not enrolled in Medi-Cal**
- **MHBG for First Episode for First Hope**
- **Child Welfare funded coordination of services for foster care involved youth**
- **Vocational Services**

AOD

- **Intensive SUD Treatment in 2 Jails (CalAIMJI) pre-release services include coordination of care with the Medical team for the provision of Medication Assistance Treatment (MAT). Warm hand-off and linkages to treatment for clients reentering the community. Pre-release, and warm handoffs with SUD DMC-ODS network. Recovery support services are provided via a recovery coach for clients post release.**
- **Screening services in Courts and Care Management for justice involved populations including AB109 and MH Diversion Court for clients with SUD or COD**
- **Juvenile Hall SUD screening, treatment and support to youth in custody and transitioning back into the community through recovery support services by a recovery coach, who also provides parent navigation.**
- **Opioid Response Team (ORT)- early engagement and initiation at touchpoint locations in the field. Harm reduction approach to services at Syringe Service Programs, homeless shelters, and distribution of Narcan/Fentanyl strips. The DMC-ODS does not provide syringe exchange services.**
- **Cannabis Awareness and Education (Prop 64) in the majority of school districts as well as technical assistance to local jurisdictions to support implementation of local policies to regulate cannabis**

- **Recovery Coaching to engage those Missing In Treatment (MIT): unhoused and justice-involved during "limbo" periods or transitions pre, during and post treatment.**
- **SUD prevention services are delivered community and school based that aim at changing norms and perceptions about SUD, increasing protective factors and reducing risk factors at individual, community and societal level. Evidence Based Practices (EBPs) combine multiple prevention strategies across IOM classification, utilizing in some cases the public health approach to prevention. Programs that are school based use screening and brief intervention for early identification of SUD and referral to treatment.**
- **SUD perinatal services, focus on women who use substances who meet the definition of perinatal, post-partum, and parenting. Services include education, targeted outreach at labor and delivery, coordination with family dependency court for women involved with Child Protective Services. The SUD perinatal outreach team conducts screenings at touchpoint locations, such as hospital's labor and delivery, health care for the homeless, WIC programs, Black Infant Health, Healthy Start Prenatal clinics, syringe support services homeless encampments. Other DMC-ODS programs, include childcare which eliminate barriers to SUD treatment for women with children.**

Care Transitions

1. Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth)?

   Yes
2. Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?

   Yes

Statewide Behavioral Health Goals

Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C.

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories to strengthen their evaluation and better understand community needs.

Priority Statewide Behavioral Health Goals for Improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County.

Access To Care

Primary Measures

Specialty Mental Health Services (SMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023.

1. How does your county status compare to the statewide rate? [above, below, or same]
    a. For adults/older adults: **above**
    b. For children/youth: **same**
2. What disparities did you identify across demographic groups or special populations?
    ☐ Age
    ☐ Gender
    ☑ **Race or Ethnicity**
    ☐ Sex
    ☐ Spoken Language
    ☐ None Identified
    ☐ No Disparities Data Available
    ☐ Other

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth DHCS), FY 2023

1. How does your county status compare to the statewide rate? [above, below, or same]
    a. For adults/older adults: **below**
    b. For children/youth: **below**
2. What disparities did you identify across demographic groups or special populations?

☐ Age

☐ Gender

☑ **Race or Ethnicity**

☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other

Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

1. How does your county status compare to the statewide rate? **N/A**
    a. For adults/older adults:
    b. For children/youth:
2. What disparities did you identify across demographic groups or special populations? **N/A**

☐ Age

☐ Gender

☐ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

1. How does your county status compare to the statewide rate? [above, below, or same]
    a. For adults/older adults: **below**
    b. For children/youth: **below**
2. What disparities did you identify across demographic groups or special populations?

☑ **Age**

☐ Gender

☑ **Race or Ethnicity**

☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other

Supplemental Measures

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023

1. How does your county status compare to the statewide rate? [above, below, or same]

   Below

2. What disparities did you identify across demographic groups or special populations?

   ☐ Age

   ☐ Gender

   ☐ Race or Ethnicity

   ☐ Sex

   ☐ Spoken Language

   ☐ None Identified

   ☑ **No Disparities Data Available**

   ☐ Other

Disparities Analysis

1. For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

   To measure disparity for race a representation index was calculated using the total Medi-Cal eligible population in Contra Costa County by race and the total count of beneficiaries with one or more SMHS or NSMHS visits by race.

   For SMHS:

   AAPI clients are underrepresented accessing SMHS services at a rate of .47 lower than the total AAPI population in the county. Hispanic clients are underrepresented accessing SMHS services at a rate .73 lower than the total Hispanic population in the county.

   For NSMHS:

   AAPI clients are underrepresented accessing NSHMS at a rate of .57 lower than the total AAPI population in the county. To measure disparity for spoken language, calMHSA's Access to Care Dashboard was used. Adult Spanish speakers are less likely to access NSMHS at rate of 5.3% vs Adult English speakers at 9.6%.

   For DMC-ODS Penetration Rates:

Children and youth are underrepresented accessing DMC-ODS services at a rate 0.03 lower than the total youth population in the county. Hispanic/Latino clients are underrepresented accessing DMC-ODS services at a rate 0.45 lower than the total Hispanic/Latino population in the county. AAPI clients are underrepresented accessing DMC-ODS services at a rate 0.18 lower than the total AAPI population in the county. Native American clients are overrepresented accessing DMC-ODS services at a rate 2.36 higher than the total Native American population in the county. Clients who identified as Other race/ethnicity are underrepresented accessing DMC-ODS services at a rate 0.30 lower than the total population of county residents who identified as Other race/ethnicity.

For IET:

No demographic-specific disparities by age, gender, race/ethnicity, sex, or spoken language are available. Contra Costa County's overall initiation rate of 33.8% is below the statewide mean of 36.6%, the statewide median of 34.3%, and the Minimum Performance Level of 44.3%.

Cross-Measure Questions

1. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026, that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing.

To address lower penetration rates among AAPI and Spanish-speaking NSMH populations, CCBH will partner with CCHP on its "Outreach Plan for NSMHS," involving the Community Advisory Committee and the Quality Improvement and Health Equity Council. Current CCHP efforts include adding nearly 200 non-physician mental health providers in 2024 and developing bilingual one-page health education materials with local resources.

CCBH SMHS ranks above penetration rates for adults and older adults, but disparities by race/ethnicity remain. To reach underrepresented populations, CCBH plans to offer incentives to strengthen partnerships with community organizations serving these groups. They will focus on targeted RFPs to engage underserved populations, such as hiring native language speakers. Based on community feedback, CCBH will improve outreach to share information on accessing SMHS and leverage enhanced CHW services to assist. CCBH also plans a care-on-demand facility for clinical assessment and connection to long-term services, assigning each member a point person to aid retention in behavioral health.

In response to community feedback on low SUD penetration, CCBH will partner with trusted local organizations for targeted outreach, contract with CBOs for event support, and implement a Promotoras de Salud model using enhanced CHWs for education and

navigation. The county will improve treatment initiation and engagement by flagging clients with two or more no-shows, tracking ED admissions and SUD referrals in real time, and offering same-day or telehealth appointments. Follow-ups will be scheduled before discharge, with recovery coaches providing reminders. A mobile IET unit will launch in spring to serve unsheltered and recently released clients, while three new outpatient providers will expand capacity.

2. Please identify the category or categories of funding that the county is using to address the access to care goal.

☑ BHSA Behavioral Health Services and Supports (BHSS)

☑ BHSA Full Services Partnership (FSP)

☑ BHSA Housing Interventions

☑ 1991 Realignment

☑ 2011 Realignment

☑ State General Fund

☑ Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)

☐ Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH)

☑ Community Mental Health Block Grant (MHBG)

☑ Substance Use Block Grant (SUBG)

☑ Other [Opioid Settlement Funds, AB109, Grants, Local Funding] Measure X funding

Homelessness

Primary Measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

1. How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region? [above, below, or same]

Below

2. What disparities did you identify across demographic groups or special populations?

☑ Age

☐ Gender

☑ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other

Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 - 2024

1. How does your county status compare to the statewide rate? [above, below, or same]

   Below

   2. What disparities did you identify across demographic groups or special populations?

      ☑ **Age**

      ☐ Gender

      ☑ **Race or Ethnicity**

      ☐ Sex

      ☑ **Spoken Language**

      ☐ None Identified

      ☐ No Disparities Data Available

      ☐ Other

Supplemental Measures

PIT Count Rate of People Experience Homelessness with Severe Mental Illness, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

1. How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region? [above, below, or same]

   Same

2. What disparities did you identify across demographic groups or special populations?

   ☐ Age

   ☐ Gender

   ☐ Race or Ethnicity

   ☐ Sex

   ☐ Spoken Language

   ☐ None Identified

   ☑ **No Disparities Data Available**

   ☐ Other

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

1. How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region? [above, below, or same]

   Same

2. What disparities did you identify across demographic groups or special populations?

   ☐ Age

   ☐ Gender

   ☐ Race or Ethnicity

   ☐ Sex

   ☐ Spoken Language

   ☐ None Identified

   ☑ **No Disparities Data Available**

   ☐ Other

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.)

1. How does your local CoC's rate compare to the average rate across all CoCs? [above, below, or same]

   Below

2. What disparities did you identify across demographic groups or special populations?

   ☑ **Age**

   ☐ Gender

   ☑ **Race or Ethnicity**

   ☐ Sex

   ☐ Spoken Language

   ☐ None Identified

   ☐ No Disparities Data Available

   ☐ Other

Disparities Analysis

1. For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

   People Experiencing Homelessness Point-in-Time Count:

Black county residents are overrepresented in the PIT count at a rate of 4.27 higher than the total Black population in the county. To measure disparity for age, CalMHSA's Homelessness Dashboard was used. The rate of homeless individuals aged 35 to 44 was 38 per 10,000 in Contra Costa County vs the overall Contra Costa County PIT rate which was 25 per 10,000.

Homeless Student Enrollment by Dwelling Type:
To measure disparity for race, a representation index was calculated using the total public school student population by race and the total count of homeless students by race in Contra Costa County. Black students are overrepresented in homelessness at a rate of 2.45 times higher than the total Black student population in the county. Hispanic students are overrepresented in homelessness at a rate of 1.42 times higher than the total Hispanic student population in the county. To measure disparity for gender, grade, and spoken language, CalMHSA's Homelessness Dashboard was used. Students in 12th grade have a higher rate of experiencing homelessness (3.2%) vs the overall rate of students experiencing homelessness (1.9%). Students identifying as English learners have a higher rate of experiencing homelessness (4.1%) vs the overall rate of students experiencing homelessness (1.9%).

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate:
To measure disparity for race, a representation index was calculated using the total census population by race and the total count of individuals accessing homelessness services by race in Contra Costa County's continuum of care. AAPI residents were underrepresented in accessing homelessness services at a rate of .17 lower than the total AAPI population in the county. Black Residents were overrepresented at a rate of 2.78 higher than the total Black population in the county.

Cross-Measure Questions

1. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing.

CCBHS will build on existing efforts to address housing and homelessness by deepening its partnership with the Continuum of Care, administered by Contra Costa Health's Health, Housing and Homelessness (H3) division. The focus will be on better identifying and prioritizing housing for individuals with serious behavioral health conditions experiencing homelessness. Community feedback emphasized the importance of serving those with the most complex needs who may not thrive in traditional shelter settings. To

meet this need, CCBHS will invest in behavioral health-enriched interim housing modeled after the successful Behavioral Health Bridge Housing Program. These homelike settings aim to provide safe, welcoming environments that support client engagement.

CCBHS also plans to contract for affinity-group housing to serve historically underserved populations, including LGBTQ+ individuals, Black/African Americans, monolingual Spanish speakers, and transitional age youth. These settings will help clients access and maintain long-term supportive housing through MCP Community Supports and wraparound services. Additionally, CCBHS will invest capital development and operating funds to expand housing options for those experiencing chronic homelessness. This includes supporting H3-led projects like a tiny home community in West County, as well as expanding short- and long-term scattered site rental subsidies to promote housing stability.

Finally, in collaboration with H3, the Department of Conservation and Development, and the County's Measure X housing initiative, CCBHS will support the development of new housing units dedicated to chronically homeless individuals with serious behavioral health needs.

2. Please identify the category or categories of funding that the county is using to address the homelessness goal.

☐ BHSA BHSS

☐ BHSA FSP

☐ BHSA Housing Interventions

☐1991 Realignment

☑ 2011 Realignment

☑ State General Fund

☑ Federal Financial Participation (SMHS, DMC/DMC-ODS)

☐ SAMHSA PATH

☐ MHBG

☑ SUBG

☑ Other [Opioid Settlement Funds, Behavioral Health Bridge Housing (BHBH), SUBG Perinatal, Grant, AB109]

Institutionalization

Context text: Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated

to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.

Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment.

Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

1. How does your county status compare to the statewide rate/average? [above, below, or same]
    a. For adults/older adults: **below**
    b. For children/youth: **N/A**
2. What disparities did you identify across demographic groups or special populations?
    ☐ Age
    ☐ Gender
    ☑ **Race or Ethnicity**
    ☐ Sex
    ☐ Spoken Language
    ☐ None Identified
    ☐ No Disparities Data Available
    ☐ Other

Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]
    a. 14-day involuntary detention rates per 10,000: **same**
    b. 30-day involuntary detention rates per 10,000: **above**
    c. 180-day post-certification involuntary detention rates per 10,000: **N/A**
2. What disparities did you identify across demographic groups or special populations?
    ☐ Age
    ☐ Gender
    ☐ Race or Ethnicity
    ☐ Sex
    ☐ Spoken Language
    ☐ None Identified

☑ **No Disparities Data Available**

☐ Other

Supplemental Measure: Conservatorships, FY 2021 - 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]
    a. Temporary Conservatorships: **N/A**
    b. Permanent Conservatorships: **N/A**
2. What disparities did you identify across demographic groups or special populations?

☐ Age

☐ Gender

☐ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☑ **No Disparities Data Available**

☐ Other

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023

1. How does your county status compare to the statewide rate/average? [above, below, or same]
    a. Crisis Intervention
        i. For adults/older adults: **below**
        ii. For children/youth: **above**
    b. Crisis Residential Treatment Services
        i. For adults/older adults: **below**
        ii. For children/youth: **below**
    c. Crisis Stabilization
        i. For adults/older adults: **above**
        ii. For children/youth: **above**
2. What disparities did you identify across demographic groups or special populations?

☐ Age

☐ Gender

☑ **Race or Ethnicity**

☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other

Disparities Analysis

1. For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis.

To measure disparity for race a representation index was calculated using the total census population by race and the total count of beneficiaries using inpatient admin days and accessing crisis utilization services by race in the County.

Inpatient Administrative Days:

Black clients are overrepresented at a rate of 2.40 higher than the total Black population in the county. Clients identified as Other race are overrepresented at a rate 6.03 higher than the total population of county residents identified as Other.

Crisis Intervention:

AAPI clients are underrepresented at a rate of .26 lower than the total AAPI population in the county. Black residents are overrepresented at a rate of 2.58 times higher than the total black population in the county. Clients identified as other race are overrepresented at a rate of3.42 times higher than the total population of people identified as other race in the County.

Crisis Residential Treatment:

Black residents are overrepresented at a rate of 3.13 times higher than the total black population in the county. Clients identified as Other race are overrepresented at a rate of 2.27 times higher than the total population of people identified as 'other' race in Contra Costa County.

Crisis Stabilization:

AAPI clients are underrepresented at a rate of .25 lower than the total AAPI population in the county. Black residents are overrepresented at a rate of 2.61 times higher than the total black population in the county. Clients identified as other race are overrepresented at a rate of 4.68 times higher than the total population of people who identified as other race in Contra Costa County.

Cross-Measure Questions

1. What additional local data do you have on the current status of institutionalization in your county?

Contra Costa Behavioral Health monitors census and financial data to determine length of stay and service efficacy. The County employs two registered nurses who manage all referrals into open contracted beds, maintain close relationships with referred clients and facilities and work in partnership with facilities to manage utilization from pre-admit, regular case conferencing while in

care pre-discharge planning and handoff to step down facilities. Client level data is captured in ccLink. Data regarding admission and discharge is currently captured at the client level in internally developed databases and may be aggregated to monitor service efficacy. The county has developed internal on-demand reporting that tracks hospitalization and CSU admits and discharges.

2. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing.

By instituting HFW, CCBH will provide intensive community-based services that will help stabilize children within their families and other support systems. CCBH will build out its capacity to provide HFW to youth with complex needs, specifically to youth at risk of hospitalization and out-of-home residential treatment.

Crisis residential:
CCBH is working to build more infrastructure to address the need for crisis residential care and anticipate by the end of the 3-year Plan that we will add 16 adult crisis residential beds along with 16 social rehabilitation beds.

Day Treatment Intensive:
We will develop capacity to provide day treatment intensive for youth and adults via county operated and contracted programming.

CCBH will implement ACT/FACT. ACT/FACT strives for members to achieve stability in the community to prevent decompensating and need for a higher level of care in a more restrictive setting. CCBH will also implement FSP ICM to provide more intensive community-based care to reduce the need for treatment in more restrictive settings. FSP services provided in institutionalized settings will engage members to reduce recidivism.

CCBH IMD liaisons will continue to strengthen relationships with conservators, and staff in the institutional settings while assuring members connect with the appropriate community-based supportive services. Housing interventions along with the most intensive services will be utilized to help stabilize members in the community.

CCBH is above the statewide average of 30-day involuntary detention rates. Therefore, FSP Intervention aims to prevent member decompensation and factors that contribute to extended involuntary detention.

Additionally, CCBH has robust crisis services and works to continue to enhance services and provide timely crisis response. These crisis services were not reflected in DHCS data.

3. Please identify the category or categories of funding that the county is using to address the institutionalization goal.

☐ BHSA BHSS

☑ **BHSA FSP**

☐ BHSA Housing Interventions

☑ **1991 Realignment**

☐ 2011 Realignment

☐ State General Fund

☑ **Federal Financial Participation (SMHS, DMC/DMC-ODS)**

☐ SAMHSA PATH

☐ MHBG

☐ SUBG

☐ Other

Justice-Involvement

Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023

1. How does your county status compare to the statewide rate/average? [above, below, or same]
    a. For adults/older adults: **below**
    b. For juveniles: **below**
2. What disparities did you identify across demographic groups or special populations?

☑ **Age**

☐ Gender

☑ **Race or Ethnicity**

☑ **Sex**

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other

Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

1. How does your county status compare to the statewide rate/average? [above, below, or same]

   Below

2. What disparities did you identify across demographic groups or special populations?

   ☑ **Age**

   ☐ Gender

   ☑ **Race or Ethnicity**

   ☑ **Sex**

   ☐ Spoken Language

   ☐ None Identified

   ☐ No Disparities Data Available

   ☐ Other

Incompetent to Stand Trial (IST) Count (Department of State Hospitals (DSH)), FY 2023

Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

1. How does your county status compare to the statewide rate/average? [above, below, or same]

   below

2. What disparities did you identify across demographic groups or special populations?

   ☐ Age

   ☐ Gender

   ☐ Race or Ethnicity

   ☐ Sex

   ☐ Spoken Language

   ☐ None Identified

   ☑ **No Disparities Data Available**

   ☐ Other

Disparities Analysis

1. For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis.

   It is well established in the literature that delinquent/criminal behavior is primarily engaged in by young males. This is further substantiated by the data provided by CalMHSA. Male juveniles are arrested at a rate 60% higher than the state average and a similar disparity (60%) is true for adult males. For adults ages 20-29 and adults ages 30-39 their arrest rates are 72% and 98% higher than the state average respectively. Similar results exist for adult recidivism rates with those ages 18 and 19 at release having a rate 61% higher than the state-wide average. Whether a function of individual behavior or an artifact of police/court processing, black males have an arrest rate more than four times the state average.

Cross-Measure Questions

1. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing.

   MH Diversion serves FIST clients with intensive outpatient services, leading to charges being dropped. A DSH Infrastructure grant will add 84 beds with supportive services to help clients succeed in diversion and reduce recidivism. A DSH grant also engages stakeholders across justice, health, and equity sectors to align resources and share data to reduce arrests tied to BH needs.

   CalAIMJI will expand to CCC custody facilities in 2026, focusing on prerelease planning, warm handoffs, and post-release contact to support care continuity and lower recidivism. CCBH will increase the focus on culturally attuned staffing. This is an opportunity to expand services to Black males, who are overrepresented in custody.

   CARE Court supports the vulnerable and underserved to remain in the community and avoid hospitalization or incarceration.

   AOT uses ACT and will add FACT capacity to the team to deliver integrated services: MH, substance use, housing, vocational support, peer/family support, and financial management, with close coordination with justice partners.

MH will strengthen collaboration with probation, and DMC-ODS will expand substance use treatment in jails, courts, and the community, including MAT and housing, supporting successful probation completion and reducing recidivism.

DMC-ODS will conduct in-custody assessments, initiate MAT, and provide treatment with warm handoffs at release. County jails allow direct calls to the Access Line.

ODS supports SUD treatment in jails for those with opioid use disorder. Clients continue MAT post-release; high-risk clients get low-barrier housing.

DUI programs serve as DMC-ODS entry points. Courts and attorneys refer repeat offenders to treatment.

Medi-Cal beneficiaries under Prop 36 access DMC-ODS benefits. County staff assess, report to courts, and coordinate placement.

MH Evaluation Teams of law enforcement and clinicians respond in-community to stabilize crises and connect individuals and families to ongoing care.

2. Please identify the category or categories of funding that the county is using to address the justice-involvement goal.

☐ BHSA BHSS

☐ BHSA FSP

☐ BHSA Housing Interventions

☐ 1991 Realignment

☐ 2011 Realignment

☐ State General Fund

☑ Federal Financial Participation (SMHS, DMC/DMC-ODS)

☐ SAMHSA PATH

☐ MHBG

☑ SUBG

☑ Other

- **Department of State hospitals (DSH): MHD grant, MHD infrastructure grant, IST Community Planning grant**
- **AB 109: Probation- mental health services, SUD Services**
- **MHSA: AOT program**
- **MHET**
- **PATH: is CalAIM**
- **SUBG perinatal**
- **OSF**

- **SUBG Perinatal**
- **Probation and School Funding**
- **Bureau of Justice Grant**
- **BHBH**

Removal Of Children from Home

Primary Measures

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025

1. How does your county status compare to the statewide rate? [above, below, or same]

   Below

2. What disparities did you identify across demographic groups or special populations?

   ☑ **Age**

   ☐ Gender

   ☐ Race or Ethnicity

   ☐ Sex

   ☐ Spoken Language

   ☐ None Identified

   ☐ No Disparities Data Available

   ☐ Other

Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

1. How does your county status compare to the statewide rate? [above, below, or same]

   Above

2. What disparities did you identify across demographic groups or special populations?

   ☑ **Age**

   ☐ Gender

   ☑ **Race or Ethnicity**

   ☐ Sex

   ☐ Spoken Language

   ☐ None Identified

   ☐ No Disparities Data Available

   ☐ Other

Child Maltreatment Substantiations (CWIP), 2022

1. How does your county status compare to the statewide rate? [above, below, or same]

Below

2. What disparities did you identify across demographic groups or special populations?

☑ **Age**

☐ Gender

☑ **Race or Ethnicity**

☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other

Disparities Analysis

1. For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis.

For children in foster care, there is a two-tailed disparity distribution. Children under 1 and those ages 1-2 have a 48% and a 36% higher rate respectively of being in foster care than the state average. Additionally, children ages 16-17 have a 27% higher rate. For open child welfare cases, children ages 6-11 and 12-17 have a 14% and 21% higher SMHS penetration rate respectively and White children had a 10% higher rate than the state average. Child maltreatment substantiations for children under 1 were almost three times that of the state average with Black children 2.5 times that of the state.

Cross-Measure Questions

1. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of the removal of children from home. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing.

<u>Problem Statement:</u>

a) **Children under 1 and those ages 1-2 have a 48% and a 36% higher rate respectively of being in foster care than the state average. Additionally, children ages 16-17 have a 27% higher rate. Child maltreatment substantiations for children under 1 were almost three times that of the state average with Black children 2.5 times that of the state.**

b) Children ages 16-17 have a 27% higher rate of being in foster care than statewide.

Strategies:

- **Collaborate with AB 2083 Interagency Leadership Team (ILT) and community partners to identify high-risk communities and populations with the goal of devising targeted early intervention programming, including Mental Health Consultation at preschools and early childhood learning centers.**
- **Expand family-based interventions in under-resourced communities, including parent education programming and evidence-based culturally responsive intervention such as Parent Child Interactive Therapy, Child Parent Psychotherapy, and other trauma-informed practices aimed at young children and their families.**
- **Expand interventions aimed at reducing the risk of children becoming system-involved, including High Fidelity Wraparound, Functional Family Therapy and Multi-systemic Therapy.**
- **Contra Costa will work with Child Welfare and the Comprehensive Prevention Plan (CPP) committee to evaluate to what extent Title IV-E funding can be leveraged to use to make these evidence-based family-based interventions available to children and families who are may not be eligible for specialty mental health services, particularly in regions that were identified as areas of high need in Contra Costa's CPP plan. "Contra Costa County – Comprehensive Prevention Plan" uploaded.**

2. Please identify the category or categories of funding that the county is using to address the removal of children from home goal.

☐ BHSA BHSS

☑ **BHSA FSP**

☐ BHSA Housing Interventions

☐ 1991 Realignment

☑ **2011 Realignment**

☐ State General Fund

☑ **Federal Financial Participation (SMHS, DMC/DMC-ODS)**

☐ SAMHSA PATH

☐ MHBG

☐ SUBG

☑ **Other: Measure X**

Untreated Behavioral Health Conditions

Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]

a. For the full population measured: **same**

2. What disparities did you identify across demographic groups or special populations?

☐ Age

☐ Gender

☐ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☑ **No Disparities Data Available**

☐ Other

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]

a. For the full population measured: **above**

2. What disparities did you identify across demographic groups or special populations?

☐ Age

☐ Gender

☐ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☑ **No Disparities Data Available**

☐ Other

Supplemental Measures

Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year (CHIS), 2023

1. How does your county status compare to the statewide rate/average? [above, below, or same]

a. For the full population measure: **below**

2. What disparities did you identify across demographic groups or special populations?

☐ Age

☑ **Gender**

☑ **Race or Ethnicity**

☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other

Disparities Analysis

1. For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis.

- **Gender: Males 18 and over in Contra Costa (53.1%) are above statewide rate for males 18+ (50.5%)**
- **Race or Ethnicity: Black or African American identifying individuals age 18+ in Contra Costa (82.4%) far exceed statewide rate for Black/African Americans 18+ (56.0%)**

Cross-Measure Questions

1. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026, that may decrease your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes).

Contra Costa's BH Plan (BHP), in partnership with CCHP, participated in the IHI collaborative (Apr 2024–Jun 2025) to improve FUA and FUM rates. Interventions included: strengthening partnerships with MCPs and the county hospital/ER, launching a real-time dashboard, outreach to disengaged members post-discharge, forming a county and ER Substance Use Navigators workgroup, and creating a peer-led ER engagement video. For Phase 2 (Fall 2025–Summer 2026), BHP is engaging Kaiser to improve FUA/FUM rates, particularly in West County.

In alignment with AB 2242, the county, PES, and YSU are implementing refining processes to ensure patients discharged from LPS holds receive coordinated care plans and timely follow-up, aiming to reduce no-show rates and improve connection to care.

BHP is working with Child & Family Services and community partners on a Comprehensive Prevention Plan to screen and connect underserved families to family-based mental health care. Efforts also aim to better support foster youth needing services.

Through the Wellness in Schools grant program, BHP collaborates with the County Office of Education and school districts to identify and link students to needed treatment.

Additionally, BHP partners with Probation to connect justice-involved youth to family-based interventions for successful reentry or prevention.

In 2023, Contra Costa had 178 opioid overdose deaths—disproportionately affecting African American residents. In response, the county launched a multi-pronged opioid strategy, including a mobile Opioid Response Team (ORT), jail-based counselors, post-release recovery housing, and MAT support. ORT also partners with HEPAC for harm reduction, provides outreach at NTPs, distributes naloxone/fentanyl strips, and engages in data-driven planning.

A countywide collaboration is underway with MCPs, Public Health, the County Hospital, and local EDs to improve referral processes for individuals with SUD and track follow-up care via internal FUA reporting.

2.Please identify the category or categories of funding that the county is using to address the untreated behavioral health condition's goal.

☐ BHSA BHSS

☐ BHSA FSP

☑ **BHSA Housing Interventions**

☐ 1991 Realignment

☑ **2011 Realignment**

☑ **State General Fund**

☑ **Federal Financial Participation (SMHS DMC/DMC-ODS)**

☐ SAMHSA PATH

☐ MHBG

☑ **SUBG**

☑ **Other:**

- **Opioid Settlement Funds**
- **Local Funding**
- **Bureau of Justice Administration (BJA) Grant**
- **Local Office of Education Grant**

Additional Statewide Behavioral Health Goals for Improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals.

