Behavioral Health
CALAVERAS COUNTY

BEHAVIORAL HEALTH SERVICES ACT

Fiscal Years 2026–2029

Integrated Plan for Behavioral Health Services & Outcomes

A three-year plan for how Calaveras County will deliver behavioral health care, housing support, and crisis response to our residents.

APPROVED BY DHCS

Calaveras County Behavioral Health Services
891 Mountain Ranch Road, San Andreas, CA 95249
(209) 754-6525

24-Hour Crisis Line
(800) 499-3030
or dial 988

About This Plan

Proposition 1, passed by California voters in March 2024, reshaped the Mental Health Services Act into the **Behavioral Health Services Act (BHSA)**. Under the BHSA, every county submits a three-year Integrated Plan describing how it will use behavioral health funds to serve residents living with mental health and substance use conditions.

This document is Calaveras County's Integrated Plan for fiscal years 2026–2029, as approved by the California Department of Health Care Services (DHCS). It has been typeset for publication and printing; the content is the plan as approved.

WHO THIS IS FOR

Residents, families, clients, community partners, providers, and anyone who wants to understand how behavioral health services are funded and delivered in Calaveras County.

WHAT'S INSIDE

Our service landscape, statewide goals and local data, the community planning process, funded programs, housing interventions, workforce strategy, and budget.

HOW TO COMMENT

Public input shapes every plan update. Contact Behavioral Health Services at (209) 754-6525 to learn about upcoming stakeholder meetings and comment periods.

Need help today?

Call our **24-hour crisis line** at **(800) 499-3030** or **(209) 754-3239**. You can also dial or text **988**. For any life-threatening emergency, call **911**.

For appointments, referrals, and general questions, call **(209) 754-6525**, Monday–Friday, 8:00 a.m.–5:00 p.m. Walk-ins are welcome at the Mental Health Clinic, 891 Mountain Ranch Road, Building N, San Andreas.

Our Community, By the Numbers

Service counts reported in this plan reflect fiscal year 2023–2024, the baseline year required by DHCS.

1,256

Adults & older adults who received mental health or substance use services

406

Children & youth under 21 who received mental health or substance use services

154

Adults who moved from unsheltered homelessness into shelter or housing

127

Of those, the number who moved into permanent housing

Six Priority Goals for 2026–2029

DHCS asks every county to select statewide behavioral health goals for focused improvement. Calaveras County prioritized these six, and reports on each of them inside this plan.

1. **Access to care**
   Getting more residents connected to mental health and substance use treatment.
2. **Homelessness**
   Housing stability for residents experiencing or at risk of homelessness.
3. **Institutionalization**
   Fewer avoidable psychiatric hospitalizations and involuntary holds.
4. **Justice involvement**
   Support for residents on probation, in custody, or reentering the community.
5. **Removal of children from home**
   Keeping families together through earlier, stronger support.
6. **Untreated conditions**
   Reaching residents who need care but are not yet receiving it.

A New Home for Behavioral Health Care

Calaveras County is building a new, county-owned behavioral health facility on the main government campus in San Andreas. Construction is underway now, and we expect to move in during **summer 2027**.

Summer
2027

Today, Calaveras County residents receive behavioral health services across several buildings and leased spaces. The new facility brings that care together under one roof — a single, recognizable front door for anyone in the county who needs help.

The building is designed around what residents and staff told us matters most:

- **Privacy and dignity** — more soundproofed rooms for counseling, assessment, and family sessions.
- **Room for crisis and walk-in support** — space to meet someone the day they ask for help, not weeks later.
- **Services side by side** — outpatient care, substance use treatment, housing navigation, and program staff in one accessible location.
- **Room to grow** — capacity for the expanded programs described throughout this plan, including field-based outreach and open-access intake.

Until the move is complete, all services continue at their current locations. The Mental Health Clinic at 891 Mountain Ranch Road, Building N remains open for walk-ins Monday through Friday, 8:00 a.m.–5:00 p.m.

Questions about the new facility?

Call Behavioral Health Services at **(209) 754-6525** or visit **behavioralhealth.calaverasgov.us** for construction updates and move-in information as summer 2027 approaches.

Contents

SECTION I

General Information

County, City, Joint Powers, or Joint Submission

County

Entity Name

Calaveras County

Behavioral Health Agency Name

Calaveras County Behavioral Health Services

Behavioral Health Agency Mailing Address

509 East St. Charles Street San Andreas, CA 95249

SECTION II

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 (i.e., for 2026-2029 IP, data from FY 2023-2024 should be used).

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.For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan.

CHILDREN AND YOUTH

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.

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	332
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	150
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	18
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	406

Criteria	Number of Children and Youth Under Age 21
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	0
Were chronically homeless or experiencing homelessness or at risk of homelessness	0
Were in the juvenile justice system	30
Have reentered the community from a youth correctional facility	<11*
Were served by the Mental Health Plan and had an open child welfare case	44
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	0
Have received acute psychiatric care	<11*

ADULTS AND OLDER ADULTS

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.

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	171
Received Medi-Cal SMHS	1127
Received DMC or DMC-ODS services	261
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	1256
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	209
Experienced unsheltered homelessness	149
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	154
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	127
Were in the justice system (on parole or probation and not currently incarcerated)	237

Criteria	Number of Adults and Older Adults
Were incarcerated (including state prison and jail)	62
Reentered the community from state prison or county jail	1104
Received acute psychiatric services	50

Input the number of persons in designated and approved facilities who were Admitted or detained for 72-hour evaluation and treatment rate

95

Admitted for 14-day and 30-day periods of intensive treatment

120

Admitted for 180-day post certification intensive treatment

95

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman- Petris-Short (LPS) Act programs

0

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)

0

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

Please explain

Due to small population size and data suppression thresholds, some reported counts may reflect limited sample sizes rather than absence of service need. The County supplements state reporting dashboards with local utilization data and program-level monitoring when available.

Please describe the local data used during the planning process

The data used primarily comes from our Electronic Health Record

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

LOCAL CARE ACT IMPLEMENTATION

Identify the specific service components within your 3-year Integrated Plan that will support CARE participants. Explain how the county will ensure these individuals receive priority access and specialized coordination within the broader behavioral health continuum, including housing if appropriate.

Calaveras County Behavioral Health has not had any individuals formally enrolled as CARE participants to date. The County has received five CARE petitions; all involved individuals who were already known to Behavioral Health and actively receiving services consistent with current system capacity.

As a small, rural county, Calaveras operates within significant workforce and infrastructure constraints. Consistent with California Welfare and Institutions Code § 5887, the County utilizes an integrated service delivery model rather than developing duplicative or parallel program structures.

The County's behavioral health continuum including outpatient services, case management, crisis response, and cross-system coordination already serves individuals who meet CARE criteria. As such, CARE has not resulted in the development of new service components or expanded capacity but has introduced additional administrative and legal coordination processes layered onto existing services.

Priority access is determined through clinical triage and medical necessity, consistent with DHCS guidance under CalAIM. High-acuity individuals are prioritized regardless of referral source.

Housing coordination is addressed through existing partnerships and Medi-Cal Community Supports where applicable; however, housing availability remains a structural limitation and has not been expanded through CARE implementation.

Describe how CARE referral pathways will be integrated into existing referral and service pathways within the county behavioral health system.

CARE referral pathways are operationally integrated into existing Behavioral Health workflows. All individuals referred through CARE to date have already been connected to services.

Referrals initiated through CARE petitions are reviewed against existing client records to confirm service engagement. In all cases to date, individuals were already open to services, receiving case management, and/or actively engaged in treatment.

CARE has introduced additional coordination requirements with the courts, County Counsel, and the Public Guardian. Behavioral Health has been required to complete CARE petitions as a procedural step prior to pursuing conservatorship, regardless of an individual's existing service connection or engagement status. As a result, CARE has functioned operationally as a procedural component within an existing legal pathway rather than as a distinct access point for previously unserved individuals. While the County remains compliant with statutory requirements, this has increased administrative workload without altering underlying service delivery pathways.

Describe the process for identifying and redirecting individuals who are potentially eligible for CARE to alternative pathways when a formal petition is not required or appropriate. For individuals redirected from CARE, describe how the county will confirm and document successful connection to services.

Calaveras County utilizes established clinical assessment, documentation, and case review processes to determine the most appropriate level of care for individuals who may be considered for CARE. When individuals are identified through CARE-related processes, Behavioral Health evaluates: • Current service engagement

• Clinical acuity and medical necessity

• Eligibility for existing services and supports

To date, all individuals identified through CARE processes have been long-term clients who were already actively engaged in services to the extent of their capacity. These individuals present with high clinical acuity and complexity that exceeds the level of care available within the County's local service array, indicating a need for a higher level of care than can be provided within existing community-based resources.

The limiting factor in these cases has not been identification or engagement, but the availability of appropriate levels of care.

As such, redirection has not involved transition to alternative local pathways, but rather continued efforts to stabilize and support individuals within system limitations while seeking access to higher levels of care when available, including out-of-county or more intensive treatment options. Access to appropriate higher levels of care and housing resources is dependent on regional and statewide availability and development, which are outside the direct control of County Behavioral Health. The County continues to actively pursue and coordinate all available options to the extent possible within these constraints.

Care is maintained and adjusted through:

• Ongoing case management

• Crisis intervention and stabilization

• Coordination with medical, housing, and community-based partners

• Efforts to identify and access higher levels of care appropriate to clinical need

Connection to services and care coordination efforts are confirmed and documented through the County's electronic health record, ensuring continuity of care and compliance with DHCS documentation requirements.

Consistent with DHCS and CalAIM performance expectations, program effectiveness is evaluated based on service access, engagement, stabilization, and functional outcomes, rather than solely on referral or petition activity.

Calaveras County will continue to monitor CARE implementation; however, within a small, resource- constrained system where the target population is already known and engaged, CARE has primarily functioned as an administrative and procedural layer often in support of existing legal pathways rather than expanding access to new populations or increasing service capacity.

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction.

> **Does the county behavioral health system use an Electronic Health Record (EHR)?**
>
> **Yes**

> **Please select which of the following EHRs the county uses**
>
> - Qualifacts credible.

> **County participates in a Qualified Health Information Organization (QHIO)?**
>
> **Yes**

> **Please select which QHIO the county participates in**
>
> - Manifest MedEx

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.

> **Please provide the link to the county's API endpoint on the county behavioral health plan's website**
>
> https://fhir.cbhstg4.crediblebh.com/

> **Does the county wish to disclose any implementation challenges or concerns with these requirements?**
>
> **No**

> **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?**
>
> **No**

County Behavioral Health System Service Delivery Landscape

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) GRANT COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT (MHBG) SUBSTANCE USE PREVENTION, TREATMENT, AND RECOVERY SERVICES BLOCK GRANT (SUBG) OPIOID SETTLEMENT FUNDS (OSF)

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

Yes

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

- Prevent Overdose Deaths and Other Harms (Harm Reduction)
- Treat Opioid Use Disorder (OUD)
- Support People in Treatment and Recovery

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

No

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

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:

- Other Programs and Services

Please describe

Calaveras County Behavioral Health provides the full array of community mental health services required under the Bronzan-McCorquodale Act (BMA). These mandated services are delivered through a combination of county-operated programs, contracted providers, and regional partnerships to ensure access across the continuum of care. Services include case management; comprehensive evaluation and assessment; group services; individualized service planning; medication education and management; pre- crisis and crisis services; rehabilitation and support services; residential services; services for individuals experiencing homelessness; twenty-four-hour treatment services; and vocational rehabilitation.

BMA funding supports the county's baseline community mental health service system and is used to sustain core operational capacity, including staffing, crisis response, outpatient and residential services, and access to higher

levels of care as required. These funds are braided with Medi-Cal reimbursement and other local resources to maintain service availability and continuity of care.

While Calaveras County ensures access to all required BMA services, certain specialized service models may be delivered using modified or hybrid approaches due to the county's rural geography, limited population size, and workforce constraints. Where full-fidelity implementation of specific models is not feasible, the county utilizes contracted services or regional partnerships to meet statutory requirements and maintain access for beneficiaries.

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

Yes

Please describe these challenges or concerns:

Calaveras County Behavioral Health faces several structural implementation challenges in sustaining the full continuum of community mental health services required under the Bronzan-McCorquodale Act (BMA). These challenges are primarily associated with rural system characteristics, including geographic dispersion, limited provider capacity, infrastructure constraints, and small population size.

The County serves a large, mountainous geographic area with limited public transportation options. Travel distances between communities can create barriers to timely access for both routine outpatient services and higher levels of care, particularly for individuals experiencing acute behavioral health needs, homelessness, or transportation instability. These geographic factors also affect the County's ability to centralize certain specialty services or maintain facility-based program models that require consistent on- site participation.

Workforce availability represents an additional implementation challenge. As a small rural jurisdiction, Calaveras County experiences ongoing difficulty recruiting and retaining licensed clinicians, psychiatric providers, and specialized program staff. Competition from larger neighboring counties, limited local housing availability, and smaller service volumes can affect the feasibility of developing and sustaining full- fidelity program models such as intensive rehabilitation services, residential treatment, and structured vocational programs. These workforce constraints may necessitate the use of hybrid service approaches, regional partnerships, contracted providers, and telehealth-supported care coordination to ensure statutory service access.

Infrastructure limitations also affect service delivery. The County does not operate certain licensed behavioral health facilities locally, such as psychiatric health facilities or crisis residential programs, due to the capital investment, regulatory requirements, and minimum utilization thresholds necessary to sustain these settings safely and effectively. As a result, access to some twenty-four-hour treatment services and residential levels of care is facilitated through regional provider networks, with County staff supporting referral coordination, discharge planning, and continuity of care upon return to the community.

Out-of-county placements can also create challenges for individuals' natural support systems. Family members and caregivers may experience difficulty maintaining regular contact due to travel distance, transportation limitations, and competing work or caregiving responsibilities. For youth in particular, this can impact opportunities for in-person family engagement, visitation, and participation in treatment planning activities, which are important components of successful stabilization and transition back to the community.

Finally, the relatively small population base in Calaveras County can create challenges in maintaining specialized group services or vocational rehabilitation programming at consistent enrollment levels. Fluctuating service demand may require flexible staffing models and integrated service delivery structures that combine multiple program functions to maintain fiscal and clinical sustainability.

Despite these implementation challenges, Calaveras County remains committed to ensuring access to all statutorily required BMA services through a combination of direct service provision, contracted partnerships, regional collaboration, and ongoing system development efforts supported through Behavioral Health Services Act (BHSA) planning and workforce investments.

PUBLIC SAFETY REALIGNMENT (2011 REALIGNMENT)

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

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

Yes

Please describe these challenges or concerns

Public Safety Realignment (AB 109, 2011) encourages the use of collaborative specialty courts such as Drug Court, Mental Health Court, Veterans Court, and other diversion models. Due to Calaveras County's small population and low participant volume, the County does not currently operate designated specialty courts, as the number of eligible participants is not sufficient to sustain separate court calendars or dedicated programs.

Similarly, Regular and Perinatal Drug Medi-Cal services can present implementation challenges in a small rural county due to low service volume, which can make it difficult to sustain specialized program structures while maintaining fiscal and operational efficiency.

In addition, collaborative court models require consistent participation from multiple justice partners, including the Court, Probation, District Attorney, Public Defender, and Behavioral Health. In a rural system with limited staffing and contracted partners such as the Public Defender, coordination can be challenging. As a result, Behavioral Health continues to provide treatment services and collaborate with justice partners on a case-by-case basis rather than through formally designated specialty courts.

Behavioral Health continues to meet statutory treatment responsibilities through individualized care coordination and court collaboration on a case-by-case basis.

MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES (SMHS)

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

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
- CSC for FEP
- FACT
- IPS Supported Employment
- Peer Support Services

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

Yes

Please describe these challenges or concerns

Calaveras County Behavioral Health is responsible for ensuring access to all medically necessary Specialty Mental Health Services (SMHS) available through the Medi-Cal program. While the County directly provides many outpatient and care coordination services, certain specialty services and facility-based levels of care are not locally operated due to structural challenges common in small rural jurisdictions.

Calaveras County has a small population base, a geographically dispersed service area, and a limited behavioral health workforce. The County's mountainous terrain, large geographic area, and limited public transportation infrastructure also create barriers to centralized service delivery, making it difficult for residents in some communities to regularly access facility-based programs located in a single site.

These factors can make it difficult to develop and sustain certain specialized services that require licensed facilities, certified evidence-based practice teams, or minimum enrollment levels to operate safely and effectively. Programs such as Day Treatment Intensive, Day Rehabilitation, residential treatment, and certain intensive youth evidence-based practices require staffing models and participant volumes that are challenging to maintain in rural communities.

In addition, some services require specialized infrastructure or licensing standards, such as Psychiatric Health Facilities or Crisis Stabilization Units. Establishing and sustaining these programs requires facility infrastructure, specialized staffing, and sufficient service utilization to maintain clinical and financial viability.

Due to the County's small population size, low service volume for certain specialty programs, and limited workforce availability, Calaveras County must rely on a combination of County-operated services, contracted providers, and regional partnerships to ensure beneficiaries have access to the full continuum of medically necessary specialty mental health services. When services are not available locally, individuals may be referred to licensed providers or facilities located in neighboring counties, with County behavioral health staff supporting care coordination, referrals, and follow-up services.

Through implementation of the Behavioral Health Services Act (BHSA), the County is also prioritizing strategic investments to strengthen local service capacity where feasible, including development of mobile field-based services, expansion of evidence-based practices for youth and families, and workforce development initiatives.

Adult Residential Treatment Services

Implementation Category: Regional / Out-of-County Access

Access / Implementation Approach: Access is provided through contracted residential treatment providers located in neighboring counties. Due to infrastructure and licensing requirements associated with residential behavioral health facilities, the County relies on regional providers when residential treatment is medically necessary.

Crisis Intervention

Implementation Category: County Direct Service

Access / Implementation Approach: Provided by County behavioral health clinicians as part of routine Specialty Mental Health Services crisis response services.

Crisis Residential Treatment Services

Implementation Category: Regional / Out-of-County Access

Access / Implementation Approach: Access arranged through regional crisis residential programs when medically necessary due to limited local facility capacity.

Crisis Stabilization

Implementation Category: Hospital Emergency Department Partnership

Access / Implementation Approach: Calaveras County does not operate a dedicated Crisis Stabilization Unit. Individuals experiencing behavioral health crises are typically transported to local hospital emergency departments for crisis evaluation, including assessments related to involuntary detention when appropriate. Individuals may receive evaluation, safety planning, and referral to outpatient services or be transferred to inpatient psychiatric facilities when hospitalization is medically necessary.

To strengthen local crisis response capacity and improve timely access to stabilization services, the County is actively exploring options to develop or contract for crisis stabilization services. This includes assessing potential partnerships with regional providers and evaluating feasible service models that align with rural service delivery constraints and available workforce resources.

Day Rehabilitation

Implementation Category: Working to Secure Provider

Access / Implementation Approach: The County is actively working to identify and contract with a qualified provider to offer Day Rehabilitation services. Limited provider availability and population volume have made development of this service locally challenging.

Day Treatment Intensive

Implementation Category: Working to Secure Provider

Access / Implementation Approach: The County is actively working to identify and contract with a qualified provider to offer Day Treatment Intensive services. Recruitment of providers capable of operating licensed day treatment programs has been challenging in the rural service area.

Mental Health Services

Implementation Category: County Direct Service

Access / Implementation Approach: Provided by County clinicians and contracted providers across outpatient behavioral health settings.

Medication Support Services

Implementation Category: County Direct Service

Access / Implementation Approach: Delivered by County psychiatric providers and contracted psychiatric services.

Mobile Crisis Services

Implementation Category: Developing Under BHSA

Access / Implementation Approach: The County is developing mobile field-based service capacity to improve crisis response, outreach, and rapid linkage to behavioral health and substance use disorder treatment services, particularly for individuals in remote areas of the County.

Psychiatric Health Facility (PHF) Services

Implementation Category: Regional / Out-of-County Access

Access / Implementation Approach: Access provided through contracted Psychiatric Health Facility providers outside the county due to infrastructure and licensing requirements associated with operating a PHF.

Psychiatric Inpatient Hospital Services

Implementation Category: Regional / Out-of-County Access

Access / Implementation Approach: Access provided through regional inpatient psychiatric hospitals when medically necessary.

Targeted Case Management

Implementation Category: County Direct Service

Access / Implementation Approach: Provided by County behavioral health staff and contracted providers.

Functional Family Therapy (FFT)

Implementation Category: Developing Under BHSA

Access / Implementation Approach: The County is planning to develop Functional Family Therapy capacity as part of BHSA service expansion to increase access to evidence-based family therapy services for youth.

High Fidelity Wraparound

Implementation Category: Developing Under BHSA

Access / Implementation Approach: The County is strengthening wraparound capacity through children's system of care development and BHSA service expansion.

Intensive Care Coordination (ICC)

Implementation Category: County Direct Service

Access / Implementation Approach: Delivered through County children's services teams coordinating care for eligible youth and families.

Intensive Home-Based Services (IHBS)

Implementation Category: County Direct Service

Access / Implementation Approach: Provided by County behavioral health staff as part of the children's system of care.

Multisystemic Therapy (MST)

Implementation Category: Service Under Evaluation

Access / Implementation Approach: MST requires specialized training, certification, and dedicated team staffing. Calaveras County does not currently operate or contract for MST services due to workforce and population limitations. The County will continue exploring regional partnerships or alternative intensive family-based services for youth when clinically appropriate.

Parent-Child Interaction Therapy (PCIT)

Implementation Category: Developing Under BHSA

Access / Implementation Approach: The County is exploring implementation of PCIT through BHSA- supported workforce development and training initiatives.

Therapeutic Behavioral Services (TBS)

Implementation Category: Contracted Provider

Access / Implementation Approach: Provided through contracted agencies serving eligible youth.

Therapeutic Foster Care (TFC)

Implementation Category: Regional / Child Welfare Partnership

Access / Implementation Approach: Access coordinated with child welfare partners and contracted agencies.

Other Medically Necessary SMHS (Under 21 – EPSDT)

Implementation Category: County Coordinated Access

Access / Implementation Approach: The County ensures access through a combination of County services, contracted providers, and regional specialty providers as required under EPSDT.

As a rural county, Calaveras must balance service development with population size, workforce availability, and program sustainability. When services cannot be locally operated, the County ensures beneficiary access through regional partnerships, contracted providers, and referrals to licensed facilities in neighboring counties.

County behavioral health staff provide care coordination, referral management, and post-discharge follow- up to ensure individuals receiving services outside the county remain connected to ongoing treatment and supports within the local behavioral health system.

Through the Behavioral Health Services Act (BHSA), Calaveras County will continue to evaluate opportunities to expand local service capacity where feasible while maintaining regional partnerships that support access to the full continuum of specialty mental health services.

DRUG MEDI-CAL (DMC)/DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

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

DMC 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 (no action required) 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 Has the county behavioral health system opted to provide the specific services identified in the list below?

- IPS Supported Employment
- Peer Support Services

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

Yes

Please describe these challenges or concerns

Calaveras County Behavioral Health faces ongoing challenges in delivering the full continuum of Drug Medi- Cal (DMC) services due to its rural geography, limited provider availability, and small population base. These structural factors affect the county's ability to develop and sustain certain specialized treatment settings locally, particularly perinatal residential substance use disorder (SUD) treatment for pregnant and postpartum individuals.

The county does not currently operate a local perinatal residential SUD facility. Establishing and maintaining such a program requires specialized clinical staffing, licensure, 24-hour coverage, and sufficient patient volume to remain operational, all of which present significant feasibility challenges in a small rural county. As a result, Calaveras County relies on contracted and out-of-county providers to meet perinatal residential treatment needs.

Accessing out-of-county perinatal residential services can create additional barriers for individuals and families, including transportation challenges, geographic separation from local supports, and delays in placement due to limited bed availability. These barriers are further compounded by workforce shortages and limited housing options within the county.

To mitigate these challenges, Calaveras County coordinates closely with regional providers, Medi-Cal Managed Care Plans, and community partners to facilitate referrals, support continuity of care, and ensure access to medically necessary DMC services. The county continues to explore opportunities to strengthen regional partnerships and improve care coordination for perinatal populations while recognizing the ongoing structural limitations associated with rural service delivery.

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 Program or service

DMC-State Plan

SUBG

Behavioral Health Bridge Housing

Care Transitions

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

Yes

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

SECTION III

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.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures.

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. For related policy information, refer to E.6.2 Primary and Supplemental Measures.

ACCESS TO CARE: PRIMARY MEASURES

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

> **How does your county status compare to the statewide rate?**

> **For adults/older adults**
>
> **Above**

For children/youth

Above

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

- Age
- Race or Ethnicity
- Spoken Language

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

How does your county status compare to the statewide rate?

For adults/older adults

Above

For children/youth

Below

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

- Age
- Race or Ethnicity
- Sex
- Spoken Language

Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023 How does your county status compare to the statewide rate?

For adults/older adults

Above

For children/youth

Above

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

- No Disparities Data Available

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023 How does your county status compare to the statewide rate?

For adults/older adults

Not Applicable

For children/youth

Not Applicable

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

- No Disparities Data Available

ACCESS TO CARE: SUPPLEMENTAL MEASURES

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023 How does your county status compare to the statewide rate?

Above

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

- None Identified

ACCESS TO CARE: DISPARITIES ANALYSIS

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

Older Adults Disparity: Many older adults are on Medicare so their data would not show up in our data; however, Calaveras County Behavioral Health has become a Medicare provider so the data will show up in the future. Additionally, we support a senior peer program that does not claim to Medi-Cal so our ability to reach seniors through this program is not reflected in the data that we get from our Electronic Health Record.

Youth Disparity: The data in this time-frame was during the COVID period and youth were difficult to reach during this time. Also, our outreach and early intervention programs, in general, do not reach high schools because the school districts play the main role for them. Therefore, our data does not include much information about high school age students.

Calaveras demonstrates above-state SMHS penetration for adults across all reported adult age categories (e.g., ages 21–32: 0.067 vs 0.036; 33–44: 0.077 vs 0.039), with no disparities flagged for adult age, sex, or language in the reporting. However, children/youth SMHS access shows an early childhood gap, with ages 0–2 and 3–5 at 0 penetration compared to statewide rates (0–2: 0 vs 0.009; 3–5: 0 vs 0.02), indicating a meaningful disparity for this age group..

For NSMHS, adults generally perform above statewide penetration, but youth NSMHS penetration is consistently below statewide across age bands (e.g., 0–2: 0.10 vs 0.262; 3–5: 0.058 vs 0.139; 12–17: 0.11 vs 0.16), with disparities flagged across multiple youth demographic categories, suggesting a broad access issue for youth in non-specialty pathways.

ACCESS TO CARE: CROSS-MEASURE QUESTIONS

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 (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

Data from Calaveras County access-to-care measures indicate a need to prioritize improved access to Non- Specialty Mental Health Services (NSMHS) for children and youth, while sustaining recent gains in adult access across mental health and substance use disorder (SUD) systems (NSMHS, SMHS, and DMC). In particular, youth NSMHS access measures fall below statewide benchmarks, reflecting local challenges related to rural geography, limited pediatric behavioral health capacity, and workforce shortages.

Beginning July 1, 2026, the County plans to strengthen access to care by leveraging existing strengths in Initiation and Engagement of SUD Treatment (IET-INI) to expand SUD initiation pathways, particularly for adolescents and transition-age youth. This includes enhancing early identification, referral, and engagement practices within existing service delivery models.

In addition, the County plans to explore and strengthen partnerships with Medi-Cal Managed Care Plans (MCPs) to improve access to NSMHS for pediatric and adolescent populations. These efforts will focus on better integration with primary care and pediatric settings, streamlined referral pathways, and coordination across systems to reduce barriers to timely access to care for youth with emerging behavioral health needs.

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)

HOMELESSNESS: PRIMARY MEASURES

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

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?

Below

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

- Race or Ethnicity
- Gender
- Age
- Other

Please describe other

Sheltered vs unsheltered status; chronic homelessness with SMI/SUD (unsheltered concentration)

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

- 2024

How does your county status compare to the statewide rate?

Above

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

- Age
- Race or Ethnicity

HOMELESSNESS: 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

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?

Below

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

- Other

Please describe other

The data did not adequately identify unsheltered individuals

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

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?

Above

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

- Other

Please describe other

The data did not adequately identify the number of unsheltered individuals in Calaveras County

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.) How does your local CoC's rate compare to the average rate across all CoCs?

Below

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

- No Disparities Data Available

HOMELESSNESS: DISPARITIES ANALYSIS

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

The PIT SMI count is higher in our CoC (Mariposa, Amador, Calaveras, and Tuolumne Counties) than statewide; student homelessness is slightly higher. The BHSA data pull notes the Calaveras CoC serves primarily white with more even male/female, while broader CoC regions show higher Hispanic representation and primarily male.

Our CoC PIT counts have detailed subgroup analysis which showed the following.

Homelessness-related disparities in the workbook are concentrated in age, race/ethnicity, gender, and sheltered status. Our CoC shows a higher proportion of unsheltered homelessness (73.0%) than statewide (66.3%), indicating greater exposure to risk and weaker shelter coverage. Older adults (65+) are overrepresented locally (10.1% vs 8.3% statewide). Race/ethnicity composition differs substantially, with White individuals comprising 78.0% locally vs 31.9% statewide, while Black (1.8% vs 22.3%) and Hispanic/Latinx (2.1% vs 23.1%) are underrepresented relative to statewide patterns.

Among people experiencing homelessness with behavioral health vulnerabilities, the workbook indicates a higher unsheltered concentration: 81% of those with SMI and 91% of those with substance use are unsheltered locally,

compared to 68% and 78% statewide respectively. For students, Calaveras County has a slightly higher homeless enrollment rate (5.40%) than statewide (5.21%) and marked geographic/district differences, including elevated instability patterns (e.g., hotels/motels) in specific districts.

HOMELESSNESS: CROSS-MEASURE QUESTIONS

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 (e.g., developing an intervention targeting a sub- population in which data demonstrates they have poorer outcomes)

Housing interventions will be paired with field-based behavioral health engagement and ongoing care coordination to support long-term stabilization. Will prioritize youth homelessness prevention (LEA liaisons; Community Supports), SUD-related homelessness (linkage to treatment/housing), and service access (increase HMIS-participating program engagement) beginning July 1, 2026.

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
- State General Fund
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- SAMHSA PATH
- MHBG
- SUBG

INSTITUTIONALIZATION

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. (no action)

INSTITUTIONALIZATION: PRIMARY MEASURES

Inpatient administrative days (DHCS) rate, FY 2023

How does your county status compare to the statewide rate/average?

For adults/older adults

Not Applicable

For children/youth

Not Applicable

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

- None Identified

INSTITUTIONALIZATION: SUPPLEMENTAL MEASURES

Involuntary Detention Rates, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

14-day involuntary detention rates per 10,000

Not Applicable

30-day involuntary detention rates per 10,000

Not Applicable

180-day post-certification involuntary detention rates per 10,000

Not Applicable

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

- None Identified

Conservatorships, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

Temporary Conservatorships

Not Applicable

Permanent Conservatorships

Not Applicable

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

- No Disparities Data Available

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

Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

How does your county status compare to the statewide rate/average?

Crisis Intervention

For adults/older adults

Above

For children/youth

Above

Crisis Residential Treatment Services

For adults/older adults

Not Applicable

For children/youth

Not Applicable

Crisis Stabilization

For adults/older adults

Not Applicable

For children/youth

Not Applicable

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

- Age
- Race or Ethnicity
- Sex
- Spoken Language

INSTITUTIONALIZATION: DISPARITIES ANALYSIS

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

Calaveras reports no crisis residential treatment services or crisis stabilization infrastructure. Crisis service utilization data indicate age and race/ethnicity gaps in crisis intervention minutes per beneficiary. Calaveras reports 0 minutes for ages 0–2 and 3–5, compared to statewide averages of 141.7 and 157.02 respectively, and substantially lower minutes for ages 6–11 (134.06 vs 283.48). By race/ethnicity, multiple categories show 0 minutes in Calaveras while statewide utilization is present because these populations are not represented here to any substantial degree (e.g., Black youth 0 vs 362.54; Asian/Pacific Islander youth 0 vs 266.28; Alaskan/American Indian youth 0 vs 303.43). Adult crisis intervention also trends below statewide for several age bands, and adult males have lower minutes than statewide (197.64 vs 244.1).

INSTITUTIONALIZATION: CROSS-MEASURE QUESTIONS

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility- Special Treatment Programs)

These facilities do not exist within Calaveras County.

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 (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

We plan to focus on the crisis continuum: mobile crisis, stabilization access, and step-down/residential options; and improve tracking for inpatient admin days and LPS metrics (if applicable) by FY 2026–27. We have performance improvement projects related to HEDIS measures for FUM (follow up for emergency department visits with mental health diagnosis) as well as dedicated staff to coordinate transition and discharge planning from inpatient facilities.

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

- BHSA BHSS
- BHSA FSP

JUSTICE-INVOLVEMENT: PRIMARY MEASURES

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023 How does your county status compare to the statewide rate/average?

For adults/older adults

Below

For juveniles

Above

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

- Age
- Race or Ethnicity
- Sex

JUSTICE-INVOLVEMENT: SUPPLEMENTAL MEASURES

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

How does your county status compare to the statewide rate/average?

Not Applicable

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

- No Disparities Data Available

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.

How does your county status compare to the statewide rate/average?

Above

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

- No Disparities Data Available

JUSTICE-INVOLVEMENT: DISPARITIES ANALYSIS

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

Our data show that key disparities involved juvenile arrests and IST which are above statewide rates. We plan to focus on supporting more diversion for youth, facilitating school-justice partnerships, and undertaking more focused forensic pathways analysis to analyze disparities in age, gender, and race utilizing DOJ/DSH data.

We also identified the following disparities: Adults show a large share of felony arrests categorized as violent offenses (139 of 284). Gender differences are notable: females have a high proportion of violent offenses among felony arrests (50 of 80). Youth arrests show a different pattern, including 0 drug offense arrests in the reporting year. Race/ethnicity counts are reported (e.g., White felony arrests 224; Hispanic felony arrests 38; Black felony arrests 8), though small numbers are representative of limited populations. For recidivism, the most recent available comparison is for data from 2018–2019, where Calaveras had a lower conviction rate (35%) than statewide (41.9%), and no demographic stratification available.

JUSTICE-INVOLVEMENT: CROSS-MEASURE QUESTIONS

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 (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

We plan to prioritize juvenile diversion, behavioral health linkage post-arrest, and IST care pathways; and leverage MCP/DSH collaborations starting July 1, 2026.

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

- BHSA BHSS
- BHSA FSP
- 1991 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)

REMOVAL OF CHILDREN FROM HOME: PRIMARY MEASURES

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025 How does your county status compare to the statewide rate?

Above

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

- No Disparities Data Available

REMOVAL OF CHILDREN FROM HOME: SUPPLEMENTAL MEASURES

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

How does your county status compare to the statewide rate?

Below

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

- Age
- Race or Ethnicity
- Sex

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?

Above

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

- Age
- Race or Ethnicity
- Sex

REMOVAL OF CHILDREN FROM HOME: DISPARITIES ANALYSIS

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

Demographic information for Child welfare cases is not available in the DHCS utilization dashboards. Moderately lower penetration rates for SMHS utilizations suggest resource allocations are necessary to ensure service access and referral pathways are in place.

Calaveras foster care counts have declined over the decade but increased in 2024-25 from 44 (2024) to 66 (2025). For open child welfare cases, SMHS penetration shows 0 values in multiple age and race categories, indicating that it was either not reported or the numbers were so low that the data was suppressed. The data showed a lower rate for ages 12–17 (0.4722) than statewide (0.5370), suggesting gaps in specialty mental health service linkage for child welfare–involved youth and/or reporting limitations due to size. Child maltreatment substantiation rates are higher than statewide across several age groups (e.g., ages 1–2: 20.7 vs 6.9 per 1,000; ages 3–5: 14.3 vs 6.0), and by race/ethnicity and sex (e.g., White 13.1 vs 4.6; male 11.7 vs 5.3; female 11.7 vs 5.7). These disparities indicate a need for prevention and early family support needs, particularly for younger ages.

REMOVAL OF CHILDREN FROM HOME: CROSS-MEASURE QUESTIONS

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 (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

Increase family-focused FSPs, prevention/early intervention, and child-welfare BH integration to reduce removals beginning July 1, 2026. Coordination with First 5 and community based organizations providing early childhood resources, trainings and support groups for new parents, and prevention/early intervention programing. CCBHS will continue to advertise and provide perinatal services.

Please identify the category or categories of funding that the county is nusing 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

UNTREATED BEHAVIORAL HEALTH CONDITIONS: PRIMARY MEASURES

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022 How does your county status compare to the statewide rate/average?

For the full population measured

Below

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

- No Disparities Data Available

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022 How does your county status compare to the statewide rate/average?

For the full population measured

Below

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

- Age

UNTREATED BEHAVIORAL HEALTH CONDITIONS: 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

How does your county status compare to the statewide rate?

For the full population measured

Above

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

- No Disparities Data Available

UNTREATED BEHAVIORAL HEALTH CONDITIONS: DISPARITIES ANALYSIS

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

Lower ED follow-up and higher unmet need warrant subgroup review by age, gender, and language. We expect our newly added contracts to provide ECM and Community Supports will provide the coordination and supports needed to close this gap.

Calaveras does not have data on follow-up after ED visit for substance use but we have some age-stratified results data for MH follow ups for 2023 and 2024. Overall, 30-day follow-up declined from 88.1% (2023) to

77.14% (2024), while 7-day follow-up remained lower than 30-day follow-up (2024: 51.43% vs 77.14%), suggesting challenges in rapid post-ED engagement.