In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

Care Experience

Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    a. For adults/older adults: **same**
    b. For children/youth: **same**

Quality Domain Score (Treatment Perception Survey (TPS)), 2024

1. How does your county compare to the statewide rate/average? [above, below, or same]

    a. For adults/older adults: **same**
    b. For children/youth: **same**

Engagement In School

Primary Measures

Twelfth Graders who Graduated High School on Time (Kids Count), 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    Same

Supplemental Measures

Meaningful Participation at School (California Healthy Kids Survey (CHKS), 2023

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    Below

Student Chronic Absenteeism Rate (Data Quest), 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    Below

Engagement In Work

Primary Measures

Unemployment Rate (California Employment Development Department (CA EDD), 2023

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    Below

Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    Below

Overdoses

Primary Measures

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH), 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]
    a. For the full population measure: **below**
    b. For adults/older adults: **below**
    c. For children/youth: **below**

Supplemental Measures

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]
    a. For the full population measure: **below**
    b. For adults/older adults: **below**
    c. For children/youth: **above**

Prevention And Treatment of Co-Occurring Physical Health Conditions

Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022. Please indicate above, below, or same.

1. How does your county status compare to the statewide rate/average? [above, below, or same]
    a. For adults: **same**
    b. For children/youth: **above**

Supplemental Measures

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS), 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    a. For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications): **same**

    b. For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing): **above**

Quality Of Life

Primary Measures

Perception of Functioning Domain Score (CPS), 2024

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    a. For the full population measured: **N/A**
    b. For adults/older adults: **same**
    c. For children/youth: **same**

Supplemental Measures

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS), 2024

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    a. For the full population measure: **same**

Social Connection

Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    a. For the full population measured: **N/A**
    b. For adults/older adults: **same**
    c. For children/youth: **same**

Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    Below

Suicides

Primary Measures

Suicide Deaths, 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    a. For the full population measured: **same**

Supplemental Measures

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

1. How does your county status compare to the statewide rate/average? [above, below, or same]

    a. For the full population measured: **below**
    b. For adults/older adults: **below**
    c. For children/youth: **above**

County-Selected Statewide Population Behavioral Health Goals

Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.

Goal #1: **Suicide**

a. Please describe why this goal was selected.

Contra Costa County recommends suicide as an additional goal grounded in epidemiological trends, community priorities, and alignment with BHSA funding and system transformation goals.

In addition to focusing on reducing suicides overall along with the demographic disparities outlined, Contra Costa will work to decrease non-fatal ED visits due to self-harm as an additional supplemental measure and goal.

b. What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals?

In support of the statewide goal to reduce suicides and self-harm, Contra Costa County identified significant disparities across age, gender, and racial/ethnic groups.

- **Suicide Disparities:**
  In 2023, Contra Costa's suicide rate rose to 11.3 per 100,000 - exceeding the state average (10.7) for the first time since 2016. Males had a significantly higher rate (18.2), and adults aged 25–84 were most impacted, particularly those 25–44 (15.7). White residents had the highest rate (16.9), while Asian (8.3) and Hispanic (7.2) residents had lower rates, though these may reflect underreporting or access barriers. These trends point to systemic gaps in culturally responsive care and access for men, White residents, and mid-to-late life adults.
- **Youth Self-Harm Disparities:**
  While Contra Costa's overall self-harm ED visit rate in 2022 (75.2 per 100,000) was below the state average (85.8), youth aged 15–19 had a much higher rate (378.2), exceeding the statewide youth rate (348.6). In 2023, disparities widened:
  - **Teen girls were nearly 3x more likely than boys to visit the ED for self-harm (464.8 vs. 162.2).**
  - **Black youth had the highest local rate (503.4), exceeding the state average (475.7).**
  - **Multiracial youth (155.2) and Hispanic youth (275.7) also exceeded state averages.**
  - **Asian youth had a lower rate (124.6 vs. 151.5).**

These disparities echoed in community input from 62 engagement events and 660 surveys, where suicide prevention, stigma, and lack of culturally competent care were top concerns. Notably, 17% of respondents reported they did not know how to access services in their language.

A recent UC Berkeley study further supports these findings, highlighting a 75% increase in self-harm among multiracial teens since 2016 and identifying multiracial girls as having the highest rates of nonfatal self-harm in California. Researchers emphasized the need for intersectional, equity-focused interventions to address this growing crisis (UC Berkeley News, April 2025).

c. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of [selected goal] and refer to any data that was used to make this decision:

According to our review of the California Department of Public Health data on deaths by suicide as well as community feedback, the County recognizes that reinforcement is needed for a continuum of early intervention that includes:

- **Trauma-informed care**
- **Peer and family engagement and resilience support**
- **Post-crisis stabilization and follow-up**

County plans to:

- **Enhance crisis response (e.g., ED, A3, PES, mobile teams).**
- **Reduce institutionalization through stabilization and linkage.**
- **Improve care continuity across justice, housing, and mental health systems.**

According to our review of the California Department of Public Health data on self-harm, as well as community feedback, the County recognizes that reinforcement is needed for a continuum of early intervention that includes:

- **School-based mental health supports help seeking and self-harm ideation**

a. **Youth mental health literacy for early identification of distress**

- **Peer and youth navigation outreach to increase engagement and reduce stigma**
- **Digital support for daily coping and mindfulness use**

In addition to the plans for our Suicide goal above, for the self-harm supplemental measure the County plans to:

- **Support school based and youth outlets for mental health literacy**
- **Improve care continuity across justice, housing, and education systems.**
- **Address stigma through peer-led and culturally responsive models.**
- **For repeat ED visits refer to existing evidence-based practice treatment that address self-harm among youth 15-19**

d. Please identify the category or categories of funding that the county is using to address this goal.

☑ **BHSA BHSS**

☐ BHSA FSP

☐ BHSA Housing Interventions

☐ 1991 Realignment

☐ 2011 Realignment

☐ State General Fund

☐ Federal Financial Participation (SMHS, DMC/DMC-ODS)

☐ SAMHSA PATH

☐ MHBG

☐ SUBG

☐ Other

Community Planning Process

Stakeholder Engagement

Link to "Stakeholder Engagement" sheet for questions 1-3

1. Please indicate the type of engagement used to obtain input on the planning process.

☑ County outreach through social media

☑ County outreach through Town Hall meetings

☐ County outreach through traditional media (e.g., television, radio, newspaper)

☑ Focus group discussions

☑ Key informant interviews with subject matter experts

☑ Meeting(s) with county

☑ Provided data to county

☐ Public e-mail inbox submission

☑ Survey participation

☑ Training, education, and outreach related to community planning

☑ Workgroups and committee meetings

☐ Other

Link to "Stakeholder Engagement" sheet for questions 1-3

2. Please specify the other strategies that demonstrate the meaningful partnerships with stakeholders.

AB109 Probation Officers and MHET Team. As a result of our strong partnerships, a community conversation was held with youth at Juvenile Hall and with TAY youth who are on Probation. Adult clients in the jail, were able to respond to survey questions using tablets. To understand the needs of the Unhoused population, two sessions were held with the leadership team of the Health, Housing and Homeless program, which is responsible for the Conty's Coordinated Entry, the second session included the Homeless Council. The close coordination with Homeless stakeholders gave us access to Point in Count results in real time. County social services and child welfare agencies were our first Stakeholder Specific Listening Session, which allowed the county to further understand the BH needs of youth and children involved in the foster care system and schools.

3. Include date(s) of stakeholder engagement for each type of engagement [question repeats for each type of engagement selected above] [format date box MM/DD/YYYY, option to add multiple entries]

County Outreach Townhall Meetings: 05/20/2025, 05/22/2025, 05/29/2025, 06/17/2025 • County Outreach Through Social Media: 05/20/2025, 05/27/2025 • Focus Group Discussions: 05/01/2025, 05/02/2025, 05/08/2025, 05/09/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/15/2025, 05/16/2025, 05/19/2025, 05/20/2025, 05/23/2025, 05/27/2025, 05/29/2025, 05/30/2025, 05/31/2025, 06/05/2025, 06/06/2025, 06/11/2025, 06/24/2025, 07/12/2025, 07/18/2025 61 • Key Informant Interviews with Subject Matter Experts: 05/16/2025, 05/23/2025, 05/27/2025, 06/06/2025, 06/10/2025, 06/23/2025 • Meeting with County: 06/13/2025, 06/10/2025 • Survey Participants: 05/11/2025, 05/21/2025, 05/27/2025 • Workgroup and Committee Meetings: 05/01/2025, 05/08/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/15/2025, 05/27/2025, 06/05/2025, 06/06/2025

4. Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals.

Agape's Restore & Renew Home; Alameda Cnty Health; Alt Fam Svcs; Antioch CARES; Aspiranet TBS; Bay Area Comm Rsrcs; BH Advis Brd; BH Prtnrshp; Bi-Bett; CCC (Advisory Cncl Aging; Board of Spvsrs; Employ & Human Svcs; Educ.; Sheriff; Dept of Cons. & Dev.; In-Home Support Svcs; VA Svcs; Cncl on Hmlssnss; Crisis Center/211; Housing Authrty; Health Plan; Reg Med Ctr; Youth Srvc Bureau); Brookside/Concord/Don Brown Shelters; Cali House; CA Dept of Rehab; Caminar; Care Parent Ntwk; Ctr for Human Dev; Child Abuse Prev Cncl; Child Advocates; Choice in Aging; Cities: Antioch/Pittsburg/Richmond; CoCoKids; Comm Corrections Ptnrshp; Comm Health for Asian Americans; Connections Clubhouse; CCC Comm College; Crestwood Healing Ctr; Delta Peers; US Dept of VA; Early Childhood MH; East/West Adult & Child MH Clinics; ELDA House; Embrace; Familias Unidas; FIERCE Advocates; First 5 CCC; Focus Strategies; Fresh Lifelines for Youth; Healthcare for Homeless; Homebase; Hope Solutions; Human Svcs Alliance; ILS Health; Int. Human Svcs Grp; James Morehouse Proj; John Muir Health; Juv. Hall; Kaiser Health; La Cheim School; Clinica De La Raza; Concordia Wellness Ctr; Lao Fam Comm Dev; Lincoln Fams; Lynn Ctr; Men & Women of Purpose; MH Connections; Mobility Matters; Mt Diablo USD; NAMI; Nuevos Comienzos; Off. of Sup. Andersen, Burges, & Carlson; Oxford Houses; Prtnrshp for Bay's Future; Peer Connections Ctrs; Pittsburg HS Parents; Psynergy; Rainbow Comm Ctr; RCF Connects; REACH Proj; Regnl Ctr East Bay; Rectory Women's Res; Restore; Richmond Commission on Aging; Richmond Youth Svcs & Empowerment; Rock Harbor Christian Flwshp; Safe Return Proj; San Pablo PD; Scotts Valley Tribal TANF; Seneca; Senior Mobility Action Cncl; Strengthening Fams - Helms MS; Sutter Health;

Telecare Hope House; Hume Ctr; Latina Ctr; Trinity Ctr; Uilkema House; Ujima Outpatient; Village Comm Rsrc Ctr; VistAbility; We Care; WC Det. Faclty; WCUSD; WestCare; White Pony Express; Youth Homes.

5. What are the five most populous cities in counties with a population greater than 200,000? For counties with a population over 200,000, this field is required.
    1. **Concord**
    2. **Richmond**
    3. **Antioch**
    4. **San Ramon**
    5. **Pittsburg**

6. Which required stakeholders/groups were engaged in the planning process?

    ☑ Area agencies on aging

    ☑ BHSA eligible adults and older adults (individuals with lived experience)

    ☑ Community-based organizations serving culturally and linguistically diverse constituents

    ☑ Continuums of care, including representatives from the homeless service provider community

    ☑ County social services and child welfare agencies

    ☐ Disability insurers

    ☑ Early childhood organizations

    ☑ Emergency medical services

    ☑ Families of BHSA eligible children and youth, eligible adults, and eligible older adults (with lived experience)

    ☑ Higher education partners

    ☑ Health care organizations, including hospitals

    ☑ Health care service plans, including Medi-Cal managed care plans

    ☑ Independent living centers

    ☑ Individuals with behavioral health experience, including peers and families

    ☑ Labor representative organizations

    ☑ Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+) communities

    ☑ Local education agencies

    ☑ Local public health jurisdictions

☑ Organizations specializing in working with underserved racially and ethnically diverse communities

☑ People with lived experience of homelessness

☑ Providers of mental health services

☑ Providers of substance use disorder treatment services

☑ Public safety partners, including county juvenile justice agencies

☑ Regional centers

☑ The five most populous cities in counties with a population greater than 200,000

☑ Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes

☑ Veterans and representatives from veterans' organizations

☑ Victims of domestic violence and sexual abuse

☑ Youth from historically marginalized communities

☑ Youths (individuals with lived experience), youth mental health organizations, or youth substance use disorder organizations

7. Please indicate whether you engaged stakeholders from this group during the planning process.

☐ Yes

☑ No << *disability insurers*

☐ Attempted but did not receive a response

☐ Stakeholder group is not applicable to county

8. What was the reason stakeholder was not engaged?

☐ Stakeholders declined to participate

☐ Unable to contact

☑ Other:

Contra Costa initially lacked clarity about this stakeholder category. Based on DHCS' feedback to our original IP submission and the clarity provided, Contra Costa intends to reach out to some of the insurers DHCS listed, after the winter holidays, in January, and incorporate any substantive feedback into the final IP. We have an existing relationship with Kaiser that we can leverage to meet these criteria.

9. Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities

Across 62 community engagement events—including town halls, community conversations, and key informant interviews—and English and Spanish surveys totaling 660 responses, county BHS gathered input on strengths, needs, and priorities from individuals representing 29 of the 30 DHCS-required stakeholder groups (excluding Disability Insurers, pending state clarification). Notes and survey responses were compiled into a single feedback database, with Spanish responses translated into English. A small research team analyzed the data using a mixed-methods approach: reading responses, extracting key quotes by theme, and using AI tools to identify common themes by stakeholder group. These findings were verified with county staff who facilitated the events. Community-identified strengths included crisis-response and peer-led programs, culturally respectful providers, and individualized treatment plans. Needs included broader outreach across channels, deeper engagement with trusted community messengers (e.g., pastors), and tailored approaches for groups such as transition-age youth, older adults, justice-involved individuals, veterans, LGTBQ and culturally diverse communities. Challenges included systemic and navigational barriers, cultural and linguistic gaps, lack of supportive housing, duplication of services by multiple providers, transportation issues and stigma around behavioral health. Key themes and representative quotes were presented to the Behavioral Health Transformation Steering Committee on July 7, during a working session where BHS leaders were tasked with incorporating community feedback into the Integrated Plan—and into ongoing program decisions.

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section.

1. Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP)? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.

   ☐ Yes.

   ☐ No.

   ☑Other.

   The CHA is currently in planning phase, with an estimated completion date in Fall 2026. In 2025, the LHJ/Public Health convened a community-based steering committee to guide its CHA, and BH has initiated collaboration through an initial meeting with public leadership focused on future data sharing and coordinated messaging to ensure inclusion of key populations once primary data collection is

initiated. The LHJ will assist with amplifying messaging regarding primary data collection and connecting to key populations served by BH once these efforts are initiated.

2. Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities. **N/A**

3. Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance? **N/A**

Collaboration

1. Please select how the county collaborated with the LHJ [multi-select list]

☐ Attended key CHA and CHIP meetings as requested.

☐ Served on CHA and CHIP governance structures and/or subcommittees as requested.

☑ **Other.**

BH has partnered with the LHJ through data sharing and community engagement.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

1. Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP [multi-select list]

☐ Access to Care

☐ Care Experience

☐ Engagement in School

☐ Engagement in Work

☐ Homelessness

☐ Institutionalization

☐ Justice Involvement

☐ Overdoses

☐ Prevention of Co-Occurring Physical Health Conditions

☐ Quality of Life

☐ Removal of Children from Home

☐ Social Connection

☐ Suicides

☐Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

☑ **Other:**

The LHJ's CHA/CHIP was not current at the time this plan was developed but they initiated a CHA/CHIP cycle in January 2025. In the absence of a CHA and/or a CHIP, Behavioral Health conducted a key informant stakeholder interview with the local Public Health Agency. In addition, data and reports were shared by the LHJ to help BH inform the plan. Data corresponding to the number of screenings at schools, health care for the homeless and MAT were provided to help BH inform the plan. The LHJ, pointed out during the interview several service gaps and unmet needs for some of the populations of focus, such as children and youth with BH conditions, unhoused individuals and specifically the lack of SUD treatment services for adolescents where they can be referred following identification of SUD.

2. Was data shared? **Yes**

Data-Sharing from MCPS and LHJs to Support IP development

1. Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development.

☐ Access to Care

☐ Care Experience

☐ Engagement in School

☐ Engagement in Work

☐ Homelessness

☐ Institutionalization

☐ Justice Involvement

☐ Overdoses

☐ Prevention of Co-Occurring Physical Health Conditions

☐ Quality of Life

☐ Removal of Children from Home

☐ Social Connection

☐ Suicides

☐ Untreated BH Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

☑ Other:

Data corresponding to the number of screenings at schools, health care for the homeless and MAT were provided to help BH inform the plan. The LHJ, pointed out during the interview several service gaps and unmet needs for some of the populations of focus, such as children and youth with BH conditions, unhoused individuals and specifically the lack of SUD treatment services for adolescents where they can be referred following identification of SUD.

2. Was data shared? **Yes**

Stakeholder Activities

1. Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities).

☐ Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.

☐ Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.

☐ Co-hosted community sessions, listening tours, and/ or other community events that can be used to strengthen stakeholder engagement for both the IP and CHA/CHIP.

☐ Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.

☑ Other:

The county engaged with the local health jurisdiction through a series of collaborative discovery sessions to share strategies, identify barriers and future opportunities to align and coordinate efforts. The LHJ's CHA and CHIP are in the early stages of development thus there will be more opportunities to coordinate in the future.

Most Recent Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) or Strategic Plan

1. Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3
    a. **Yes**
        i. Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP.
        CCBH reviewed the last completed Community Health Assessment (CHA). However, Contra Costa County has not completed a formal CHA since 2010. As a result of the existing CHA being dated, CCBH relied on alternative sources to inform the Integrated Plan, including existing behavioral health strategic priorities, program-level needs assessments, service utilization data, equity-focused analyses, and stakeholder and community input. The absence of a current CHA highlights an important opportunity for future collaboration and alignment and efforts as noted in the response above are underway.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

1. Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes.
    - **Contra Costa Health Plan**
    - **Kaiser**
2. Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?

    The MCP Community Reinvestment Plan is not due to DHCS until Q3 2026, and early internal discussions have just begun. The plan will involve input from key stakeholders, including the County Behavioral Health and Public Health Directors. However, submission is only required if the MCP reports net profits, and current projections indicate a financial loss, meaning no reinvestment may be required for this cycle.

    Given this, it is too early to determine alignment with the BHSA community planning process or the county's Integrated Plan (IP). The County will continue to monitor progress and collaborate with the MCP as planning develops.

Comment Period and Public Hearing

1. Date the draft Integrated Plan (IP) was released for stakeholder comment: **11/10/2025**
2. Date the stakeholder comment period closed: **12/10/2025**
3. Date of behavioral health board public hearing on draft IP: **1/7/2026**
   a. Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality [single-select list]
      i. **Link**
         1. [If link selected] Please provide the link to the public posting ii. PDF, image, or other document
         https://www.cchealth.org/home/showpublisheddocument/32686/638983905095470000
         1. [if PDF, image, or document selected] Please upload the PDF image, or other file documenting the public posting
4. [Optional] If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page [validate link or option to upload PDF]
5. Please select the process by which the draft plan was circulated to stakeholders
   ☑ **Public posting**
   ☑ **Email outreach** [if selected, attach email (no file type restrictions)] **See Appendix: Comment Period and Public Hearing – Email Outreach**
   ☐ Other [logic: if selected, populate question 6 below]
6. Please specify the other process the draft plan was circulated to stakeholders [narrative box]
7. Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table

Table 7. Stakeholder Input

Stakeholder group that provided feedback	Summarize the substantive revisions recommended this stakeholder during the comment period
Forthcoming	**Forthcoming**

8. Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A. [narrative response, with unlimited option to add new entries]

County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate

planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

County Provider Monitoring and Oversight

Cities submitting their Integrated Plan independently from their counties do not have to complete the Medi-Cal Quality Improvement Plan questions or Question 1 under All BHSA Provider Locations.

Medi-Cal Quality Improvement Plans

1. For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027

   See Appendix: MH QI Work Plan FY26-27 uploaded

2. Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?

   Yes

   a. For standalone DMC-ODS, please upload a copy of the county's current QIP for SFY 2026-2027.

      See Appendix: MH QI Work Plan FY26-27 uploaded

Contracted BHSA Provider Locations

1. As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services.

Table 8. Contracted BHSA Provider Locations Offering Non-Housing Services

Services Provided	Number of Contracted BHSA Provider Locations
Mental Health (MH) services only	**46**
Substance Use Disorder (SUD) services only	**0**
Both MH and SUD services	**0**

2. Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26

Table 9. Contracted BHSA Provider Locations that Participate in Medi-Cal BHDS

Services Provided	Number of Contracted BHSA Provider locations
SMHS only	**11**
DMC/DMC-ODS only	**0**
Both SMHS and DMC/DMC-ODS systems	**0**

All BHSA Provider Locations

1. Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS *Note: DHCS will provide each county with a list of their SMHS providers that also contract with MCPs. Counties will then calculate a final percentage after excluding SMHS providers that do not offer any services that may be covered as NSMHS.*

   18%

   a. Please describe the county's plans to enhance rates of MCP contracting starting July 1, 2027, and over the subsequent two years among the BHSA provider locations that are providing services that can/should be reimbursed by Medi-Cal MCPs.

   The rate listed above (18%) was provided by DHCS for the county SMHS provider sites that also contract with Medi-Cal MCPs for NSMHS. CCBH has a strong partnership with our primary MCP and will add the initiative to enhance rates of MCP contracting for these provider sites to our quarterly meetings to discuss strategies and progress. CCBHS will coordinate with the MCP on outreach and communication to providers to increase awareness around this initiative.

2. To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions).

   a. Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening.
   b. Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and
   c. Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding.

i. Does the county wish to describe implementation challenges or concerns with these requirements? **No**

1. Please describe any implementation challenges or concerns with the requirements for BHSA providers.

3. Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county.

   Does the county intend to adopt this recommended monitoring schedule for BHSA funded providers that:

   a. Also participate in the county's Medi-Cal Behavioral Health Delivery System?
      Yes
      i. If not, please describe how the county will monitor these providers for compliance with BHSA requirements
   b. Do not participate in the county's Medi-Cal Behavioral Health Delivery System?
      Yes

i. If not, please describe how the county will monitor these providers for compliance with BHSA requirements Behavioral Health Services Act/Fund Programs.

Behavioral Health Services and Supports (BHSS)

General

1. Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan [multi-select list]

☐ Children's System of Care (non-Full Service Partnership (FSP))

☑ Adult and Older Adult System of Care (non-FSP)

☑ Early Intervention Programs (EIP) – 51%

☐Outreach and Engagement (O&E)

☑ Workforce, Education and Training (WET)

☑ Capital Facilities and Technological Needs (CFTN)

Children's System of Care (Non-Full Service Partnership (FSP)

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add additional program" button.

Program One: N/A

1. Please select the service types provided under Program One. **N/A**

   ☐ Mental health services

   ☐ Supportive services

   ☐ Substance Use Disorder treatment services

2. Please describe the specific services provided. **N/A**

   Mental Health Services:
   Supportive Services:
   Substance Use Services

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below.

Table 10. Number of Individuals in the Children's System of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**N/A**
FY 2027 – 2028	**N/A**
FY 2028 – 2029	**N/A**

3. Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care. **N/A**

Adult and Older Adult System of Care (Non-Full-Service Partnership (FSP))

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add additional program" button.

1. Please select the service type provided under Program One.

   ☑ Mental health services

☑ **Supportive services**

a. Substance Use Disorder (SUD) treatment services

2. Please describe the specific services provided.

In the Adult/Older adult system of care, clients receive support services in a variety of settings such as outpatient clinics, in the field and in the county run adult CSU. Support services include linkage to services and programs, psychosocial rehabilitation, financial support and management, psychoeducation, peer support, system navigation, linkage to SUD services, and maintain engagement. Staff assigned to the Adult CSU provide linkage to both behavioral health programs and SUD outpatient and residential programs.

Additional staff will be added to the outpatient clinic to provide supportive and mental health services to all adults and older adults served in specialty mental health. This will prevent clients from falling out of care and avoid unnecessary institutionalization.

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below.

Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**6300**
FY 2027 – 2028	**6500**
FY 2028 – 2029	**6700**

4. Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care

Projections were based on estimates of the number of current clients receiving supportive services and an expansion to those clients with unmet needs.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3, but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "add additional program" button.

Program One

1. Program or service name: **At Risk Youth Engagement**

2. Please select which of the three EI components are included as part of the program or service

☑ **Outreach**

☑ **Access and Linkage: Screenings**

☐ Access and Linkage: Assessments

☑ **Access and Linkage: Referrals**

☐ Access and Linkage: Other

☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)

☑ **Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**

☑ **Treatment Services and Supports: Services to address co-occurring mental health and substance use issues**

☐ Treatment Services and Supports: Other

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs.
   a. **No**
   b. Please select the EBPs and CDEPs that apply.
4. Please describe intended outcomes of the program or service.
   a. Reduce onset and severity of mental illness in children and youth.
   b. Increase resilience, social-emotional development, and coping skills.
   c. Improve school attendance, academic engagement, and peer relationships.
   d. Provide early identification and supports for youth experiencing behavioral health concerns.
   e. Address co-occurring risks, including substance use and trauma exposure.
   f. Services will include education, screening, and referral pathways for youth at risk of developing substance use disorders, with early supports to reduce co-occurring MH/SUD challenges
   g. Mental/Emotional Health: improved emotional regulation, reduced symptoms of MH disorders, improved self-esteem, enhanced coping/resilience, decreased suicidal ideation/self-harm.
   h. Social/Relational: improved social skills, increased prosocial behavior, positive relationships with peers/adults, reduced high-risk peer associations, improved family relationships.
5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2 **N/A**
   a. Additional priority name

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program.

6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**1700**
FY 2027 – 2028	**1775**
FY 2028 – 2029	**1850**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs.

The county's projections are informed by annual reporting from both historical and current contractors serving this population. These reports establish a baseline of individuals reached each year. Projections also include a modest year-over-year increase to account for anticipated growth in program participation.

Program Two

1. Program or service name: **LGBTQ+ engagement**

2. Please select which of the three EI components are included as part of the program or service.

☑ Outreach

☑ Access and Linkage: Screenings

☐ Access and Linkage: Assessments

☑ Access and Linkage: Referrals

☐ Access and Linkage: Other

☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)

☑ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

☑ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

☐ Treatment Services and Supports: Other

☐ Please specify "other" type of Access and Linkage

☐ Please specify "other" type of Treatment Services and Supports

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs.

No

a. Please select the EBPs and CDEPs that apply. **N/A**

4. Please describe intended outcomes of the program or service.

a. **Reduce disparities in access to culturally competent behavioral health services.**
b. **Improve mental health outcomes for LGBTQ+ children, youth, and adults.**
c. **Decrease stigma, discrimination, and isolation experienced by LGBTQ+ participants.**
d. **Increase protective factors, including family acceptance, peer support, and affirming community networks.**
e. **Provide early intervention for co-occurring MH/SUD issues disproportionately affecting LGBTQ+ populations.**
f. **Given higher rates of substance use among LGBTQ+ youth and young adults, programs shall integrate culturally competent SUD prevention and treatment linkages.**
g. **Mental & Emotional Health: reduce elevated rates of depression, anxiety, PTSD, and suicidal ideation/self-harm for LGBTQ+ youth, via disparities reduction, stigma reduction, protective factors, co-occurring MH/SUD, culturally competent supports.**
h. **Social & Relational: stronger positive peer/family relationships, reduced association with high-risk peers, improved family communication.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

a. Additional priority name

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program.

6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

Estimated Number of Individuals Served in Early Intervention Programs by Plan Year Plan (can add up to 10):

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**550**
FY 2027 – 2028	**600**
FY 2028 – 2029	**650**

b. Please describe any data or assumptions the county used to project the number of individuals served through EI programs.

The county's projections are informed by annual reporting from both historical and current contractors serving this population. These reports establish a baseline of individuals reached each year. Projections also include a modest year-over-year increase to account for anticipated growth in program participation.