The County will implement performance monitoring strategies aimed at restoring 30-day follow-up rates to at least prior baseline levels by FY 2027–28.

UNTREATED BEHAVIORAL HEALTH CONDITIONS: CROSS-MEASURE QUESTIONS

> **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 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 count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)**
>
> We plan to strengthen post-ED outreach, care navigation, and same-day access (including MAT for SUD) to improve follow-up and reduce unmet need beginning July 1, 2026.

> **Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal**
>
> - BHSA BHSS
> - BHSA FSP
> - BHSA Housing Interventions
> - 1991 Realignment
> - Federal Financial Participation (SMHS, DMC/DMC-ODS)

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.

For related policy information, refer to E.6.2 Primary and Supplemental Measures.

CARE EXPERIENCE: PRIMARY MEASURES

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

> **How does your county status compare to the statewide rate/average?**

> **For adults/older adults**
>
> **Below**

> **For children/youth**
>
> **Below**

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

How does your county status compare to the statewide rate/average?

For adults/older adults

Below

For children/youth

Below

ENGAGEMENT IN SCHOOL: PRIMARY MEASURES

Twelfth Graders who Graduated High School on Time (Kids Count), 2022 How does your county status compare to the statewide rate/average?

Above

ENGAGEMENT IN SCHOOL: SUPPLEMENTAL MEASURES

Meaningful Participation at School (California Health Kids Survey (CHKS)), 2023 How does your county status compare to the statewide rate/average?

Below

Student Chronic Absenteeism Rate (Data Quest), 2022

How does your county status compare to the statewide rate/average?

Above

ENGAGEMENT IN WORK: PRIMARY MEASURES

Unemployment Rate (California Employment Development Department (CA EDD)), 2023 How does your county status compare to the statewide rate/average?

Below

ENGAGEMENT IN WORK: SUPPLEMENTAL MEASURES

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023 How does your county status compare to the statewide rate/average?

Above

OVERDOSES: PRIMARY MEASURES

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH)), 2022 How does your county status compare to the statewide rate/average?

For the full population measured

Above

For adults/older adults

Above

For children/youth

Above

OVERDOSES: SUPPLEMENTAL MEASURES

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022 How does your county status compare to the statewide rate/average?

For the full population measured

Above

For adults/older adults

Above

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

How does your county status compare to the statewide rate/average?

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)

Below

For children/youth (specific to Child and Adolescent Well-Care Visits)

Below

PREVENTION AND TREATMENT OF CO-OCCURRING PHYSICAL HEALTH CONDITIONS: 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 How does your county status compare to the statewide rate/average?

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

Above

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

Not Applicable

QUALITY OF LIFE: PRIMARY MEASURES

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured

Not Applicable

For adults/older adults

Not Applicable

For children/youth

Not Applicable

QUALITY OF LIFE: SUPPLEMENTAL MEASURES

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS)), 2024 How does your county status compare to the statewide rate/average?

For the full population measured

Not Applicable

SOCIAL CONNECTION: PRIMARY MEASURES

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured

Not Applicable

For adults/older adults

Not Applicable

For children/youth

Not Applicable

SOCIAL CONNECTION: SUPPLEMENTAL MEASURES

Caring Adult Relationships at School (CHKS), 2023

How does your county status compare to the statewide rate/average?

Above

SUICIDES: PRIMARY MEASURES

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?

For the full population measured

Above

SUICIDES: SUPPLEMENTAL MEASURES

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

How does your county status compare to the statewide rate/average?

For the full population measured

Above

For adults/older adults

Not Applicable

For children/youth

Not Applicable

County-selected statewide population behavioral health goals

For related policy information, refer to 3.E.6 Statewide 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.

- Overdoses

OVERDOSES

Please describe why this goal was selected

Calaveras County selected reducing overdose deaths as its Optional Measure priority because drug-related overdoses continue to represent a significant public health concern locally, with mortality rates exceeding the California average. According to the 2023 Community Health Assessment, Calaveras County experienced 21 overdose deaths per 100,000 residents, compared to 17 per 100,000 statewide, indicating a locally elevated burden of fatal overdoses. State opioid surveillance data further indicate ongoing opioid misuse at the county level, with age-adjusted opioid overdose rates among California counties remaining at levels that warrant targeted prevention and response efforts.

This goal aligns with the Behavioral Health Services Act (BHSA) emphasis on prevention, early intervention, outreach, and system integration. Reducing overdose deaths also directly responds to documented local gaps in timely access to substance use disorder treatment, overdose prevention resources, and coordinated follow-up care, which contribute to preventable overdose-related mortality.

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

Local overdose mortality data is derived from the Community Health Assessment and CDPH surveillance datasets.

Analysis of local data and service access patterns indicates that overdose-related harms in Calaveras County disproportionately affect several priority populations that experience barriers to care and poorer outcomes. These disparities are most evident among:

Individuals with untreated or inadequately treated substance use disorders, particularly those living in rural or remote areas where provider availability is limited.

Individuals experiencing housing instability or homelessness, who face elevated overdose risk and significant barriers to sustained engagement in treatment and recovery services.

Justice-involved individuals transitioning back into the community without consistent linkage to substance use disorder treatment, behavioral health services, or recovery supports.

Individuals with co-occurring mental health conditions, whose complex needs are often unmet in fragmented service systems.

These disparities reflect a combination of behavioral health system capacity limitations and broader social determinants of health, including geographic isolation, transportation barriers, workforce shortages, and stigma. The elevated overdose mortality rate documented in the Community Health Assessment and state opioid surveillance data support the identification of these populations as experiencing disproportionate risk and poorer outcomes related to overdose.

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 Overdoses and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Beginning July 1, 2026, Calaveras County will strengthen and expand a coordinated set of BHSA-funded programs and initiatives designed to reduce overdose deaths through prevention, outreach, engagement, care coordination, and workforce development. These efforts are informed by local overdose mortality data and identified service gaps affecting high-risk populations.

Planned strategies include expanded field-based outreach and engagement, with peer specialists providing navigation, engagement, and linkage to substance use treatment and supportive services. The County will also enhance overdose prevention and early intervention activities, including increased naloxone distribution, overdose response training, and harm reduction education delivered in community and non- clinical settings.

To improve continuity of care, the County will strengthen care coordination and cross-system linkages with emergency departments, first responders, law enforcement, and corrections to support warm handoffs into treatment and recovery services following overdose events. Integration with housing supports, primary care, and recovery-oriented services will further support stabilization and retention for individuals at elevated risk.

Implementation will be supported by workforce and capacity-building initiatives, including training for County staff and partners on overdose prevention, engagement practices, and culturally responsive service delivery, as well as expansion of the peer workforce and community navigators to enhance outreach reach and continuity.

These efforts will be carried out in partnership with healthcare providers, first responders, community- based organizations, Public Health, and Medi-Cal Managed Care partners to improve coordination, reduce service gaps, and support timely connection to care for individuals most at risk of overdose.

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

SECTION IV

Community Planning Process

Stakeholder Engagement

For related policy information, refer to 3.B.1 Stakeholder involvement

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

- County outreach through social media
- County outreach through townhall 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

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

The County conducted multiple outreach attempts via email invitations, public meeting notices, and partner coordination efforts but did not receive responses from certain required stakeholder groups. Invitation to and planned participation in the Tribal biannual roundtable (February)

Countywide email push (10/01/2025)

Targeted email invitations to partners (Crisis Center, hospital CMO, LGBTQ+ representative, 10/20/2025)

Include date(s) of stakeholder engagement for each type of engagement

Type of engagement	Date
Training, education, and outreach related to community planning	6/18/2025
Training, education, and outreach related to community planning	6/3/2025
Training, education, and outreach related to community planning	7/18/2025

Type of engagement	Date
Workgroups and committee meetings	7/23/2025
Key informant interviews with subject matter experts	9/24/2025
Key informant interviews with subject matter experts	9/25/2025
Key informant interviews with subject matter experts	9/29/2025
Key informant interviews with subject matter experts	10/10/2025
Key informant interviews with subject matter experts	9/22/2025
Key informant interviews with subject matter experts	9/25/2025
Key informant interviews with subject matter experts	2/18/2025
Focus group discussions	9/29/2025
Focus group discussions	11/24/2025
County outreach through townhall meetings	10/16/2025
Survey participation	10/1/2025
County outreach through social media	10/20/2025
County outreach through social media	9/19/2025
County outreach through traditional media (e.g., television, radio, newspaper)	10/2/2025
County outreach through social media	11/1/2025
Provided data to county	10/1/2025
Workgroups and committee meetings	7/30/2025
Workgroups and committee meetings	10/29/2025
Workgroups and committee meetings	8/27/2025

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

Calaveras County Public Health

Office of Education

Probation Department

Sheriff's Office

Department of Social Services / Child Welfare

Housing Services / CoC

HHSA Employment Services

Anthem & Health Net (Managed Care Plans)

Mark Twain Health Care District

Tribal TANF

Crisis Center (Domestic Violence)

DA / Victim Witness

Red Cross

Clients, peers, and families via Peer Wellness Center

What are the five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State)

	City name
1	
2	
3	
4	
5	

Were you able to engage all required stakeholders/groups in the planning process?

No

If not, which required stakeholder/groups were you unable to engage in the planning process?

- Area agencies on aging
- Emergency medical services
- Higher education partners
- Independent living centers
- Regional centers
- Victims of domestic violence and sexual abuse

Area agencies on aging

Stakeholder group is not applicable to county

Emergency medical services

Attempted but did not receive a response

Higher education partners

Stakeholder group is not applicable to county

Independent living centers

Attempted but did not receive a response

Regional centers

Other

Please describe

Invited and receives updates, no dedicated engagement session

Victims of domestic violence and sexual abuse

Other

Please describe

Crisis Center contacted, unable to schedule focus group

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

The County developed the Integrated Plan through an ongoing community engagement process that prioritized input from a broad range of stakeholders, including individuals with lived experience, families, service providers, community partners, healthcare representatives, public safety stakeholders, and system partners.

Stakeholder input was gathered through public meetings, advisory group discussions, community surveys, and targeted outreach efforts designed to hear directly from community members about what is working well, where gaps remain, and what priorities should guide future behavioral health and housing investments. Engagement efforts emphasized inclusion of voices from underserved populations and those most impacted by behavioral health and housing challenges.

Calaveras County Behavioral Health Services made good faith efforts to include Emergency Medical Services (EMS) providers in the CPP process but was unable to secure direct participation within the planning timeline. Input related to EMS-involved populations was nevertheless incorporated through engagement with cross-system partners, including healthcare and public safety stakeholders, as well as through community survey feedback identifying needs related to crisis response, emergency access, and continuity of care. The County will continue efforts to engage EMS partners during BHSA implementation and future planning activities.

Calaveras County Behavioral Health Services also made reasonable efforts to engage Independent Living Centers (ILCs) but did not receive direct participation during the CPP process. The needs of individuals with disabilities were considered through input from community-based organizations, service providers, and public feedback identifying barriers related to access, transportation, and service navigation. The County will prioritize outreach to regional ILCs to strengthen inclusion in ongoing BHSA implementation and future updates.

Feedback consistently highlighted community strengths such as strong collaboration across agencies in a rural setting and dedicated local providers, as well as ongoing needs related to housing availability, access to services, workforce capacity, crisis response, transportation barriers, and supports for justice-involved and underserved populations.

This stakeholder input was reviewed alongside local data, service utilization trends, and system capacity considerations to shape key elements of the Integrated Plan, including priority goals, service and housing strategies, workforce investments, and the phased approach to implementing new BHSA requirements. Stakeholder perspectives helped ensure the Plan reflects both community priorities and the practical realities of service delivery in a small rural county.

- BHSA CPP STAKEHOLDER INPUT.pdf
- BHSA CPP THEMES.pdf
- BHSA CPP Survey Summary.pdf

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes.

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

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

Engagement with Public Health through CHA alignment, prevention focus, early intervention planning Meetings with MCPs (Anthem, Health Net) to strengthen ECM/Community Supports and coordinate surveys and communications

Ongoing CHA–BHSA coordination

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?

No

COLLABORATION

Please select how the county collaborated with the LHJ

- Attended key CHA and CHIP meetings as requested.
- Served on CHA and CHIP governance structures and/or subcommittees as requested.

DATA-SHARING

Data-Sharing to Support the CHA/CHIP

Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP

- Access to Care
- Quality of Life
- Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

Was data shared?

Yes

Data-Sharing from MCPS and LHJs to Support IP development

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

- Homelessness
- Overdoses
- Suicides
- Other

Please describe

chronic illness, social media

Was data shared?

Yes

STAKEHOLDER ACTIVITIES

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. Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP

development and CHA/CHIP engagement.

MOST RECENT COMMUNITY HEALTH ASSESSMENT (CHA), COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) OR STRATEGIC PLAN

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

Yes

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP

Prevalence of substance use: Community expressed a need for youth mental and behavioral health services, particularly for youth who have experienced drug or alcohol-related difficulties in their family, abuse, homelessness, food insecurity or neglect

IP: The IP prioritizes outreach to youth with robust early intervention services, strong collaborations with the schools and child welfare services, and capital investments in a youth center geographically located within walking distance of a middle school with a high incidence of substance use issues among students. In addition, CCBH will work with the Medi-Cal managed care plans to expand SUD initiation pathways for youth and with our Public Health Agency to support preventive care efforts related to substance abuse by youth.

Mental health: Community members who struggle with stigma, barriers to accessing services, and social isolation

IP: The IP increases investments in evidence-based practices to support community-based outreach in the community, including adding peer support for outreach and engagement, transforming our Wellness Center into a Clubhouse model, and increasing specific outreach aimed at hard-to-reach communities such as non-English speakers, native Americans, and veterans and the elderly who are geographically isolated. In addition, by adding

resources for interim and permanent housing, CCBH will have more success at engaging individuals struggling with housing insecurity.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes.

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes

Anthem BlueCross

HealthNet

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 MCPs have engaged the County in a collaborative Community Reinvestment planning process and have committed to sharing their draft MCP Community Reinvestment Plan with the County for review prior to submission to DHCS by the September 1, 2026 due date.

SECTION V

Comment Period and Public Hearing

For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan.

Date the draft Integrated Plan (IP) was released for stakeholder comment

3/30/2026

Date the stakeholder comment period closed

5/1/2026

Date of behavioral health board public hearing on draft IP

5/5/2026

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality

PDF,image,or other document

Please upload the PDF, image, or other file documenting the public posting

- BHSA IP Public Posting.pdf

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

N/A

Please select the process by which the draft plan was circulated to stakeholders

- Public posting
- Email outreach

Attach email

- Email draft for BHSA IP.pdf

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table

Stakeholder group that provided feedback

N/A FOR DRAFT IP

Summarize the substantive revisions recommended this stakeholder during the comment period

N/A FOR DRAFT IP

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. Substantive recommendations

N/A FOR DRAFT IP

SECTION VI

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.

- Mark section as complete

SECTION VII

County Provider Monitoring and Oversight

Medi-Cal Quality Improvement Plans

Cities submitting their Integrated Plan independently from their counties do not have to complete this section or Question 1 under All BHSA Provider Locations.

> **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**
>
> - FY 26-27 QAPI Work Plan.pdf

> **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)?**
>
> **No**

Contracted BHSA Provider Locations

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. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	2
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	26

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

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	5
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes.

> **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?**
>
> **25**

> **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**
>
> Beginning July 1, 2027, and over the subsequent two years, Calaveras County Behavioral Health plans to continue collaborating with local Medi-Cal Managed Care Plans (MCPs), including Health Net and Anthem Blue Cross, to support contracting opportunities for BHSA-funded provider locations delivering non- specialty mental health services (NSMHS) that may be reimbursable through MCPs.
>
> The County plans to strengthen coordination between MCPs and County-operated or contracted providers by identifying services and provider locations that may be appropriate for MCP reimbursement and supporting providers in meeting MCP contracting, credentialing, documentation, and billing requirements. Efforts will include ongoing technical assistance related to compliance, service documentation, and operational readiness for participation in MCP networks.
>
> As part of BHSA implementation, the County will continue evaluating opportunities to expand access to community-based behavioral health services through partnerships with MCPs where appropriate and feasible within a small rural county system. These efforts are intended to improve service integration, increase sustainability of behavioral health services, and enhance access to reimbursable non-specialty mental health services for Medi-Cal beneficiaries.

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 Does the county wish to describe implementation challenges or concerns with these requirements?

Yes

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

Calaveras County recognizes the importance of maximizing resource efficiency through eligibility screening and payer billing; however, implementation of these requirements presents unique challenges in a small, rural county.

Many BHSA-funded providers in Calaveras operate with limited administrative infrastructure and small staffing models that prioritize direct service delivery over billing and eligibility functions. Requiring providers to routinely verify insurance coverage, conduct eligibility screening referrals, and pursue reimbursement from multiple payers adds administrative complexity that can be difficult to absorb without reducing service capacity.

Rural service delivery also involves geographic dispersion and limited connectivity, which can affect real- time eligibility verification and coordination with Medi-Cal Managed Care Plans and commercial insurers. Providers often serve individuals experiencing homelessness, justice involvement, or unstable living situations, where insurance status may change frequently and documentation may be difficult to obtain, increasing the time and effort required to complete billing-related activities.

In addition, Medi-Cal Managed Care Plan contracting and billing processes can be challenging for small rural providers due to varying requirements, lower service volume, and limited billing expertise. While the county supports good faith efforts to seek reimbursement, pursuing multiple payer pathways may not always be operationally feasible or cost-effective for all providers.

Calaveras County will work to support providers through technical assistance, coordination, and training opportunities, including participation in BH-CONNECT activities, while taking a phased and practical approach to implementation that reflects local capacity and ensures continued access to services for individuals who rely on BHSA-funded programs.

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:

Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)

Yes

Do not participate in the county's Medi-Cal Behavioral Health Delivery System?

Yes

SECTION VIII

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to 7.A.1 Behavioral Health Services and Supports Expenditure Guidelines

GENERAL

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan

- Children's System of Care (non-Full Service Partnership (FSP))
- Adult and Older Adult System of Care (non-FSP)
- Early Intervention Programs (EIP)
- Workforce, Education and Training (WET)
- Capital Facilities and Technological Needs (CFTN)
- Outreach and Engagement (O&E)

CHILDREN'S SYSTEM OF CARE (NON-FULL SERVICE PARTNERSHIP (FSP)) PROGRAM

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 on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care.

Please select the service types provided under Program

- Mental health services
- Substance Use Disorder treatment services
- Supportive services

Please describe the specific services provided

The County plans to implement substance use early intervention services for children and youth through a partnership with Public Health, with services delivered on school campuses. These non-FSP services are designed to identify and address early substance use concerns and reduce progression to higher levels of need.