Program Three

1. Program or service name: **Culturally and linguistically specific outreach/engagement**
2. Please select which of the three EI components are included as part of the program or service

☑ Outreach

☑ Access and Linkage: Screenings

☐ Access and Linkage: Assessments

☑ Access and Linkage: Referrals

☐ Access and Linkage: Other

☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)

☑ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

☑ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

☐ Treatment Services and Supports: Other

☐ Please specify "other" type of Access and Linkage

☐ Please specify "other" type of Treatment Services and Supports

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

a. Please select the EBPs and CDEPs that apply.

4. Please describe intended outcomes of the program or service.

a. **Reduce barriers to behavioral health services for underserved cultural and linguistic groups.**
b. **Increase early identification and engagement in treatment and support.**
c. **Reduce stigma and cultural isolation surrounding behavioral health.**
d. **Address cultural trauma, acculturation stress, and intergenerational impacts.**
e. **Programs shall provide culturally relevant education and referrals for prevention and treatment of mental health and substance use disorders, addressing stigma and access barriers.**
f. **Social & Relational: stronger family communication and relationships, reduced association with high-risk peers, improved social skills.**
g. **Mental & Emotional Health: improved emotional regulation, reduced MH symptoms, enhanced coping.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

a. Additional priority name

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program

6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

Estimated Number of Individuals Served in Early Intervention Programs by Plan Year Plan (can add up to 10):

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**1600**
FY 2027 – 2028	**1675**
FY 2028 – 2029	**1750**

The county's projections are informed by annual reporting from both historical and current contractors serving this population. These reports establish a baseline of individuals reached each year. Projections also include a modest year-over-year increase to account for anticipated growth in program participation.

Program Four

1. Program or service name: **Parent/caregiver education/support**

2. Please select which of the three EI components are included as part of the program or service.

☑ Outreach

☑ Access and Linkage: Screenings

☐ Access and Linkage: Assessments

☑ Access and Linkage: Referrals

☐ Access and Linkage: Other

☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)

☐ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

☐ Treatment Services and Supports: Other

☐ Please specify "other" type of Access and Linkage

☐ Please specify "other" type of Treatment Services and Supports

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

a. Please select the EBPs and CDEPs that apply.

4. Please describe intended outcomes of the program or service.

a. **Increase positive parenting practices and family stability.**
b. **Reduce child abuse, neglect, and family violence.**
c. **Reduce parental stress, anxiety, and depression.**
d. **Enhance caregiver capacity to support children's social-emotional development.**
e. **Strengthen protective factors, including parental resilience and social connections.**
f. **Reduce caregiver stress and improve mental health help-seeking.**
g. **Programs should equip caregivers with tools to recognize early signs of substance use for self and in youth and connect families to prevention and treatment services.**
h. **Social/Relational: improved family relationships and communication, improved social skills, increased prosocial behavior.**
i. **Mental/Emotional Health: improved emotional regulation in both parents and children, reduced MH symptoms, enhanced coping/resilience.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

a. Additional priority name.

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program.

6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

Estimated Number of Individuals Served in Early Intervention Programs by Plan Year Plan (can add up to 10):

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**750**
FY 2027 – 2028	**800**
FY 2028 – 2029	**850**

The county's projections are informed by annual reporting from both historical and current contractors serving this population. These reports establish a baseline of individuals reached each year. Projections also include a modest year-over-year increase to account for anticipated growth in program participation.

Program Five

1. Program or service name: **Peer and family support**

2. Please select which of the three EI components are included as part of the program or service.

☑ **Outreach**

☑ **Access and Linkage: Screenings**

☐ Access and Linkage: Assessments

☑ **Access and Linkage: Referrals**

☐ Access and Linkage: Other

☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)

☑ **Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**

☑ **Treatment Services and Supports: Services to address co-occurring mental health and substance use issues**

☐ Treatment Services and Supports: Other

☐ Please specify "other" type of Access and Linkage

☐ Please specify "other" type of Treatment Services and Supports

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs.

No

a. Please select the EBPs and CDEPs that apply

4. Please describe intended outcomes of the program or service.

a. **Increase coping skills, self-advocacy, and recovery-oriented behaviors.**
b. **Improve family and peer support networks for individuals living with mental illness.**
c. **Reduce hospitalization, relapse, and crisis episodes.**
d. **Support skill-building for employment, education, and housing stability.**
e. **Foster inclusion and reduce isolation through community-based activities.**
f. **Peer support programs will emphasize wellness and recovery, including support for individuals and families impacted by substance use disorders.**
g. **Mental/Emotional Health: improved self-esteem, emotional regulation, and decreased symptoms of MH disorders.**
h. **Social/Relational: improved peer/family communication, stronger positive relationships, reduced association with high-risk peers.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

a. Additional priority name

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program.

6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

Estimated Number of Individuals Served in Early Intervention Programs by Plan Year Plan (can add up to 10):

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served

FY 2026 – 2027	**750**
FY 2027 – 2028	**800**
FY 2028 – 2029	**850**

The county's projections are informed by annual reporting from both historical and current contractors serving this population. These reports establish a baseline of individuals reached each year. Projections also include a modest year-over-year increase to account for anticipated growth in program participation.

Program Six

1. Program or service name: **Outreach and Engagement of Older Adults**

2. Please select which of the three EI components are included as part of the program or service.

☑ **Outreach**

☑ **Access and Linkage: Screenings**

☐ Access and Linkage: Assessments

☑ **Access and Linkage: Referrals**

☐ Access and Linkage: Other

☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)

☑ **Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**

☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

☐ Treatment Services and Supports: Other

☐ Please specify "other" type of Access and Linkage

☐ Please specify "other" type of Treatment Services and Supports

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs.

No

a. Please select the EBPs and CDEPs that apply.

4. Please describe intended outcomes of the program or service.

a. **Reduce isolation, depression, and anxiety in older adults.**
b. **Improve overall wellness, functioning, and quality of life.**
c. **Reduce suicide risk factors associated with aging, bereavement, and physical illness.**
d. **Increase access to case management, supports, and linkages to behavioral health services.**

e. **Programs shall include screening and referral for co-occurring mental health/substance use conditions.**
f. **Mental/Emotional Health: reduced depression, improved coping/resilience, decreased suicidal ideation.**
g. **Social/Relational: improved relationships, reduced isolation, increased prosocial engagement.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

a. Additional priority name

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program

6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

Estimated Number of Individuals Served in Early Intervention Programs by Plan Year Plan (can add up to 10):

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**200**
FY 2027 – 2028	**225**
FY 2028 – 2029	**250**

The county's projections are informed by annual reporting from both historical and current contractors serving this population. These reports establish a baseline of individuals reached each year. Projections also include a modest year-over-year increase to account for anticipated growth in program participation.

Program Seven

1. Program or service name: **Early Intervention for Veterans**

2. Please select which of the three EI components are included as part of the program or service

☑ **Outreach**

☑ **Access and Linkage: Screenings**

☐ Access and Linkage: Assessments

☑ **Access and Linkage: Referrals**

☐ Access and Linkage: Other

☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)

☑ **Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**

☑ **Treatment Services and Supports: Services to address co-occurring mental health and substance use issues**

☐ Treatment Services and Supports: Other

☐ Please specify "other" type of Access and Linkage

☐ Please specify "other" type of Treatment Services and Supports

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

a. Please select the EBPs and CDEPs that apply

4. Please describe intended outcomes of the program or service

a. **Increase access to veteran-affirming behavioral health and recovery supports through system navigation, especially by using peer supports.**
b. **Improve reintegration into civilian life, including employment and housing stability.**
c. **Address co-occurring SUD and mental health concerns.**
d. **Programs should provide early intervention and recovery-oriented supports for veterans experiencing substance use challenges, including linkage to VA and community-based SUD treatment.**
e. **Mental/Emotional Health: reduced PTSD/depression symptoms, decreased suicidal ideation, improved resilience and coping.**
f. **Social/Relational: improved family relationships, stronger bonds with prosocial peers, mentors, and community.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

a. Additional priority name

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program

6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**125**
FY 2027 – 2028	**150**

FY 2028 – 2029	**175**

The county has not historically done outreach, engagement and early intervention with veterans but given this was a need identified during community/stakeholder engagement, the county plans to address this need. However, there is no baseline for projected number of individuals served so this is an estimate and may be adjusted.

Program Eight

1. Program or service name: **Early intervention for those at high risk for suicide**

2. Please select which of the three EI components are included as part of the program or service

☑ Outreach

☑ Access and Linkage: Screenings

☐ Access and Linkage: Assessments

☑ Access and Linkage: Referrals

☐ Access and Linkage: Other

☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)

☑ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

☑ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

☐ Treatment Services and Supports: Other

☐ Please specify "other" type of Access and Linkage

☐ Please specify "other" type of Treatment Services and Supports

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs

No

a. Please select the EBPs and CDEPs that apply

4. Please describe intended outcomes of the program or service

a. **Reduce suicide attempts and deaths through early intervention.**
b. **Increase access to crisis support, safety planning, and postvention services.**
c. **Improve identification of individuals at elevated risk (e.g., LGBTQ+, veterans, youth, older adults).**
d. **Strengthen community-based safety nets and reduce barriers to care.**
e. **Programs should recognize and respond to the strong link between substance misuse and suicide risk, integrating screening and referral to SUD treatment in prevention activities.**

f. **Mental & Emotional Health: reduced mental health symptoms, improved coping skills, decreased suicidal ideation/self-harm**
g. **Social & Relational: increase strong bonds with peers, mentors, and family and natural supports as protective factors against suicide.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2

No

a. Additional priority name

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program

6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

Table 12. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**200**
FY 2027 – 2028	**250**
FY 2028 – 2029	**300**

The county's projections are informed by annual reporting from both historical and current contractors serving this population. These reports establish a baseline of individuals reached each year. Projections also include a modest year-over-year increase to account for anticipated growth in program participation.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

1. Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program

a. CSC program name: **Clinical High Risk & First Episode Psychosis, First Hope**

b. CSC program description

Contra Costa's First Hope Program is a Coordinated Specialty Care program for early intervention in psychosis. Encompassing two components, First Hope supports individuals who show early signs of developing psychosis (component 1, Clinical High-Risk Program – CHRP) and individuals who are in the early stages of a psychotic disorder (component 2, First Episode Program – FEP). By providing immediate access to services uniquely suited to their needs, we engage clients in recovery-oriented services and prevent the problems associated with chronicity and multiple relapses. Through early intervention in psychosis, the programs aims to decrease hospitalization and institutional placement, and to reduce the morbidity and subsequent disability associated with chronic untreated psychosis. During

participation in the program, clients and families actively engage in furthering their understanding of physical and mental health. Clients and families participate in a program that includes psychoeducation, a focus on improved functioning, and the development of skills that support the client's life goals. While family involvement is not a requirement for treatment, including the family (as defined by the client) whenever possible increases the strength of the support system available to the client. Comprising multi-disciplinary teams, First Hope offers evidence-based treatment in CHRP and FEP. The CHRP is modeled after the Portland Identification and Early Referral program (PIER) and the FEP after RAISE /NAVIGATE. Both components promote client-driven, recovery-oriented services based on engaging with clients' goals and promoting functioning, rather than focusing solely on symptom reduction. Clients and families are provided with an array of services suited to their individualized needs. First Hope actively engages the community by providing outreach presentations and training with the goals of identifying individuals needing support early.

2. Please review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5).
   Please input the estimates provided to the county in the table below.

Table 13. Estimated Number of Individuals Eligible for CSC and Estimated Number of Teams Needed to Serve Total Eligible Population

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**150 county estimate. No estimate from State yet. 133**
Number of Uninsured Individuals	**12**
CSC Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	**17**
Number of Teams Needed to Serve Total Eligible Population	**4**

3. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the

   total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

Table 14. Total Number of CSC Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29

Total Number of Practitioners	**25**	**25**	**25**
Total Number of Teams	**6**	**6**	**6**

4. Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?
Yes

a. Please list the other funding source(s).

MHBG and Realignment to cover services that are not accounted for in the model.

Outreach and Engagement (O&E)

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add additional program" button.

Program One: N/A

1. Program or activity name

2. Please describe the program or activity

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Table 15. Estimated Number of Individuals Served in O&E Programs by Plan Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**N/A**
FY 2027 – 2028	**N/A**
FY 2028 – 2029	**N/A**

4. Please describe any data or assumptions the county used to project the number of individuals served through O&E programs.

County Workforce, Education, and Training (WET)

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of

Health Care Access and Information (HCAI). Counties should prioritize available BHCONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's cft program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan
(IP).

For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add additional program" button.

Program One

1. Program or activity name: **Loan Repayment Program**
2. Please select which of the following categories the activity falls under:

☐ Continuing Education

☐ Internship and Apprenticeship Programs

☑ **Loan Repayment**

☐ Professional Licensing and/or Certification Testing and Fees

☐ Retention Incentives and Stipends

☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program

☐ Workforce Recruitment, Development, Training, and Retention

☐Other

a. Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9

Loan Repayment Program: CCBHS will continue its County funded Loan Repayment Program supported through contracting with CalMHSA to deliver payment. This program assists in addressing diversity equity and inclusion and critical staff shortages, such as language need, and hard-to-fill, hard-to-retain positions with a primary focus on filling psychiatric and nurse practitioner shortages within CCBHS. Additionally, CCBHS has partnered with CalMHSA to administer the Workforce Education and Training Greater Bay Area Regional Partnership Loan Repayment Program. This partnership is between the Bay Area counties, the California Department of Health Care Information Access (HCAI), formerly known as the Office of Statewide Health Planning and Development (OSHPD), and CalMHSA. No additional funds were allocated this fiscal year, as CCBHS provided the necessary 33% matching funds in 2022 to CalMHSA, as part of the contingency from HCAI, which provided the remaining 67% of funding. This loan repayment program is patterned after state level loan repayment programs but differing in providing flexibility in the

amount awarded to each individual, and the County selecting the awardees based upon workforce needs. This program focuses but is not limited to providers such as; Registered Nurses, Psychologists, LCSWs, LMFTs, LPCCs, and peer providers, and other behavioral health professionals prioritizing providers with language and cultural capacity to fill needs both within CCBHS and contracted CBO partners.

- **Training contracts**
- **BHS Internship Program**
- **WET Positions**
- **SPIRIT**
- **NAMI**
- **Senior Peer Counseling Program**
- **Transitional Work Program**
- **MOTIVO**
- **Medi-Cal Peer Support Certification Program**
- **Enhanced Community Health Workers**

Capital Facilities and Technological Needs (CFTN)

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add additional project" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5.

Project One

1. Project name: **El Portal Social Rehabilitation Campus**
2. Please select the type of project

   ☑ Capital facilities project

   ☐Technological needs project

3. Please describe the project: **Develop new crisis residential and transitional residential programs in West County**
4. If capital facilities project, please indicate which of the following categories the project falls under.

   ☑ Acquiring, renovating, or constructing buildings that are or will be county-owned. *The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.*

   ☐ Acquiring facilities not secured to a foundation that is permanently affixed to the ground

   ☐ Establishing a capitalized repair or replacement reserve

   ☐ Meeting match requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award

☐ Renovating or constructing buildings that are privately owned

5. Please indicate if the project involves leasing or renting to own a building
   No. building is already owned.
   a. Please explain why purchase of the building was not possible.

Project Two

6. Project name: **Repair and renovation of Hope House**
7. Please select the type of project
   ☑ Capital facilities project
   ☐Technological needs project
8. Please describe the project: **Structural repair and renovation of Hope House, a county-owned crisis residential facility**,
9. If capital facilities project, please indicate which of the following categories the project falls under.
   ☑ Acquiring, renovating, or constructing buildings that are or will be county-owned. *The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.*
   ☐ Acquiring facilities not secured to a foundation that is permanently affixed to the ground
   ☐ Establishing a capitalized repair or replacement reserve
   ☐ Meeting match requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award
   ☐ Renovating or constructing buildings that are privately owned

10. Please indicate if the project involves leasing or renting to own a building.
    No
    a. Please explain why purchase of the building was not possible.
       N/A

Project Three

1. Project name: **Interoperability**
2. Please select the type of project:
   ☐ Capital facilities project
   ☑ Technological needs project
3. Please describe the project: **Interoperability is a key goal on the BHP IT priority list. In particular, Contra Costa is assessing various possibilities for sharing both claiming and clinical data from our contract providers, who render roughly 50% of our outpatient**

services. The county currently has on its project list two options for improving interoperability – one focused on claim submission using batch service files or a HIPAA compliant claim submission, and a second option that would lead to more sharing of clinical information. The latter requires further evaluation to determine the most feasible solution for sharing clinical data between the county and contract agencies. These are in addition to the DHCS mandates for the various interoperability APIs and implementation of an interface with an HIE and/or a QHIO.

4. If Technological Needs Project, please select the focus area(s) of the project.

    ☑ Data exchange and interoperability

    ☐ Data security and privacy

    ☐ Data warehouse

    ☐ Electronic health record system

    ☐ Individual/family access to computing resources

    ☐ Imaging/paper conversion

    ☐ Monitoring

    ☐ Online information resources for individuals/families

    ☐ Personal health record system

    ☐ Resources to support web content and mobile app accessibility

    ☐ System maintenance costs

    ☐ Telemedicine

    ☐ Other

Project Four

1. Project name: **eSignature**
2. Please select the type of project:

    ☐ Capital facilities project

    ☑ Technological needs project

3. Please describe the project: **Contra Costa BHP has a high number of both contracting agencies as well as individual providers who render services for clients in the system of care. There is a need for robust and secure interfaces for common workflows such as secure e-signatures for providers who are not on the county's EHR (Epic, aka ccLink).**

4. If Technological Needs Project, please select the focus area(s) of the project [multiselect dropdown]

    ☐ Data exchange and interoperability

☑ **Data security and privacy**

☐ Data warehouse

☐ Electronic health record system

☐ Individual/family access to computing resources

☐ Imaging/paper conversion

☐ Monitoring

☐ Online information resources for individuals/families

☐ Personal health record system

☐ Resources to support web content and mobile app accessibility

☐ System maintenance costs

☐ Telemedicine

☐ Other

Project Five

1. Project name: **ASCMI**
2. Please select the type of project:

   ☐ Capital facilities project

   ☑ **Technological needs project**

3. Please describe the project: **BHS will be implementing the ASCMI consent form and will need to integrate into the EHRs for AODS and MH. The ASCMI is the Authorization to Share Confidential Member Information, a standardized form in California designed to address the challenges of sharing sensitive health, behavioral health, and social services information among various "Care Partners" such as providers, health plans, and community organizations.**

4. If Technological Needs Project, please select the focus area(s) of the project.

   ☐ Data exchange and interoperability

   ☑ **Data security and privacy**

   ☐ Data warehouse

   ☐ Electronic health record system

   ☐ Individual/family access to computing resources

   ☐ Imaging/paper conversion

☐ Monitoring

☐ Online information resources for individuals/families

☐ Personal health record system

☐ Resources to support web content and mobile app accessibility

☐ System maintenance costs

☐ Telemedicine

☐ Other

Project Six:

1. Project name: **Bed Management Utilization Software**
2. Please select the type of project:

   ☐ Capital facilities project

   ☑ Technological needs project

3. Please describe the project: **Given the magnitude of the Contra Costa BHP investment in residential level of care, Contra Costa BHP will implement a software solution for managing beds at all levels of care (inclusive of county owned MHRC, adult residential treatment facilities, county owned and contracted crisis residential facilities, detox and withdrawal management programs. Bed management and utilization in this context not only includes census and utilization but also tracking ongoing costs and contract monitoring.**

4. If Technological Needs Project, please select the focus area(s) of the project [multiselect dropdown]

   ☐ Data exchange and interoperability

   ☐ Data security and privacy

   ☐ Data warehouse

   ☑ Electronic health record system

   ☐ Individual/family access to computing resources

   ☐ Imaging/paper conversion

   ☐ Monitoring

   ☐ Online information resources for individuals/families

   ☐ Personal health record system

   ☐ Resources to support web content and mobile app accessibility

   ☐ System maintenance costs

☐ Telemedicine

☐ Other

Project Seven:

1. Project name: **EBP Program Performance and Fidelity Data Tracking**
2. Please select the type of project:

   ☐ Capital facilities project

   ☑ **Technological needs project**

3. Please describe the project: **Contra Costa BHP will implement changes in the EHR (Epic) to handle bundled billing, a new format for sending claims to DHCS which includes major configuration changes to ccLink Professional Billing (PB), care teams, prior authorizations, where applicable, referrals and any necessary documentation changes. Similarly, to support tracking of EBP outcomes and fidelity monitoring, Contra Costa BHP will need to develop extracts from the EHR (Epic) and interfaces, where feasible, to Center of Excellence IT systems**.

4. If Technological Needs Project, please select the focus area(s) of the project [multiselect dropdown]

   ☐ Data exchange and interoperability

   ☐ Data security and privacy

   ☐ Data warehouse

   ☑ **Electronic health record system**

   ☐ Individual/family access to computing resources

   ☐ Imaging/paper conversion

   ☑ **Monitoring**

   ☐ Online information resources for individuals/families

   ☐ Personal health record system

   ☐ Resources to support web content and mobile app accessibility

   ☐ System maintenance costs

   ☐ Telemedicine

   ☐ Other

Project Eight:

1. Project name: **Scheduling Expansion and Improvements**
2. Please select the type of project

   ☐ Capital facilities project

☑ **Technological needs project**

3. Please describe the project: **This project includes expansion of EHR (Epic) scheduling features, mobile scheduling, standardization of scheduling protocols and workflows, and will improve client access to services, clinic efficiency, No Show Tracking, and is necessary for the full implementation of the patient portal.**

4. If Technological Needs Project, please select the focus area(s) of the project

☐ Data exchange and interoperability

☐ Data security and privacy

☐ Data warehouse

☑ **Electronic health record system**

☐ Individual/family access to computing resources

☐ Imaging/paper conversion

☐ Monitoring

☐ Online information resources for individuals/families

☐ Personal health record system

☐ Resources to support web content and mobile app accessibility

☐ System maintenance costs

☐ Telemedicine

☐ Other

Project Nine:

1. Project name: **Dashboards and Reporting**
2. Please select the type of project:

☐ Capital facilities project

☑ **Technological needs project**

3. Please describe the project: **This includes development of reports and dashboards for revenue integrity, quality outcomes, and fraud waste and abuse for county and contracting agencies. In addition performance measures are needed to understand effectiveness of clinical services.**

4. If Technological Needs Project, please select the focus area(s) of the project.

☐ Data exchange and interoperability

☐ Data security and privacy

☐ Data warehouse

☐ Electronic health record system

☐ Individual/family access to computing resources

☐ Imaging/paper conversion

☑ **Monitoring**

☐ Online information resources for individuals/families

☐ Personal health record system

☐ Resources to support web content and mobile app accessibility

☐ System maintenance costs

☐ Telemedicine

☐ Other

Project Ten:

1. Project name: **Client Portal Optimization**
2. Please select the type of project:

   ☐ Capital facilities project

   ☑ **Technological needs project**

3. Please describe the project: **This project includes improving functionality in MyChart, the client portal to include features such as secure messaging and client self-scheduling. Adding this functionality will require testing, training, and ongoing maintenance but will provide much improved access to services for clients.**

4. If Technological Needs Project, please select the focus area(s) of the project [multiselect dropdown]

   ☐ Data exchange and interoperability

   ☐ Data security and privacy

   ☐ Data warehouse

   ☐ Electronic health record system

   ☐ Individual/family access to computing resources

   ☐ Imaging/paper conversion

   ☐ Monitoring

   ☐ Online information resources for individuals/families

   ☑ **Personal health record system**

☐ Resources to support web content and mobile app accessibility

☐ System maintenance costs

☐ Telemedicine

☐ Other

Full-Service Partnership Program

[Context text: DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements.]

1. Please review the total estimated number of individuals who may be eligible for each of the following Full-Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide, the Policy Manual Chapter 7, Section B, and forthcoming High-Fidelity Wraparound (HFW) Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full-Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below

Table 16. Estimated Number of Individuals Eligible for Full Service Partnership Services This table uses Diagnosis-Based SMI Projections from CalMHSA for ages 19-64. Does not include Children. Thes numbers accurately reflect CalMHSA preliminary Diagnosis-based SMI for ADULT FSP only.

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**2085**
Number of Uninsured Individuals	**239**
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	**616**

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Eligible Population

1. Please input the estimates provided to the county in the table below

Table 17. Estimated Number of Individuals Eligible for ACT and FACT and Estimated Number of Teams Needed to Serve Total Eligible Population

ACT and FACT Eligible Population	Estimates

Number of Medi-Cal Enrolled Individuals	**229**
Number of Uninsured Individuals	**26**
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	**127**

ACT and FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**40**
Number of Teams Needed to Serve Total Eligible Population	**4**

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., fulcurrent and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

Table 18. Total Number of ACT and FACT Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**55**	**55**	**55**
Total Number of Teams	**5**	**5**	**5**

Full-Service Partnership (FSP) Intensive Case Management (ICM) Eligible Population

1. Please input the estimates provided to the county in the table below

Table 19. Estimated Number of Individuals Eligible for FSP ICM and Estimated Number of Teams Needed to Serve Total Eligible Population

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**1742**
Number of Uninsured Individuals	**200**
FSP ICM Practitioners and Teams Needed	**Estimates**

Number of Practitioners Needed to Serve Total Eligible Population	**80**
Number of Teams Needed to Serve Total Eligible Population	**16**

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

Table 20. Total Number of FSP ICM Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**78**	**78**	**78**
Total Number of Teams	**12**	**12**	**12**

High Fidelity Wraparound (HFW) Eligible Population

1. Please input the estimates provided to the county in the table below

Note: HFW guidance is forthcoming; DHCS will provide these estimates in accordance with HFW guidance

Table 21. Estimated Number of Individuals Eligible for HFW and Estimated Number of Teams Needed to Serve Total Eligible Population

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**200**
Number of Uninsured Individuals	**25**
HFW Practitioners and Teams Needed	***Estimates***
Number of Practitioners Needed to Serve Total Eligible Population	**61**
Number of Teams Needed to Serve Total Eligible Population	**23**

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

Table 22. Total Number of HFW Practitioners and Teams

County Actuals			
	FY 26-27	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	**61**	**61**	**61**
Total Number of Teams	**23**	**23**	**23**

Individual Placement and Support (IPS) Eligible Population

1. Please input the estimates provided to the county in the table below

Table 23. Estimated Number of Individuals Eligible for IPS and Estimated Number of Teams Needed to Serve Total Eligible Population

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**3395**
Number of Uninsured Individuals	**388**
IPS Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	**238**
Number of Teams Needed to Serve Total Eligible Population	**95**

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

Table 24. Total Number of IPS Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**13**	**20**	**20**

Total Number of Teams	**6**	**9**	**9**

Full Service Partnership (FSP) Program Overview

Please provide the following information about the county's BHSA FSP program

1. Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?

   No

   a. Please describe how the estimated practitioners will provide more than one EBP

2. Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports.

   FSPs (whether contracted or county-operated) should be guided by the insight that behavioral disturbances are frequently an expression of the adverse experiences in childhood and beyond. Programs need to be able to screen for adverse and traumatic experiences and engage families with the understanding that their presenting problems may be an adaptation to adverse circumstances. Programs will need to be able to provide trauma-focused treatment.

   BHSA FSP employs a whole-person approach by assuring multidisciplinary teams are diversly staffed to meet the unique and complex needs of individuals. BHSA FSP lead staff provide oversight to assure appropriate coordination of care between primary care, behavioral health, housing and other supports. FSP team members are trained to identify and strengthen members natural supports as an integral part of the member working towards achieving long term stability in their community. In cases where natural supports are not available, development of these supports becomes prioritized. Staff supervision and training emphasize provision of services are to be done through a trauma informed lens. This approach reflects the understanding that trauma can impact all aspects of a member's wellbeing. Each team member brings value, experience and contributes to maintaining the culture of trauma informed, whole person care. Each team will include peer providers who's essential role is to provide feedback to the team through the lens of their lived experience. CCBH will establish a framework for levels of care within specialty mental health which will enable members to step down to outpatient from FSP and still receive robust supports.

3. Please describe the county's efforts to reduce disparities among FSP participants.

   Representation indices were calculated to assess the proportional representation of county-enrolled Full Service Partnership (FSP) clients by race relative to their representation in the overall county population and in the certified Medi-Cal–eligible population. Data were drawn from the Commission for Behavioral Health dashboard for FY 2022–23 and compared with 2023 American Community Survey (ACS) population

estimates and California Health and Human Services (CalHHS) data for Medi-Cal certified eligibles in Contra Costa County for calendar year 2023.

Results indicate significant underrepresentation for several groups. Asian and Pacific Islander (API) residents had a representation index of 0.26 when compared to the general county population and 0.50 when compared to the Medi-Cal–eligible population. Latino residents were also underrepresented, with representation indices of 0.91 relative to the ACS population and 0.67 relative to the Medi-Cal–eligible population.