Services will include screening, brief intervention, early education, referral to treatment as appropriate, and coordination with school staff and caregivers. Supportive services may include care coordination, linkage to behavioral health services, and collaboration with other child-serving systems.

These services are intended to support early identification and timely intervention for youth who do not meet criteria for Full Service Partnership enrollment and to strengthen the County's Children's System of Care

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	140
FY 2027 – 2028	144
FY 2028 – 2029	148

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

Estimates for the Public Health youth substance use Early Intervention program are based on Public Health's experience delivering youth-focused prevention and early intervention activities and expected referral volume through school and community partnerships. Based on current capacity and planned outreach, Public Health anticipates serving approximately 140 youth in a typical year.

For planning purposes, the County assumes the program will continue operating at a similar scale, with gradual increases as awareness grows and referral pathways become more established. To reflect this, the County applied a modest 3 percent annual increase for FY 2027–28 and FY 2028–29. Projections are rounded to whole individuals and are intended for planning purposes rather than precise counts.

CHILDREN'S SYSTEM OF CARE (NON-FULL SERVICE PARTNERSHIP (FSP)) PROGRAM

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 on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care.

Please select the service types provided under Program

- Supportive services
- Mental health services

Please describe the specific services provided

The County provides non-Full Service Partnership (non-FSP) Children's System of Care services to support children and youth with behavioral health needs. Services are primarily clinic-based and community-based and are designed to promote early intervention, stabilization, and functional improvement.

Mental health services include assessment, diagnosis, individual therapy, family therapy, and collateral services delivered by licensed and supervised clinicians. Services are provided to children and youth who do not meet FSP criteria or who require lower-intensity supports.

Supportive services include care coordination, case management activities, consultation with schools and other child-serving systems, linkage to community resources, and caregiver support. These services aim to reduce barriers to care, support engagement in treatment, and address social and environmental factors impacting a child's mental health.

Services are delivered in outpatient clinic settings and, when appropriate, in schools or other community locations, and are coordinated with education, child welfare, and primary care partners as part of the broader Children's System of Care.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	392
FY 2027 – 2028	404
FY 2028 – 2029	416

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

Numbers are assumed based on actuals served in FY 24-25 (the most recent full FY of data available) and includes a 3% increase modifier for year over year projections.

CHILDREN'S SYSTEM OF CARE (NON-FULL SERVICE PARTNERSHIP (FSP)) PROGRAM

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 on program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care.

Please select the service types provided under Program

- Mental health services
- Supportive services

Please describe the specific services provided

Through a contract with MACT, the County provides non-Full Service Partnership (non-FSP) Children's System of Care services for children and youth. Services support access to outpatient mental health and supportive services for youth who do not require FSP-level services.

Services include assessment, individual and family therapy, collateral services, and supportive care coordination delivered by licensed and supervised clinicians. Supportive services emphasize engagement, coordination with caregivers, schools, and other child-serving systems, and linkage to community resources.

Services are delivered in outpatient and community-based settings, including school-linked settings when appropriate, and are coordinated as part of the County's broader Children's System of Care to promote stabilization, engagement in treatment, and connection to appropriate levels of care.

MACT is listed in multiple sections of the Integrated Plan to reflect the age groups and service categories it supports. Projected individuals served reflect the overall service reach of the program and are not additive across sections.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	112
FY 2027 – 2028	115
FY 2028 – 2029	119

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care

Projected service counts for children, youth, and transition-age youth were developed using historical

MACT quarterly service data. Quarterly averages by age group were calculated across multiple reporting periods and annualized to reflect a full year of service activity. Projections assume stable program capacity, consistent referral patterns, and no planned expansion or reduction in service delivery. Estimates reflect service utilization rather than unduplicated individuals and are intended for planning purposes.

ADULT AND OLDER ADULT SYSTEM OF CARE (NON-FULL SERVICE PARTNERSHIP (FSP)) PROGRAM

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" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

- Mental health services
- Substance Use Disorder (SUD) treatment services
- Supportive services

Please describe the specific services provided

The County provides non-Full Service Partnership (non-FSP) Adult and Older Adult System of Care services to individuals who do not require Full Service Partnership–level services.

Mental health services include assessment, diagnosis, individual and group therapy, medication support, and collateral services delivered by licensed and supervised clinicians. Services focus on stabilization, symptom management, recovery, and functional improvement.

Substance use disorder services are provided through the County's Drug Medi-Cal (DMC) program and include screening and assessment, individual and group counseling, treatment planning, and recovery services for individuals with substance use disorders. Services are delivered in accordance with DMC requirements and are designed to support engagement, reduce substance use, and promote long-term recovery and stability.

Supportive services include care coordination, case management activities, linkage to community resources, assistance with benefits and referrals, and collaboration with primary care, DMC providers, and other community partners to support engagement and continuity of care across systems.

Services are primarily delivered in outpatient clinic settings and, when appropriate, in community-based locations as part of the County's Adult and Older Adult System of Care.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1295
FY 2027 – 2028	1333
FY 2028 – 2029	1373

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

Numbers are assumed based on actuals served in FY 24-25 (the most recent full FY of data available) and includes a 3% increase modifier for year over year projections.

ADULT AND OLDER ADULT SYSTEM OF CARE (NON-FULL SERVICE PARTNERSHIP (FSP)) PROGRAM

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" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

- Mental health services
- Supportive services

Please describe the specific services provided

Through a contract with MACT, the County provides non-Full Service Partnership (non-FSP) Adult and Older Adult System of Care services for individuals who do not require FSP-level services.

Mental health services include assessment, diagnosis, individual and group therapy, medication support, and collateral services provided by licensed and supervised clinicians. Supportive services include care coordination, assistance with referrals and benefits, linkage to community resources, and collaboration with primary care and other service providers.

Services are primarily delivered in outpatient and community-based settings and are designed to support engagement, stabilization, recovery, and continuity of care within the County's Adult and Older Adult System of Care.

MACT is listed in multiple sections of the Integrated Plan to reflect the age groups and service categories it supports. Projected individuals served reflect the overall service reach of the program and are not additive across sections.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	304
FY 2027 – 2028	313
FY 2028 – 2029	323

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

Projected service counts for adults and older adults were estimated using historical MACT quarterly service data and reflect observed utilization trends across multiple reporting periods. Average quarterly service volumes were annualized to produce a one-year planning estimate. Projections assume steady demand, stable staffing, and no significant changes to program scope or capacity. Estimates represent service activity for planning purposes and may include individuals served across multiple quarters.

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” button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

CCOE Family Connections

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

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

Yes

Please select the EBPs and CDEPs that apply

- Triple P - Positive Parenting Program (Triple P)
- The Strengthening Families Programs (SFP)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs

Triple P, The Strengthening Families

Please describe intended outcomes of the program or service

The program is intended to reduce behavioral health risk factors, strengthen protective factors, and prevent escalation to higher levels of behavioral health care by promoting mental wellness, resilience, and positive school climate.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	60
FY 2027 – 2028	62
FY 2028 – 2029	64

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

Projected individuals served were estimated using historical Family Connections participation data from FY 2024–25, which reflects consistent monthly engagement by adult caregivers and the children and youth in their care. Reported participation patterns indicate a small, stable program with ongoing engagement by returning families rather than high annual turnover.

For planning purposes, observed participation levels were annualized to establish a baseline estimate of individuals served across all ages. A modest 3 percent annual growth factor was applied to projections for FY 2027–28 and FY 2028–29 to reflect anticipated incremental increases in outreach, referrals, and engagement over time, while assuming no significant expansion in program capacity. Estimates are provided for planning purposes and may include individuals served across multiple reporting periods.

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" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

CCOE LGBTQ+

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

- Outreach
- Access and Linkage: Referrals

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

Please describe intended outcomes of the program or service

The intended outcomes of the group are to improve emotional well-being and resilience among participating LGBTQ+ youth by increasing self-confidence, sense of belonging, and peer support. The group focuses on strengthening protective factors, including positive identity development, coping skills, and connection to supportive adults, while reducing social isolation and risk for emotional distress.

The group is designed to support early identification of behavioral health needs and provide timely, developmentally appropriate intervention to prevent escalation to more intensive services. Services will be delivered using evidence-informed practices appropriate for youth social support and skill-building, consistent with Early Intervention goals.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	20
FY 2027 – 2028	21
FY 2028 – 2029	21

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

Projected individuals served were estimated using available FY 2024–25 participation and evaluation data from school-based LGBTQ+ support activities, including Gay-Straight Alliance (GSA) club programming. The data reflects small, consistent participation among youth and is not intended to represent unduplicated countywide prevalence.

For planning purposes, the County established a conservative annual baseline reflecting ongoing group participation across the school year. A modest 3 percent annual growth factor was applied to projections for FY 2027–28 and FY 2028–29 to reflect anticipated incremental increases in awareness, outreach, and engagement, while assuming no significant expansion in program scope or capacity. Estimates are provided for planning purposes only

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" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Question, Persuade, Refer (QPR)

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

- Outreach

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

Please describe intended outcomes of the program or service

The intended outcomes of QPR are to increase participants' knowledge of suicide risk factors and warning signs, and to build skills to recognize, respond to, and refer individuals who may be at risk. The training aims to improve confidence in initiating conversations about suicide and making appropriate referrals to behavioral health and crisis services.

QPR is intended to support early identification of individuals at risk and timely connection to care, contributing to reduced suicide risk and improved access to appropriate behavioral health services.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	85
FY 2027 – 2028	88
FY 2028 – 2029	91

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

Projected participation in QPR training was developed using historical training data. Based on prior years of implementation, the County identified an average of approximately 85 individuals trained annually as a stable baseline.

For planning purposes, the County assumed continued delivery of QPR at a similar scale, with modest growth over the Integrated Plan period. To reflect anticipated incremental increases in outreach, awareness, and participation, the County applied a 3 percent annual growth factor to the baseline estimate for subsequent fiscal years.

Using this approach, projected participation is estimated at 85 individuals in FY 2026–27, approximately 88 individuals in FY 2027–28, and approximately 91 individuals in FY 2028–29. These estimates assume stable training capacity and reflect participation levels rather than unduplicated individuals. Projections are provided for planning purposes and may be adjusted based on demand, scheduling capacity, and available resources.

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" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

MACT

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

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

Yes

Please select the EBPs and CDEPs that apply

- Cognitive Behavioral Therapy (CBT) for Anxiety
- Cognitive Behavioral Therapy (CBT) for Depression
- Cognitive Behavioral Therapy (CBT) for Psychosis
- Motivational Enhancement Therapy (MET) / Motivational Interviewing

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs

CBT, MI

Please describe intended outcomes of the program or service

Expected outcomes include reduced symptoms of anxiety, depression, and emotional distress; improved coping and problem-solving skills; increased engagement in services; and strengthened protective factors such as resilience, social support, and help-seeking behaviors. Through early therapeutic intervention, the program aims to prevent progression to crisis services or more intensive behavioral health treatment.

MACT is listed in multiple sections of the Integrated Plan to reflect the age groups and service categories it supports. Projected individuals served reflect the overall service reach of the program and are not additive across sections.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	416
FY 2027 – 2028	428
FY 2028 – 2029	442

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

MACT is listed in multiple sections of the Integrated Plan to reflect the age groups and service categories it supports. Projected individuals served reflect the overall service reach of the program and are not additive across sections.

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" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Veterans Operation Resilience

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
- 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

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

Yes

Please select the EBPs and CDEPs that apply

- CBT for PTSD
- Cognitive Behavioral Therapy (CBT) for Anxiety
- Cognitive Behavioral Therapy (CBT) for Depression
- Cognitive Behavioral Therapy (CBT) for Late Life Depression
- Cognitive Behavioral Therapy (CBT) for Psychosis

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs

Cognitive Behavioral Therapy, Cognitive Processing Therapy

Please describe intended outcomes of the program or service

Operation Resilience is intended to increase access to trauma-informed behavioral health services for veterans, strengthen engagement in care, and reduce risk for suicide and crisis escalation. The program aims to improve emotional well-being, coping skills, and resilience through a combination of evidence- based clinical services, peer support, and early intervention activities.

Expected outcomes include reduced symptoms of trauma, depression, and anxiety; increased connection to behavioral health services and community supports; improved housing stability and social functioning; and strengthened coordination across County, VA, and community partner systems. The program is designed to support early identification of behavioral health needs and timely intervention to prevent progression to more intensive or emergency services.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	15
FY 2027 – 2028	16
FY 2028 – 2029	17

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

Veterans Operation Resilience is a new program that has not previously been implemented by the County. As a result, projected individuals served were estimated using a conservative, pilot-based approach informed by local veteran engagement patterns, referral pathways, and anticipated program capacity.

The County assumed a modest initial cohort size for the first year of implementation to allow for program development, outreach, and relationship building with veteran partners. A gradual 3 percent annual increase was applied in subsequent fiscal years to reflect anticipated growth in awareness, referrals, and participation as the program becomes established.

Projections are provided for planning purposes and may be adjusted based on actual utilization, veteran engagement, and available resources.

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” button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Crisis Intervention Training

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

- Outreach

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

Please describe intended outcomes of the program or service

Crisis Intervention Team (CIT) training is included as an Early Intervention activity when it focuses on early identification of behavioral health conditions, trauma-informed de-escalation, diversion from the justice system, and timely referral to behavioral health services. The County prioritizes CIT as a preventive strategy to reduce escalation, avoid unnecessary hospitalization or incarceration, and promote earlier engagement in care. The expected outcomes of the program are to improve early identification of behavioral health needs, increase confidence and skill in de-escalation and crisis response, and strengthen coordination between behavioral health, law enforcement, first responders, and community partners. The program is intended to reduce unnecessary crisis escalation, arrests, and emergency responses; increase appropriate referrals to behavioral health services; reduce stigma related to mental illness and suicide; and improve safety and wellbeing for individuals in distress, responders, and the community.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	51
FY 2027 – 2028	53
FY 2028 – 2029	54

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

Projected participation in Crisis Intervention Team (CIT) training is based on historical delivery data. In the most recent year, the County provided CIT training to 51 individuals, which was used as the baseline for future projections.

For planning purposes, the County assumes continued delivery of CIT training at a similar scale, with modest growth over time. A 3 percent annual increase was applied to projections for FY 2027–28 and FY 2028–29 to reflect anticipated incremental increases in training demand and participation. Estimates are provided for planning purposes and may be adjusted based on capacity and scheduling.

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" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name

Substance Use Early Intervention & Overdose Prevention

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

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

Yes

Please select the EBPs and CDEPs that apply

- Motivational Enhancement Therapy (MET) / Motivational Interviewing
- Screening, Brief Intervention, Referral to Treatment (SBIRT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs

MI, SBIRT

Please describe intended outcomes of the program or service

Expected outcomes include increased early identification of substance use and overdose risk, improved engagement in early intervention services, and expanded access to naloxone and harm-reduction resources. The program is intended to increase timely connection to appropriate services and supports, strengthen protective factors, and reduce the likelihood of overdose and escalation to crisis or higher levels of behavioral health care.

Outcomes also include improved coordination across behavioral health, medical, and community partners to support early intervention and ongoing engagement in care.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	25
FY 2027 – 2028	40
FY 2028 – 2029	50

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

We currently do not provide Early Intervention Substance Use services. We are anticipating ongoing programming would reach approximately 30% of the current substance use client count and anticipate expanding a moderate amount each fiscal year.

COORDINATED SPECIALTY CARE FOR FIRST EPISODE PSYCHOSIS (CSC) PROGRAM

For related policy information, refer to 7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis.

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

CSC program name

Coordinated Specialty Care for First Episode Psychosis

CSC program description

The County will implement a Coordinated Specialty Care for First Episode Psychosis (CSC-FEP) program to provide early, intensive, and recovery-oriented services to individuals experiencing a first episode of psychosis. The program will operate as a single multidisciplinary team consisting of four practitioners, consistent with DHCS guidance.

CSC-FEP services will include comprehensive assessment, individualized treatment planning, psychotherapy, medication support, family education and engagement, care coordination, and supported services aimed at improving functional outcomes. The program emphasizes early identification, timely intervention, and coordinated team-based care to reduce symptom severity, support recovery, and prevent progression to higher levels of care.

Services will be delivered in outpatient and community-based settings and coordinated with other behavioral health and community partners as part of the County's broader behavioral health continuum of care.

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.

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	<11*
Number of Uninsured Individuals	<11*

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	4
Number of Teams Needed to Serve Total Eligible Population	1

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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	1	1	1
Total Number of Teams	1	1	1

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

No

OUTREACH AND ENGAGEMENT (O&E) PROGRAM

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" button. For related policy information, refer to 7.A.3 Outreach and Engagement.

Program or activity name

Integrated Outreach and Engagement Activities (Embedded Across Systems of Care)

Please describe the program or activity

The County does not operate a single standalone Outreach and Engagement (O&E) program. Instead, outreach and engagement activities are integrated and embedded across multiple behavioral health programs and systems of care, consistent with BHSA guidance.

Outreach and engagement activities are conducted by County staff and contracted providers as part of routine service delivery and include community outreach, relationship-building with partner agencies, engagement of individuals and families, coordination with schools, health care providers, law enforcement, and community-based organizations, and support for initial access to behavioral health services.

These activities are designed to identify individuals with unmet behavioral health needs, reduce barriers to care, promote early engagement, and connect individuals to appropriate levels of care across the behavioral health continuum, including non-FSP services, Early Intervention programs, and Full Service Partnerships when appropriate.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	180
FY 2027 – 2028	185
FY 2028 – 2029	191

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

Because the County does not operate a standalone Outreach and Engagement program, projected individuals served were estimated using a proxy approach consistent with BHSA guidance. Outreach and engagement activities are embedded across multiple behavioral health programs and systems of care and are a routine component of initial contact, relationship-building, and linkage to services.

For planning purposes, the County estimated the number of individuals engaged through outreach by applying a conservative proportion of individuals served through Early Intervention and non-FSP programs that rely on

outreach and engagement to support access to care. Based on historical service patterns and anticipated program capacity, the County estimates approximately 180 individuals will be engaged through outreach and engagement activities in FY 2026–27.

A modest 3 percent annual increase was applied for FY 2027–28 and FY 2028–29 to reflect incremental growth in outreach, partnerships, and community awareness as BHSA implementation continues. Estimates are provided for planning purposes and are not additive across programs.

COUNTY WORKFORCE, EDUCATION, AND TRAINING (WET) PROGRAM

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 BH- CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET 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" button. For related policy information, refer to 7.A.4 Workforce Education and Training.

Program or activity name

Workforce Recruitment and Retention

Please select which of the following categories the activity falls under

Workforce Recruitment, Development, Training, and Retention

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

The County implements workforce recruitment, development, training, and retention activities to address persistent behavioral health workforce disparities associated with rural geography, limited local workforce pipelines, and challenges recruiting and retaining qualified staff.

Efforts focus on strengthening recruitment into behavioral health positions, supporting professional development and training for existing staff, and improving retention through ongoing support and workforce investment. Activities may include recruitment incentives, staff development opportunities, supervision and training supports, and strategies to promote workforce stability.