To address these disparities, Contra Costa Behavioral Health (CCBH) will implement several targeted strategies. First, CCBH will release an RFP for a community-based organization to conduct outreach, engagement, and Intensive Case Management (ICM) services, with an emphasis on Spanish language capacity and culturally responsive service delivery. In addition, CCBH will incorporate explicit language access and cultural capacity expectations into upcoming Health, Family & Workforce (HFW) RFPs to strengthen engagement with underrepresented populations.

Further, Community-Based Organizations and Prevention and Early Intervention (PEI) providers contracted to conduct outreach and engagement with underrepresented populations—particularly API and Latino communities—will receive training on FSP eligibility criteria and referral processes. These providers will maintain active coordination with FSP programs to support timely referrals and warm handoffs into FSP-level services when indicated.

In addition, Contra Costa County is preparing an RFP using Measure X funds to conduct a comprehensive behavioral health needs assessment focused on API communities. The assessment will examine behavioral health needs, disparities, strengths, and service gaps to inform culturally responsive early intervention and treatment strategies aligned with the Behavioral Health Services Act (BHSA), CalAIM, and the Children and Youth Behavioral Health Initiative (CYBHI). Objectives include identifying unmet needs; assessing access, engagement, and quality of services; documenting cultural and linguistic barriers; mapping community assets; and producing actionable recommendations with an implementation roadmap.

Findings from these efforts, along with new partnerships developed through the RFP processes, will inform ongoing strategies to reduce FSP enrollment disparities. CCBH will routinely monitor and trend FSP enrollment demographics to assess the effectiveness of outreach and engagement strategies and to guide continuous quality improvement and course correction as needed.

4. Select which goals the county is hoping to support based on the county's allocation of FSP funding.

All statewide goals: Overdoses, Untreated BH conditions, Institutionalizations, Homelessness, Justice involvement, removal of children from home, access to care, social connection, prevention and treatment of co-occurring physical health conditions, engagement in work, engagement in school, quality of life, suicides.

5. Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM.
   Contra Costa Behavioral Health FSP ICM programs will engage in assertive outreach and engagement to continually engage members in their own care. Treatment plans are individualized and created in collaboration with the member increasing member engagement in their care. CCBH works to build on members' strengths and to involve members in goal setting based on their readiness for change. CCBH works to identify barriers to care so that strategies can be implemented to overcome those barriers. CCBH embraces the 'whatever it takes' approach, which allows staff to be flexible with service delivery and meet clients where they are in the community. CCBH providers work with members where they are both physically and emotionally. Peer providers are key members of every team and play a key role in helping the members navigate the healthcare system. Peers also have the opportunity to educate team members from a lived experience perspective in strategies to continue to keep members engaged in care.

   a. Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW. Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP

6. Please describe how the county will comply with the required FSP levels of care.

   CCBH will have regional ACT/FACT teams to serve the most vulnerable and highest-needed population. To assure members meet medical necessity criteria for this intensive service, prior authorization will be required. As a step down from ACT/FACT, BH will have regional FSP ICM teams. FSP ICM may also serve as a step down from hospitalization or crisis residential when clients do not meet criteria for ACT/FACT. BH will maintain outpatient treatment for clients stepping down from FSP ICM but still meet criteria for SMHS. Members will be assessed regularly to assure they are being served at the most appropriate level of care. Staff will be trained regarding criteria for the different levels of care to assure clients receive appropriate referrals and receive the care that meets their individual needs.

7. Please indicate whether the county FSP program will include any of the following optional and allowable services:

   Contra Costa Behavioral Health's FSP program will include the following optional and allowable services: Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP and Other recovery-oriented services, such as MAT and Co-occurring (COD) Capable FACT and ACT teams.

a. Primary substance use disorder (SUD) FSPs: **No**

   i. If Y, please describe

b. Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP: **Yes**

   i. Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program

   CCBH Transition team was designed with the goal of minimizing the number of members not successfully accessing specialty mental health services. CCBH will leverage the existing Transition team as they are designed to outreach to severely and persistently mentally ill clients, who are utilizing hospital based psychiatric services but are not connected to outpatient specialty mental health. Transition team connects with referral sources including psychiatric hospitals, outpatient programs, Mobile Crisis, homeless service staff and family members. Transition team engages with and outreaches to individuals who qualify for FSP programs and provide warm handoffs to FSP teams.

c. Other recovery-oriented services:

   Yes

   i. Please describe the other recovery-oriented services the county's FSP program will include.

   Outreach, Recovery Support Services and Care Management. Each ACT and/or FACT team will include substance abuse counselors who will lean on their skills to coordinate the SUD needs of the clients and provide crisis/relapse prevention interventions as needed. Recovery Support services will be offered and include referrals to self-help groups as needed by the client.

8. If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams.

MAT and Co-occurring (COD) Capable. FACT and ACT Teams to ensure greater effectiveness and broader reach to highly vulnerable populations, whether those are justice involved or the unsheltered, the county proposes to make all ACT or FACT Teams be COD and MAT capable in 2 (two) phases. During the first phase the goal will be to comprise all the FSPs by integrated teams with capacity to serve clients with COD under the notion that co-occurring conditions are an expectation and not an exception. Training to increase understanding of Medication Assisted Treatment (MAT) will start in phase 1 (one) to include Naloxone training, understanding of addiction, crisis intervention and harm reduction approaches to engage individuals not ready for

treatment through Motivational interviewing. Regardless, in phase 1 (one) all teams will carry Naloxone and fentanyl strips. The second phase will ensure that all medical providers in the FSP team are MAT prescribers who can initiate someone on all FDA approved medications for SUD including Medications for Opioid Use Disorders (MOUD). Training in substance use disorders to all FSP staff will continue on an ongoing basis via contract with UCLA and a local contractor. Counselors in the FSPs will hand-hold each beneficiary who was just initiated to their next appointment to a MAT provider, to guarantee follow up to their first appointment to and establish care. In addition, if willing depending on where they are on stage of change beneficiaries with a history of overdoses, will be offered low-barrier housing, or a recovery residence.

9. What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's FSP program (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

    a. In, or at-risk of being in, the juvenile justice system:

    The county conducted two separate community conversations with young people at the Juvenile Hall facility to understand their unique needs. In addition, county staff conducted a Community Conversation with Transition Age Youth (TAY), many of whom had been formerly in custody or in the Foster Care system. At the time, of the Community Conversation they were all on Probation. The latter group is supported by a community-based organization that specifically serves youth who are justice involved, the county then conducted a Stakeholder-specific session with this provider (FLY) to elicit their perspective about unmet needs, quality and access to services. Lastly, the county reviewed existing data from the electronic health record system and reports made available through Probation. Both youth and providers, expressed to increase awareness about BH services that ease access to services and reduce incarceration. TAY youth expressed the need for more system navigation support during high school and before graduation considered by them a pivotal moment in their lives.

    b. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+):
    In alignment with our Community Engagement Planning process, two groups were actively engaged in our input efforts. The Rainbow Center and ScoutQ were extremely outspoken about the specific needs of the LGTBQ+ community. Social isolation, current environment/fear, need for BH support and housing were clearly at the top of their priorities.

    c. In the child welfare system:
    The County conducted focus groups with the AB 2083 Interagency Leadership Committee and the Comprehensive Prevention Plan (CPP) workgroup to understand the unique needs of Child Welfare Involved youth. Furthermore, Contra Costa regularly reviews data about youth entering foster care, placement types, and related data points shared by Child Welfare.

10. What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's FSP (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

    a. Older adults:

    As part of the community planning process, behavioral health leadership presented BHSA FSP informative materials to community be stakeholders specific to this population and engaged in discussion designed to obtain feedback and better understand barriers and needs specific to this population for consideration in the planning process. Leadership staff overseeing services for the older adult population played an instrumental role in the planning process for BHSA FSP programs to assure feedback specific to the needs of the older adult population are incorporated. FSP ICM teams located within the older adult program have a staffing pattern to meet the needs of this population including geropsychiatrists and a lower staff to client ratio. Both prescribing and non-prescribing staff can meet clients in their community. Additionally, team make up includes dedicated staff assisting members in addressing barriers to appointments including primary care needs.

    b. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+):

    As part of the community planning process, CCBH received feedback from LGBTQIA+ community members and allies. Adult FSP programs will continue to require training focusing on service provision to the LGBTQ+ community. All staff including FSP staff are required to complete evidence-based cultural competency training regarding providing trans-inclusive healthcare. CCBH plans to ensure staff are aware of LGBTQ+ resources in the community and how to connect members. The teams will incorporate staff with lived experience and ongoing education about identified resources that are welcoming of the LGBTQ+ community. The staff will also focus on efforts to increase the resources available.

    c. In, or are at risk of being in, the justice system:

    BHS currently operates an AOT program using the ACT model. Based on successful outcomes, we estimated the need for a FACT team. We also analyzed data from our CARE program launched in December 2024 and used six months of outcomes to further inform planning. Our experience with AOT ACT supported the development of a coordinated FACT team serving both civil court programs.

    Additional input came from existing programs with probation, Mental Health Diversion court, and the CalAIM JI initiative. Using data from these efforts, we proposed a FACT team to engage individuals involved in or at risk of justice system involvement. Community outreach included conversations with law enforcement BH liaisons, probation teams, youth on probation, and individuals

currently in custody. These groups provided valuable insights that inform planning, training, and implementation of FACT/ACT services.

In partnership with Forensic Mental Health Services, CCBH will establish a dedicated FACT team and forensic FSP ICM team. All regional ACT teams will also be structured to deliver FACT services. FMH's ACT team includes staff with lived experience, and this model will be expanded to all FACT-capable teams.

The county held stakeholder sessions with unsheltered and incarcerated individuals, and professionals supporting them. Housing and housing-related services, including transportation, ranked as top needs. Law enforcement emphasized the importance of a specialized BH team to coordinate client care, reduce fragmentation, and support continuity, especially after events like hospitalizations or incarcerations. Others highlighted that lack of family connections and employment post-release were major stressors contributing to recidivism.

Assertive Field-Based Substance Use Disorder (SUD) Questions

1. Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

   MAT and Co-occurring (COD) Capable. FACT and ACT Teams. To ensure greater effectiveness and broader reach to highly vulnerable populations, whether those are justice involved or unhoused, the county proposes to comprise all ACT or FACT Teams be COD and MAT capable in 2-phases. During the first phase the goal will be to all of the FSPs by integrated teams with capacity to serve clients with COD under the notion that co-occurring conditions are an expectation and not an exception. Training to increase understanding of Medication Assisted Treatment (MAT) will start in phase 1 to include Naloxone training, understanding of addiction, crisis intervention and harm reduction approaches to engage individuals not ready for treatment through Motivational Interviewing. Regardless, in phase 1 all teams will carry Naloxone and fentanyl strips. The second phase will ensure that all medical providers in the FSP team are MAT prescribers who can initiate someone on all FDA approved medications for SUD including Medications for Opioid Use Disorders (MOUD). Contra Costa proposes to include recovery coaches who will hold hands of clients to continue their F/Us MAT appointments. Recovery Residences or low barrier

housing will be included, to support stabilization and adherence to treatment. While in housing, staff will address all social determinants of health through DMC care management.

Table 25. Existing Programs for Assertive Field-Based SUD Treatment Services

Requirement	Existing Program	Program Description	Current Funding Source	BHSA Changes to Existing Program(s) to Meet BHSA Requirements	Expected Timeline of Operation
Targeted Outreach	**Opioid Response Team (ORT) Outreach at Syringe Services Programs Perinatal Outreach Homeless Shelters & Encampments**	**Distribution of Naloxone /Fentanyl Strips Early engagement to MAT Follow Up to first MAT appointment**	**Opioid Settlement Funds**	**n/a**	**Available now, not a part of a FACT/ACT**
Mobile Field-Based Program(s)	**ORT, Perinatal Outreach Services in Jails and Courts AB-109 Mobile BH-treatment on demand (TOD) Clinic**	**Specific outreach to clients with OUD and who are Pregnant and using drugs**	**OSF SUBG Perinatal AB109 DMC-FFP**	**n/a**	**The services are available now**
Open-Access Clinic(s)		**n/a**	**n/a**	**n/a**	**n/a**

Table 26. New Programs for Assertive Field-Based SUD Treatment Services

Requirement	New Program(s)	Program Description(s)	Planned Funding	Planned Operations	Expected Timeline of implementation
Targeted Outreach	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**

Requirement	New Program(s)	Program Description(s)	Planned Funding	Planned Operations	Expected Timeline of implementation
Mobile Field-Based Program(s)	**AB-109 Treatment on Demand (TOD) mobile clinic**	**COD and MAT capable, comprised by a Behavioral Health team that will be able to initiate justice involved clients on MAT and link to a wide-variety of BH services, including scheduling to appointments post-release**	**Initially, AB109, then OSF and DMC**	**In the field, outside the jail in West County and at the Reentry Clinic**	**July 1, 2026**
Open-Access Clinic(s)	**There are 5 new residential program certified by DHCS under the Bridge program for MAT access that cover the central and eastern part of the county. All 5 programs will have open access to MAT for clients administer in**	**All 5 programs are MAT certified by DHCS and still undergoing development. MAT services will be accessible to anyone open to outpatient and residential SUD services. Following on the success of Bridge's low-threshold emergency department (ED) buprenorphine treatment, the 5 programs are considered an expansion of MAT services throughout the County. We currently have 3 methadone/Bupe clinic per region which provide treatment on**	**The 5 new clinics are expected to be funded by Bridge funding through State General Funds and State Opioid Response Program. The Oak Grove center will be funded under Measure X.**	**All 5 Bridge funded programs are expected to go live in the Fall of 2026. New added programs will be expected to go in operations on July 1 2027**	**There are currently: 3 licensed Methadone/ Buprenorphine licensed clinics, one in each main region of the county 7 FQHCs, the county has 7 buprenorphine clinics, which also provide same day appointments, the clinics are part of our Choosing Change program operated by hospitals and clinics**

	residential treatment. The County will release an RFP to replicate the Bridge model for a residential program in West County and 3 outpatient programs, in addition to a Sobering Center in East County which will include a Youth MAT open access clinic for youth. Oak Grove Center in Concord area (Central Contra Costa)	demand, with same day appointments. In addition, under FQHCs, the county has 7 buprenorphine clinics, which also provide same day appointments, the clinics are part of our Choosing Change program operated by hospitals and clinics. Referrals all come through the Behavioral Health Access Line. The Choosing Change program is also established at the 3 jails in the county, with a large number of MAT prescribers. With implementation of CalAIMJI, the Choosing Change program will cover FDA approved medications for SUD as required by CalAIMJI. The Oak Grove center combines a wide range of BH disciplines to support the needs of Medi-Cal		The Oak Grove Center is expected to operate 5	1 Health Care for the Homeless under Public Health MAT low barrier clinic 5 Bridge-funded residential treatment facilities – Fall, 2026 RFPs released on July 1, 2026 1 New West County residential facility and 3 outpatient (regional) – July 1, 2027 1 Open Access MAT-capable Sobering Center and 1 MAT Outpatient Youth on July 1, 2028 The Oak Grove Program is

		beneficiaries. The Oak Grove Center will provide same day appointments, crisis support, MAT access, coordination of care, and BH system navigation. Staffing includes prescribers, Psychiatrists, nurses, peer counselors, mental health clinicians, substance abuse counselors, etc.		**days a week and incrementally add weekend appointments, leading into some evening hours once the demand is established. The expected operation is: same day appointments, crisis support, drop-ins and MAT access as well as substance use support. Clients will receive immediate care with the goal of reestablishing care at the local MH provider or SUD program. The program will provide access to MAT for all SUD FDA-approved medications.**	**expected to launch July 1, 2026**

Medications for Addiction Treatment (MAT) Details

1. Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs.

The county has analyzed the number of clients in the jail who are on MAT on any given day as well as the number of unhoused clients who are on MAT. In addition, the county collects monthly reports of clients in MH clinics who are on MAT. The county has compared those numbers against the number of people receiving MAT treatment in the community and compared with those who are eligible but not receiving treatment. The county has pulled the number of clients who only showed to their first appointment with multiple missed appointments. The majority of such clients are unhoused, lack transportation and phones, with multiple admissions to the jail and hospital. The county will target those who are Missing in Treatment (MITs) defined as: 1) Just released from jail, disengaged from treatment but frequently visiting Syringe Exchange Services, multiple (more than 2) admissions to the hospital and overdoses, unhoused and 3) Tri-morbidity

2. Select the following practices the county will implement to ensure same day access to MAT

   ☑ Contract directly with MAT providers in the county

   ☐ Operate MAT clinics directly

   ☑ Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal

   ☑ Leverage telehealth model(s)

   a. Partner with neighboring counties: **No**
      i. Please provide the names of the neighboring counties [narrative box]

   b. Contract with MAT providers in other counties:
   Yes
      i. Please provide the names of neighboring counties:

      We have contracted with Berkeley Addiction Treatment Services (BATS) and Horizons in Alameda County.

   c. Other strategy:

   As an integrated Health System, the County already collaborates with Choosing Change, a MAT provider under all FQHCs operated by County Health Services. We do not have referral agreements; there are workflows already in place in Epic (EHR) to ensure referrals to MAT from the point of contact. While we have contracts in place with several MAT and NTP providers, the strategy works extremely well for those motivated to receive MAT treatment. Contra Costa's approach will aggressively target the MITs. Lastly, we have secured a contract for two consecutive years with Recover, this is a telehealth provider with an ability to prescribe on demand.

d. **Housing Interventions Recovery Residences as well as low barrier housing have been secured already for individuals who may still not be ready for abstinence, should be compliant with medications (all), with a history of overdoses/suicides. This intervention is not just to house people, Behavioral Health will provide recovery coaches to support people seeking recovery and help from SUD/OUD. Housing Interventions are critical in the process of stabilization for MAT, secure independence, improve other health care needs, increase self-worth and self-reliance, as well as reinforce accountability and restore human dignity.**

3. What forms of MAT will the county provide utilizing the strategies selected above?

☑ Buprenorphine

☑ Methadone

☑ Naltrexone

☐ Other

Planning

System Gaps

1. Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question.
    a. Supportive housing: **Medium gap**
    b. Apartments, including master-leased apartments: **Medium gap**
    c. Single and multi-family homes: **Small gap**
    d. Housing in mobile home communities: **Large gap**
    e. (Permanent) Single room occupancy units: **Medium gap**
    f. (Interim) Single room occupancy units: **Medium gap**
    g. Accessory dwelling units, including junior accessory dwelling units: **Small gap**
    h. (Permanent) Tiny homes: **Medium gap**
    i. Shared housing: **No gap**
    j. (Permanent) Recovery/sober living housing, including recovery-oriented housing: **Medium gap**
    k. (Interim) Recovery/sober living housing, including recovery-oriented housing: **Small gap**
    l. Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care): **No gap**

m. License-exempt room and board: **Small gap**
n. Hotel and Motel stay: **Small gap**
o. Non-congregate interim housing models: **Medium gap**
Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings): **Medium gap**
p. Recuperative Care: **Medium gap**
q. Short-Term post-hospitalization housing: **Large gap**
r. (Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units: **Large gap**
s. Peer Respite: **N/A**
t. Permanent rental subsidies: **Large gap**
u. Housing supportive services: **Small gap**

2. What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals?

- **CCCBHS funding sources**
  - **Behavioral Health Continuum Infrastructure Program (BHCIP) grant**
  - **Community Care Expansion (CCE) Grant**
- **Contra Costa Health Plan (our Managed Care Plan)**
- **Health, Housing, and Homeless Services (H3)**
- **Contra Costa Continuum of Care (CoC), funded by Housing and Urban Development (HUD)**
- **Homeless Management Information System (HMIS)**
- **Housing Authority of the County of Contra Costa (HACCC)**
- **Contra Costa County Department of Conservation and Development (DCD) including their "Affordable Housing" developments**
- **Contra Costa County Employment and Human Services Department (EHSD) including Children & Family Services (CFS)**
- **Contra Costa County Probation Department including Office of Reentry and Justice (ORJ)**
- **Local cities including the cities of Richmond, Antioch, San Pablo which have secured Encampment Resolution Funding (ERF) grants**
- **Non-Profit Developers**
- **CBO partners**
- **California Department of Housing and Community Development (HCD)**
- **Department of Veteran Affairs (VA)**

3. How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?

BHCIP Grant: Seek additional funding to enhance crisis residential services during crisis without affecting participants' return to stable living situations.

CCE Preservation Grant: Encourage licensed adult and senior care homes serving SSI/SSP or CAPI recipients to apply for operating subsidies and capital funding.

CCHP, H3, CoC: Collaborate on referrals, data sharing, and streamlining access to Community Supports while leveraging funding opportunities.

HMIS: Use our EHR to track eligibility, services, program impact, and gaps, enabling data-driven decisions across providers.

HACCC: Through CoC, identify disability unit referrals and supportive services. Strengthen partnerships for capital development and rental subsidy programs.

DCD: As a CoC Council member, will align BHSA funds with affordable housing loans, grants, and development initiatives.

EHSD: Supports programs via H3 and CoC including APS HomeSafe, CFS, and CalWORKS housing. Families/children can access BHSA housing; funds will enhance existing services.

ORJ: May serve as a referral source.

ERF Grantees: Potential partners to extend program reach or transition individuals into long-term BHSA-supported programs.

Nonprofit Developers: Vital to affordable housing creation. We will allocate funds for subsidies, services, and rent assistance to increase BHSA-eligible unit access.

CBO Partners: CBOs (e.g., Hope Solutions, Shelter Inc.) provide master leases and services. We will contract with CBOs to expand service access.

HCD: Will engage in programs like Homekey and No Place Like Home to fund and develop supportive housing.

VA: For BHSA-eligible veterans in VA housing, BHSA may provide behavioral health support.

4. What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?

We employ a comprehensive strategy to promote permanent housing placement and retention for individuals receiving Behavioral Health Services Act (BHSA) interventions, focusing on those with serious mental illness, substance use disorders, or co-occurring conditions—particularly those experiencing or at risk of homelessness. This approach integrates recovery-oriented, person-centered care, cross-system collaboration, and

evidence-based practices in resource development and management to ensure long-term housing stability.

Integrated Services: CCBHS funds—and aims to enhance—a robust Housing Support Services Team delivering on-site mental health, substance use, and housing support services. The team provides linkage to clinic-based and Full-Service Partnership (FSP) services, as needed, to prevent housing loss and help individuals find and keep housing.

Cross-System Collaboration: Partnerships with the Contra Costa County Continuum of Care, H3, CBOs, and housing/development partners are essential to building a full continuum of housing resources tailored to individual needs. Coordination with managed care plans will help leverage Community Supports and transitional rental assistance.

Resource Development and Management: CCBHS views permanent housing as a goal for every participant. Our strategy is to meet clients where they are with appropriate services. This includes culturally responsive, dual-diagnosis capable interim housing to support exits from homelessness, longer recovery residence stays, adequate adult residential facility access, and the use of BHCIP funds to expand adult residential treatment options. We also provide rental subsidies and develop dedicated permanent supportive housing (PSH) units using BHSA-funded landlord mitigation, operating subsidies, and field-based supportive services.

5. What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?

   Contra Costa County Behavioral Health Services (CCBHS) is implementing several initiatives to connect individuals with Behavioral Health needs to permanent supportive housing (PSH), ensuring stability through rental subsidies, operating subsidies, supportive services, and capital development.

   Rental Subsidies: CCBHS provides rental subsidies via two master lease programs and Behavioral Health Bridge Housing, which the County will continue as a Housing Intervention after sunset. CCBHS may offer subsidies in existing affordable and/or supported housing developments to expand access.

   Operating Subsidies: CCBHS participated in the 2007 MHSA Housing Program, which provided capitalized operating subsidies for PSH targeting individuals with serious mental illness experiencing homelessness. This model continues to yield dedicated PSH units. Under BHSA, CCBHS plans to partner with community and development organizations to create operating subsidies in affordable housing, expanding PSH for those with serious behavioral health conditions.

Supportive Services: Supportive services are central to CCBHS' strategy for long-term housing stability. CCBHS continues to develop high-quality field- and development-based supportive service teams. Through successful partnerships under the No Place Like Home program, CCBHS has delivered development-based services. Supportive services offset operating costs in PSH projects and may be paired with rental or operating subsidies.

Capital Development: A portion of BHSA funds will be allocated to create permanent housing for individuals with serious behavioral health conditions who are chronically homeless. Expanding this housing stock is critical to addressing chronic homelessness.

Coordination: CCBHS collaborates with the Contra Costa Continuum of Care (administered by H3), the Housing Authority, Department of Conservation and Development, and parole. Oversight is provided by a County steering committee with leadership from all partners.

6. Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services.

BHS has a comprehensive strategy to integrate clinical and supportive behavioral health care with housing services, ensuring stability for individuals with mental health and SUD needs.

Supportive Services: BHS embeds mental health and SUD services in housing support teams and programs through care management and clinical support. Housing Support teams may provide tenancy support, health and safety visits, referrals to financial counseling, and landlord dispute resolution, prioritizing those with serious mental illness or chronic conditions. BHS integrates case management, peer support, and community workers into housing programs to assist with care coordination and recovery plans that integrate Taking Action for Whole Health and Wellbeing, formerly Wellness Recovery Action Plan (WRAP). Partnerships with organizations like NAMI Contra Costa offer peer-driven support and culturally responsive services for diverse populations.

Clinical Behavioral Health Access: Housing support staff are able to create direct linkage to the County operated regional mental health clinics and contracted CBO's offering outpatient services like psychiatric assessments, medication management, therapy, and crisis intervention. A 24/7 Access Line connects residents to care and referrals. Specialized programs like First Hope, for youth with early psychosis, and Assisted Outpatient Treatment (AOT) provide tailored clinical support, including 24-hour responses.

Crisis Intervention: The Measure X-funded Anyone, Anywhere, Anytime (A3) program provides 24/7 mobile crisis response to prevent housing loss. Diversion programs with law enforcement support individuals transitioning from incarceration with housing and behavioral health care.

Accessibility and Equity: BHS accepts Medi-Cal/Medicare and offers low-cost services. The Access Line and community partners provide language interpretation and culturally competent care, including BIPOC-focused programs.

Eligible Populations

1. Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions.

   Contra Costa County Behavioral Health will continue to use a structured approach to ensure those who are eligible for BHSA Housing Interventions are identified, screened, and referred. The process focuses on collaboration, equity, and timely access to supportive housing resources for individuals with serious behavioral health needs

   Identification: Eligible individuals will be identified through the following access points in our system of care.

   - **Inpatient psychiatric hospitals, outpatient mental health clinics, mobile crisis response teams, 24/7 Access Line, community-based organizations, detention facilities, homeless outreach teams, and coordinated entry systems**

   Screening: Referrals are screened and prioritized based on an individual's vulnerability.

   - **Assessment of behavioral health diagnosis and their presence of impairment**
   - **Homeless status: What is their situation? On the street, car, shelter, etc.**
   - **Screening tools: CCBH will use a screen using a needs assessment tool.**

   Referral: Individuals who are qualified will be referred to BHSA housing interventions using a coordinated process where referrals are tracked in our ccLink/Epic EHR to ensure compliance with BHSA housing supports requirements and prevent duplication of services. Referral pathways use a "no wrong door" approach and can include:

   - **Referrals from multiple identified access points to BHSA housing supports through**
     - **ccLink/Epic EHR**
     - **Email referral forms directly to BHSA housing provider**
     - **Coordinated Entry**
     - **Direct Phone Contact**
     - **Weekly care coordination meeting**

2. Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only?

   Yes

   a. Please indicate why the county behavioral health system will not provide BHSA funded Housing Interventions to individuals living with a SUD only and include data to support.

      ☐ Insufficient need

      ☐ Insufficient resources

☐ Other

b. Please explain why there is insufficient need to provide BHSA-funded Housing Interventions living with a SUD only.

c. Please explain why there are insufficient resources to provide BHSA-funded Housing Interventions to individuals living with an SUD only.

d. Other than insufficient need or insufficient resources, please explain why the county is not providing BHSA-funded Housing Interventions to individuals living with a SUD only.

3. What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's Housing Interventions services who are:

a. In, or at risk of being in, the juvenile justice system

Across 62 community engagement English and Spanish bilingual events—including town halls, community conversations, and key informant interviews at various times and locations—and English and Spanish surveys totaling 660 responses, county BHS gathered input on strengths, needs, and priorities from individuals representing 29 of the 30 DHCS-required stakeholder groups (excluding Disability Insurers, pending state clarification).

Specifically, meetings were held at Juvenile Hall with Transition Age Youth (TAY), at County Probation, and with the REACH Project to solicit feedback from youth in the juvenile justice system. Various other meetings specifically engaged children, youth, and families.