These efforts are intended to improve access to a qualified behavioral health workforce that reflects the needs of the community, reduce service gaps caused by vacancies and turnover, and support continuity of care across systems of care. Workforce strategies emphasize building and sustaining capacity in underserved and hard-to-recruit areas to better serve individuals and families across the behavioral health continuum.

COUNTY WORKFORCE, EDUCATION, AND TRAINING (WET) PROGRAM

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 BH- CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET 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" button. For related policy information, refer to 7.A.4 Workforce Education and Training.

> **Program or activity name**
>
> Professional Licensing, Certification and Exam Support

> **Please select which of the following categories the activity falls under**
>
> Professional Licensing and/or Certification Testing and Fees

> **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**
>
> The County supports professional licensing, certification, and exam-related costs for clinical staff, including mental health clinicians, substance use disorder counselors, and peer support staff, to reduce financial barriers to workforce participation and retention.
>
> By covering costs associated with license and certification renewal, required examinations, and related professional requirements, the County seeks to support staff in maintaining active credentials necessary for service delivery. These efforts are particularly important in a small, rural county where workforce shortages and limited local training pipelines create challenges in recruiting and retaining qualified behavioral health professionals.
>
> This activity addresses workforce disparities by improving access to credentialed positions, supporting career advancement, and promoting workforce stability, which in turn strengthens continuity of care and access to services for individuals and families across the behavioral health system.

COUNTY WORKFORCE, EDUCATION, AND TRAINING (WET) PROGRAM

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 BH- CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET 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" button. For related policy information, refer to 7.A.4 Workforce Education and Training.

Program or activity name

Retention

Please select which of the following categories the activity falls under

Retention Incentives and Stipends

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

The County implements retention incentives and stipends to address workforce disparities related to recruitment and retention challenges in a small, rural behavioral health system. These efforts are designed to promote workforce stability, reduce turnover, and support continuity of care.

Retention strategies include providing equal sign-on stipends for eligible behavioral health staff and annual longevity stipends upon completion of defined years of service. Stipends are structured to be applied consistently and equitably across eligible positions to support retention without creating disparities between roles.

By reducing financial and workforce instability and recognizing continued service, these incentives help retain qualified staff in hard-to-recruit positions, support workforce sustainability, and improve access to behavioral health services for underserved populations across the County.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) PROGRAM

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" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5.

Project name

CCBH Building

Please select the type of project

Capital facilities project

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.

Please indicate if the project involves leasing or renting to own a building

No

Please describe the project

The County is developing a new county-owned facility that will support the delivery of behavioral health services. While primary construction of the building is funded through grant and County resources, the County anticipates potential capital facility needs to ensure the space is appropriately configured and equipped for behavioral health service delivery.

Capital facility activities may include space build-out, minor renovations, accessibility or safety enhancements, and other improvements necessary to support outpatient and community-based behavioral health services. These improvements are intended to ensure the facility meets programmatic, operational, and regulatory requirements for behavioral health use.

Capital facility needs will be addressed as necessary during the planning period to support service delivery across systems of care and to maximize use of County-owned infrastructure.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) PROGRAM

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" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5.

Project name

CCBH Building

Please select the type of project

Technological needs project

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

- Data exchange and interoperability
- Data security and privacy
- Electronic health record system
- Resources to support web content and mobile app accessibility
- System maintenance costs
- Telemedicine

Please describe the project

The CCBH Building is a new county-owned facility being developed to support the delivery of behavioral health services across multiple systems of care. Primary construction of the building is funded through grant and County resources; however, the County anticipates capital and technological needs to ensure the facility is fully equipped and operational for behavioral health service delivery.

Capital facilities activities may include space build-out, minor renovations, accessibility and safety enhancements, and other improvements necessary to meet programmatic, operational, and regulatory requirements for behavioral health services.

Technological needs associated with the project may include information technology infrastructure, electronic health record system functionality, telemedicine capacity, data security and privacy safeguards, system maintenance, and resources to support digital access for individuals and families. These technology components are intended to support care coordination, service access, compliance, and continuity of care.

Capital and technological improvements will be implemented as needed during the planning period to support effective use of the CCBH Building and strengthen the County's behavioral health infrastructure.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) PROGRAM

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" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5.

Project name

Systemwide Capital Facilities

Please select the type of project

Capital facilities project

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.

Please indicate if the project involves leasing or renting to own a building

No

Please describe the project

The CCBH Building is a new county-owned facility being developed to support the delivery of behavioral health services across multiple systems of care. Primary construction of the building is funded through grant and County resources; however, the County anticipates capital and technological needs to ensure the facility is fully equipped and operational for behavioral health service delivery.

Capital facilities activities may include space build-out, minor renovations, accessibility and safety enhancements, and other improvements necessary to meet programmatic, operational, and regulatory requirements for behavioral health services.

Technological needs associated with the project may include information technology infrastructure, electronic health record system functionality, telemedicine capacity, data security and privacy safeguards, system

maintenance, and resources to support digital access for individuals and families. These technology components are intended to support care coordination, service access, compliance, and continuity of care.

Capital and technological improvements will be implemented as needed during the planning period to support effective use of the CCBH Building and strengthen the County's behavioral health infrastructure.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) PROGRAM

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" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5.

Project name

Systemwide Technological Infrastructure and Systems

Please select the type of project

Technological needs project

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

- Electronic health record system
- Telemedicine
- Data security and privacy
- Data exchange and interoperability
- System maintenance costs
- Resources to support web content and mobile app accessibility

Please describe the project

The County implements technological improvements on a systemwide basis to support the delivery, coordination, and reporting of behavioral health services across programs and systems of care.

Technological needs activities may include electronic health record system functionality, telemedicine capacity, information technology infrastructure, data security and privacy safeguards, system maintenance, and tools that support digital access to services and information for individuals and families.

Technology enhancements will be implemented as needed during the planning period to support access to care, continuity of services, compliance with state and federal requirements, and effective operation of the County's behavioral health system.

Full Service Partnership Program

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. For related policy information, refer to 7.B.3 Full Service Partnership Program Requirements and 7.B.4 Full Service Partnership Levels of Care

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

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	105
Number of Uninsured Individuals	14
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	40

ASSERTIVE COMMUNITY TREATMENT (ACT) AND FORENSIC ASSERTIVE COMMUNITY TREATMENT (FACT) ELIGIBLE POPULATION

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

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	13
Number of Uninsured Individuals	<11*

FACT Eligible Population (ACT with Justice- System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	7
Number of Uninsured Individuals	1

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	<11*
Number of Teams Needed to Serve Total Eligible Population	<11*

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., current 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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	5	5	5
Total Number of Teams	1	1	1

FULL SERVICE PARTNERSHIP (FSP) INTENSIVE CASE MANAGEMENT (ICM) ELIGIBLE POPULATION

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

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	84
Number of Uninsured Individuals	11

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	5
Number of Teams Needed to Serve Total Eligible Population	1

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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of	5	5	5

County Actuals	FY 26-27	FY 27-28	FY 28-29
Practitioners			
Total Number of Teams	1	1	1

HIGH FIDELITY WRAPAROUND (HFW) ELIGIBLE POPULATION

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	64
Number of Uninsured Individuals	<11*

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	24
Number of Teams Needed to Serve Total Eligible Population	1

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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	3	3	3
Total Number of Teams	1	1	1

INDIVIDUAL PLACEMENT AND SUPPORT (IPS) ELIGIBLE POPULATION

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

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	147
Number of Uninsured Individuals	22

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	12
Number of Teams Needed to Serve Total Eligible Population	5

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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	12	12	12
Total Number of Teams	5	5	5

FULL SERVICE PARTNERSHIP (FSP) PROGRAM OVERVIEW

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

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

> **Please describe how the estimated practitioners will provide more than one EBP**
>
> Due to the County's size, rural workforce constraints, and approved exemptions from fidelity requirements for certain evidence-based practices (EBPs), practitioners will be cross-trained and assigned to provide services across more than one EBP as appropriate.
>
> Practitioners will primarily be assigned to a core program or service area and may also provide additional EBPs based on client need, service intensity, and workforce availability. This approach allows staff to support multiple EBPs at different times or across varying levels of care, including step-up and step-down transitions, without duplicating staffing resources.
>
> For EBPs where fidelity requirements apply, the County will ensure appropriate training, supervision, and role clarity. For EBPs with approved fidelity exemptions, services will be delivered in a flexible, needs-based manner consistent with DHCS guidance and the County's exemption approvals.
>
> This staffing model enables the County to maximize limited workforce capacity, reduce service gaps, and expand access to EBPs across the behavioral health continuum while remaining compliant with BHSA requirements and approved exemptions.

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

The County employs a whole-person, trauma-informed approach across its behavioral health system that recognizes the impact of trauma, social determinants of health, and co-occurring needs on an individual's well-being. Services are designed to address mental health, substance use, physical health, housing stability, safety, and social supports in an integrated manner.

Trauma-informed principles—including safety, trustworthiness, choice, collaboration, and empowerment—are incorporated into assessment, service planning, and service delivery. Staff are trained to engage individuals in a respectful, strengths-based manner that promotes autonomy, cultural responsiveness, and recovery.

The County partners with families and individuals' natural supports, as appropriate and with consent, as active participants in treatment planning and service delivery. This may include family education, collateral contacts, coordination with caregivers and community supports, and inclusion of natural supports in goal setting and care coordination.

Through collaboration with community-based organizations, schools, health care providers, and other local partners, the County supports continuity of care and coordinated responses that reduce re- traumatization, strengthen protective factors, and promote long-term recovery and stability.

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

The County works to reduce disparities among Full Service Partnership (FSP) participants by prioritizing access to services for individuals with the highest needs and greatest barriers to care, including those impacted by serious mental illness, justice-system involvement, housing instability, geographic isolation, and limited access to local resources.

FSP services are designed to be flexible, person-centered, and responsive to individual needs, allowing the County to tailor intensity, location, and supports to address disparities related to rural geography, transportation barriers, and limited service availability. Services are delivered in community-based settings whenever possible to improve engagement and reduce access barriers.

The County emphasizes culturally responsive and trauma-informed practices, including engaging individuals in shared decision-making, respecting individual preferences, and incorporating family members and natural supports when appropriate and with consent. Coordination with community partners, including housing, justice, health care, and social service systems, further supports equitable access to care and continuity of services.

Through these approaches, the County seeks to reduce disparities in access, engagement, and outcomes for FSP participants and to ensure services are responsive to the needs of underserved and historically marginalized populations within the community.

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

- Access to care
- Homelessness
- Institutionalization
- Justice involvement
- Removal of children from home
- Untreated behavioral health conditions
- Care experience
- Engagement in school
- Engagement in work
- Overdoses
- Prevention of co-occurring physical health conditions
- Quality of life
- Social connection
- Suicides

Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM

The County provides ongoing engagement services for individuals receiving Full Service Partnership Intensive Case Management (FSP ICM) through consistent, relationship-based contact and flexible service delivery approaches tailored to individual needs.

Engagement activities include regular outreach and follow-up, coordination of appointments and services, and field-based contact in community settings when appropriate to reduce barriers to participation. Services are delivered with high frequency and intensity based on client need, typically involving multiple contacts per week, with the capacity for daily contact during periods of increased acuity. Services are primarily community-based and delivered through a team-oriented approach to support continuity of care and ongoing engagement.

Case managers maintain continuity of relationships over time to support trust, stability, and sustained engagement. The County emphasizes person-centered and trauma-informed practices that respect individual choice and readiness for services. Engagement strategies may include adjusting the frequency and location of contact, incorporating family members or natural supports with consent, and coordinating with other providers and systems involved in an individual's care.

Through ongoing communication, care coordination, and responsive service planning, the County supports continued participation in services, reduces disengagement, and promotes progress toward recovery and stability for individuals receiving FSP ICM.

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

N/A

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)

The County will comply with required Full Service Partnership (FSP) levels of care by implementing the Level of Care Utilization System (LOCUS) to support standardized, needs-based placement and transitions across FSP service models.

LOCUS will be used to assess individual clinical need, functional impairment, risk, and service intensity requirements to inform appropriate placement within FSP levels of care, including FSP Intensive Case Management (ICM), Assertive Community Treatment (ACT), and Forensic Assertive Community Treatment (FACT), as applicable.

Assessment results will guide step-up and step-down decisions over time, allowing individuals to transition between FSP ICM and ACT based on changes in need and acuity, while maintaining continuity of care. This approach supports individualized, person-centered services and alignment with FSP service criteria.

Implementation of required FSP levels of care will be phased based on workforce capacity, funding availability, and DHCS guidance. The County may transition existing FSP ICM capacity, stand up new ACT teams, and/or expand FSP ICM services during the planning period as needed to meet required levels of care.

Through use of LOCUS-informed decision-making and coordinated service planning, the County will ensure FSP services are delivered at the appropriate level of intensity and remain compliant with BHSA and DHCS FSP requirements.

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

N/A

Primary substance use disorder (SUD) FSPs

Yes

If Yes, please describe

The County will provide Full Service Partnership (FSP) services to individuals with primary substance use disorder needs through case managers who hold appropriate substance use disorder (SUD) credentials. These services will be delivered to individuals who meet FSP eligibility criteria and require intensive, coordinated supports related to substance use.

SUD-focused FSP services will include comprehensive assessment, individualized service planning, intensive case management, care coordination, and linkage to treatment, recovery supports, and community resources. Services will be person-centered and trauma-informed and may be delivered in community-based settings to support engagement and reduce barriers to care.

Case managers providing SUD FSP services will coordinate closely with mental health, medical, housing, and social service partners to address co-occurring needs and support stabilization, recovery, and continuity of care. Services will be delivered consistent with FSP requirements and integrated within the County's broader behavioral health system.

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)

Yes

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

The County conducts outreach activities to identify, engage, and support individuals with significant behavioral health needs who may benefit from enrollment in a Full Service Partnership (FSP). Outreach efforts focus on individuals who are not currently engaged in services or who experience barriers to accessing care due to acuity, geographic isolation, housing instability, justice involvement, or other social factors.

Outreach activities include assertive engagement, relationship-building, coordination with community partners, and assistance navigating access to behavioral health services. Staff may conduct outreach in community-based settings and collaborate with hospitals, law enforcement, housing providers, public health, and other local systems to identify individuals who meet FSP eligibility criteria.

These outreach activities are intended to facilitate timely identification and enrollment into FSP services and support continuity of care. Outreach related to the initiation of substance use disorder treatment services is addressed separately, consistent with program requirements.

Other recovery-oriented services

Yes

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

The County provides other recovery-oriented services as part of Full Service Partnership (FSP) programs to support individuals in achieving stability, independence, and self-directed recovery. These services are person-centered and tailored to individual goals and needs.

Recovery-oriented services may include care coordination and recovery planning, support accessing benefits and community resources, assistance with housing stability, skill-building to support daily functioning, and coordination with natural supports and community partners. Services emphasize strengths, promote autonomy, and support progress toward individualized recovery goals.

These supports are integrated into FSP service delivery and are intended to enhance engagement, improve quality of life, and support long-term recovery outcomes.

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. If no additional FSP services, use "N/A"

N/A

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

The County considered the needs of youth in or at risk of juvenile justice involvement by reviewing local data, collaborating with probation and child-serving partners, and incorporating trauma-informed and developmentally appropriate best practices into FSP planning. These efforts informed service design focused on early engagement, coordination across systems, and continuity of care for justice-impacted youth.

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

The County considered the needs of LGBTQ+ youth by reviewing local data and community feedback, engaging child-serving partners, and incorporating trauma-informed and culturally responsive best practices into FSP planning. These efforts informed service design focused on inclusive, affirming engagement and reducing disparities in access and outcomes for LGBTQ+ children and youth.

In the child welfare system

The County considered the needs of child welfare-involved youth by reviewing local data, collaborating with child welfare and education partners, and incorporating trauma-informed and family-centered best practices into FSP planning. These efforts informed service design focused on stability, continuity of care, and coordinated support across systems.

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

Older adults

The County considered the needs of older adults by reviewing local data, collaborating with aging-focused partners, and incorporating age-appropriate and trauma-informed best practices into FSP planning. These efforts informed service design focused on coordination of care, functional needs, and inclusion of caregivers and natural supports.

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

The County considered the needs of LGBTQ+ adults by reviewing local data and community feedback, engaging service partners, and incorporating affirming and trauma-informed practices into FSP planning. These efforts informed service design aimed at reducing barriers, improving engagement, and supporting equitable outcomes.

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

In developing the County's Full Service Partnership (FSP) program for adults, the County considered the unique needs of individuals who are involved in, or at risk of involvement in, the justice system through targeted planning activities, cross-system collaboration, and review of local data.

The County examined information related to justice involvement, behavioral health needs, service utilization, and system touchpoints to better understand barriers to engagement, continuity of care challenges, and opportunities for early intervention and diversion.

Planning efforts included coordination with justice system partners, including probation, law enforcement, courts, and community-based organizations, to identify gaps in services and strategies to support individuals with co-occurring behavioral health needs who frequently cycle between systems.

The County also considered evidence-informed practices related to trauma-informed care, reentry support, and community-based service delivery for justice-impacted populations. These considerations informed FSP service design emphasizing engagement, coordination across systems, continuity of care during transitions, and flexible service delivery responsive to justice-related conditions.

Through these actions, the County developed an FSP approach intended to reduce disparities in access and outcomes for justice-involved adults and to support stabilization, recovery, and reduced justice system involvement.

ASSERTIVE FIELD-BASED SUBSTANCE USE DISORDER (SUD) QUESTIONS

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Targeted outreach

Existing programs

None.

The County does not currently operate a dedicated targeted outreach or assertive field-based substance use disorder (SUD) treatment initiation program.

Program descriptions

At this time, the County does not have a standalone targeted outreach program designed to provide assertive field-based initiation of SUD treatment services. Outreach and engagement related to behavioral health and substance use currently occur on a limited, ad hoc basis through other service functions but are not organized as a dedicated outreach program consistent with BHSA Policy Manual Chapter 7, Section B.6 requirements.

Current funding source

not applicable at this time

BHSA changes to existing programs to meet BHSA requirements

To meet BHSA assertive field-based initiation requirements, the County will develop a targeted outreach function focused on engaging individuals with substance use disorder needs who are not currently connected to treatment. This will include establishing dedicated workflows for field-based engagement, standardized screening and engagement protocols, and warm handoff procedures to support rapid linkage to SUD treatment.

The County will leverage existing staff capacity where appropriate and braid funding sources, including

BHSA service expansion funds and other available resources, to support staffing, training, and operational infrastructure.

Expected timeline of operation

FY 26–27: Program planning and design, including defining service model, staffing approach, training needs, referral pathways, and funding sources

FY 27–28: Initial implementation and pilot of targeted outreach and assertive engagement workflows for SUD treatment initiation

FY 28–29: Expansion and full implementation to meet BHSA programmatic requirements by July 1, 2029

Mobile-field based programs

Existing programs

None.

The County does not currently operate a dedicated mobile field-based service for substance use disorder (SUD) treatment initiation.

Program descriptions

The County does not currently have a mobile field-based program designed to provide assertive, community-based initiation of substance use disorder treatment services. At present, services are primarily delivered in clinic or office-based settings, and there is no dedicated mobile team providing field-based SUD treatment initiation consistent with BHSA Policy Manual Chapter 7, Section B.6 requirements.

Current funding source

Not applicable at this time

BHSA changes to existing programs to meet BHSA requirements

To meet BHSA requirements for mobile field-based initiation of SUD treatment services, the County will develop a mobile service capacity to deliver engagement, assessment, and initiation supports in community-based settings. Planned activities include establishing mobile workflows, defining staffing models, procuring necessary equipment and technology, and developing protocols for safety, documentation, and coordination with treatment providers.

The County will leverage BHSA service expansion funds and other available funding sources, as appropriate, to support staffing, training, and operational infrastructure. Mobile services will be designed to complement targeted outreach efforts and support rapid linkage and continuity of care.

Expected timeline of operation

FY 26–27: Program planning and design, including development of mobile service model, staffing approach, training requirements, safety protocols, and identification of funding sources

FY 27–28: Pilot implementation of mobile field-based services supporting engagement and initiation of SUD treatment

FY 28–29: Expansion and full implementation to meet BHSA programmatic requirements by July 1, 2029

Open-access clinics

Existing programs

Same-day behavioral health appointment availability within existing outpatient clinics

Crisis services available at all times

Program descriptions

The County does not operate a standalone or formally designated open access clinic. However, the County currently provides same-day behavioral health appointment availability within existing outpatient services when capacity allows, and crisis services are available on an ongoing basis to respond to urgent behavioral health needs.

These functions provide timely access points for individuals seeking services and support immediate engagement, though they are not currently structured as a comprehensive open access clinic model with dedicated walk-in hours or same-day initiation workflows for substance use disorder treatment.

Current funding source

Medi-Cal (for eligible outpatient and crisis services)

Local funds and/or Realignment

BHSA changes to existing programs to meet BHSA requirements

To meet BHSA requirements related to timely access and assertive initiation of substance use disorder treatment services, the County will build upon existing same-day appointment capacity and crisis services to further formalize open access functions. Planned enhancements may include designating same-day or rapid access appointment slots, standardizing intake and triage workflows, and improving coordination between crisis services, outpatient clinics, and outreach or mobile service functions.

The County will assess staffing, workflow, and funding needs to determine the feasibility of expanding open access capacity within existing clinic settings.

Expected timeline of operation

FY 26–27: Assessment and planning to formalize same-day access workflows, intake processes, and coordination with crisis services

FY 27–28: Pilot enhanced open access functions within existing outpatient clinics, including standardized same-day intake and referral processes

FY 28–29: Expansion or refinement of open access capacity, as appropriate, to meet BHSA programmatic requirements by July 1, 2029

Targeted outreach

New programs

Assertive Field Based SUD Targeted Outreach

Program descriptions

The County plans to implement assertive field-based targeted outreach for substance use disorder (SUD) treatment to meet BHSA requirements by building on existing behavioral health outreach, care coordination, and crisis response functions. The planned program will focus on engaging individuals with significant SUD needs who are not successfully accessing clinic-based services, including individuals experiencing homelessness, housing instability, or justice involvement.

Outreach activities will emphasize proactive, field-based engagement, screening, linkage to SUD treatment services, and coordination with housing and supportive services. The program will be designed to complement, rather than duplicate, Medi-Cal MCP-funded services.

Planned funding

Planned funding sources include BHSA service expansion funds, in coordination with existing behavioral health funding and Medi-Cal Managed Care Plan (MCP) resources where applicable. BHSA funds will be used to support non-duplicative outreach and engagement activities not otherwise covered by Medi-Cal.

Planned operations

The County plans to operationalize targeted outreach through a phased approach that may include cross- trained behavioral health staff, contracted providers, and coordination with existing outreach, crisis, and care coordination teams. Operations will emphasize collaboration with MCPs, Enhanced Care Management (ECM), Community Supports providers, housing partners, and justice system partners to support identification, engagement, and referral to appropriate SUD treatment services.

The County will use a combination of state and local data sources to identify areas and populations with higher risk of substance use-related harm. This includes overdose and mortality data from the California Department of Public Health, treatment and utilization data from the California Department of Health Care Services, EMS reports including naloxone use and overdose reversals, and information from local hospitals, law enforcement, MCP partners, and HMIS. Data will be reviewed at least quarterly and used to identify priority communities and populations, including individuals experiencing homelessness and those with frequent emergency service utilization.

This information will guide where and how outreach activities are deployed, including coordination with crisis response, ECM, housing, and other community-based partners. The County will continue to assess staffing models, partnerships, workflows, and outreach strategies to ensure alignment with BHSA requirements, local capacity, and evolving community needs, while improving engagement and connection to SUD treatment services over time.

Expected timeline of implementation

The County anticipates planning and development activities during the early years of the Integrated Plan period, with phased implementation of assertive field-based SUD targeted outreach prior to July 1, 2029, consistent with

BHSA requirements. The County will implement a phased approach with key milestones tied to planning, partnership development, and service rollout.

Initial milestones include development of program protocols, identification of staffing models, and coordination with MCPs, ECM providers, and community partners. Additional early implementation activities include establishing data-sharing processes, training staff, and launching limited targeted outreach in priority areas identified through local planning efforts and data review.

Subsequent milestones include expanding outreach coverage, refining workflows based on early implementation experiences, and increasing coordination with crisis response, housing, healthcare, and justice system partners. Full implementation of assertive field-based SUD outreach is anticipated prior to July 1, 2029, with ongoing adjustments based on workforce capacity, funding availability, program performance, and any additional DHCS guidance.

Mobile-field based programs New programs

Assertive Field Based SUD Targeted Outreach Program

Program descriptions

The County will implement an Assertive Field-Based SUD Targeted Outreach Program to provide mobile, field-based services that engage individuals with significant substance use disorder needs who are not currently connected to treatment. Services will be delivered in community settings, including encampments, shelters, and other locations where individuals reside or frequent.

The program will include assertive outreach and engagement, screening for substance use and overdose risk, brief intervention, and support with initiating SUD treatment services, including medication-assisted treatment where appropriate. Staff will provide warm handoffs and care coordination with SUD treatment providers, behavioral health services, and community partners to support timely access and continuity of care.

Services will be integrated with existing crisis, housing, and care coordination efforts, and will prioritize individuals at high risk for overdose, including those experiencing homelessness or with frequent emergency service utilization.

Planned funding

The County plans to use BHSA service expansion funds to support staffing, operations, and implementation of the Assertive Field-Based SUD Targeted Outreach Program, including mobile, field-based service delivery. Funding will support outreach staff, supervision, training, transportation, and coordination activities necessary to deliver services in community settings.

Where allowable, the County will leverage Medi-Cal reimbursement for covered services, including screening, brief intervention, care coordination, and treatment linkage activities. BHSA funding will be used to support non-billable outreach and engagement activities that are necessary to connect individuals to care but are not otherwise reimbursable.

The County will also coordinate with Managed Care Plans and community partners to align funding and service delivery, with the goal of sustaining the program over time and maximizing available resources.

Planned operations

Planned operations will include delivery of mobile, field-based services by designated outreach staff who engage individuals in community settings, including encampments, shelters, and other locations where individuals reside or frequent. Staff will conduct in-person outreach, screening for substance use and overdose risk, and provide brief intervention, harm reduction support, and education.

Outreach staff will facilitate immediate linkage to SUD treatment services through warm handoffs, care coordination, and scheduling support, including connection to medication-assisted treatment where appropriate. Services will include follow-up engagement to support ongoing participation in care.

Program operations will be integrated with existing behavioral health, crisis response, housing, and care coordination services to support continuity of care. Staff will document services and coordinate with providers and partners to ensure timely access to treatment and ongoing engagement.

Expected timeline of implementation

FY 26–27: Program planning and design, including review of DHCS guidance, definition of service model, staffing approach, operational workflows, and funding structure

FY 27–28: Initial implementation of assertive field-based targeted outreach for SUD treatment services

FY 28–29: Expansion and refinement of program operations to fully meet BHSA programmatic requirements by July 1, 2029

Open-access clinics

New programs

Open Access Behavioral Health

Program descriptions

The County will develop and formalize open access behavioral health and substance use disorder (SUD) intake services to meet BHSA requirements outlined in Policy Manual Chapter 7, Section B.6. While the County does not currently operate a designated open access clinic, it does provide same-day appointment availability within existing outpatient services and continuous crisis response.

The planned open access model will build upon these existing access points to support timely assessment, engagement, and initiation of services for individuals with SUD needs. Program design will align with DHCS guidance and emphasize rapid access, standardized intake and triage processes, and coordination with outreach, mobile field-based services, and treatment providers.

Planned funding

The County anticipates utilizing BHSA service expansion funds to support development and implementation of open access intake functions. Additional funding sources may include Medi-Cal reimbursement for eligible services and other available local or state resources. Final funding decisions will be informed by program design, staffing capacity, and DHCS guidance.

Planned operations

Planned operations will focus on formalizing and expanding same-day access capacity within existing clinic settings rather than establishing a new standalone facility. Operational planning will include defining open access workflows, standardizing intake and triage procedures, identifying staffing models to support same- day access, and coordinating referrals and warm handoffs to SUD treatment services.

Open access functions will be integrated with crisis services, targeted outreach, and mobile field-based service strategies to ensure seamless transitions into treatment and continuity of care.

Expected timeline of implementation

FY 26–27: Planning and design, including assessment of open access models, workflow development, staffing feasibility, and funding structure

FY 27–28: Pilot implementation of enhanced open access intake and same-day access functions within existing outpatient services

FY 28–29: Expansion and refinement of open access capacity, as appropriate, to meet BHSA programmatic requirements by July 1, 2029

Medications for Addiction Treatment (MAT) Details

Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029. 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

Calaveras County Behavioral Health has worked extensively over the last two years to bring a MAT treatment facility and provider to our county. In coordination with Aegis Treatment Centers and our neighboring county (Amador) we have created a plan for mobile MAT services to be provided Monday- Friday for a 4 hour window to community members at our Health and Human Services agency. We have used actual numbers of current MAT users as well as data on opioid prescription rates and overdoses in our county to project daily dosing needs with the MAT provider.

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

- Contract directly with MAT providers in the County
- 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

- Partner with neighboring counties
- Contract with MAT providers in other counties

Please provide the names of the neighboring counties the county will partner with

Amador

Please provide the names of other counties the contracted MAT providers are located in

Amador, Tuolumne, San Joaquin, Merced, Sacramento

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

- Buprenorphine
- Methadone

Housing Interventions

PLANNING

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations

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. Supportive housing

Large gap

Apartments, including master-lease apartments

Large gap

Single and multi-family homes

Large gap

Housing in mobile home communities

Large gap (Permanent) Single room occupancy units

Large gap (Interim) Single room occupancy units

Large gap

Accessory dwelling units, including junior accessory dwelling units

Large gap (Permanent) Tiny homes

Large gap

Shared housing

Large gap (Permanent) Recovery/sober living housing, including recovery-oriented housing

Large gap (Interim) Recovery/sober living housing, including recovery-oriented housing

Large gap

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)

Medium gap

License-exempt room and board

Large gap

Hotel and Motel stays

Medium gap

Non-congregate interim housing models

Large 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)

Large gap

Recuperative Care

Large gap

Short-Term Post-Hospitalization housing

Large gap (Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units

Large gap

Peer Respite

Large gap

Permanent rental subsidies

Large gap

Housing supportive services

Medium gap

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?

To expand housing supply and increase access to housing for Behavioral Health Services Act (BHSA) eligible individuals, the County will leverage a combination of non-BHSA resources, partnerships, and funding sources at the local, state, and federal levels.

Local and County Partnerships: The County will coordinate with the local Continuum of Care (CoC), County Housing and Human Services programs, Public Health, Probation, and community-based organizations to align housing resources, referral pathways, and supportive services for individuals with behavioral health needs. Cross-department collaboration supports shared use of housing vouchers, coordinated entry processes, and integration of behavioral health supportive services with housing placements.

Housing Assistance and Voucher Programs: The County will utilize existing housing assistance programs, such as Rapid Re-Housing, permanent rental subsidies, and other locally administered housing supports, to increase access to housing for BHSA-eligible individuals. Behavioral health staff will support individuals in navigating eligibility, documentation, and placement processes associated with these programs.

State and Federal Funding Sources: The County will continue to leverage non-BHSA state and federal funding sources, including programs such as HOME, HOME-ARP, Emergency Solutions Grant (ESG), Homeless Housing, Assistance and Prevention (HHAP), Housing and Disability Advocacy Program (HDAP),

Bringing Families Home, and other available housing and homelessness funding streams, to expand housing options and supportive services.

Data Sharing and Coordination: The County will use data sharing agreements and participation in Homeless Management Information System (HMIS) and Coordinated Entry to improve identification, referral, and tracking of housing placements for individuals with behavioral health needs. These systems support coordination across housing and service providers and improve access to available resources.

Through these combined non-BHSA resources and partnerships, the County will work to expand access to housing and supportive services for BHSA-eligible individuals, recognizing that housing development and availability remain constrained in a rural, multi-county region.

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?

BHSA Housing Interventions will intersect with existing local, state, and federal housing resources to strengthen coordination, improve access, and expand the continuum of housing supports available to BHSA-eligible individuals, rather than operate as a standalone housing system.

BHSA housing interventions will be used to address gaps not fully met by other housing programs by providing flexible, behavioral health–focused supports that complement existing housing assistance, voucher programs, and homelessness response resources. This includes aligning BHSA-funded housing supports with Continuum of Care (CoC) programs, Rapid Re-Housing, permanent rental subsidies, and other housing initiatives to support timely placement and housing stability for individuals with significant behavioral health needs.

The County will coordinate BHSA housing interventions with Coordinated Entry, HMIS, and cross- department referral processes to ensure individuals are connected to the most appropriate housing resource while receiving integrated behavioral health services. BHSA-funded supportive services will help individuals successfully access and maintain housing obtained through non-BHSA funding sources by addressing engagement, care coordination, and ongoing behavioral health needs.

Through collaboration with County housing programs, community-based organizations, and system partners, BHSA housing interventions will support step-up and step-down options across the housing continuum, including interim, transitional, and permanent housing settings, as available. This coordinated approach is intended to reduce service fragmentation, improve continuity of care, and maximize the impact of limited housing resources in a rural environment.

By intentionally intersecting BHSA housing interventions with existing housing systems and funding sources, the County will strengthen the overall housing continuum and improve outcomes for BHSA- eligible individuals experiencing homelessness or housing instability.

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

The County's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions is to pair flexible, behavioral health–focused housing supports with coordinated access to existing housing resources, while strategically expanding local housing infrastructure to address long-term capacity gaps.

BHSA Housing Interventions will prioritize rapid connection to permanent housing opportunities available through non-BHSA resources, including permanent supportive housing, rental subsidies, and other housing assistance programs. Behavioral health staff will provide care coordination, engagement, and supportive services to promote housing stability and address barriers that commonly interfere with retention, such as untreated behavioral health needs, difficulty navigating systems, and lack of ongoing support.

To strengthen housing retention, the County will emphasize ongoing engagement, coordination with landlords and housing providers when appropriate, and integration of behavioral health services with housing placements. Services will be person-centered, trauma-informed, and responsive to changes in individual needs over time.

Recognizing the limited housing inventory and infrastructure in a rural setting, the County is requesting an increase to the BHSA Housing Intervention capital development allocation to expand and improve local housing capacity. A key component of this strategy is the development of approximately 20 non- congregate, time-limited interim housing units.

These interim housing units are designed to function as a critical bridge to permanent housing by:

Providing immediate, low-barrier placements for individuals experiencing homelessness or housing instability, reducing time spent unsheltered or in higher levels of care

Stabilizing individuals through integrated behavioral health services, allowing them to address clinical and functional needs prior to permanent housing placement

Creating a structured pathway to permanent housing by connecting residents to Transitional Rent, housing navigation, and permanent housing resources during their stay

Improving housing readiness and tenancy success, thereby increasing the likelihood of long-term retention in permanent housing

In a rural environment where permanent housing opportunities are limited and often not immediately accessible, the development of non-congregate interim housing increases system flow by ensuring individuals are stabilized and actively engaged while permanent housing options are secured. This approach reduces returns to homelessness, supports continuity of care, and strengthens the overall permanent housing continuum by linking interim placements directly to permanent housing exits.

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)?

The County engages in a range of activities to support access to and stability in permanent supportive housing (PSH) for BHSA-eligible individuals by coordinating housing resources, delivering behavioral health–focused supportive services, and investing in housing infrastructure where feasible.

To support connection to PSH, the County works collaboratively with housing and homelessness partners through Coordinated Entry and other referral processes to identify appropriate housing opportunities and assist individuals in navigating eligibility, documentation, and placement requirements. Behavioral health staff provide engagement and care coordination to support timely connection to available PSH and other permanent housing options.

The County supports housing stability by providing ongoing behavioral health supportive services to individuals residing in PSH and other permanent housing settings. These services include care coordination, engagement, linkage to treatment and benefits, and support addressing behavioral health–related barriers that may impact housing retention.

Where rental or operating subsidies are available through non-BHSA programs, the County aligns BHSA supportive services to enhance housing stability and maximize the effectiveness of those housing investments. BHSA funds are not used to replace other housing subsidies but to complement them through behavioral health supports.

In recognition of limited PSH inventory, the County is also pursuing opportunities to expand and improve PSH capacity through capital development and infrastructure investments. Capital development funding, including requested increases to the BHSA housing capital allocation, will be used to support infrastructure improvements that increase the availability and suitability of housing for individuals with significant behavioral health needs.

Through these coordinated efforts, the County seeks to strengthen pathways into PSH, improve housing retention, and support long-term stability for BHSA-eligible individuals.

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

The County will ensure that all Housing Intervention settings provide access to clinical and supportive behavioral health care and housing services through coordinated service delivery, flexible engagement strategies, and integration of behavioral health supports across the housing continuum.

Behavioral health services will be provided through a combination of outpatient, community-based, and field-based service delivery models, depending on individual need and housing setting. Individuals receiving BHSA Housing Interventions will have access to clinical services, care coordination, and supportive services that address mental health, substance use, and related functional needs.

The County will utilize care coordination and case management to connect individuals in housing settings to appropriate behavioral health services, including assessment, treatment, medication support, and crisis response. Services will be delivered in a person-centered and trauma-informed manner and may occur in the home, in community settings, or at clinic locations, as appropriate.

Housing supportive services will be coordinated with clinical care to support housing stability and retention. This includes assistance navigating housing-related issues, coordination with housing providers and landlords when appropriate, and ongoing engagement to address barriers that may impact tenancy.