Community-identified strengths included crisis-response and peer-led programs, culturally respectful providers, and individualized treatment plans. Needs included broader outreach across channels, deeper engagement with trusted community messengers (e.g., pastors), and tailored approaches for groups such as transition-age youth, older adults, justice-involved individuals, veterans, LGTBQ and culturally diverse communities. Challenges included systemic and navigational barriers, cultural and linguistic gaps, lack of supportive housing, duplication of services by multiple providers, transportation issues and stigma around behavioral health.

b. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)

Across 62 community engagement English and Spanish bilingual events—including town halls, community conversations, and key informant interviews at various times and locations—and English and Spanish surveys totaling 660 responses, county BHS gathered input on strengths, needs, and priorities from individuals representing 29 of

the 30 DHCS-required stakeholder groups (excluding Disability Insurers, pending state clarification).

Specifically, we held an English and Spanish meeting that focused on LGBTQ+ social inclusion and were facilitated by our Service Provider Individualized Recovery Intensive Training (SPIRIT) program team to solicit feedback from LGBTQ+ community members including youth.

Community-identified strengths included crisis-response and peer-led programs, culturally respectful providers, and individualized treatment plans. Needs included broader outreach across channels, deeper engagement with trusted community messengers (e.g., pastors), and tailored approaches for groups such as transition-age youth, older adults, justice-involved individuals, veterans, LGTBQ and culturally diverse communities. Challenges included systemic and navigational barriers, cultural and linguistic gaps, lack of supportive housing, duplication of services by multiple providers, transportation issues and stigma around behavioral health.

c. In the child welfare system:

Across 62 community engagement English and Spanish bilingual events—including town halls, community conversations, and key informant interviews at various times and locations—and English and Spanish surveys totaling 660 responses, county BHS gathered input on strengths, needs, and priorities from individuals representing 29 of the 30 DHCS-required stakeholder groups (excluding Disability Insurers, pending state clarification).

Specifically, we held various English and Spanish meeting that engaged children, youth, families, and schools. We also held one English and Spanish meeting with Childhood Prevention and Intervention providers and stakeholder to solicit their feedback.

Community-identified strengths included crisis-response and peer-led programs, culturally respectful providers, and individualized treatment plans. Needs included broader outreach across channels, deeper engagement with trusted community messengers (e.g., pastors), and tailored approaches for groups such as transition-age youth, older adults, justice-involved individuals, veterans, LGTBQ and culturally diverse communities. Challenges included systemic and navigational barriers, cultural and linguistic gaps, lack of supportive housing, duplication of services by multiple providers, transportation issues and stigma around behavioral health.

4. What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services who are:

a. Older adults:

Across 62 community engagement English and Spanish bilingual events—including town halls, community conversations, and key informant interviews at various times and locations—and English and Spanish surveys totaling 660 responses, county BHS gathered input on strengths, needs, and priorities from individuals representing 29 of the 30 DHCS-required stakeholder groups (excluding Disability Insurers, pending state clarification).

Specifically, meetings were held throughout the County at shelters, health centers, the Elder Wellness and Advocacy Coalition, and with Board and Care Operators. Through these meetings, we engaged with older adults as well as individuals who care for and advocate for older adults.

Community-identified strengths included crisis-response and peer-led programs, culturally respectful providers, and individualized treatment plans. Needs included broader outreach across channels, deeper engagement with trusted community messengers (e.g., pastors), and tailored approaches for groups such as transition-age youth, older adults, justice-involved individuals, veterans, LGTBQ and culturally diverse communities. Challenges included systemic and navigational barriers, cultural and linguistic gaps, lack of supportive housing, duplication of services by multiple providers, transportation issues and stigma around behavioral health.

b. In, or are at risk of being in, the justice system:

Across 62 community engagement English and Spanish bilingual events—including town halls, community conversations, and key informant interviews at various times and locations—and English and Spanish surveys totaling 660 responses, county BHS gathered input on strengths, needs, and priorities from individuals representing 29 of the 30 DHCS-required stakeholder groups (excluding Disability Insurers, pending state clarification).

Specifically, English and Spanish meetings were held throughout the County at shelters, health facilities, recovery residences, and Alcoholics Anonymous meetings to engage with and solicit feedback from individuals who are in, or at risk of being in, the justice system. We also engaged with and solicited feedback from advocates and administrators who work with individuals in, or at risk of being in, the justice system. Surveys were also conducted with individuals detained in the County jail.

Community-identified strengths included crisis-response and peer-led programs, culturally respectful providers, and individualized treatment plans. Needs included broader outreach across channels, deeper engagement with trusted community messengers (e.g., pastors), and tailored approaches for groups such as transition-age youth, older adults, justice-involved individuals, veterans, LGTBQ and culturally diverse communities. Challenges included systemic and navigational barriers, cultural

and linguistic gaps, lack of supportive housing, duplication of services by multiple providers, transportation issues and stigma around behavioral health.

c. In underserved communities:

Across 62 community engagement English and Spanish bilingual events—including town halls, community conversations, and key informant interviews at various times and locations—and English and Spanish surveys totaling 660 responses, county BHS gathered input on strengths, needs, and priorities from individuals representing 29 of the 30 DHCS-required stakeholder groups (excluding Disability Insurers, pending state clarification).

Specifically, meetings were held with Scotts Valley Band of Pomo Indians Tribal staff and participants from the Tribal Temporary Assistance for Needy Families (TANF) program. The meetings were facilitated by our Service Provider Individualized Recovery Intensive Training (SPIRIT) program team with the goal of generating feedback regarding their social inclusion. Several meetings were held in English and Spanish to ensure engagement and feedback.

Community-identified strengths included crisis-response and peer-led programs, culturally respectful providers, and individualized treatment plans. Needs included broader outreach across channels, deeper engagement with trusted community messengers (e.g., pastors), and tailored approaches for groups such as transition-age youth, older adults, justice-involved individuals, veterans, LGTBQ and culturally diverse communities. Challenges included systemic and navigational barriers, cultural and linguistic gaps, lack of supportive housing, duplication of services by multiple providers, transportation issues and stigma around behavioral health.

Local Housing System Engagement

11. How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?

CCBHS collaborates with the CoC in a variety of ways. The most important aspect is the bi-directional case conferencing over the by name list for housing targeted for those living with serious behavioral health conditions. In addition, there are monthly coordination meetings between leaderships of both organizations. Going forward both entities will coordinate over the provision and management of community support referrals and transitional rent. CCBH is currently participating in the redesign of the prioritization tool redesign.

12. Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

a. Local CoC:

There is a Behavioral Health dedicated seat on the CoC board. There is a coordinated focus group for integration plans.

b. Public Housing Agency:

Maintains a seat on the CoC board. Frequent connection over new site-based vouchers and new project development.

c. MCPs:

We have two MOUs with two MCPs: Kaiser Permanente and Contra Costa Health Plan (CCHP). Moreover, we have an integrated health system where CCHP acts as our primary MCP. Behavioral Health is a contracted ECM provider with MCP CCHP. This includes monthly provider meetings and quarterly joint operations meetings with the MCP to ensure that ECM is being provided in accordance with the MCP and DHCS requirements.

d. ECM and Community Supports Providers:

Behavioral Health ECM has established relationships with other ECM providers that provide services to other Populations of Focus (POF) and has established relationships with the various Community Supports providers with emphasis on the Community Supports that are utilized the most by the population being served. CCBH leadership has a monthly meeting with the ECM providers.

e. Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)

The CoC partners with Contra Costa Employment and Human Services Department administer CalWORKS housing programs including the Bringing Families Home program from Children and Family Services, HousingWORKS, and HomeSafe with Adult Protective Services.

i. Please define:

CCBHS may access these programs through Coordinated Entry and in partnership with the CoC. When appropriate CCBHS can provide critical housing interventions to prevent family separation due to homelessness and support reunification efforts in partnership with EHSD, H3, and CBO providers.

13. How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?

Our County applied for a small Homekey+ project as a portion of a campus. In addition, the County partnered with the City of Antioch in another application agreeing to provide on-site supportive services if awarded.

14. Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?

    No

    a. How will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community? **N/A**

BHSA Housing Interventions Implementation

Rental Subsidies (Chapter 7. Section C.9.1)

1. Is the county providing this intervention?
   Yes
   a. Please explain why the county is not providing this intervention. **N/A**
2. Is the county providing this intervention to chronically homeless individuals?
   Yes
3. How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
   Approximately 185 individuals – Shelter Inc., Hope Solutions, BHBH
   Approximately 800 individuals in recovery housing with an average length of stay of 3 months.
   a. How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
      Approximately 185 individuals

   b. How many of these individuals will receive rental subsidies for interim housing on an annual basis?
      Approximately 40 individuals currently, which is the approximate target moving forward.
4. What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?

   CCBHS's methodology includes:

   - **Program Data Tracking**
   - **Funding Allocation**
   - **Partnership Coordination**
   - **Annual Reporting**

For Individuals Served in Interim and Permanent Settings:

- **Service Tracking Systems**:

  BHS tracks individuals through case management and service coordination systems. For example, BHS's Full-Service Partnerships (FSP) provide intensive support with detailed client tracking.

- **Facility and Program Data**:

Related to capacity.

- **Crisis and Outpatient Services**:

  The A3 Miles Hall Crisis Call Center and mobile response teams track individuals served during behavioral health crises, many of whom are connected to interim or permanent housing.

- **Community Partner Data**:
  CBOs that CCBHS partners with to support mental health consumers within the county MH system.
- **MHSA Metrics**:
  The MHSA framework emphasizes outcomes for underserved populations, including those in housing programs. BHS's annual reports under MHSA likely include counts of individuals served in housing-related services, based on program enrollment and service delivery data.
- **Planning:**
  Available funding drives the number of individuals that we can serve in recovery residences. Annual gap analysis is based on data collected from prior years, provider's Annual Reports that capture the number of residents they served and demographics, and trends in the community that further identify special populations like women/perinatal, individuals with an opioid use disorder, etc. Client's identified needs are measured through surveys, providers reports, focus groups, etc. We engage in ongoing fiscal analysis, forecasting, and budget management. We incorporate DMC-ODS's annual evaluation of the recovery residences service delivery network, which includes several metrics such as length of stay, grievances, dismissals, clients who gained employment, achievement of permanent housing and financial stability, and reunification with family. Lastly, we look at utilization reports and fiscal reconciliation reports.

5. For which setting types will the county provide rental subsidies?

Non-Time-Limited Permanent Settings:

☑ Supportive housing

☑ Apartments, including master-leased apartments

☑ Single and multi-family homes

☑ Single room occupancy units

☑ Shared housing

☑ Recovery/Sober Living housing, including recovery-oriented housing

☑ Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)

☑ **License-exempt room and board**

☑ **Other settings identified under the Transitional Rent benefit**

Time Limited Interim Settings:

☑ **Hotel and motel stay**

☑ **Non-congregate interim housing models**

☑ **Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) (does not include behavioral health residential treatment settings)**

☐ Short-Term Post-Hospitalization housing

☑ **Peer respite**

5. Will this Housing Intervention accommodate family housing?
   Yes

6. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.

   We leverage funding from the Behavioral Health Services Act (BHSA), passed as Proposition 1 in March 2024, to support housing interventions for individuals and families with significant mental health and substance use disorder (SUD) needs. Specific uses of BHSA Housing Interventions funding in Contra Costa County include:

   - **Rental Subsidies: Providing financial assistance to cover rent for eligible families, helping them secure stable housing.**
   - **Operating Subsidies: Supporting operational costs for housing facilities to ensure sustainability of housing programs.**
   - **Shared Housing: Funding programs that facilitate shared living arrangements for families and individuals to reduce housing costs and promote stability.**
   - **Family Housing for Eligible Children and Youth: Allocating funds to provide housing solutions tailored for families with children and youth who have behavioral health needs.**
   - **Non-Federal Share of Transitional Rent: Covering transitional rent costs not funded by federal programs to bridge gaps during housing transitions.**

   Additionally, Contra Costa Health secured significant funding from the Behavioral Health Continuum Infrastructure Program (BHCIP) in the effort to integrate housing with behavioral health services to better support families and individuals. Master lease housing supports adult head-of-household with minor children. Children may be the qualifying party.

7. Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?

   ☑ Project-based

   ☑ Tenant-based

8. How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in.

To identify a portfolio of available units the County will continue to partner with local housing service providers to maintain existing master lease contracts and seek partners with affordable housing developers, Contra Costa County Housing Authority, local jurisdictions as well as by using internally funded housing navigators to maintain and identify new unit's resources. The County intends to continue funding landlord outreach and mitigation resources currently being used under the Behavioral Health Bridge Housing program. In partnering with developers and the housing authority the County will seek to leverage operating subsidies, rental subsidies and onsite service provision to make partnership more attractive and develop additional access opportunities for BHSA eligible individuals. In addition, the County is developing workflows and coordination around community support and rent with H3, a sister agency in Contra Costa Health, who has been designated as the primary provider of community support benefits and is also the administrator for the Continuum of Care to ensure maximum access BHSA eligible clients to all the County's portfolio of interim and supported units.

9. Total number of units funded with BHSA Housing Interventions per year:
   855

10. (Optional question) Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units.

Operating Subsidies (Chapter 7, Section C.9.2)

1. Is the county providing this intervention?
   Yes
   a. Please explain why the county is not providing this intervention. **N/A**
2. Is the county providing this intervention to chronically homeless individuals?
   Yes

3. Anticipated number of individuals served per year:
   100
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.

The County intends to budget for operating subsidies to develop additional resources for individuals experiencing chronic homelessness with serious behavioral health conditions. The County is preparing to fund a small Homekey+ project with these subsidies. While no specific projects have been identified at this time, operating subsidy funds will be made available through a Request for Proposal (RFP) process that will be advertised as a continuous solicitation until budget limits are reached. This strategy is intended to open the funding opportunity to the community and supporting the braiding of funds with other State funding opportunities—such as Encampment Resolution Funding (ERF) grants—as well as with private and/or non-profit developers who dedicate units for the target population.

5. For which setting types will the county provide operating subsidies?

Non-Time-Limited Permanent Settings:

☑ Supportive housing

☑ Apartments, including master-leased apartments

☑ Single and multi-family homes

☐ Housing in mobile home communities

☑ Single room occupancy units

☐ Accessory dwelling units, including Junior Accessory Dwelling units

☑ Tiny Homes

☑ Shared housing

☑ Recovery/Sober Living housing, including recovery-oriented housing

☑ Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)

☐ License-exempt room and board

☐ Other settings identified under the Transitional Rent benefit

Time Limited Interim Settings:

☑Non-congregate interim housing models

☑ Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) (does not include behavioral health residential treatment settings)

☐ Recuperative Care

☐ Short-Term Post Hospitalization Housing

☑ Tiny homes, emergency sleeping cabins, emergency stabilization units

☐ Peer Respite

☐ Other settings identified under the Transitional Rent benefit

6. Will this be a scattered site initiative?
   Yes
7. Will this Housing Intervention accommodate family housing?
   Yes
8. Total number of units funded with BHSA Housing Interventions per year.

   50
9. [Optional question] Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units.

   Operating subsides total includes bundled and non-bundled units.

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

1. Is the county providing this intervention?
   Yes
   a. Please explain why the county is not providing this intervention. **N/A**
2. Is the county providing this intervention to chronically homeless individuals?
   Yes
3. Anticipated number of individuals served per year.
   25

4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.
   The County intends to fund Landlord Outreach and Mitigation to develop and maintain a portfolio of units for County referral as well as to support individuals who, through work with housing navigators, are experiencing challenges obtaining housing in the private market. This intervention will augment, not supplant, Community Support benefits.

5. Total number of units funded with BHSA Housing Interventions per year.
   50

6. [Optional question] Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units.

   Landlord outreach and mitigation funds will be determined on a case-by-case basis subject to client preference and need. Budgeted amount intended to support 50 potential units/clients.

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

1. Is the county providing this intervention?
   Yes

a. Please explain why the county is not providing this intervention. **N/A**

2. Is the county providing this intervention to chronically homeless individuals?
   Yes
3. Anticipated number of individuals served per year.
   150
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.

   Housing interventions funding for participant assistance will be used to support eligible clients to remove housing barriers and support immediate housing needs. Participant Assistance funds will be used if/when another Medi-Cal benefit is not available and may include but is not limited to:

   - **Obtaining government issued identification or other documents.**
   - **Housing application fees**
   - **Security Deposits (when not covered by community support)**
   - **Pet deposits**
   - **Utility deposits**
   - **Rent and utility arrears**
   - **Other supports necessary for successful tenancy.**

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)

1. Is the county providing this intervention?

   Yes

   a. Please explain why the county is not providing this intervention. **N/A**

2. Is the county providing this intervention to chronically homeless individuals?
   Yes

   1. Anticipated number of individuals served per year. **485**
   2. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.

      BHSA Housing Interventions provide innovative, housing-focused solutions to support mental health and stability, particularly for chronically homeless individuals. Key features:

      - **Housing First Principles: Prioritizes tenant selection without barriers like sobriety, treatment completion, or poor credit/history. Offers tenant-driven supportive services.**
      - **Comprehensive Support: Includes prevention, early intervention, treatment, and housing stabilization through PSH, recovery housing, or other state-defined supports.**

- **Non-Discrimination: Protects those using addiction treatment or authorized medications from discrimination.**

Funding Uses (non-duplicative of Medi-Cal Managed Care Plans):

- **Permanent Supportive Housing: Acquiring, developing, or operating housing with integrated mental health and support services for chronically homeless individuals.**
- **Recovery Housing: Recovery-focused housing supporting harm reduction and voluntary service participation, aligned with HUD definitions.**
- **Capital Development: Constructing or rehabilitating housing units for chronically homeless individuals meeting WIC Section 5830(a) criteria.**
- **Project-Based Assistance: Supporting master leasing or subsidies to secure housing for chronically homeless individuals.**
- **Family Housing: Providing housing for eligible children, youth, and families to promote stability and reunification.**
- **Other Housing Supports: Includes state-defined services like housing navigation, tenancy support, and move-in assistance to prevent homelessness.**
- **Housing Navigation & Tenancy Support: Offers move-in assistance, tenancy skill-building, and landlord engagement for housing stability.**
- **Non-Federal Medi-Cal Share: If federally approved, covers non-federal share of Medi-Cal-eligible housing-related services not covered by MCPs.**
- **Wraparound Services: Provides flexible, individualized supports (e.g., case management, peer support) to address mental health, substance use, or housing retention barriers.**

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

1. Is the county providing this intervention?

   No

   Please explain why the county is not providing this intervention.

   Outreach and Engagement is well supported through other parts of the Health delivery system. The County currently operates a fully functioning outreach team, known as Coordinated, Outreach, Referral and Engagement (CORE) through our Health, Housing and Homeless (H3) division. It is also anticipated that support teams such as those assigned to CARE and FSP as well as the Transition Team, that supports inpatient discharges and crisis residential referrals, will provide adequate outreach services to the BHSA eligible individual. Outreach and Engagement is well supported through other parts of the Health.

2. Is the county providing this intervention to chronically homeless individuals?

   N/A

3. Anticipated number of individuals served per year.

0

4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding.

   N/A

Capital Development Projects (Chapter 7, Section C.10)

1. Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
   Yes
   a. Please explain why the county is not providing this intervention. **N/A**
2. Is the county providing this intervention to chronically homeless individuals?
   Yes
3. How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?

   5

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions.

1. Name of Project:

   Forthcoming

2. What setting types will the capital development project include? [
   Non-Time-Limited Permanent Settings:
   - ☑ **Supportive housing**
   - ☐ Apartments, including master-leased apartments
   - ☐ Single room occupancy units
   - ☐ Shared housing
   - ☐ Recovery/Sober Living housing, including recovery-oriented housing

   Time Limited Interim Settings:
   - ☑ **Non-congregate interim housing models**
   - ☑ **Tiny homes, emergency sleeping cabins, emergency stabilization units**

3. Capacity (Anticipated number of individuals housed at a given time):

   35

4. Will this project braid funding with non-BHSA funding source(s)?

   Yes

5. Total number of units in project, inclusive of BHSA and non-BHSA funding sources:

35

6. Total number of units funded with Housing Interventions funds only:

   0

7. [Optional question] Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units.

   The County intends to budget for capital development to develop additional resources for individuals experiencing chronic homelessness with serious behavioral health conditions. While no specific projects have been identified at this time operating subsidy funds will be made available through a Request for Proposal process that will be advertised as a continuous solicitation until budget limits are reached. This strategy is intended to open funding opportunities to the community including supporting braiding of funding with other State funding opportunities or with private and/or non-profit developers who would dedicate units for the target population.

8. Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)

   07/01/2027

9. Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)

   $371,428

10. Have you utilized the "by right" provisions of state law in your project?

    No

    a. If you have not incorporated use of the "by right" provisions into your project, please explain why.

       Finalized project details are not full available at this time. Projects in planning have not explored this feature until funding is approved and available.

Other Housing Interventions (Optional)

1. If the county is providing another type of Housing Interventions not listed above, please describe the intervention. **N/A**
   a. Is the county providing this intervention to chronically homeless individuals?
   b. Anticipated number of individuals served per year

Continuation of Existing Housing Programs

1. Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
   Contra Costa County is eager to continue the investments in interim and low barrier housing, participant assistance, landlord outreach and mitigation funds, shared housing

and rental subsides developed through the Behavioral Health Bridget Housing Program. The community planning process has also highlighted the need for the maintenance of this program.

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

1. Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of? **None**

   ☐ Housing Transition Navigation Services

   ☐ Housing Deposits

   ☐ Housing Tenancy and Sustaining Services

   ☐ Short-Term Post-Hospitalization Housing

   ☐ Recuperative Care

   ☐ Day Habilitation

   ☐ Transitional Rent

2. For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of? **None**

   ☐ Housing Transition Navigation Services

   ☐ Housing Deposits

   ☐ Housing Tenancy and Sustaining Services

   ☐ Short-Term Post-Hospitalization Housing

   ☐ Recuperative Care

   ☐ Day Habilitation

   ☐ Transitional Rent

3. How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)

Our policies and procedures will describe how our County staff will:

- **Identify Medi-Cal members who could benefit from housing-related Community Supports through targeted outreach followed by clinical assessments and individualized care planning. For example, all clients who are authorized for the Behavioral Health ECM program would meet criteria for specialty mental health and/or DMC, DMC-ODS services and that will support in identifying and confirming eligibility for housing-related Community Supports covered by MCPs.**
- **Confirm eligibility in compliance with DHCS guidelines and BHSA Policy Manual program requirements**
- **Refer to Medi-Cal Managed Care Plans (MCPs) through a collaborative and streamlined process between various county departments, recognizing that**

MCPs are the entities responsible for delivering and reimbursing Community Supports. For example, there will be established protocols for referrals to H3 for Housing Deposits.

4. Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county.

   Contra Costa Health operates as an integrated health department which streamlines coordination with the primary MCP, the Contra Conta Health Plan (CCHP), Behavioral Health, H3, and contracted housing providers. H3 has been identified as the designated hub for community supports benefit referrals from County agencies. CCBHS is actively meeting with H3 to develop share training regarding accessing community supports benefits and is working jointly to develop workflows for transitional rent. H3 acts as liaison for both BH and the provider community to CCHP through their regular contract provider meetings. BH has also begun meeting with the other MCP, Kaiser, to coordinate housing interventions including community support benefits and transitional rent.

5. Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?
   No
   a. Please describe the county behavioral health system's coordination efforts to align network development. **N/A**

6. What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?

   By leveraging ECM and the expansion of the FSPs as required by BHSA, the system should be able to provide high level case/care management services to those who were unable to access MCP housing services prior to those being exhausted.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here:
Flexible Housing Subsidy Pools - Technical Assistance Resource. Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

1. Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?

   No

   a. Is the county behavioral health system participating in or planning to participate in the Flex Pool? **N/A**
      i. Please explain why the county is not participating in the Flex Pool.
   b. What role does the county behavioral health system have or plan to have in the Flex Pool? **N/A**
      ☐ Lead Entity
      ☐ Operator
      ☐ Funder
      ☐ Housing Supportive Services Provider
   c. What organization is serving as the Operator? **N/A**
   d. Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?
      i. Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?
2. [Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?

   No

   a. What role does the county behavioral health system plan to have in the Flex Pool?
      ☐ Lead Entity
      ☐ Operator
      ☐ Funder
      ☐ Housing Supportive Services Provider
   b. Have you identified an Operator of the Flex Pool? **N/A**
   c. What organization will serve as the Operator? **N/A**
   d. Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool? **N/A**
      i. Which Housing Interventions does the county plan to administer through or in coordination with a Flex Pool? **N/A**
3. Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above. **N/A**

Behavioral Health Services Fund:

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button.

1. Does the county's plan include the development of innovative programs or pilots?

Yes

Program One:

1a. What Behavioral Health Services Act (BHSA) component will fund the innovative program?

☐ Housing Interventions

☐ Full-Service Partnership

☑ **Behavioral Health Services and Supports**

1b. Please describe how the innovative program or pilot will help build the evidence base for the effectiveness of new statewide strategies.

The Psychiatric Advanced Directives (PADs) project will build the evidence based by testing a peer-driven, multi-county model for implementing standardized PAD templates and training tools to support treatment decision-making during mental health crisis. The project will evaluate the feasibility and impact of a customized, cloud-based PAD technology platform that enhances access and utilization while maintaining privacy standards outside of HIPAA constraints. Through structured evaluation and stakeholder collaboration, the project will generate data on the effectiveness of PADS in promoting client autonomy, improving crisis response coordination, and informing statewide best practices for consumer-directed care planning.

1.c. Please describe intended outcomes of the project.

- **Increased understanding and utilization of Psychiatric Advanced Directives among consumers, families, and providers.**
- **Enhanced cross-system collaboration and peer engagement in treatment planning.**
- **Development of a scalable, standardized PAD template and multilingual training toolkit.**
- **Improved crisis response outcomes and client self-determination during mental health emergencies.**
- **Generation of replicable models and best-practice guidelines to inform future statewide strategies for consumer-led care planning.**

Program Two:

1.a. What Behavioral Health Services Act (BHSA) component will fund the innovative program?

☐ Housing Interventions

☐ Full-Service Partnership

☑ **Behavioral Health Services and Supports**

1.b. Please describe how the innovative program or pilot will help build the evidence base for the effectiveness of new statewide strategies

The Community-Defined Practices (CDP) innovation project will build the evidence base by supporting and evaluating culturally rooted approaches that promote equitable access to behavioral health care for underserved and unserved communities, including AAPI, Latino/a/x, Black/African American, and LGBTQ+ populations. Through a competitive RFP process, the project funds local community organizations to design and implement practices grounded in the traditions, values, and beliefs of their communities. Evaluation activities will capture how these community-defined practices enhance engagement, trust, and wellness outside traditional systems of care. Findings will inform statewide strategies for integrating community-driven and culturally responsive models into the broader behavioral health continuum.

1.c. Please describe intended outcomes of the project

- **Increased access to culturally relevant behavioral health supports historically underserved populations.**
- **Strengthened community partnerships and trust between county behavioral health systems and diverse cultural groups.**
- **Identification and documentation of effective community-defined practices that can be replicated or adapted statewide.**
- **Greater inclusion of peers, traditional healers, and community health workers as providers of culturally grounded wellness services.**
- **Improved mental health outcomes, engagement, and wellness among targeted populations through approaches that reflect each community's values and definitions of healing.**

Program Three:

1.a. What Behavioral Health Services Act (BHSA) component will fund the innovative program?

☐ Housing Interventions

☐ Full-Service Partnership

☑ **Behavioral Health Services and Supports**

1b. Please describe how the innovative program or pilot will help build the evidence base for the effectiveness of new statewide strategies

The PIVOT Innovation Project will build the evidence base by piloting a comprehensive framework to strengthen infrastructure, coordination, and evaluation systems essential for Behavioral Health Transformation. The project will test new implementation processes for integrating community-defined practices, evidence-based interventions, and systemwide data tools such as BH-CONNECT.

Through evaluation and iterative learning, PIVOT will generate evidence on how streamlined operational supports, workforce development, and technology integration can improve service quality and equity across the behavioral health continuum. Findings will inform statewide strategies for aligning county behavioral health systems with the Behavioral Health Services Act transformation goals.

1.c. Please describe intended outcomes of the project

- **Improved infrastructure and operational capacity for implementing Behavioral Health Transformation requirements.**
- **Streamlined processes for community-defined and evidence-based practices within county systems of care.**
- **Expanded support for Full-Service Partnership (FSP) and Housing Interventions through integrated service delivery models.**
- **Enhanced workforce readiness through targeted education and training initiatives.**
- **Better data collection, monitoring, and outcome evaluation through BH-CONNECT technology integration.**
- **Strengthened coordination between county programs and statewide initiatives to ensure alignment, sustainability, and equitable access to behavioral health services.**

Workforce Strategy

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

1. Maintains and monitors a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and
2. Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.
3. The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual. Does the county intend to adopt this recommended approach for BHSA-funded providers that
   a. Also participate in the county's Medi-Cal Behavioral Health Delivery System?

Yes

i. If not, please describe how the county will ensure that BHSA-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner

b. Do not participate in the county's Medi-Cal Behavioral Health Delivery System?

Yes

i. If not, please describe how the county will ensure that BHSA-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner.