Through cross-department collaboration, partnerships with housing providers and community-based organizations, and integration with existing access points such as crisis services and outpatient care, the County will ensure that individuals in all Housing Intervention settings have ongoing access to behavioral health and housing supports necessary to promote stability, recovery, and continuity of care.

Eligible Populations

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

The County behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions through existing behavioral health access points, coordinated care processes, and collaboration with housing and community partners.

Identification of individuals with housing needs will occur across multiple entry points, including outpatient behavioral health services, Full Service Partnership (FSP) programs, crisis services, care coordination, and cross-system referrals from partner agencies such as housing programs, hospitals, justice system partners, and social services.

Screening for housing needs will be incorporated into routine behavioral health assessments and ongoing engagement activities. Staff will assess housing status, risk of homelessness, behavioral health acuity, and functional needs to determine appropriateness for BHSA Housing Interventions.

Referrals to housing interventions will be coordinated with County housing programs, the local Continuum of Care (CoC), and Coordinated Entry processes, as applicable. Behavioral health staff will support individuals with referrals, documentation, and navigation of housing systems to facilitate timely connection to appropriate housing resources.

Through integrated identification, screening, and referral processes, the County will ensure that BHSA- eligible individuals experiencing homelessness or housing instability are connected to housing interventions and supportive services aligned with their behavioral health needs.

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

Yes

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 (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

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

In developing the County's Housing Interventions for children and youth, the County considered the unique needs of individuals who are in, or at risk of being in, the juvenile justice system through data review, cross- system coordination, and stakeholder engagement.

The County reviewed available information related to youth justice involvement, housing instability, and behavioral health needs to better understand the intersection of system involvement, placement disruptions, and risk of homelessness among justice-impacted youth.

Planning efforts included coordination with probation, child-serving systems, schools, and community partners to identify challenges faced by justice-involved youth, including frequent transitions between settings, limited access to stable housing options, and the need for coordinated behavioral health and supportive services.

The County also considered best practices related to trauma-informed, developmentally appropriate, and family-centered housing supports for justice-impacted youth. These considerations informed Housing Intervention planning that emphasizes stability, continuity of care, coordination across systems, and alignment with behavioral health services to reduce the risk of deeper justice involvement and housing instability.

Through these activities, the County shaped Housing Interventions intended to address the complex needs of justice-involved and justice-impacted youth and to support safe, stable housing outcomes.

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

In developing the County's Housing Interventions for children and youth, the County considered the unique needs of Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+) individuals through review of available data, stakeholder input, and incorporation of equity- and trauma-informed best practices related to housing stability.

The County examined information and community feedback indicating that LGBTQ+ youth experience higher rates of housing instability, family rejection, and barriers to accessing safe and affirming housing environments. These factors were considered alongside behavioral health needs to better understand risks of homelessness and disengagement from services.

Planning activities included coordination with schools, child-serving agencies, and community partners to identify challenges faced by LGBTQ+ youth in housing settings, including safety concerns, lack of affirming placements, and the need for supportive services that respect identity and promote stability.

The County also reviewed best practices related to affirming, developmentally appropriate, and trauma- informed housing supports for LGBTQ+ youth. These considerations informed Housing Intervention planning that emphasizes safety, inclusivity, coordinated behavioral health support, and flexibility to respond to individual needs.

Through these efforts, the County shaped Housing Interventions intended to reduce disparities, improve access to safe and supportive housing, and promote stability and well-being for LGBTQ+ children and youth.

In the child welfare system

In developing the County's Housing Interventions for children and youth, the County considered the unique needs of individuals involved in the child welfare system through review of local data, cross-system collaboration, and stakeholder engagement.

The County reviewed information related to child welfare involvement, placement instability, housing disruptions, and behavioral health needs to better understand how system involvement contributes to housing vulnerability and risk of homelessness for children, youth, and transition-age youth.

Planning activities included coordination with Child Welfare Services, schools, and other child-serving partners to identify challenges related to placement changes, reunification timelines, caregiver availability, and the need for stable, supportive housing environments paired with behavioral health services.

The County also considered best practices related to trauma-informed, developmentally appropriate, and family-centered housing supports for child welfare–involved youth. These considerations informed Housing Intervention planning that emphasizes stability, continuity of placements, coordination across systems, and alignment of housing supports with behavioral health and permanency goals.

Through these efforts, the County shaped Housing Interventions intended to reduce placement disruptions, support housing stability, and improve outcomes for children and youth involved in the child welfare system.

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 (e.g., review data, engage with stakeholders, analyze research, etc.) who are Older adults

In developing the County's Housing Interventions for adults, the County considered the unique needs of older adults through review of available data, coordination with service partners, and incorporation of best practices related to aging and housing stability.

The County reviewed information related to housing instability, health and behavioral health needs, and service utilization among older adults to better understand barriers such as limited income, mobility challenges, chronic health conditions, cognitive impairment, and social isolation that may impact access to and retention in housing.

Planning activities included collaboration with internal County programs and community partners serving older adults, including health care providers, social services, and aging-focused organizations, to identify service gaps and strategies to support stable, accessible housing paired with behavioral health supports.

The County also considered evidence-informed practices related to age-appropriate, trauma-informed, and whole-person housing supports for older adults. These considerations informed Housing Intervention planning that emphasizes accessibility, coordination with medical and supportive services, and inclusion of caregivers and natural supports when appropriate and with consent.

Through these activities, the County developed Housing Interventions intended to address the intersecting housing and behavioral health needs of older adults and to promote housing stability, safety, and quality of life.

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

In developing the County's Housing Interventions for adults, the County considered the unique needs of individuals who are involved in, or at risk of involvement in, the justice system through review of local data, cross-system coordination, and stakeholder engagement.

The County reviewed information related to justice involvement, housing instability, and behavioral health needs to better understand how system contact, reentry transitions, and supervision requirements contribute to increased risk of homelessness and housing disruption.

Planning activities included coordination with probation, law enforcement, courts, reentry partners, and community-based organizations to identify barriers to housing access for justice-involved adults, including eligibility restrictions, timing of release, and the need for coordinated behavioral health and housing supports.

The County also considered evidence-informed practices related to trauma-informed housing supports, reentry-focused service models, and coordination across systems for justice-impacted populations. These considerations informed Housing Intervention planning that emphasizes timely housing access, continuity of care during transitions, and alignment of behavioral health services with housing placements.

Through these activities, the County shaped Housing Interventions intended to reduce housing instability, support successful reentry, and improve housing retention for justice-involved and justice-impacted adults.

In underserved communities

In developing the County's Housing Interventions for adults, the County considered the unique needs of individuals in underserved communities through review of local data, community input, and analysis of barriers related to access, geography, and resource availability.

The County examined information related to housing instability, behavioral health needs, and service utilization among individuals in underserved communities, including rural residents, individuals with limited income, and populations experiencing barriers related to transportation, language access, and limited local service availability.

Planning activities included engagement with community partners, service providers, and internal County programs to identify gaps in housing access and supportive services for underserved populations, particularly in geographically isolated areas and communities with limited housing options.

The County also considered best practices related to equity-focused, trauma-informed, and culturally responsive housing supports. These considerations informed Housing Intervention planning that emphasizes flexible service delivery, coordination across systems, and alignment of behavioral health services with housing supports to reduce access barriers.

Through these activities, the County developed Housing Interventions intended to improve access to stable housing, reduce disparities, and support housing retention for individuals in underserved communities.

Local Housing System Engagement

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

The County behavioral health system will coordinate with the Continuum of Care (CoC) to support referrals for Housing Interventions through established collaborative processes, shared referral pathways, and ongoing cross-system communication.

The County will participate in CoC planning and coordination activities and align Housing Interventions with CoC processes, including Coordinated Entry, to support identification and referral of individuals experiencing homelessness or housing instability who are eligible for BHSA Housing Interventions.

Referrals to Housing Interventions may originate through multiple pathways, including CoC partners, Coordinated Entry, housing providers, and County behavioral health programs. Behavioral health staff will work collaboratively with CoC partners to assess needs, support referral completion, and coordinate connection to appropriate housing resources and supportive services.

The County will also utilize data sharing and coordination tools, such as participation in the Homeless

Management Information System (HMIS) and cross-department referral processes, to support communication, track referrals, and promote continuity of care.

Through ongoing coordination with the CoC, housing providers, and community partners, the County will facilitate timely referrals, align behavioral health supports with housing placements, and strengthen access to Housing Interventions for BHSA-eligible individuals.

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

Local CoC

The County behavioral health system will collaborate closely with the local Continuum of Care (CoC) to implement Housing Interventions through coordinated planning, shared referral processes, and ongoing cross-system communication.

The County will participate in CoC meetings, planning activities, and coordination efforts to align Housing Interventions with the broader homelessness response system. This includes coordination around Coordinated Entry processes, prioritization of individuals with significant behavioral health needs, and alignment of housing resources with supportive behavioral health services.

Behavioral health staff will work collaboratively with CoC partners and housing providers to support referrals, share information as permitted, and coordinate services that promote housing access and stability for BHSA-eligible individuals. This coordination supports timely placement into available housing resources and ensures that behavioral health supports are aligned with housing placements.

The County will also coordinate with the CoC through participation in data-sharing systems such as the Homeless Management Information System (HMIS) to support tracking of referrals, placements, and service connections, and to improve communication across systems.

Through ongoing collaboration with the CoC, the County will support a coordinated and integrated approach to Housing Interventions that strengthens the local housing continuum and improves outcomes for individuals with behavioral health needs.

Public Housing Agency

The County will coordinate with the Public Housing Agency administering housing vouchers and public housing resources for County residents to align referral processes and supportive services. BHSA-funded behavioral health supports will complement PHA housing assistance to promote access to and retention in permanent housing.

MCPs

The County behavioral health system will collaborate with Medi-Cal Managed Care Plans (MCPs) to align Housing Interventions with health care, care coordination, and housing-related supports for BHSA-eligible individuals. Coordination with MCPs will focus on improving access to housing, stabilizing individuals with significant behavioral health needs, and supporting whole-person care.

The County is in the process of contracting with MCPs to serve as a Transitional Rent provider for behavioral health–involved and justice-involved populations of focus. Through this role, the County will coordinate closely with MCP care teams to support short-term housing assistance paired with behavioral health services to promote stabilization and transition to longer-term housing solutions.

Collaboration with MCPs will include coordination around referrals, eligibility, and service planning for individuals enrolled in Medi-Cal, including alignment with Enhanced Care Management (ECM) and Community Supports. Behavioral health staff will work with MCPs to ensure housing needs are identified early and addressed alongside clinical and supportive services.

MCP-funded services will complement BHSA Housing Interventions by supporting engagement, continuity of care, and stabilization for individuals experiencing homelessness or housing instability. The County will coordinate with MCPs to reduce service duplication, align housing supports with behavioral health care, and promote housing retention.

Through ongoing communication, contracting, and cross-system coordination, the County will strengthen partnerships with MCPs to expand access to housing supports, improve service integration, and enhance housing stability outcomes for BHSA-eligible individuals.

ECM and Community Supports Providers

The County behavioral health system will collaborate with Enhanced Care Management (ECM) and Community Supports (CS) providers to coordinate Housing Interventions and ensure that services delivered by multiple systems are aligned and complementary for BHSA-eligible individuals.

Coordination with ECM and CS providers will focus on individuals receiving MCP-funded services that address needs not directly provided by the County, such as housing-related supports, care coordination, and other Community Supports. The County will work with ECM and CS providers to clarify roles, share information as permitted, and align service planning to avoid duplication and service gaps.

Behavioral health staff will coordinate with ECM care managers and Community Supports providers around referrals, eligibility, and timing of services, particularly for individuals experiencing homelessness, housing instability, or frequent system involvement. This coordination supports continuity of care and ensures that behavioral health services and housing supports are delivered in a complementary manner.

As the County develops Housing Interventions and Transitional Rent capacity, collaboration with ECM and CS providers will support smooth transitions between short-term housing supports and longer-term housing solutions. The County will continue to participate in cross-system meetings and coordination efforts to align BHSA Housing Interventions with MCP-funded ECM and Community Supports.

Through this collaborative approach, the County will strengthen integration across behavioral health, health care, and housing systems and improve housing stability outcomes for BHSA-eligible individuals.

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

N/A

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?

The County behavioral health system will work with Homekey+ and other supportive housing sites through coordination, referral alignment, and integration of behavioral health services to support housing placement and stability for BHSA-eligible individuals.

Where Homekey+ or other supportive housing sites are available within the region, the County will collaborate with housing providers, project operators, and system partners to support referrals of BHSA- eligible individuals whose behavioral health needs align with program criteria. Behavioral health staff will assist with screening, referral coordination, and navigation of eligibility and placement processes.

The County will provide behavioral health services and supportive care to individuals residing in Homekey+ and supportive housing settings through outpatient, community-based, and field-based service delivery models, as appropriate. These services will support engagement, stabilization, and ongoing tenancy and will be coordinated with housing providers to promote housing retention.

While housing development and operating subsidies are administered through non-BHSA programs, the County will align BHSA-funded supportive services and care coordination with Homekey+ and supportive housing placements to complement housing investments and address behavioral health–related barriers to stability.

Through ongoing collaboration with housing developers, supportive housing operators, and system partners, the County will strengthen referral pathways, align services with housing placements, and support long-term housing outcomes for BHSA-eligible individuals.

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

No

BHSA HOUSING INTERVENTIONS IMPLEMENTATION

The following questions are specific to BHSA Housing Interventions funding (no action needed). For more information, please see 7.C.9 Allowable expenditures and related requirements

Rental Subsidies(Chapter 7. Section C.9.1)

The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed) Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?

The County anticipates serving approximately <11*–25 individuals annually with rental subsidies under BHSA Housing Interventions. This estimate reflects current housing system utilization, anticipated use of BHSA housing funds to complement existing housing resources, and planned expansion of housing capacity over the Integrated Plan period. Actual numbers may vary by year based on housing availability, partnerships, and funding alignment.

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?

<11*

How many of these individuals will receive rental subsidies for interim housing on an annual basis?

<11*

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?

The County's estimates for rental subsidies and the number of individuals served in permanent and interim housing settings were developed as planning-level projections informed by current housing system capacity, funding roles, and anticipated implementation of BHSA Housing Interventions.

Because the Integrated Plan requires entry of a single numeric value, the County selected conservative midpoint estimates for reporting purposes. These values reflect the middle of a reasonable planning range based on local conditions and are not intended to represent fixed annual targets.

For planning purposes, the County estimates that approximately 6–15 individuals annually may receive rental subsidies for permanent housing under BHSA Housing Interventions, and approximately 4–10 individuals annually may receive rental subsidies for interim housing. The single values entered in the Integrated Plan (10 for permanent housing and 5 for interim housing) represent conservative point estimates within these ranges.

These ranges were informed by:

Distinguishing rental subsidies funded through BHSA Housing Interventions from housing placements supported by other funding sources, including Full Service Partnerships (FSP), Behavioral Health Bridge Housing (BHBH), Medi-Cal Community Supports (including Transitional Rent), and Continuum of Care housing programs

Limited permanent and interim housing inventory available within a rural, multi-county Continuum of Care

Anticipated prioritization of permanent housing placements, with interim housing used selectively as a bridge to long-term stability

Phased implementation of Housing Interventions and planned expansion of housing infrastructure over the Integrated Plan period

Actual numbers served may vary by year based on housing availability, length of stay, funding alignment, and partnerships. The County will revisit and adjust projections as housing capacity and resources evolve.

For which setting types will the county provide rental subsidies?

- Non-Time-Limited Permanent Settings: Supportive housing
- Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
- Non-Time-Limited Permanent Settings: Single and multi-family homes
- Non-Time-Limited Permanent Settings: Housing in mobile home communities
- Non-Time-Limited Permanent Settings: Single room occupancy units
- Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
- Non-Time-Limited Permanent Settings: Tiny Homes
- Non-Time-Limited Permanent Settings: Shared housing
- Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
- Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
- Non-Time-Limited Permanent Settings: License-exempt room and board
- Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit Time Limited Interim Settings: Hotel and motel stays
- Time Limited Interim Settings: Non-congregate interim housing models
- Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
- Time Limited Interim Settings: Recuperative Care
- Time Limited Interim Settings: Short-Term Post-Hospitalization housing

- Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units Time Limited Interim Settings: Peer respite
- Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this Housing Intervention accommodate family housing?

Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

The County will use BHSA Housing Interventions funding to provide targeted rental subsidies that support housing stability for BHSA-eligible individuals with significant behavioral health needs. Rental subsidies will be used to reduce housing cost burden and address financial barriers that prevent individuals from obtaining or maintaining stable housing.

BHSA Housing Interventions funding may be used to provide time-limited or ongoing rental assistance, paid on behalf of eligible individuals directly to landlords or housing providers, in permanent or interim housing settings as appropriate. Rental subsidies will be paired with behavioral health supportive services, including care coordination and engagement, to promote housing retention and stability.

Rental subsidies funded through BHSA Housing Interventions will be used selectively and in coordination with non-BHSA housing resources, such as Continuum of Care programs, Medi-Cal Community Supports, and other local, state, or federal housing assistance. BHSA funds will complement, rather than replace, other housing subsidies and will be targeted to individuals whose behavioral health needs create barriers to housing access or retention.

This intervention is intended to support stabilization, reduce returns to homelessness, and facilitate transitions to longer-term housing solutions when available.

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

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

The County behavioral health system will identify and maintain a portfolio of available housing units for BHSA-eligible individuals through coordinated partnerships, cross-department collaboration, and participation in local housing systems rather than through a standalone housing inventory.

The County will work closely with internal County partners, including Housing and Human Services programs, to identify available housing opportunities across permanent and interim settings. This includes coordination around rental subsidies, transitional housing options, and other housing resources administered outside of BHSA but available to County residents.

Collaboration with the local Continuum of Care (CoC) and participation in Coordinated Entry will support identification of available units, prioritization of individuals with significant behavioral health needs, and alignment of placements with appropriate housing interventions. Behavioral health staff will coordinate with housing providers and system partners to understand unit availability, eligibility requirements, and timing of placements.

As applicable, the County will explore and participate in Flex Pool strategies, such as master leasing or other shared housing arrangements, in collaboration with County partners and housing administrators. Flex Pools may be used to increase access to housing units in a constrained rental market and to provide greater flexibility in placing individuals with complex behavioral health needs.

The County will also engage with existing and prospective housing providers, landlords, and supportive housing operators to identify potential units and develop referral pathways that align behavioral health services with housing placements. Behavioral health staff will support navigation, coordination, and service linkage to facilitate placement and housing stability.

Through these partnerships and collaborative efforts, the County will assemble a flexible and evolving portfolio of housing options to support timely placement and retention of BHSA-eligible individuals, recognizing ongoing limitations in housing supply within a rural context.

Total number of units funded with BHSA Housing Interventions per year

15

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

N/A

Operating Subsidies(Chapter 7, Section C.9.2)

Is the county providing this intervention?