Build Workforce to Address Statewide Behavioral Health Goals

Assess Workforce Gaps

1. What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?

   16%

2. Upload any data source(s) used to determine vacancy rate [optional file upload]

3. For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates

   ☐ Advanced Emergency Medical Technicians

   ☐ Certified Nurse Specialist

   ☑ **Community Health Workers (CHW) defined in the Enhanced Community Health Workers Services benefit**

   ☐ Community Paramedics

   ☐ Emergency Medical Technicians

   ☐ Licensed Clinical Social Worker

   ☐ Licensed Marriage and Family Therapist

   ☐ Licensed Professional Clinical Counselor

   ☑ **Licensed Psychologist**

   ☐ Licensed Vocational Nurse

   ☐ Medical assistant

   ☐ Medi-Cal Certified Peer Support Specialist

   ☐ Mental Health Rehabilitation Specialist

☑ **Nurse practitioner**

☐ Occupational Therapist

☐ Pharmacist

☐ Physician

☐ Physician assistant

☐ Psychiatric Technician (PT)

☐ Psychiatrist

☐ Registered nurse

☑ **Substance Use Disorder Counselor**

☑ **Other: MH Specialist**

4. Please describe any other key workforce gaps in the county.

   The positions above reflect the classifications with the highest vacancy rate, however, that rate may not reflect the largest system needs, or classifications with the highest number of vacancies. For example, the classifications of Community Health Worker and Licensed Psychologist have under 6 vacancies each, but due to having a relatively low number of slots overall, rank as having one of the highest vacancy rates. Other key workforce gap, particularly as we build out our ACT/FACT, FSP-ICM which include Prescribers (psychiatrist or NPs) who are willing to go out into the community to provide services and medical providers who are MAT prescribers.

5. How does the county expect workforce needs to shift over the next three FYs given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

   CCBH expects the workforce needs to shift given the growth of new programming to meet the needs of the most vulnerable populations. Achieving the staffing needed will include re-allocating current staffing where applicable and possible, hiring new staff when current staffing cannot meet that capacity, and contracting services where necessary. There is a need for more supervisors dedicated to the implementation of FFT, MST, and PCIT and a HFW supervisor/fidelity coach. There is also a need for additional Spanish speaking direct service providers.

   In the adult system of care, as providers shift into roles supporting BH-CONNECT EBP's and FSP ICM, the general outpatient programs will need additional positions including direct service providers and supervisors to assure adequate support to non-FSP clients as well as assure members receive timely access to care (e.g., assessments, medication support, therapy, groups and care management). The adult system will also need staff to meet the needs of FSP clients needing vocational services.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

1. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?

   Yes

   a. Please explain any actions or activities the county is engaging in to leverage the program.

      CCBHS intends to leverage the Behavioral Health Scholarship Program to expand the local pipeline of culturally responsive behavioral health professionals. Scholarships will target undergraduate and graduate students pursuing degrees in psychology, social work, marriage and family therapy, psychiatric nursing, and related behavioral health disciplines. The program will be promoted through existing collaborations with Contra Costa College, Cal State East Bay, and local internship sites that host behavioral health trainees. Priority outreach will focus on individuals with lived experience and bilingual/multicultural backgrounds to strengthen workforce diversity and representation within Full-Service Partnership (FSP) and Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP) programs.

2. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?

   Yes

   a. Please explain any actions or activities the county is engaging in to leverage the program.

      CCBHS will apply for the Behavioral Health Student Loan Repayment Program to improve recruitment and retention of licensed professionals serving in high-need programs, including FSP, Crisis Services, and CSC for FEP. The loan repayment option will serve as a critical incentive for clinicians—particularly those in underserved` geographic areas of the county—helping to stabilize the workforce and reduce turnover. This initiative aligns with Contra Costa's WET priorities by supporting long-term retention of licensed clinicians, supervisors, and bilingual providers. Coordination with the County HR Department and Behavioral Health Finance unit will ensure integration with internal retention strategies, including ongoing training, supervision support, and career development pathways.

3. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?

   Yes

a. Please explain any actions or activities the county is engaging in to leverage the program.
CCBHS will leverage the BH-CONNECT Community-Based Provider Training Program to expand training opportunities for community-based organizations and county staff. Training priorities will include evidence-based practices such as Cognitive Behavioral Therapy for Psychosis (CBTp), Motivational Interviewing, Trauma-Informed Care, and Integrated Co-Occurring Disorder (COD) interventions. Through collaboration with Stanford University, UCLA, and local partners, CCBHS will coordinate statewide and local training contracts to ensure equitable access for contracted providers. These trainings will directly address workforce gaps in specialized service delivery for youth and adults with serious mental illness and co-occurring disorders.

4. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?

Yes

a. Please explain any actions or activities the county is engaging in to leverage the program.
CCBHS provides paid internships within county-operated and contracted agencies, preparing clinicians to practice in the public mental health system, focusing on culturally responsive and linguistically competent trainees in FSP, CSC, and crisis programs. We plan to participate in and leverage the Behavioral Health Community-Based Provider Training Program to expand supervised postgraduate clinical placements within county-operated and contracted behavioral health programs. Training will emphasize multidisciplinary learning and clinical supervision under licensed staff, preparing associates for full licensure in marriage and family therapy, clinical social work, and clinical psychology. Placements will be prioritized in high-need service areas, including FSP, CSC for FEP, and Crisis Response programs. The program will complement existing WET-funded supervision support (e.g., Motivo Clinical Supervision Project) and create a sustainable pipeline from trainee to licensed clinician.

5. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?

Yes

a. Please explain any actions or activities the county is engaging in to leverage:
CCBH will build on current efforts to expand the pipeline of qualified adult and child psychiatrists within the county behavioral health system through the CalMedForce+ Grant. This grant supports the creation of a Psychiatry Residency Program in Contra Costa County. The County's Health Services executive leadership

has approved the launch of a residency class of four trainees per year. Training will occur at Contra Costa Regional Medical Center (CCRMC) and affiliated Behavioral Health Services (BHS) outpatient clinics. The program aims to cultivate a diverse and locally trained psychiatric workforce equipped to meet the complex behavioral health needs of the community. By developing this residency program, Contra Costa seeks to strengthen long-term workforce sustainability and improve access to timely, high-quality psychiatric care across the county.

6. Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training.

   CCBHS continues to advance workforce development through its Behavioral Health Workforce, Education, and Training (WET) initiatives. These other efforts include:

   - **Countywide 5150 Designation Training Program: Ensuring readiness and compliance among qualified licensed staff.**
   - **Motivo Remote Supervision Platform: Providing accessible clinical supervision to registered associates and contracted partners to accelerate licensure pathways.**
   - **Behavioral Health Transformation Implementation Plan: Integrating cross-sector training in cultural humility, behavioral health integration for co-occurring mental health and substance use disorders, and data-driven service redesign.**
   - **Peer and Family Workforce Expansion: The SPIRIT Peer Career Pathway program strengthens career pathways for peers and family advocates through training, certification, and partnership with community colleges.**
   - **Together, these efforts support a coordinated approach to workforce development, ensuring a competent, diverse, and sustainable behavioral health workforce for Contra Costa County.**

Budget And Prudent Reserve

Download and complete the budget template using the button below before starting this section

1. Please upload the completed budget template See Appendix: Budget Template Uploaded
2. Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template.

   a. Behavioral Health Services and Supports (BHSS): **no excess prudent reserve**

   b. Full-Service Partnership (FSP): **no excess prudent reserve**

   c. Housing Interventions: **no excess prudent reserve**

3. Enter date of last prudent reserve assessment: **10/01/2024**
4. Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan.
    a. BHSS: **no excess prudent reserve**
    b. FSP: **no excess prudent reserve**
    c. Housing Interventions: **no excess prudent reserve**

Plan Approval and Compliance

Behavioral Health Director Certification

1. I hereby certify that **Contra Costa County** has complied with all statutes, regulations, and guidelines in preparing and submitting this Three-Year Integrated Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that (please select all below)
   [multi-select list]
    - ✓ The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
    - ✓ I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
    - ✓ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
    - ✓ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
    - ✓ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
    - ✓ The IP was submitted to the local behavioral health board
2. Does the county wish to disclose any implementation challenges or concerns with these requirements? **No**
    a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

Contact information

1. County Name: **Contra Costa County**
2. Certification for:
    - ☑ **Three-Year Integrated Plan**

☐ Annual Update

3. County Behavioral Health Agency Director
    a. Name: **Suzanne Tavano**
    b. Title: **Director**
    c. Phone: **925-957-5169**
    d. Email: **suzanne.tavano@cchealth.org**
4. [optional additional contact for counties with separate MH and SUD directors] County Behavioral Health Agency Director **N/A**
    a. Name: **N/A**
    b. Title: **N/A**
    c. Phone: **N/A**
    d. Email: **N/A**

Printed Name
__**Suzanne Tavano, Ph.D**_____

Title: Behavioral Health Director:

Signature Date

See Appendix: Behavioral Health Director Certification

County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

1. I hereby certify that (please select all below) [multi-select list]
    a. The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
    b. Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
    c. BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use

of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

2. Does the county wish to disclose any implementation challenges or concerns with these requirements? **No**

    a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements [narrative box]

Printed Name
Monica Nino

Title **Chief Administration Officer**

Signature Date

Contact information

1. County Name **Contra Costa County**
2. Certification for
    - ✓ **Three-Year Integrated Plan**
    - Annual Update
3. County Chief Administration Officer
    - ✓ Name **Monica Nino**
    - ✓ Phone: **925-655-2075**
    - ✓ Email: **monica.nino@cao.cccounty.us**

See Appendix: County Administrator or Designee Certification

Board of Supervisors Certification

[optional file upload]

1. [Entity name] Board of Supervisors certifies the following (please select all below) [multi-select list]
    a. [Entity name] Board of Supervisors has reviewed and approved this Integrated Plan for the period of [FY-FY]
    b. County will meet its realignment obligations pursuant to W&I Code section 14197, including but not limited to time or distance standards and appointment time standards set forth in W&I Code section 14197 or other applicable guidance, without utilizing waitlists
2. Does the county wish to disclose any implementation challenges or concerns with these requirements? [Yes/No radio button; if Y, populate question 2.a below]
    a. Please describe any implementation challenges or concerns with their

realignment obligations [narrative box]

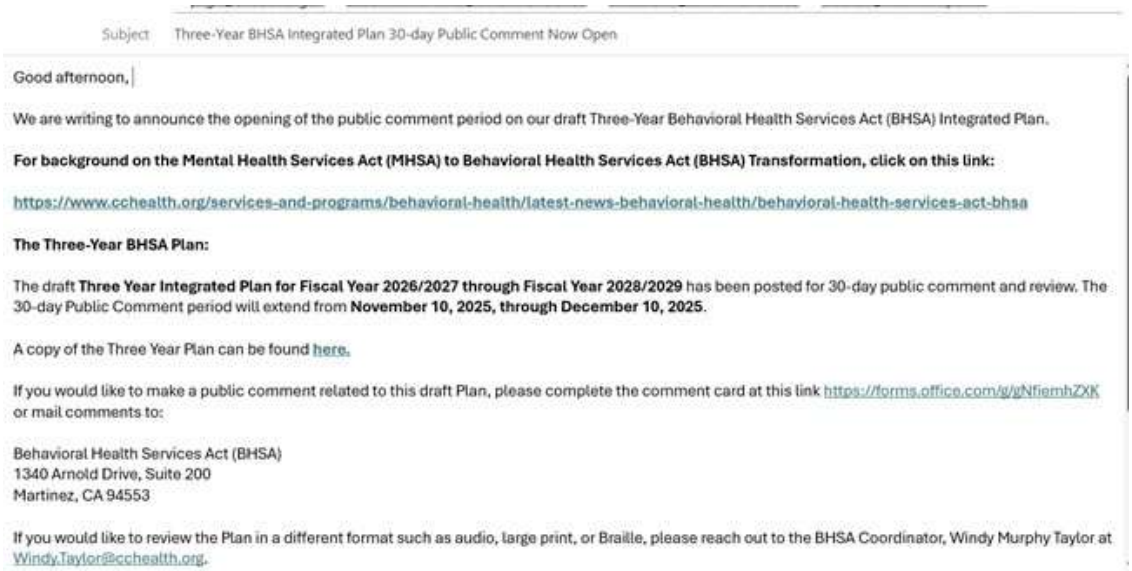
Printed Name

_____

Title: Designated Representative, [Entity Name] Board of Supervisors

Signature Date

Appendix A



Subject Three-Year BHSA Integrated Plan 30-day Public Comment Now Open

Good afternoon,

We are writing to announce the opening of the public comment period on our draft Three-Year Behavioral Health Services Act (BHSA) Integrated Plan.

For background on the Mental Health Services Act (MHSA) to Behavioral Health Services Act (BHSA) Transformation, click on this link:

https://www.cchealth.org/services-and-programs/behavioral-health/latest-news-behavioral-health/behavioral-health-services-act-bhsa

The Three-Year BHSA Plan:

The draft **Three Year Integrated Plan for Fiscal Year 2026/2027 through Fiscal Year 2028/2029** has been posted for 30-day public comment and review. The 30-day Public Comment period will extend from **November 10, 2025, through December 10, 2025**.

A copy of the Three Year Plan can be found here.

If you would like to make a public comment related to this draft Plan, please complete the comment card at this link https://forms.office.com/g/gNfiemhZXK or mail comments to:

Behavioral Health Services Act (BHSA)
1340 Arnold Drive, Suite 200
Martinez, CA 94553

If you would like to review the Plan in a different format such as audio, large print, or Braille, please reach out to the BHSA Coordinator, Windy Murphy Taylor at Windy.Taylor@cchealth.org.

Appendix B

Contra Costa Behavioral Health

2026-2027 FY Quality Improvement Plan

Contra Costa Behavioral Health – Quality Improvement & Quality Assurance Unit (QIQA)

Quality Improvement and Performance Improvement (QAPI) Program Description

Contra Costa Behavioral Health Services' Quality Improvement and Quality Assurance (QI/QA) Unit oversees the Quality Assessment and Performance Improvement Program in Behavioral Health to support service delivery, enhance care processes and better meet beneficiary needs. The Unit is led by the Quality Management Coordinator, who also chairs the Quality Improvement Committee (QIC).

The QIC, composed of Behavioral Health leadership, QI/QA staff, providers, and beneficiaries, meets monthly and operates under the guidance of the Quality Improvement Work Plan (QIWP). Its core functions include:

- Collecting and analyzing data to assess progress on prioritized goals
- Identifying and acting on improvement opportunities
- Collaborating with other relevant committees to share information
- Gathering input from providers, clients, and families to identify service barriers
- Designing and implementing interventions to improve care
- Evaluating outcomes and integrating successful strategies into operations
- Monitoring and reviewing grievances, appeals, clinical records, and service trends
- Monitoring timeliness, satisfaction, access, penetration, and retention
- Working with Ethnic Services and Training to improve workforce development and promote cultural competency

Based on these activities, the QIC makes policy recommendations, monitors progress, initiates follow-ups, and documents all decisions in meeting minutes.

FY 2026–2027 Quality Improvement Work Plan

The FY 2026–2027 QIWP was developed based on the QIC's oversight activities, State and County-level priorities, and feedback from the External Quality Review (EQR) team. The plan enables Behavioral Health Services to:

1. Meet QI requirements under the State DHCS Mental Health Plan contract
2. Address quality issues identified through oversight of the Mental Health

The QIWP is reviewed annually to track progress toward identified goals. Each activity is marked as *new*, *ongoing*, or *completed*, along with its frequency (e.g., annual, quarterly). Activities related to both Mental Health and Substance Use Disorder services are shaded gray. Activities that are in Monitoring status are shaded green.

The plan is organized into the following sections:

- Service Capacity [page 2]
- Accessibility of Services [pages 3-4]
- Beneficiary Satisfaction [page 5]
- Cultural and Linguistic Responsiveness [page 6]
- Client Safety and Medication Practices [page 7]
- Service Delivery and Clinical Issues [pages 8-10]
- Establishing Beneficiary and System Outcomes [pages 11-12]

Service Capacity

Behavioral Health DHCS Contractual Element: Assess the capacity of service delivery for beneficiaries, including monitoring the number, type, and geographic distribution of services within the delivery system. Behavioral Health Information Notice: 23-04: The physical location where beneficiaries receive services shall meet the State's time or distance standards or an approved Alternative Access Standard request. Title 42 Code of Federal Regulations (CFR) Part 438.68, 438.206, and 438.207; Welfare and Institutions Code (WIC) section 14197: For outpatient mental health services: Up to 15 miles or 30 minutes from the beneficiary's place of residence.

Goal 1: Monitor service delivery measurements	
Objectives	**Actions/Frequency**
1. Ensure network adequacy for service delivery.	1. Provider psychiatry ratios meet network adequacy standards. [ongoing] [Annually]
	2. Provider ratios for outpatient SMHS meet network adequacy standards. [ongoing] [Annually]
	3. The MHP meets time and distance standards of providing outpatient mental health service within 15 miles or 30 minutes of clients' homes or approved alternative access standard. [ongoing] [Annually]
	4. If network adequacy or time and distance standards are not being met, identify opportunities for improvement, implement interventions, and measure effectiveness of new interventions. [ongoing] [Annually]

Goal 2: Perform credentialing and certification for delivery system	
1. Perform Provider credentialing and monitoring	1. Credential all staff (County, CBO, network) seeking to provide services and claim payments. [new]
2. Certify/recertify county and CBO sites.	1. Perform site certifications for new sites and re-certification as required to ensure compliance with all federal and state guidelines. [new]

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Accessibility of Services

Behavioral Health DHCS Contractual Elements: Assess the accessibility of services within service delivery area, including:

- *Timeliness of routine appointments;*
- *Timeliness of services for urgent conditions;*
- *Access to after-hours care; and*
- *Responsiveness of the 24 hour, toll free telephone number.*

Goal 3: Beneficiaries will have timely access to the services they need	
Objectives	**Actions/Frequency**
1. Clients requesting non-urgent mental health services are provided an initial appointment and follow-up within 10 business days.	1. At least 80% of first appointments are offered to clients within 10 business days. [ongoing] [Quarterly]
	2. Report the average number of business days offered for follow-up non-psychiatric treatment appointments. [ongoing] [quarterly]
	3. 80% of follow-up appointments with a non-physician are offered within 10 business days of the prior appointment. [ongoing] [quarterly]
2. Clients meeting medical necessity are offered an initial psychiatric appointment within 15 business days.	1. At least 80% of first appointments are offered to clients within 15 business days. [ongoing] [Quarterly]
3. Disparities in access to timely care will be identified.	1. The MHP will analyze timeliness data by demographic factors to identify disparities by gender, race, ethnicity, and language. [ongoing] [Quarterly]
4. Clients will receive timely access to network-provided services.	1. Monitor timeliness metrics for network referrals. [new] [Quarterly]
	2. Track resolution of timeliness grievances for referrals to network services. [new] [Quarterly]
5. Urgent care mental health service requests are offered an appointment within 48 hours.	1. 80% of urgent outpatient mental health appointments are offered within 48 hours of request. [ongoing] [Quarterly]
	2. Track the percentage of urgent service requests resulting in a completed urgent assessment. [ongoing] [Quarterly]
6. Clients discharged from hospitals receive a follow-up	1. Clients receive an outpatient appointment within an average of 7 calendar days from hospital discharge. [ongoing] [Quarterlyl]
7. Clients discharged from Emergency Departments will receive timely follow-up care.	1. Clients receive an outpatient appointment within an average of 7 calendar days from ED discharge. [ongoing] [Quarterly]

Goal 4: Improve penetration and retention in SMHS	
Objectives	***Actions/Frequency***
1. Increase penetration rates for underserved populations, Asian/Pacific Islanders, Birth to Five, and Older Adults.	1. By 6/30/2027, penetration rates for underserved populations increase from previous years. [ongoing] [Quarterly]
2. Increase Engagement in SMHS.	1. By 6/30/2027, increase the percentage of clients, from last year, who receive 5+ services during the year. [ongoing] [Quarterly]

Goal 5: Improve the Behavioral Health Access Line triaging and referral processes into the behavioral health system of care	
Objectives	**Actions/Frequency**
1. The MHP will provide beneficiaries with accurate information on how to access services.	1. On quarterly basis, conduct 15 test calls, 10 (including 4 in Spanish) during business hours and 5 (including 2 in Spanish) after hours. [ongoing] [Quarterly]
	2. Meet requirements for business hour test calls to provide callers with accurate information on how to access Specialty Mental Health Services (SMHS) at least 80% of the time. [ongoing] [Quarterly]
	3. Monitor test calls to ensure requirement to provide information about services needed to treat urgent conditions is met. [ongoing] [Quarterly]
	4. The MHP will conduct 4 calls quarterly to test the Access Line on beneficiary problem resolution and fair hearing process, 2 calls during business hours and 2 calls after-hours. [ongoing] [Quarterly]

Beneficiary Satisfaction

Behavioral Health DHCS Contractual Elements: Assess beneficiary or family satisfaction at least annually by:

- *Surveying beneficiary/family satisfaction with services;*
- *Informing providers of the results of beneficiary/family satisfaction activities.*

Goal 6: Monitor client/family satisfaction	
Objectives	**Actions/Frequency**
1. Obtain client feedback on services.	1. Conduct the Mental Health Statistics Improvement Program (MHSIP) during the DHCS designated period. [ongoing] [Annually]
2. Monitor client satisfaction on the survey domain means on the MHSIP survey.	1. Client scores on MHSIP are 4.0 or higher for all domains, indicating satisfaction with care. [ongoing] [Annually]
	2. Client scores improve on the MHSIP domains of Outcomes and Functioning. [ongoing] [Annually]
	3. Client scores improve on MHSIP domain of Social Connectedness. [ongoing] [Annually]
	4. Report satisfaction survey findings to clinics and contracted providers.
	5. Implement changes based on survey data. [ongoing] [Annually]
3. Ensure provider agencies are actively participating in MHSIP efforts.	1. Track the number of completed surveys by provider agency to ensure provider compliance. [ongoing] [Annually]

Cultural and Linguistic Responsiveness

Behavioral Health DHCS Contractual Elements: Comply with the requirements for cultural and linguistic competence.

Goal 7: Provide all clients with culturally- and linguistically-appropriate client-centered care	
Objectives	**Actions/Frequency**
1. All services are delivered in a culturally responsive manner.	1. By 6/30/2027, update the Cultural Humility Plan, incorporating DHCS cultural competency plan requirements and National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Healthcare by HHS. [ongoing] [Annually]
	2. 100% of staff complete cultural humility training by 6/30/2027. [ongoing] [Annually]
	3. At least 75% of staff will complete cultural humility training within recommended timeframe of 1 year. [ongoing] [Annually]
2. Increase Access to services for non/limited English speakers.	1. Monitor accessibility of Access Line services to non-English speakers by conducting quarterly test calls. [ongoing] [Quarterly]
	2. Monitor number of HCIN interpretation encounters to gauge other language needs. [ongoing] [Quarterly]
	3. Monitor volume of Language Line use for encounters. [ongoing] [Quarterly]

Client Safety and Medication Practices

Behavioral Health DHCS Contractual Elements: Monitor safety and effectiveness of medication practices.

Goal 8: Promote safe and effective medication practices	
Objectives	**Actions/Frequency**
1. Identify behavioral health clients who are medication stable.	1. Collaborate with treating psychiatrists and primary care doctors to review 100% of charts of clients who are stable on anti-depressants and ADHD medication to address Level of Care and Utilization Management Strategies. [ongoing] [Annually]
2. Monitor safe medication practices.	1. Review safe medication reports quarterly. [ongoing] [Quarterly]
	2. Use established reporting for data driven improvement projects and care enhancements. [ongoing]
3. Ensure access to medications will be provided.	1. Pharmacy services are provided within 24 hours for prescriptions with prior authorization, and within 72 hours for emergency supply. [ongoing]
	2. Pharmacy services are provided within 10 miles or 30 minutes of client place of

Goal 9: Promote safe and effective medication practices	
Objectives	**Actions/Frequency**
1. Meet HEDIS measures for children and adolescents, including foster care children.	1. Monitor clients prescribed ADHD medication in children's System of Care for three to four appointments. [ongoing] [Quarterly]
	2. Monitor clients prescribed multiple concurrent antipsychotic medications. [ongoing]
	3. Monitor the percentage of children and adolescents who had psychosocial care as first-line treatment before new prescription for an antipsychotic. [ongoing] [Quarterly]
	4. Increase the percentage of children and adolescents who had psychosocial care as a first-line treatment before new prescription for an antipsychotic. [ongoing] [Annually]
2. Promote medication adherence for adults.	1. Increase medication adherence for clients diagnosed with schizophrenia and schizoaffective disorder prescribed antipsychotic medication. [ongoing] [Quarterly]
	2. Monitor clients newly treated with antidepressant medication to determine whether they remain on their medications for at least 84 days (12 weeks). [ongoing] [Quarterly]
	3. Monitor effective continuation of clients treated with antidepressant medication to determine whether they remain on their medication for at least 180 days (6 months). [ongoing] [Quarterly]
3. Monitor clients taking antipsychotic medications for	1. Use established reports to track clients for diabetes and cholesterol screening. [ongoing] [Quarterly]

Service Delivery and Clinical Issues

Behavioral Health DHCS Contractual Elements:

a. Address meaningful clinical issues affecting beneficiaries system-wide.
b. Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
c. Evaluate beneficiary grievances, appeals, and fair hearings.
d. Evaluate requests to change persons providing services.

Goal 10: Implement Performance Improvement Projects to improve client care and outcomes	
Objectives	**Actions/Frequency**
1. Increase the percentage of appointments meeting timeliness standards.	1. Convene clinic improvement workgroups for clinics not meeting standards to implement interventions. [Non-Clinical PIP] [ongoing]
2. Increase adherence to Antipsychotic Medications for Individuals with Schizophrenia.	1. Implement interventions to ensure clients maintain medication adherence. [Clinical PIP] [ongoing]

Goal 11: Increase utilization of targeted EBPs in the Adult System of Care	
Objectives	**Actions/Frequency**
1. Increase the number of clients enrolled in targeted EBPs.	1. By 6/30/2027, increase enrollment numbers from prior year for ACT, FACT, CSC for FEP, IPS, CHWS, and Peer Support. [ongoing] [Quarterly]

Goal 12: Increase utilization of targeted EBPs in the Children System of Care	
Objectives	**Actions/Frequency**
1. Increase the number of clients enrolled in targeted EBPs and FSP.	1. By 6/30/2027, increase enrollment numbers from prior year for the number of youth enrolled in MST, FFT, PCIT, and HFW. [ongoing] [Quarterly]

Goal 13: Increase utilization of Enhanced Care Management (ECM)	
Objectives	**Actions/Frequency**
1. Increase enrollment in ECM	1. Increase the number of clients enrolled in ECM. [ongoing] [Quarterly]

Goal 14: Improve tracking and monitoring of Evidence Based Practices (EBPs) in adult and children's systems of care	
Objectives	**Actions/Frequency**
1. EBP outcome measures data available to programs on demand.	1. Develop iSite reports and dashboards to allow for real time access to outcome data for targeted EBPs. [ongoing]

Goal 15: Evaluate client grievances, unusual occurrence notifications, and change of provider appeal requests	
Objectives	**Actions/Frequency**
1. Review and respond to 100% of grievances, change of provider, and appeal requests within the policy guidelines and state regulations to identify system improvement issues.	1. Collect and analyze behavioral health service grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, and provider appeals to examine patterns that may inform the need for changes in policy or programing. [ongoing] [Annually]
	2. Collect and analyze change of provider requests for patterns that may inform need for policy or programming changes. [ongoing] [Annually]
	3. Track and trend the number of grievances and appeals received over time. [ongoing] [Annually]
	4. Present finding to the QIC to identify strategies to improve reporting and address issues related to grievances, appeals, and state hearings. [ongoing] [Annually]
	5. Respond to 100% of grievances and appeals. [ongoing] [Annually]
	6. Respond to 100% of change of provider requests. [ongoing] [Annually]
2. Review 100% of unusual occurrences to identify trends.	1. Collect and analyze trends in unusual occurrences using SERS. [ongoing] [Annually]
	2. Track and trend unusual occurrences. [ongoing] [Annually]
	3. Report on unusual occurrences annually to the QIC. [ongoing] [Annually]

Goal 16: Inform clients of decisions to deny, modify, terminate, reduce or defer a service or when failing to meet standards of timely access	
Objectives	**Actions/Frequency**
1. NOABDs will be issued to all clients when an adverse benefit determination has been made.	1. Sample at least 8 clients per quarter from the NOABD report to ensure compliance with NOABD issuance. [ongoing] [Quarterly]
	2. Track and trend compliance for clients sampled. [ongoing] [Quarterly]
	3. Track and trend NOABDs issued. [ongoing] [Quarterly]

Goal 17: Monitor utilization management	
Objectives	**Actions/Frequency**
1. Track over-and under-utilization.	1. Identify and evaluate clients for step-down. [new] [Quarterly]

Goal 18: Establish clinical practice guidelines	
Objectives	**Actions/Frequency**
1. Establish clinical practice guidelines for at least 2	1. Identify and adopt at least 2 evidence-based clinical practice guidelines for adults by 6/30/2027. [new] [Quarterly]

Goal 18: Establish clinical practice guidelines	
Objectives	**Actions/Frequency**
behavioral health conditions for adults.	
2. Establish at least 1 clinical practice guideline for a behavioral health condition for children/adolescents.	2. Identify and adopt at least 1 evidence-based clinical practice guideline for children/adolescents by 6/30/2027. [new] [Quarterly]

Establishing Beneficiary and System Outcomes

Behavioral Health DHCS Contractual Elements: conduct performance monitoring activities throughout operations, including beneficiary and system outcomes.

Goal 19: Improve clients' outcomes	
Objectives	**Actions/Frequency**
1. Improve health outcomes and QOL among clients receiving ACT.	1. Reduce Emergency Department (ED) visits among members receiving ACT. [ongoing] [Quarterly]
	2. Reduce hospital admission among clients receiving ACT. [ongoing] [Quarterly]
	3. Reduce the rate of homelessness among clients receiving ACT. [ongoing] [Quarterly]
	4. Reduce justice involvement among clients receiving ACT. [ongoing] [Quarterly]
	5. Increase QOL among clients receiving ACT. [ongoing] [Quarterly]
2. Improve health outcomes and QOL among clients receiving FACT.	1. Reduce Emergency Department (ED) visits among clients receiving FACT. [ongoing] [Quarterly]
	2. Reduce hospital admission among clients receiving FACT. [ongoing] [Quarterly]
	3. Reduce the rate of homelessness among clients receiving FACT. [ongoing] [Quarterly]
	4. Reduce justice involvement among clients receiving FACT. [ongoing] [Quarterly]
	5. Increase QOL among clients receiving FACT. [ongoing] [Quarterly]
3. Improve health outcomes and QOL among members receiving CSC for FEP.	1. Reduce ED visits among clients receiving CSC for FEP. [ongoing] [Quarterly]
	2. Reduce hospital admission among clients receiving CSC for FEP. [ongoing] [Quarterly]
	3. Reduce homelessness among clients receiving CSC for FEP. [ongoing] [Quarterly]
	4. Increase school/work involvement among clients receiving CSC for FEP. [ongoing] [Quarterly]
	5. Increase QOL among clients receiving CSC for FEP. [ongoing] [Quarterly]
4. Improve health outcomes among clients receiving supported employment.	1. Reduce ED visits among clients receiving Supported Employment. [ongoing] [Quarterly]
	2. Decrease hospital admissions among clients receiving Supported Employment. [ongoing] [Quarterly]
	3. Increase school/work involvement among clients receiving Supported Employment. [ongoing] [Quarterly]
	4. Increase QOL among clients receiving Supported Employment. [ongoing] [Quarterly]

Goal 20: Increase use of outcome measures	
Objectives	**Actions/Frequency**
1. Use aggregate data to evaluate client progress.	1. Track and trend CANS data quarterly. [ongoing] [Annually]
	2. Strengths identified on CANS will increase by 10% by 6/30/27. [ongoing] [Annually]

Goal 20: Increase use of outcome measures	
Objectives	**Actions/Frequency**
2. Improve CANS data collection.	1. Increase CANS discharges. [ongoing]
3. Build internal HEDIS dashboards.	1. Build HEDIS dashboards for the following measures: 1. FUM, 2. FUH, 3. AMM, 4. APP, and 5. SAA by 9/30/2026. [new]

Goal 21: Maintain effective and consistent practices to safeguard Protected Health Information (PHI)	
Objectives	**Actions/Frequency**
1. Decrease the rate of HIPAA incidents	1. 100% of staff complete HIPAA training by 6/30/27. [ongoing] [Annually]
	2. Increase the % of staff who complete HIPPA training within recommended timeframe of 1

Goal 22: Evaluate QI Program	
Objectives	**Actions/Frequency**
1. Evaluate the QI Program	1. By 12/31/27, complete an evaluation of the QI program. [new] [Annually]

FY 2026-27 Quality Improvement Work Plan

Contra Costa Behavioral Health Alcohol and Other Drugs Services

September 2025

Contra Costa Behavioral Health Services' Quality Improvement and Quality Assurance (QI/QA) Unit monitors service delivery with the aim of improving the processes of providing care and better meeting the needs of beneficiaries. The Quality Management Coordinator oversees the Unit and chairs the Quality Improvement Committee (QIC). The Quality Improvement Committee comprised of Behavioral Health Management, QIQA staff, providers and beneficiaries, meets on a monthly basis and is informed by the Quality Improvement Plan. QIC activities include collecting and analyzing data to measure against the goals or prioritized areas of improvement that have been identified; identifying opportunities for improvement and deciding which opportunities to pursue; identifying relevant committees and workgroups to ensure appropriate exchange of information with the QIC; obtaining input from substance use disorder providers, beneficiaries, and family members in identifying barriers to delivery of clinical care and administrative services; designing and implementing interventions for improving performance; measuring effectiveness of the interventions; incorporating successful interventions into the operations of behavioral health services; and reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review. The QIC also reviews timeliness of services, client satisfaction, penetration and retention rates, service accessibility, and other service trends. In addition, the QIC works in collaboration with the Behavioral Health Services Act (BHSA) Work Force Education & Training manager to monitor and improve the quality of offered training and education for its workforce, inclusive of promoting greater cultural diversity, humility, and competency. As a result of the monitoring activities described above, the QIC recommends policy decisions, reviews and evaluates the results of quality improvement activities including performance improvement projects, institutes needed quality improvement actions, ensures follow-up of QI processes, and documents QIC meeting minutes regarding decisions and actions taken.

Guided by the above, the BHSD developed its FY 2026-2027 Quality Improvement Plan. The contents of the Quality Improvement Plan were also informed by feedback from our External Quality review team. This Quality Improvement Plan provides a vehicle for BHSD management to: 1) meet quality improvement requirements specified in the Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan contract with the State Department of Health Care Services (DHCS) for the expenditure of Medi-Cal (Medicaid) dollars; 2) meet quality improvement requirements specified under the DMC-ODS; and 3) address and resolve quality issues raised in the monitoring of the CCMH and DMC-ODS Plans.[1] The QI Plan is evaluated annually to assess progress towards identified goals and actions. Activities are marked in brackets as being new, ongoing (continuing from the previous year), and/or completed in comparison to previous years. The frequency which activities are conducted (e.g., annually, quarterly, etc.) is also included in brackets. The quality improvement activities are divided into the following sections:

Service Capacity [p 2]
Access to Care [p 3-5]

Beneficiary Satisfaction [p 5-6]

Cultural and Linguistic Competence [p 7]
Medication Practices [p 8]

Service Delivery and Clinical Issues [p 8-9]
Continuity and Coordination of Care [p 10]
Opioid Response [p 11]

Housing [p 1]

Prevention [p 12-13]

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Service Capacity

Behavioral Health DHCS Contractual Element: Assess the capacity of service delivery for beneficiaries, including monitoring the number, type, and geographic distribution of services within the delivery system.

Goal 1: Monitor service delivery capacity			
Objectives	**Actions/Frequency**	**Person Responsible**	**Baseline/Achieved**
1. Ensure network adequacy for service delivery.	1. Monitor the number of zip codes requiring alternative access standards. [Continuing]	David Kekuewa Fatima Matal Sol	FY 2022-2023: 0 FY 2023-2024: 17 FY 2024-2025: 0
	2. Review network adequacy to prioritize expansion of services to meet clients' needs. [Continuing]	David Kekuewa Fatima Matal Sol	
	3. Ensure West County Outpatient provider becomes operational in FY 25-26. [New]	Fatima Matal Sol	
	1. Add 1FTE Program Manager for youth. [New]	Fatima Matal Sol	
2. Expand services to meet network adequacy standards.	2. Expand residential programs for youth. [New]	Fatima Matal Sol	FY 2023-2024: None FY 2024-2025: None
3. Increase service utilization among Latino communities.	1. Continue targeted outreach to Latino communities. [Continuing]	Marissa Ibarra Fatima Matal Sol SUD Latino Workgroup	CY 2021: 0.44% CY 2022: 0.52%
4. Increase services for Spanish-speaking clients.	1. Continue to hire Spanish speaking staff throughout AODS [Continuing]	Fatima Matal Sol David Kekuewa	FY 2022-2023: 8 FY 2023-2024: 11 FY 2024-2025: 12
	2. Provide residential services for Spanish Speaking monolingual women. [Continuing]	Fatima Matal Sol	FY 2023-2024: 0 FY 2024-2025: 0
	3. Develop measures to evaluate effectiveness of Latino Outreach and SUD Latino Work Group. [Continuing]	Fatima Matal Sol Marissa Ibarra	
	4. Monitor number of claims for services provided through Nuevo Comienzo. [Continuing]	Fatima Matal Sol David Kekuewa	FY 2023–2024: 4085 FY 2024–2025: 5396

Access to Care

Behavioral Health DHCS Contractual Elements: Assess the accessibility of services within service delivery area, including:

- *Timeliness of routine appointments*
- *Timeliness of services for urgent conditions*
- *Access to after-hours care*
- *Responsiveness of the 24-hour, toll-free telephone number*

Goal 2: Beneficiaries will have timely access to the services they need			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. 90% of screened clients will be offered routine care services within 10 days of initial request for appointments.	1. At least 90% of first appointments are offered to clients within 10 business days. [Quarterly]	Sofia Campos	FY 2022-2023: 90.2% FY 2023-2024: 100% FY 2024-2025: 100%
	2. Monitor compliance with timeliness. [Quarterly]	Mark Messerer Sofia Campos	
2. Monitor timeliness of first dose of MAT provided by NTPs	1. Monitor timeliness of first dose of MAT provided by NTPs. [Monthly]	Mark Messerer	
3. 50% of clients successfully discharged from residential treatment will be offered appointments to lower level of care within 7 days.	1. Track and Monitor percentage of Level of Care (LOC) transfer from residential by Treatment Program and explore new initiatives to enhance LOC transfer. [Quarterly]	Sofia Campos Mark Messerer	
	2. Report on WM data in the Data Quality Workgroup. [Annually]	Mark Messerer Sofia Campos	
4. Enhance continuity of care for clients transitioning from residential treatment.	1. Continue to hold Care Coordination reviews with residential providers every other week.	Fatima Matal Sol	
	2. Expand Recovery Support Services and Care Management.	Faye L. Ferguson-Manly Fatima Matal Sol	

	3. Monitor Claims Data for Recovery Support Services.	Davud Kekuewa Fatima Matal Sol	FY 2023–2024: 0 FY 2024–2025: 3424
	4. Review Recovery Support Services Claim Data in the SUD Data Quality Workgroup and Staff Meetings. [Continuing] [Quarterly]	Mark Messerer, Fatima Matal Sol	
	5. Analyze readmission data to identify new interventions for clients with more than one readmission. [Continuing]	Mark Messerer	
5. Ensure timely follow-up after SUD treatment. (HEDIS FUA measure)	1. Track percentage of clients who receive a follow-up service within 7 days (residential) or 30 days (outpatient) of discharge. [Monthly] [New]	Mark Messerer Marissa Ibarra	

Goal 3: Improve the Behavioral Health Access Line triaging and referral processes into the AODS system of care			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Reduce the percentage of calls answered by clerks.	1. No more than 20% of calls were answered by clerks. [Continuing]	Mark Messerer	FY 2022-2023: 42% FY 2023-2024: 31%
2. Access Line call abandonment rate is under 10%.	1. Reduce the percentage of calls that are abandoned. [Quarterly] [Continuing]	Mark Messerer Mitch Brown	FY 2022-2023: 16% FY 2023-2024: 14%

Goal 4: Reduce appointment no-show rates			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Enhance recovery support and referral processes by strengthening linkages between hospital and public health and reducing missed intake appointments. (15% AODS)	1. Improve no show rate for initial appointment. [Quarterly] [Continuing]	Sofia Campos Fatima MatalSol Sonya Blunt Jesse Farrar	FY 2022-2023: 26.1%

Beneficiary Satisfaction

Behavioral Health DHCS Contractual Elements: Assess beneficiary or family satisfaction at least annually by:

- *Surveying beneficiary/family satisfaction withservices*
- *Evaluating beneficiary grievances, appeals, and fair hearings*
- *Evaluating requests to change persons providing services*
- *Informing providers of the results of beneficiary/family satisfaction activities*

Goal 5: Evaluate client grievances, unusual occurrence notifications, and change of provider and appeal requests			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Review and respond to 100% of grievances and appeal requests within the policy guidelines and state regulations to identify system improvement issues.	1. Collect and analyze Behavioral Health Services grievances and appeals to examine patterns that may inform the need for changes in policy or programming. [Continuing]	Katherine Alpi	FY 2021-2022: 100% FY 2022-2023: 100% FY 2023-2024: 100% FY 2024-2025: 100%
	2. Collect and analyze State Fair Hearing requests.	Katherine Alpi	
	3. Compare grievances and appeals received from last FY to this FY.	Katherine Alpi	FY 2022-2023: Grievance: 24, Appeals: 0 FY 2023-2024: Grievances: 16, Appeals: 0 FY 2024-2025:

			Grievance: 13, Appeals: 0
	4. Respond to 100% of grievances, appeals, and expedited appeals within the Final Rule timelines.	Katherine Alpi	
	5. Present findings to the QIC and DMC- ODS system of care on a quarterly basis to identify strategies to improve reporting and address issues.	Katherine Alpi	
2. Review 100% of unusual occurrences to identify trends	1. Collect and analyze trends in unusual occurrences. [Quarterly]	Katherine Alpi	
	2. Report on unusual occurrences quarterly to the QIC and DMC-ODS system of care. [Quarterly]	Katherine Alpi	
	3. Track type of grievances and create intervention if needed.	Katherine Alpi Mark Messerer	

Goal 6: Monitor client/family satisfaction			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. All TPS survey means are 4.0 or higher (indicating clients and/or their families are satisfied with their care).	1. Conduct an annual Treatment Perception Survey to gather quantitative and qualitative data about satisfaction with services. [Annually]	Mark Messerer	
	2. Report satisfaction survey findings to contracted providers. [Annually]	Mark Messerer	
	3. Monitor participation in TPS by treatment programs. [Annually]	Mark Messerer	2022: 16 2023: 617 2024: 627
2. Conduct survey to obtain feedback from families of clients receiving SUD services.	1. Engage providers in identifying opportunities to obtain feedback from families of clients receiving SUD Services. [Quarterly]	Mitchell Brown Fatima Matal Sol	

Cultural and Linguistic Competence

Behavioral Health DHCS Contractual Elements: Comply with the requirements for cultural and linguistic competence.

Goal 7: Provide all clients with welcoming, engaging, and culturally- and linguistically appropriate client-centered care			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. All services are delivered in a culturally responsive manner.	1. Update the Cultural Humility Plan, incorporating DHCS cultural competency plan requirements. [Annually]	Annamarie Baker Fatima Matal Sol	
	2. Invite the BHSA Work Force Education & Training to the QI Workplan Committee	Fatima Matal Sol Annamarie Baker	
2. 100% of clients are served in their preferred language.	1. Monitor accessibility of Access Line and services to non-English speakers. [Quarterly]	Mark Messerer	
	2. Monitor CBOs utilization of translation services and hearing-impaired line. [Annually]	Fatima Matal Sol Sonya Blunt	
	3. All materials are translated into threshold languages. [Continuing]	Fatima Matal Sol Sofia Campos	
3. 100% of staff complete a cultural competency training.	1. 100% of all AODS county and provider staff complete cultural competency training in recommended timeframe of one year. [Annually] [Continuing]	Annamarie Baker	FY 2021-FY 2022: 74.0% FY 2023-2024: 82.5% FY 2024-2025: 100%
4. Ensure all clients are served in a culturally competent manner.	1. Monitor new Residential treatment providers and Recovery Residences have procedures in place regarding LGBTQ+ population. [Annually] [Continuing]	Fatima Matal Sol Faye L. Ferguson-Manly Darren Webb	

Medication Practices

Behavioral Health DHCS Contractual Elements: Monitor safety and effectiveness of medication practices.

Goal 8: Promote safe and effective medication practices			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Increase use of Medication Assisted Treatment (MAT) for clients with Alcohol Use Disorder (AUD) or Opioid Use Disorder (OUD).	1. Monitor programs for MAT referrals through chart review and site visits. [Annually]	Mark Messerer	
2. Ensure clients using Pharmacotherapy for Opioid Use Disorder (POD) will maintain medication for at least 180 days.	1. Track and monitor continuation of medication for clients using Pharmacotherapy for Opioid Use Disorder (POD) [PIP]	Sofia Campos	

Service Delivery and Clinical Issues

Behavioral Health DHCS Contractual Elements:

- *Address meaningful clinical issues affecting beneficiaries' system-wide.*
- *Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.*

Goal 9: Expand services and improve provider collaboration			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Maintain collaborative relations with contract providers.	1. Continue to host various meetings and workgroups with SUD providers to address specific topics and system concerns. [Quarterly]	Fatima Matal Sol, Mark Messerer	
	2. Provide real time updates to providers using "SUD Newsflash" communication tool and Brown Bags. [Monthly]	Fatima Matal Sol Myesha Jamerson	

Goal 10: Increase use of evidence-based practices			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Plan and implement Contingency Management Program.	1. Track and Monitor clients in Recovery Incentives Programs. [Monthly]	Fatima Matal Sol Faye L. Ferguson-Manly Marissa Ibarra	FY 23-24: 60
	2. Expand Recovery Incentive services in Central County. [New]	Fatima Matal Sol Faye L. Ferguson-Manly	
	3. Analyze Recovery Incentives data. [Quarterly]	Marissa Ibarra	

Goal 11: Effectively collect data and communicate data findings to staff and the community			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Review data regularly to identify areas of quality improvement.	1. Report CalOMS data at Data Quality Workgroup. [Quarterly]	Mark Messerer	
	2. Review performance measurement data during management team and system of care meetings.	Mark Messerer Sofia Campos	
	3. Monitor and reduce CalOMS administrative discharge rate.	Mark Messerer	
2. Monitor and review women in treatment data	1. Track number of women who enter treatment. [Monthly] [Continuing]	Sonya Blunt	
	2. Monitor AODS perinatal counselor data. [Quarterly]	Sony Blunt Marissa Ibarra	

Goal 12: Maintain effective and consistent utilization review practices			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Improve communication with those who interface with or are part of the UR Team.	1. Hold periodic UR meetings with providers as needed. [Annually]	Mark Messerer Fatima Matal Sol Regina Griffiths Scott Alexander	

Continuity and Coordination of Care

Behavioral Health DHCS Contractual Elements: Work to ensure continuity and coordination of care with physical health care providers. Coordinate with other human services agencies used by beneficiaries.

Goal 13: Integrate behavioral health services with other County Hospitals			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Coordinate Drug Medi-Cal services with mental health services.	1. Track and increase referral numbers from AODS to SUD Treatment programs by 5% for clients referred from counselor at PES. [Quarterly]	Jesse Farrar Fatima Matal Sol Marissa Ibarra	
2. Coordinate Drug Medi-Cal services for justice involved clients	1. Participate in the HSD CalAIM justice involved initiative including CARE Court. [New]	Fatima Matal Sol Sonya Blunt Darren Webb	
	2. Coordinate and track services for justice involved clients and those stepping down from prison via warm hand offs [New]	Fatima Matal Sol Darren Webb	
	3. Continue monitoring implementation of CrossRoad (RSAT grant) to provide SUD treatment in jail. [Monthly]	Fatima Matal Sol Sofia Campos Darren Webb	
	4. Provide individual and group services in West County and Martinez Detention Facilities.	Darren Webb Melissa Mata Eric Clark	

Opioid Pandemic Response

Goal 14: Respond to Opioid Pandemic and Reduce Adverse Outcome in Community			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Monitor opioid overdoses within Contra Costa County.	1. Continue to monitor California Overdose Surveillance Dashboard and share data with stakeholders. [Monthly]	Elissa Kim Fatima Matal Sol	
2. Provide Opioid overdose related training and harm reduction to community.	1. Continue to partner with MEDS Coalition to provide Naloxone trainings within Contra Costa County. [Continuing]	Elissa Kim MEDS coalition Fatima MatalSol	
	2. Track numbers of Naloxone kits distributed to the community. [Continuing] [Annually]	Elissa Kim Jessica Recinos MEDS Coalition	
	3. Track numbers of Fentanyl strips distributed to the community. [Continuing] [Annually]	Jessica Recinos Elissa Kim MEDS Coalition Staff	
3. Continue use of Opioid Settlement Funds and monitor implementation.	1. Collaborate with Public Health and Sheriff to purchase Public Health Naloxone Vending Machine to place at 2 Detention Facilities. [Continuing]	Elissa Kim Fatima Matal Sol	
4. Continue use of Opioid Settlement Funds and monitor implementation.	1. Offer guidance and support for implementation of services outlined in executed RFPs (Request for Proposal). [Continuing] [New]	Elissa Kim	

Recovery Residences

Goal 15: Offer Housing for clients with Co-Occurring disorders who otherwise will not be able to access housing			
Objectives	**Actions**	**Person Responsible**	**Baseline/Achieved**
1. Monitor and coordinate with Recovery Residences	1. Monitor capacity and demand of Recovery Housing needs. [Continuing]	Darren Webb	
	2. Collect pre and post for all recovery residence surveys for clients. [Continuing]	Sofia Campos Darren Webb Shelter Inc. Staff	

Prevention

Goal 16: Strengthen countywide substance use prevention through strategic planning, resource development, and education for youth and families.			
Objectives	**Actions/Frequency**	**Person Responsible**	**Baseline/Achieved**
1. Implement year one of a comprehensive five-year County Strategic Prevention Plan (2026–2031) to guide substance use prevention efforts and align with DHCS Substance Use Prevention Plan (SUPP).	1. Identify priority areas and measurable goals for substance use prevention based on assessment findings. [Annually]	Sofia Campos Jessica Recinos Fatima Matal Sol	
	2. Monitor implementation and make adjustments as needed. [Annually]	Sofia Campos Jessica Recinos Fatima Matal Sol	
	3. Present new County Strategic Prevention Plan as needed. [New]	Jessica Recinos	
2. Expand awareness and capacity for substance use education among parents and youth throughout the county.	1. Develop and distribute educational materials for parents and youth, including fact sheets, guides, and online resources. [Continuing]	Jessica Recinos	
	2. Host community workshops and webinars focused on substance use prevention and early intervention strategies. [Continuing]	Jessica Recinos	

Goal 17: Ensure effective monitoring and support of the Cannabis Awareness Prevention Project (CAPP) for successful cannabis awareness and prevention outcomes.			
Objectives	**Actions/Frequency**	**Person Responsible**	**Baseline/Achieved**
1. Conduct consistent contract monitoring and technical assistance to support successful implementation of the CAPP.	1. Provide ongoing technical assistance (TA) to Office of Education regarding implementation and ongoing services. [Monthly]	Jorge Flores	

Cannabis Control and Community Engagement (Prop 64)

Support the implementation of cannabis control policies aimed at reducing youth access and mitigating the public health impacts of cannabis legalization on vulnerable populations, including monitoring community engagement activities, policy development, and community education efforts.

Goal 18: Enhance Youth Engagement and Leadership in Cannabis Control Efforts			
Objectives	**Actions/Frequency**	**Person Responsible**	**Baseline/Achieved**
1. Form and maintain a youth/adult coalition to lead cannabis control activities focused on policy, systems, and environmental changes.	1. Recruit about 6-12 youth/adult members from underserved communities and schools to participate in coalition activities.	Jorge Flores	
	2. Host at least six (6) youth/adult coalition meetings annually to educate youth on cannabis-related issues	Jorge Flores Marissa Ibarra	
	3. Organize three (3) non-meeting activities each year, such as community events or school presentations, to engage the coalition and increase public awareness on cannabis control activities.	Jorge Flores Marissa Ibarra	
2. Provide training for coalition members to effectively participate in cannabis control advocacy.	1. Conduct 4-6 trainings on public speaking, policy advocacy, community education, and other relevant skills.	Jorge Flores Marissa Ibarra	

Goal 19: Support Policy Development to Reduce Cannabis-Related Harms			
Objectives	**Actions/Frequency**	**Person Responsible**	**Baseline/Achieved**
1. Advance the adoption of a local cannabis-related policy under Prop 64.	1. Conduct key informant interviews with elected officials and policymakers to gather insights on cannabis policy needs and considerations. [New]	Marissa Ibarra Jorge Flores	
	2. Gather input from community stakeholders to inform policy considerations. [New]	Marissa Ibarra Jorge Flores	
	3. Draft policy proposals based on collected feedback. [New]	Marissa Ibarra Jorge Flores	
	4. Track progress and refine policy drafts as needed. [New]	Marissa Ibarra Jorge Flores	

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Behavioral Health Director Certification

Certification

1. I hereby certify that Contra Costa Coun has complied with all statuses, regulations, and guidelines in preparing and submitting this Three-Year Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that:

   ✔ The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct

   ✔ I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP

   ✔ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance

   ✔ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance

   ✔ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

   ✔ The IP was submitted to the local behavioral health board

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?

- ○ Yes
- ◉ No

---

a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

County Behavioral Health Agency Director contact information

3. County Name

   Contra Costa County

4. Certification for

   - ◉ Three-Year Integrated Plan
   - ○ Annual Update
   - ○ Intermittent Update

4a. Submission type

   - ◉ Draft
   - ○ Final

5. County Behavioral Health Agency Director name

   Suzanne Tavano

6. County Behavioral Health Agency Director phone number

   925-957-5169

7. County Behavioral Health Agency Director email

   suzanne.tavano@cchealth.org

Additional contact information for counties with separate MH and SUD directors (optional)

8. Name

9. Title

10. Phone

11. Email

County Behavioral Health Agency Director signature

12. Print name

Suzanne Tavano

13. Title

Director

14. Date

November 3, 2025

15. Signature

Suzanne Tavano, Digitally signed by Suzanne Tavano, PhD Date: 2025.11.10 16:52:49 -

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

17. Title

18. Date

19. Signature

County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Certification

1. I hereby certify that:

   { The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute

   Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute

   BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties fre>m the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?

   r . Yes

   (e No

a. If a.nswered yes above, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

Signature

3. Print name
   Monica Nino

4. Date
   November 3, 2025

5. Signature


Contact information

6. County Name
   !Contra Costa County

7. Certification for

   ® Three-Year Integrated Plan

   0 Annual Update

   0 Intermittent Update

7a. Submission type

   ® Draft

8. County Chief Administration Officer Name
   :Monica Nino

9. County Chief Administration Officer Phone number
   925-655-2075

10. County Chief Administration Officer Email
    monica.nino@cao.cccounty.us

Instructions

Counties shall report their planned expenditures for all behavioral health funding sources, not limited to only BHSA, along the Behavioral Health Care Continuum in Table One.

Column C: counties shall indicate whether they provide each category of services using the check box.

Columns D through I: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs by each Behavioral Health Care Continuum category.

Columns J and K: counties shall input their estimated total count of all individuals served through the county behavioral health system across all funding sources/programs. These counts may be duplicated.

Row 44: the total projected expenditures in columns D through I and total projected individuals served annually in columns J and K will be auto-populated from rows 26 through 42.

Note: For a list of all funding streams that should be included in the projected expenditures calculation for each BH Care Continuum Category, please see the Behavioral Health Services Act (BHSA) County Policy Manual Chapter 3, Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Counties must promote access to care through efficient use of state and county resources as outlined Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table One: Behavioral Health Care Continuum Projected Expenditures

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults			Total Projected Expenditures on Children/Youth (under 21)			Projected Individuals to be Served Annually (May be duplicated)	
		Year One	Year Two	Year Three	Year One	Year Two	Year Three	Eligible Adults and Older	Eligible
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 2,190,680.00	$ 2,322,594.00	$ 2,465,085.00	$ 2,494,653.00	$ 2,744,119.00	$ 3,018,531.00	380	1450.00
Early Intervention Services	☑	$ 2,367,919.00	$ 2,474,664.00	$ 2,588,182.00	$ 1,383,955.00	$ 1,515,906.00	$ 1,660,859.00	200.00	500.00
Outpatient Services	☑	$ 10,065,343.00	$ 10,988,240.00	$ 12,000,918.00	$ 1,248,581.00	$ 1,343,079.00	$ 1,446,115.00	1930.00	250.00
Intensive Outpatient Services	☑	$ 4,608,926.00	$ 5,069,819.00	$ 5,576,801.00	$ 1,222,499.00	$ 1,344,749.00	$ 1,479,224.00	781.00	100.00
Crisis and Field-Based Services	☑	$ 3,678,614.00	$ 3,818,028.00	$ 3,964,531.00	$ 466,890.00	$ 492,862.00	$ 520,810.00	834.00	145.00
Residential Treatment Services	☑	$ 16,958,986.00	$ 18,495,923.00	$ 20,181,784.00	$-	$-	$ -	1463.00	50.00
Inpatient Services	☑	$ 7,341,695.00	$ 7,876,946.00	$ 8,459,755.00	$-	$-	$-	50.00	10.00
Mental Health (MH) Services									
Primary Prevention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0
Early Intervention Services	☑	$ 19,641,228.00	$ 20,432,078.00	$ 21,262,060.00	$ 9,984,099.00	$ 10,388,731.00	$ 10,813,976.00	2004	4271
Outpatient and Intensive Outpatient Services	☑	$ 98,245,509.00	$ 103,046,636.00	$ 107,720,332.00	$ 69,947,259.00	$ 70,714,204.00	$ 71,532,391.00	15796	9099
Crisis Services	☑	$ 32,863,152.00	$ 33,539,437.00	$ 34,247,144.00	$ 1,527,612.00	$ 1,586,665.00	$ 1,648,398.00	5796	2982
Residential Treatment Services	☑	$ 1,559,978.00	$ 1,557,965.00	$ 1,556,328.00	$ 4,609,862.00	$ 4,603,911.00	$ 4,599,074.00	426	81
Hospital and Acute Services	☑	$ 69,890,411.00	$ 69,881,388.00	$ 69,874,053.00	$ -	$ -	$ -	860	540
Subacute and Long-Term Care Services	☑	$ 9,295,078.00	$ 9,283,079.00	$ 9,273,326.00	$ -	$ -	$ -	151	3
Housing Services (MH + SUD)									
Housing Intervention Component Services	☑	$ 35,587,730.00	$ 37,586,112.00	$ 38,848,454.00	$ -	$ -	$ -	#	#
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)	-	$ 314,295,249.00	$ 326,372,909.00	$ 338,018,753.00	$ 92,885,410.00	$ 94,734,226.00	$ 96,719,378.00	30671	19481

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activites, other than those that are part of the Behavioral Health Care Continuum in Table Two.

Rows 19 through 22: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Table One, "BH CoC Expenditures."

Row 24: total projected expenditures will be auto-populated from rows 19 through 22.

Note:

For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures**		
	Year One	**Year Two**	**Year Three**
Capital Infrastructure Activities	$ 27,389,352.00	$ 25,389,352.00	$ 25,389,352.00
Workforce Investment Activities	$ 3,191,089.00	$ 3,255,054.00	$ 3,321,784.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 31,218,825.00	$ 32,609,613.00	$ 34,082,700.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs	$ 19,046,574.00	$ 19,445,398.00	$ 19,861,059.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 80,845,840.00	$ 80,699,417.00	$ 82,654,895.00

Instructions

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Table Three.

Rows 19 through 34: counties shall report projected expenditures for each funding source/program.

Row 22: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 27: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 36: total expenditures will be auto-populated from rows 19 through 34.

Row 37: will be auto-validated by DHCS against rows 36, 38, and 39. Validation: total projected unspent BHSA funds should total out to $0.

Rows 38 and 39: will be auto-validated by DHCS against total projected expenditures in Tables One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Three: Projected Annual Expenditures by County BH Funding Source			
	Total Annual Projected Expenditures (Year One)	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
BHSA	$ 108,059,686.00	$ 114,586,317.00	$ 120,529,012.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 41,964,597.00	$ 42,422,741.00	$ 43,695,423.00
2011 Realignment (Public Safety Realignment)	$ 62,924,967.00	$ 64,184,461.00	$ 67,217,434.00
State General Fund	$ 17,902,257.00	$ 18,392,667.00	$ 18,931,210.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 142,267,392.00	$ 148,098,598.00	$ 154,640,006.00
Projects for Assistance in Transition from Homelessness (PATH)	$ -	$ -	$ -
Community Mental Health Block Grant (MHBG)	$ 2,701,265.00	$ 2,701,265.00	$ 2,701,265.00
Substance Use Block Grant (SUBG)	$ 6,837,706.00	$ 6,837,706.00	$ 6,837,706.00
Commercial Insurance	$ 520,000.00	$ 520,000.00	$ 520,000.00
County General Fund	$ 41,640,000.00	$ 41,640,000.00	$ 41,640,000.00
Opioid Settlement Funds	$ 10,757,891.00	$ 11,709,802.00	$ 12,602,459.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 1,206,614.00	$ 1,229,000.00	$ 1,252,863.00
Other state funding (including DSH funding)	$ 40,916,896.00	$ 39,041,638.00	$ 36,258,773.00
Other county mental health or SUD funding	$ 10,327,228.00	$ 10,442,357.00	$ 10,566,875.00
Other foundation funding	$ -	$ -	$ -
Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**
Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 488,026,499.00	$ 501,806,552.00	$ 517,393,026.00
Total projected unspent BHSA funds	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 407,180,659.00	$ 421,107,135.00	$ 434,738,131.00
Auto-validation: Table 2: Other County Expenditures	$ 80,845,840.00	$ 80,699,417.00	$ 82,654,895.00

Instructions
Counties shall report all of their planned transfers and approved Housing Intervention Component Exemption 1 in Table Four.
Rows 38-47: this section will be auto-populated from the sections below it.
Rows 38, 41, and 44: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.
Rows 39, 42, and 45: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.
Row 46: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.
Row 47: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.
Row 50: enter the base funding for Housing Interventions in dollars in D50. The base percentage will be auto-populated in C50.
Note: the base funding available for all three components is net of BHSA plan administration expenses as detailed on tab "8. BHSA_PlanAdmin." For example, a total BHSA allocation of $1 million - 9% Plan Admin (4% I&M for a small county + 5% IP annual planning) = $910,000 total allocation available for all three components. This would result in $273,000 in base funding for HI (30% of $910,000) and $318,500 for both FSP and BHSS (35% of $910,000)".
Row 51: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components in C51. Enter this percentage as a positive value.
It will automatically display as a negative value in the cell.
Row 52: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions in C52. Enter this percentage as a positive value.
Row 55: enter the base funding for Full Service Partnerships, in dollars, in D55. The base percentage will be auto-populated in C55. See the "Note" for Row 50 related to the total BHSA allocation and plan admin.
Row 59: enter the base funding for Behavioral Health Services and Supports, in dollars, in D59. The base percentage will be auto-populated in C59. See the "Note" for Row 50 related to the total BHSA allocation and plan admin.
Rows 56 and 60: enter the percentage transferred from Housing Interventions for Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.
Rows 53, 57, and 61: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively.
Rows 65, 71, and 77: auto-populated.
Rows 66, 72, and 78: Enter the transfer-out percentage as a positive number. It will automatically display as a negative value in the cell.
Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 66) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.
Rows 67, 73, and 79: enter your transfer in percentage as a positive number.
Rows 68, 74, and 80: the new base percentage is auto-populated for each year.
Row 83-87: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Unspent MHSA funds do not include encumbered WET, CFTN, or INN projects that were operational prior to July 1, 2026. Please see Policy Manual Chapter 6, Section 7 for additional information regarding MHSA to BHSA transitions.
Row 88: the total dollar amount is auto-populated.
Row 91: enter the dollar amount of prior year prudent reserve ending balance
Row 92: enter the prudent reserve maximum for your county.
Row 93: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate.
Row 94-96: enter the amount of excess prudent reserve funds to allocated to each component.
Row 97: auto-populated.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Four: BHSA Transfers
Summary (auto-populated)

	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Year One				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 36,661,051.50	$ 42,771,226.75	$ 42,771,226.75	$ 122,203,505.00
Year Two				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 36,661,051.50	$ 42,771,226.75	$ 42,771,226.75	$ 122,203,505.00
Year Three				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 36,661,051.50	$ 42,771,226.75	$ 42,771,226.75	$ 122,203,505.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ 36,661,051.50	$ 42,771,226.75	$ 42,771,226.75	$ 122,203,505.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)

Base Component	Housing Intervention Component Percentage	Housing Intervention Funds
Base Percentage	30%	$ 36,661,051.50
Amount Transferring Out	0%	$ -
Amount Transferring In	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 36,661,051.50
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage	35%	$ 42,771,226.75
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 42,771,226.75
Transferred To/From	**Behavioral Health Services and Support Percentage**	
Base Percentage	35%	$ 42,771,226.75
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 42,771,226.75

Funding Transfer Request Allocations

	Housing Intervention Component (1)	Full-Service Partnership	Behavioral Health Services and Support
Year 1			
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%
Amount Transferring Out	0%	0%	0%
Amount Transferring In	0%	0%	0%
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%
Year 2			
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%
Amount Transferring Out	0%	0%	0%
Amount Transferring In	0%	0%	0%
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%
Year 3			
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%
Amount Transferring Out	0%	0%	0%
Amount Transferring In	0%	0%	0%
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%

MHSA Transfers to BHSA

MHSA Component	Available Unspent BHSA Funds	Transferred to Housing Intervention Component	Transferred to Full-Service Partnership	Transferred to Behavioral Health Services and Support
CSS	$ 76,179,025.00	$ 36,661,051.50	$ 39,517,973.50	$ -
PEI	$ 26,459,825.00	$ -	$ 3,253,253.25	$ 23,206,571.75
INN	$ 15,016,452.00	$ -	$ -	$ 15,016,452.00
WET	$ 1,421,770.00			$ 1,421,770.00
CFTN	$ 3,126,433.00			$ 3,126,433.00
Total (auto-populated)	$ 122,203,505.00	$ 36,661,051.50	$ 42,771,226.75	$ 42,771,226.75

Excess Prudent Reserve to BHSA Components

Transfer from Prudent Reserve to BHSA Component Allocation	Amount
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 8,465,231.00
Local Prudent Reserve Maximum (2)	$ 15,355,931.81
Excess Prudent Reserve Funding that must be transferred	$ **(6,890,700.81)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

1. BHSA County Policy Manual section 6.8.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.

2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the totalfunds distributed to the county Behavioral Health Services Fundover past five years (25% for counties with a population of less than 200,000).

3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.

4. W&I Code § 5892, subdivision (b)(6)(A) states counties must spend prudent reserve funds Housing Intervention, FSP, and/or BHSS programs or services only.

Instructions
Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Table Five.

Rows 35-37: input the estimated total Housing Intervention component allocation received for each year. Row 35 will include projected BHSA funding received. Row 36 will include unspent MHSA dollars carried over. Row 37 will auto-populate the sum of Rows 35-36 to account for total funding.

Rows 42-57: input the projected expenditures and projected slots for each Housing Intervention component service category or program for each year.

Row 41: The aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent through their Medi-Cal MCP.

Row 46: Pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, E, and G. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns I - K.

Row 58: the sub-total of rows 42 - 57 will be auto-acoculated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

Row 60: input the projected expenditures for Housing Interventions component's administration for each year (see Policy Manual Chapter 6, Section B.8. Cost Principals).

Row 61: the overall total of Housing Intervention expenditures will be auto-populated from rows 58 and 60.

Row 63: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population, allocations This amount should equal 50% of Housing Interventions component

Row 64: input the total dollar amount for Housing Intervention components programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 63.

Row 66: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable.

Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 69: the proportion of funds dedicated to capital development funds will be auto-populated from rows 55 and 37.

Row 70: the proportion of funds dedicated to the chronically homeless population will be auto-populated from rows 63 and 37.

Rows 72 and 73: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Five: BHSA Components

	Total Housing Interventions Funding (1)		
	Year 1	**Year 2**	**Year 3**
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 29,353,487.00	$28,809,759	$28,636,825
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 36,661,051.50		
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 66,014,538.50	$ 28,809,759.00	$ 28,636,825.00

	Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - All Other Funding Sources		
Housing Interventions Component Programs/Services	**Year 1**	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ -	$ 1,362,690.00	$ 1,430,825.00	$ 1,297,800.00	$ -	$ -
Operating Subsidies	$ -	$ 174,269.00	$ 179,497.00	$ 169,193.00	$ -	$ -
Bundled Rental and Operating Subsidies	$ 18,741,229.00	$ 21,524,200.00	$ 22,150,524.00	$ 1,087,751.00	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 1,250,000.00	$ 2,130,114.00	$ 2,236,620.00	$ 967,869.00	$-	$-
Operating Subsidies	$ 207,571.00	$ 213,798.00	$ 220,212.00	$ 492,970.00	$ 492,970.00	$ 507,759.00
Bundled Rental and Operating Subsidies	$ 5,661,482.00	$ 7,570,848.00	$ 7,819,563.00	$ 2,834,984.00	$ 719,671.00	$ 719,671.00
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Other Housing Supports: Landlord Outreach and Mitigation Funds) (2)	$ 100,000.00	$ 100,000.00	$ 10,000.00	$ 52,080.00	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 50,000.00	$ 250,000.00	$ 250,000.00	$ 291,000.00	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ -	$ -	$ -	$-	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$-	$-	$-	$-	$ -	$ -
Capital Development Projects	$ 7,750,000.00	$ 2,500,000.00	$ 2,500,000.00	$-	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -			
Subtotal (auto-aoculated)	$ 33,760,282.00	$ 35,825,919.00	$ 36,797,241.00	$ 7,193,647.00	$ 1,212,641.00	$ 1,227,430.00

Housing Interventions Component Administrative Information	**Year 1**	**Year 2**	**Year 3**
Housing Interventions Component Administration	$ 645,967.06	$ 727,142.06	$ 746,257.26
Total Housing Interventions Expenditures (auto-populated)	$ 34,406,249.06	$ 36,553,061.06	$ 37,543,498.26

Housing Interventions Populations to be Served	**Year 1**	**Year 2**	**Year 3**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 20,844,074.00	$ 17,549,225.00	$ 18,067,107.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 1,250,000.00	$ 1,312,500.00	$ 1,378,125.00

Housing Interventions Transfer Information	**Year 1**	**Year 2**	**Year 3**
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -

Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	12%	9%	9%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	32%	61%	63%

Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY	100	110	125
Eligible Adults/Older Adults	1125	1175	1190

References
1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.
2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.
3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.
4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.
5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).
6. W&I Code § 5892, subdivision (b)(2).
7. W&I Code § 5892, subdivision (a)(1)(A)(ii) states no more than 25% of Housing Interventions funds may be used for capital development.
8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Instructions

Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Table Six.

Rows 22-24: input the total estimated FSP component allocation received for each year. Row 22 will include projected BHSA funding received. Row 23 will include unspent MHSA dollars carried over. Row 24 will auto-populate the sum of Rows 22-23 to account for total funding.

Rows 29-37: input the projected expenditures for each FSP service category or program for each year.

Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 29 - 34. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 35 and 36, accordingly.

Row 38: the subtotal of FSP programs/services will be auto-populated from rows 29 through 37.

Row 40: input the projected expenditures for the FSP component's administration for each year (see Policy Manual Chapter 6, Section B.8 Cost Principals).

Row 41: total projected expenditures for FSP for each year will be auto-populated from rows 38 and 40.

Row 43: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable.

Row 44: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.

Rows 46 and 47: input the estimated unduplicated count of individuals that will be served across all FSP programs.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Six: BHSA Components

Total Full Service Partnership (FSP) Funding	Year 1	Year 2	Year 3
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$34,245,735	$33,611,385	$33,409,630
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ 42,771,226.75		
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 77,016,961.75	$ 33,611,385.00	$ 33,409,630.00

Full Service Partnership Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - Federal Financial Participation			Projected Expenditures - All Other Funding Sources		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 3,098,327.00	$ 3,253,243.00	$ 3,415,905.00	$ 2,500,000.00	$ 2,500,000.00	$ 2,500,000.00	$ -	$ -	$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 3,880,133.00	$ 4,074,139.00	$ 4,277,846.00	$ 1,125,000.00	$ 1,125,000.00	$ 1,125,000.00	$ -	$ -	$ -
FSP Intensive Case Management	$ 8,112,575.00	$ 8,473,383.00	$ 9,004,480.00	$ 2,620,000.00	$ 2,620,000.00	$ 2,620,000.00	$ -	$ -	$ -
High Fidelity Wraparound	$ 5,964,101.00	$ 6,262,306.00	$ 6,575,422.00	$ 2,900,000.00	$ 2,900,000.00	$ 2,900,000.00	$ -	$ -	$ -
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 1,816,675.00	$ 3,633,349.00	$ 5,450,024.00	$ 500,000.00	$ 500,000.00	$ 500,000.00	$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$ 223,891.00	$ 234,586.00	$ 245,815.00	$ -	$ -	$ -	$ -	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ 15,016,143.00	$ 15,120,123.00	$ 15,521,923.00	$ -	$ -	$ -	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc,.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Innovative FSP Pilots and Projects	$ -	$ -	$ -						
Subtotal (auto-populated)	$ 38,111,845.00	$ 41,051,129.00	$ 44,491,415.00	$ 9,645,000.00	$ 9,645,000.00	$ 9,645,000.00	$ -	$ -	$ -
FSP Administrative Information	**Year 1**	**Year 2**	**Year 3**						
Full Service Partnership Administration	$ 203,355.00	$ 213,523.00	$ 224,199.00						
Total Full Service Partnership Expenditures (auto-populated)	$ 38,315,200.00	$ 41,264,652.00	$ 44,715,614.00						
FSP Transfer Information	**Year 1**	**Year 2**	**Year 3**						
Transfers into FSP component from Local Prudent Reserve	$ -	$ -	$ -						
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -						
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**						
Eligible Children/TAY	616	616	616						
Eligible Adults/Older Adults	2262	2262	2262						

References
1. W&I Code § 5892, subdivision (a)(2)(A) states 35% of BHS funds distributed to counties shall be used for Full Service Partnership Programs.
2. May be bundled or un-bundled depending on county BH-CONNECT opt-in.

Instructions
Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Table Seven.
Row 26-28: input the total estimated BHSS component allocation received for each year. Row 26 will include projected BHSA funding received. Row 27 will include unspent MHSA dollars carried over. Row 28 will auto-populate the sum of Rows 26-27 to account for total funding.
Rows 31-43: input the projected expenditures for each BHSS service category or program for each year.
Row 44: the subtotal for projected expenditures will be auto-populated from rows 31-33, 36, 37, 40, and 43.
Row 46: input the total projected expenditures for BHSS administration for each year (see Policy Manual Chapter 6, Section B.8. Cost Principals).
Row 47: the total for projected BHSS expenditures will be auto-populated from rows 44 and 46.
Row 49: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable).
Row 50: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.
Row 52: the proportion of EI funds will auto-populate from rows 33 and 28. Note: MHSA WET and CF/TN funds in Row 61-62 will be deducted from the revenue.
Row 53: the proportion of Youth-Focused EI funds will auto-populate from rows 33 and 34.
Rows 55 and 56: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.
Rows 58 and 59: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.
Rows 61 and 62: auto-populates projected estimated amount of MHSA WET and CF/TN funds that will be available in the BHSA BHSS component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.
2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Seven: BHSA Components									
Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - Federal Financial Participation			Projected Expenditures - All Other Funding Sources		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$34,245,735	$33,611,385	$33,409,630						
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 42,771,226.75	$ -	$ -						
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 77,016,961.75	$ 33,611,385.00	$ 33,409,630.00						
Behavioral Health Services and Supports Category (1)									
BHSS Programs/Services									
Children's System of Care-Non FSP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 1,108,155.00	$ 1,364,238.00	$ 1,628,991.00	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ -	$ -	$ -
Early Intervention Expenditures	$ 19,579,666.00	$ 20,370,061.00	$ 21,203,876.00	$ 2,000,000.00	$ 2,000,000.00	$ 2,000,000.00	$ -	$ -	$ -
Total Youth-Focused (25 years and younger) Early	$ 9,984,099.00	$ 10,388,731.00	$ 10,813,976.00	$ -	$ -	$ -	$ -	$ -	$ -
Coordinated Specialty Care for	$ 4,188,771.00	$ 4,410,299.00	$ 4,624,665.00	$ -	$ -	$ -	$ -	$ -	$ -
Outreach and Engagement	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 2,995,328.00	$ 3,051,463.00	$ 3,110,049.00	$ 750,000.00	$ 750,000.00	$ 750,000.00	$ -	$ -	$ -
Dedicated BHSA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 5,000,000.00	$ 5,000,000.00	$ 5,000,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Innovative BHSS Pilots and Projects	$ -	$ -	$ -						
Subtotal (auto-populated)	$ 28,683,149.00	$ 29,785,762.00	$ 30,942,916.00	$ 3,000,000.00	$ 3,000,000.00	$ 3,000,000.00	$ -	$ -	$ -
BHSS Administrative Information	**Year 1**	**Year 2**	**Year 3**						
Behavioral Health Services and Supports Administration	$ 6,655,088.00	$ 6,982,842.00	$ 7,326,984.00						
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 35,338,237.00	$ 36,768,604.00	$ 38,269,900.00						
BHSS Prudent Reserve Transfer Information	**Year 1**	**Year 2**	**Year 3**						
Transfers into BHSS component from Local Prudent Reserve	$ -	$ -	$ -						
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -						
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**						
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	27%	70%	73%						
Youth-Focused Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	51%	51%	51%						
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**						
Eligible Children/TAY	5110	5350	5590						
Eligible Adults/Older Adults	12560	12920	13280						
Projected BHSS Funds transferred to WET or CF/TN	**Year 1**	**Year 2**	**Year 3**						
BHSS transfer to WET	$ -	$ -	$ -						
BHSS transfer to CF/TN	$ -	$ -	$ -						
Projected MHSA-Origin WET and CF/TN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**						
Estimated MHSA WET Funds	$ 1,421,770.00	$ 1,421,770.00	$ 1,421,770.00						
Estimated MHSA CF/TN Funds	$ 3,126,433.00	$ 3,126,433.00	$ 3,126,433.00						

References

1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).

2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.

3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.

4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.

5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Instructions

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in Table Eight.

Row 30: the total dollar amounts of BHSA component allocations dedicated to improvement and monitoring activities, including plan operations, quality and outcomes, data reporting pursuant to W&I Code § 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants by year. Under W&I Code § 5892 (e)(2)(B), the total amount shall equal 2% or less of total projected annual revenues of the local behavioral health services fund for counties with a population over 200,000 or 4% of the total projected annual revenues of the local behavioral health services fund for counties with a population of less than 200,000. Any costs that exceed that amount will be included in the governor's budget.

Row 31: the total dollar amount of BHSA component allocations dedicated to county Integrated Plan annual planning costs, including stakeholder engagement in planning and local Behavioral Health Board activities by year. Under W&I Code § 5892 (e)(1)(B), this amount shall be 5% or less of total projected annual revenues of the local behavioral health services fund. Any costs that exceed that amount will be included in the governor's budget.

Row 32: The total dollar amounts for new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 34: the total projected annual revenues of the Local Behavioral Health Services Fund.

Row 35: the proportion of funding used for improvement and monitoring will be auto-populated from rows 30 and 34.

Row 36: the proportion of funding used for planning expenditures will be auto-populated from rows 31 and 34.

Row 37: For counties with a population under 200,000: add any Improvement and Monitoring expenditures that exceed 4% of the total projected annual revenues of the Local Behavioral Health Services Fund, any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund, and any new and ongoing administrative costs to obtain the input for this cell.

For counties with a population over 200,000: add any Improvement and Monitoring expenditures that exceed 2% of the total projected annual revenues of the Local Behavioral Health Services Fund, any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund, and any new and ongoing administrative costs to obtain the input for this cell.

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year 1**	**Year 2**	**Year 3**
Total Projected Improvement and Monitoring Expenditures	$ 1,956,899.14	$ 1,920,650.60	$ 1,909,121.70
Total Projected County Integrated Plan Annual Planning Expenditures	$ 664,396.21	$ 684,328.10	$ 704,857.94
New and Ongoing Administrative Costs	$ -	$ -	$ -
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$97,844,957	$ 96,032,529.00	$ 95,456,085.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	2%	2%	2%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	1%	1%	1%
Supplemental BHT Implementation Funding (1)	$ -	$ -	$ -

References
1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision.

Instructions

Counties shall report their estimated local prudent reserve maximums for each allocation component in Table Nine.

Rows 18 and 19: dollar amounts will be auto-populated from Table 4 rows 91 and 92

Row 20: total excess prudent reserve dollars will be auto-populated from rows 18 and 19.

Rows 21-23: total dollar amounts will be auto-populated from Table 4, rows 94-96.

Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21 through 23.

Row 25: auto-validates from rows 20 and 24 to ensure the dollar amounts match with "equal" or "does not equal" statements.

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations for each plan year will be auto-populated from Table 5 row 65, Table 6 row 42, and Table 7 row 46.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations for each plan year will be auto-populated from Table 5 row 64, Table 6 row 41, and Table 7 row 45.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 8,465,231.00
Local Prudent Reserve Maximum (1)	$ 15,355,931.81
Excess Prudent Reserve Funds (auto-populated)	$ (6,890,700.81)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reservice funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	DOES NOT EQUAL
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -
References	
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the totalfunds distributed to the county Behavioral Health Services Fundover past five years (25% for counties with a population of less than 200,000).	

Instructions

Counties will complete Tables One through Nine prior to completing Table Ten. Data on other tables will auto-populate to Table Ten.

Row 22: the new base percentage for each component will be auto-populated from Table 4, row 38.

Rows 23-25: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Table 5, row 35; Table 6, row 22; and Table 7, row 25, respectively.

Row 28: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Table 4 row 46.

Rows 30, 37, and 44: The total amount of funding transfered from each BHSA component into the prudent reserve for each plan year will be auto-populated from Table 5, row 67; Table 6, row 44; and Table 7, row 49.

Rows 31, 38, and 45: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Table 5, row 66; Table 6, row 43; and Table 7, row 48.

Rows 32, 39, and 46: estimated available funding will be auto-populated from rows 28 through 31, 35 through 38, and 42 through 45.

Rows 33, 40, and 47: estimated expenditures for each component will be auto-populated from Table 5, row 61; Table 6, row 41; and Table 7, row 46.

Rows 35 and 42: The estimated unspent funds from prior fiscal years will be auto-populated from rows 32 and 33 and rows 39 and 40, respectively.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Ten: BHSA Funding Summary (auto-populated)

	Housing Interventions	Full-Service Partnerships	Behavioral Health Services and Supports	Total
Allocation Percentage, with Transfers	30%	35%	35%	100%
Year One Component Allocations	$ 29,353,487.00	$ 34,245,735.00	$ 34,245,735.00	$ 97,844,957.00
Year Two Component Allocations	$ 28,809,759.00	$ 33,611,385.00	$ 33,611,385.00	$ 96,032,529.00
Year Three Component Allocations	$ 28,636,825.00	$ 33,409,630.00	$ 33,409,630.00	$ 95,456,085.00
BHSA Funding Summary	**Housing Interventions**	**Full Service Partnerships**	**Behavioral Health Services and Supports**	**Totals**
Year One				
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) ***(Unspent Carryover MHSA Funds)***	$ 36,661,051.50	$ 42,771,226.75	$ 42,771,226.75	$ 122,203,505.00
Estimated Year One Component Allocations ***(BHSA Funding Only)***	$ 29,353,487.00	$ 34,245,735.00	$ 34,245,735.00	$ 97,844,957.00
Transfers Into PR	$ -	$ -	$ -	$ -
Transfers From PR	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year One	$ 66,014,538.50	$ 77,016,961.75	$ 77,016,961.75	$ 220,048,462.00
Estimated Total Year One Expenditures	$ 34,406,249.06	$ 38,315,200.00	$ 35,338,237.00	$ 108,059,686.06
Year Two				
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 31,608,289.44	$ 38,701,761.75	$ 41,678,724.75	$ 111,988,775.94
Estimated New Year Two Component Allocations ***(BHSA Funding Only)***	$ 28,809,759.00	$ 33,611,385.00	$ 33,611,385.00	$ 96,032,529.00
Transfers Into PR	$ -	$ -	$ -	$ -
Transfers from PR	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year Two	$ 60,418,048.44	$ 72,313,146.75	$ 75,290,109.75	$ 208,021,304.94
Estimated Total Year Two Expenditures	$ 36,553,061.06	$ 41,264,652.00	$ 36,768,604.00	$ 114,586,317.06
Year Three				
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 23,864,987.38	$ 31,048,494.75	$ 38,521,505.75	$ 93,434,987.88
Estimated New Year Three Component Allocations ***(BHSA Funding Only)***	$ 28,636,825.00	$ 33,409,630.00	$ 33,409,630.00	$ 95,456,085.00
Transfers Into PR	$ -	$ -	$ -	$ -
Transfers from PR	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year Three	$ 52,501,812.38	$ 64,458,124.75	$ 71,931,135.75	$ 188,891,072.88
Estimated Total Year Three Expenditures	$ 37,543,498.26	$ 44,715,614.00	$ 38,269,900.00	$ 120,529,012.26