No

Please explain why the county is not providing this intervention

The County is not providing operating subsidies under BHSA Housing Interventions due to structural, fiscal, and operational considerations related to housing development and management.

Operating subsidies are typically tied to the ongoing operation of specific housing projects and require long-term commitments to property management, maintenance, and building operations. At this time, the County does not own or operate permanent supportive housing projects and does not have existing housing developments structured to receive operating subsidy support through BHSA.

Instead, the County's approach prioritizes the use of BHSA Housing Interventions funding for rental subsidies and behavioral health supportive services that directly support individuals in accessing and maintaining housing, while leveraging non-BHSA housing programs and partners to fund housing development, ownership, and ongoing operations.

In a rural housing market with limited inventory and project-scale housing opportunities, this approach allows the County to deploy BHSA resources flexibly, avoid duplicating other housing funding streams, and align with existing housing system roles and capacities.

The County will continue to assess opportunities for future housing development and infrastructure expansion, including potential capital investments, as housing capacity and partnerships evolve.

Landlord Outreach and Mitigation Funds(Chapter 7, Section C.9.4.1) Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year

15

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

The County uses BHSA Housing Interventions funding to support landlord outreach and mitigation activities that facilitate access to housing for BHSA-eligible individuals, including those who are chronically homeless.

Landlord outreach and mitigation efforts are integrated into the County's rental subsidy and housing placement activities and may include engagement with landlords to identify available units, address concerns related to tenant behavioral health needs, and reduce perceived risks associated with renting to high-acuity populations.

BHSA Housing Interventions funding may be used for landlord mitigation supports such as reimbursement for tenant-caused damages beyond normal wear and tear, assistance addressing unpaid rent related to behavioral health crises, and other landlord engagement strategies designed to promote placement and housing retention. These efforts are paired with ongoing behavioral health supportive services to support tenancy and housing stability.

This intervention is intended to expand housing access, increase landlord participation, and reduce barriers to permanent and interim housing for BHSA-eligible individuals.

Total number of units funded with BHSA Housing Interventions per year

15

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

N/A

Participant Assistance Funds(Chapter 7, Section C.9.4.2)

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year

15

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

The County will use BHSA Housing Interventions funding to provide Participant Assistance Funds that address one-time or short-term financial barriers to housing access and stability for BHSA-eligible individuals, including those who are chronically homeless.

Participant Assistance Funds may be used for eligible housing-related expenses such as security deposits, utility setup or arrears, application fees, move-in costs, and other necessary housing-related expenses that are not covered by Medi-Cal or other housing programs. These funds are intended to remove immediate financial obstacles that prevent individuals from securing or maintaining interim or permanent housing.

Participant Assistance Funds will be provided in coordination with rental subsidies, landlord outreach and mitigation, and behavioral health supportive services to promote successful housing placement, stabilization, and retention.

Housing Transition Navigation Services and Tenancy Sustaining Services(Chapter 7, Section C.9.4.3)

Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year

15

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

Services to support individuals, including those who are chronically homeless, in obtaining and maintaining stable housing. Housing Transition Navigation Services will include housing search and placement support, assistance with completing applications, coordination with landlords, and support in securing appropriate housing based on individual needs.

Tenancy Sustaining Services will include ongoing support to help individuals maintain housing stability, such as developing independent living skills, addressing lease compliance issues, coordinating with property managers, and providing problem-solving support related to tenancy. Services will be coordinated with behavioral health treatment, case management, and community partners to support long-term housing stability and prevent returns to homelessness.

Housing Interventions Outreach and Engagement(Chapter 7, Section C.9.4.4) Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year

15

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

The County provides Housing Interventions outreach and engagement activities to support BHSA-eligible individuals, including those who are chronically homeless, in accessing and sustaining housing. Outreach and engagement activities are embedded within the County's housing placement, rental subsidy, and supportive service efforts rather than delivered as a standalone program.

BHSA Housing Interventions funding may be used to support engagement activities that assist individuals in identifying housing options, completing housing-related documentation, navigating referral and placement processes, and maintaining contact during housing transitions. Outreach efforts prioritize individuals with significant behavioral health needs who may face barriers to engaging with traditional housing systems.

These activities are coordinated with behavioral health supportive services, landlord outreach and mitigation efforts, and participant assistance funds to promote timely housing placement, reduce disengagement, and support housing stability. Outreach and engagement under this intervention are distinct from Medi-Cal-covered services and are focused on facilitating access to housing resources and interventions funded through BHSA.

Capital Development Projects(Chapter 7, Section C.10)

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

Is the county providing this intervention to chronically homeless individuals?

Yes

How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?

7

CAPITAL DEVELOPMENT PROJECT

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project

Haven on The Hill

What setting types will the capital development project include?

- Time Limited Interim Settings: Non-congregate interim housing models

Capacity (Anticipated number of individuals housed at a given time)

20

Will this project braid funding with non-BHSA funding source(s)?

Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources

20

Total number of units funded with Housing Interventions funds only

12

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

N/A

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)

7/1/2027

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)

75000

Have you utilized the "by right" provisions of state law in your project?

No

If you have not incorporated use of the "by right" provisions into your project, please explain why

The project is a previously zoned multi unit residential facility and did not require discretionary review.

CAPITAL DEVELOPMENT PROJECT

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project

District 1 Housing

What setting types will the capital development project include?

- Non-Time-Limited Permanent Settings: Single and multi-family homes

Capacity (Anticipated number of individuals housed at a given time)

9

Will this project braid funding with non-BHSA funding source(s)?

Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources

9

Total number of units funded with Housing Interventions funds only

9

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 anticipates pursuing acquisition and rehabilitation opportunities that expand access to supportive housing within underserved areas of the County. Final project scope may vary based on available properties, community partnerships, and development feasibility.

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)

12/1/2028

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)

75000

Have you utilized the "by right" provisions of state law in your project?

No

If you have not incorporated use of the "by right" provisions into your project, please explain why

At this time, the County has not incorporated "by right" provisions into the project because a specific property/site has not yet been identified or acquired. The County anticipates evaluating all feasible development and acquisition pathways, including opportunities that may qualify for streamlined or "by right" approval processes under applicable state and local laws, once a final project site and scope are determined.

CAPITAL DEVELOPMENT PROJECT

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project

District 2

What setting types will the capital development project include?

- Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)

9

Will this project braid funding with non-BHSA funding source(s)?

Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources

9

Total number of units funded with Housing Interventions funds only

9

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 leverage BHSA Housing Intervention funding alongside additional local, state, federal, and community partner resources where feasible to maximize housing capacity and long-term sustainability.

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)

12/1/2028

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)

75000

Have you utilized the "by right" provisions of state law in your project?

No

If you have not incorporated use of the "by right" provisions into your project, please explain why

At this time, the County has not incorporated "by right" provisions into the project because a specific property/site has not yet been identified or acquired. The County anticipates evaluating all feasible development and acquisition pathways, including opportunities that may qualify for streamlined or "by right" approval processes under applicable state and local laws, once a final project site and scope are determined.

CAPITAL DEVELOPMENT PROJECT

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project

District 3

What setting types will the capital development project include?

- Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)

6

Will this project braid funding with non-BHSA funding source(s)?

Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources

6

Total number of units funded with Housing Interventions funds only

6

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

Project implementation may include acquisition, rehabilitation, furnishing, infrastructure improvements, and accessibility modifications intended to support rapid development of supportive housing opportunities within rural portions of the County.

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)

6/1/2029

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)

75000

Have you utilized the "by right" provisions of state law in your project?

No

If you have not incorporated use of the "by right" provisions into your project, please explain why

At this time, the County has not incorporated "by right" provisions into the project because a specific property/site has not yet been identified or acquired. The County anticipates evaluating all feasible development and acquisition pathways, including opportunities that may qualify for streamlined or "by right" approval processes under applicable state and local laws, once a final project site and scope are determined.

CAPITAL DEVELOPMENT PROJECT

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions Name of Project

District 4

What setting types will the capital development project include?

- Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)

5

Will this project braid funding with non-BHSA funding source(s)?

Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources

5

Total number of units funded with Housing Interventions funds only

5

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

Final project design and housing configuration may vary depending on acquisition opportunities, permitting considerations, infrastructure needs, and leveraged funding availability.

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)

6/1/2029

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)

75000

Have you utilized the "by right" provisions of state law in your project?

No

If you have not incorporated use of the "by right" provisions into your project, please explain why

At this time, the County has not incorporated "by right" provisions into the project because a specific property/site has not yet been identified or acquired. The County anticipates evaluating all feasible development and acquisition pathways, including opportunities that may qualify for streamlined or "by right" approval processes under applicable state and local laws, once a final project site and scope are determined.

CAPITAL DEVELOPMENT PROJECT

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project

District 5

What setting types will the capital development project include?

- Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)

7

Will this project braid funding with non-BHSA funding source(s)?

Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources

7

Total number of units funded with Housing Interventions funds only

7

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 strategically distribute supportive housing opportunities throughout all supervisorial districts to improve access to housing and behavioral health supportive services countywide. Final project scope may vary based on identified housing opportunities and available leveraged resources.

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)

12/1/2029

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)

75000

Have you utilized the "by right" provisions of state law in your project?

No

If you have not incorporated use of the "by right" provisions into your project, please explain why

At this time, the County has not incorporated "by right" provisions into the project because a specific property/site has not yet been identified or acquired. The County anticipates evaluating all feasible development and acquisition pathways, including opportunities that may qualify for streamlined or "by right" approval processes under applicable state and local laws, once a final project site and scope are determined.

CAPITAL DEVELOPMENT PROJECT

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project

Valley Springs Housing Development Project

What setting types will the capital development project include?

- Non-Time-Limited Permanent Settings: Supportive housing
- Non-Time-Limited Permanent Settings: Single and multi-family homes
- Non-Time-Limited Permanent Settings: Single room occupancy units

Capacity (Anticipated number of individuals housed at a given time)

12

Will this project braid funding with non-BHSA funding source(s)?

Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources

12

Total number of units funded with Housing Interventions funds only

12

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 anticipates utilizing BHSA Housing Intervention funding for acquisition, development, infrastructure improvements, furnishing, accessibility modifications, and rehabilitation activities necessary to operationalize the project. Final project scope and configuration may vary based on property availability, permitting requirements, development feasibility, and leveraged funding opportunities.

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)

6/1/2028

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)

75000

Have you utilized the "by right" provisions of state law in your project?

No

If you have not incorporated use of the "by right" provisions into your project, please explain why

At this time, the County has not incorporated "by right" provisions into the project because a specific property/site has not yet been identified or acquired. The County anticipates evaluating all feasible development and acquisition pathways, including opportunities that may qualify for streamlined or "by right" approval processes under applicable state and local laws, once a final project site and scope are determined.

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention

N/A

Is the county providing this intervention to chronically homeless individuals?

No

Anticipated number of individuals served per year

0

Continuation of Existing Housing Programs

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)

BHSA Housing Interventions funding may be used to support the orderly transition and continuity of housing supports for individuals who would otherwise be at risk of losing housing due to the expiration of time-limited housing programs, such as Behavioral Health Bridge Housing (BHBH).

As temporary housing programs and funding sources sunset, the County will utilize BHSA Housing Interventions to prevent disruptions in housing stability by supporting eligible individuals through rental subsidies, participant assistance funds, landlord outreach and mitigation, and other allowable housing interventions. These supports are intended to serve as a bridge to longer-term housing solutions when appropriate and available.

BHSA Housing Interventions funding will not replace expiring housing program funding or be used to extend time-limited programs indefinitely. Instead, BHSA resources will be used selectively to complement existing housing systems, support transitions to permanent or interim housing settings, and reduce the risk of returns to homelessness for BHSA-eligible individuals.

This approach allows the County to maintain continuity of care and housing stability for individuals with significant behavioral health needs while aligning with the intended purpose and allowable uses of BHSA Housing Interventions funding.

RELATIONSHIP TO HOUSING SERVICES FUNDED BY MEDI-CAL MANAGED CARE PLANS

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?

- Transitional Rent
- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services

Yes

When does the county behavioral health system plan to become an MCP-contracted provider?

4/1/2026

Housing Deposits

Yes

When does the county behavioral health system plan to become an MCP-contracted provider?

4/1/2026

Housing Tenancy and Sustaining Services

Yes

When does the county behavioral health system plan to become an MCP-contracted provider?

4/1/2026

Short-Term Post-Hospitalization Housing

No

Recuperative Care

No

Day Habilitation

No

Transitional Rent

Yes

When does the county behavioral health system plan to become an MCP-contracted provider?

4/1/2026

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)?

The County behavioral health system will identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by Medi-Cal Managed Care Plans (MCPs), including Transitional Rent, through coordinated screening, care planning, and cross-system collaboration.

Identification of Medi-Cal members who may benefit from housing-related Community Supports will occur through existing behavioral health access points, including outpatient services, Full Service Partnerships (FSP), crisis services, care coordination, and housing intervention activities. Behavioral health staff will identify housing instability, homelessness, or risk of housing loss as part of routine assessments and ongoing engagement.

Eligibility for MCP-covered Community Supports will be confirmed in coordination with MCPs and Enhanced Care Management (ECM) providers, as applicable. The County will work with MCP care teams to verify Medi-Cal enrollment, population of focus eligibility, and appropriateness for specific Community Supports, including Transitional Rent.

Referrals to Community Supports will be made through MCP-established referral pathways and in collaboration with ECM and Community Supports providers. Behavioral health staff will support referral completion, information sharing as permitted, and coordination of services to ensure timely connection to housing-related supports.

As the County is in the process of contracting to serve as a Transitional Rent provider for behavioral health- involved and justice-involved populations of focus, coordination with MCPs will support smooth referrals, role clarity, and alignment between MCP-funded housing supports and County-provided behavioral health services.

Through these coordinated processes, the County will ensure Medi-Cal members are appropriately referred to MCP-covered housing-related Community Supports while avoiding duplication of services and supporting continuity of care and housing stability.

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

The County behavioral health system will ensure that the Housing Interventions provider network is known and shared with Medi-Cal Managed Care Plans (MCPs) through ongoing coordination, communication, and participation in cross-system planning and operational processes.

The County will communicate information about County-contracted Housing Interventions providers, services offered, and eligibility parameters to MCPs through established coordination channels, including regular meetings, care coordination discussions, and implementation planning related to CalAIM, Enhanced Care Management (ECM), and Community Supports.

As the County develops and implements Housing Interventions and Transitional Rent capacity, the County will work with MCPs to clarify roles, referral pathways, and points of contact to support timely and appropriate referrals. Updates to the Housing Interventions provider network will be shared with MCPs as contracts are executed, modified, or expanded.

The County will also coordinate with MCPs through operational workflows such as referral processes, case conferencing, and information sharing, as permitted, to ensure MCP care teams are aware of available Housing Interventions supports and how they align with MCP-covered services.

Through these ongoing coordination efforts, the County will promote shared understanding of the Housing Interventions provider network, support effective referrals, and strengthen integration between behavioral health services, housing supports, and MCP-funded care.

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

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?

The County behavioral health system has processes in place to minimize gaps in service for Medi-Cal members with significant behavioral health conditions when MCP-funded housing services are exhausted, to the extent resources are available, through coordinated care planning, early transition planning, and use of allowable BHSA Housing Interventions.

County behavioral health staff coordinate with Medi-Cal Managed Care Plans (MCPs), Enhanced Care Management (ECM) providers, and Community Supports providers to identify time-limited housing services early and plan for transitions well in advance of service exhaustion. This coordination includes communication regarding service timelines, eligibility changes, and anticipated housing needs.

When MCP housing services end, the County may utilize BHSA Housing Interventions, as appropriate and available, to support continuity of housing and services. This may include rental subsidies, participant assistance funds, landlord outreach and mitigation, and housing-focused outreach and engagement to prevent housing loss and support stabilization.

Behavioral health services, including care coordination and engagement, will continue regardless of MCP housing service status, ensuring individuals remain connected to clinical and supportive behavioral health care. County staff will reassess needs and coordinate referrals to other available housing or supportive resources as appropriate.

Through proactive planning, cross-system coordination, and flexible use of BHSA Housing Interventions, the County seeks to reduce service disruptions, support housing stability, and promote continuity of care for Medi-Cal members with significant behavioral health needs.

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.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools.

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)?

Yes

Is the county behavioral health system participating in or planning to participate in the Flex Pool?

Yes

What role does the county behavioral health system have or plan to have in the Flex Pool?

- Lead Entity
- Operator
- Housing Supportive Services Provider

What organization is serving as the Operator?

Calaveras County Behavioral Health

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?

Yes

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?

- Landlord Outreach and Mitigation Funds
- Participant Assistance Funds
- Housing Transition Navigation Services and Tenancy and Sustaining Services
- Outreach and Engagement (up to 7 percent)

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

In addition to the coordination activities described above, the County behavioral health system is undertaking planning, assessment, and system development functions to support the potential launch and scaling of a Flex Pool model.

The County has been awarded Flex Pool technical assistance and is actively participating in technical assistance activities, including meetings with consultants, to assess feasibility, identify appropriate models, and evaluate how a Flex Pool could function within the County's housing and behavioral health systems. These efforts include analysis of local housing inventory, market constraints, administrative capacity, and alignment with existing housing and funding structures.

As part of this planning process, the County is exploring partial implementation approaches that align with current system roles, including coordination with Medi-Cal Managed Care Plans and the County's development of Transitional Rent provider capacity. This includes assessing how Flex Pool strategies, such as master leasing or shared unit access, could complement Transitional Rent and other housing supports without duplicating existing programs.

The County's role includes convening partners, clarifying roles and responsibilities, developing referral and coordination workflows, and identifying operational requirements needed to support Flex Pool participation if determined to be feasible. Decisions regarding full implementation or scaling of a Flex Pool will be informed by ongoing technical assistance, system readiness, and housing availability.

Through these activities, the County is laying the groundwork to support Flex Pool strategies in a manner that is responsive to local conditions, fiscally responsible, and aligned with behavioral health housing needs.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects.

Does the county's plan include the development of innovative programs or pilots?

No

SECTION IX

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:

> **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 also participate in the county's Medi-Cal Behavioral Health Delivery System?**
>
> Yes

> **Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?**
>
> Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

ASSESS WORKFORCE GAPS

> **What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?**
>
> 13

> **Upload any data source(s) used to determine vacancy rate**

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates

- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Professional Clinical Counselor
- Other qualified provider
- Registered nurse

Please describe any other key workforce gaps in the county

Calaveras County experiences ongoing workforce turnover across multiple departments, including public safety, health and human services, and administrative functions. These broader staffing pressures affect behavioral health operations by reducing cross-departmental capacity for coordination, referrals, eligibility processing, billing, and support functions that are critical to service delivery.

Recruitment and retention of behavioral health staff are further challenged by limited local housing availability, high housing costs relative to county wages, and competition with neighboring counties and private providers that can offer higher salaries, signing incentives, or remote work options. These market conditions contribute to longer hiring timelines, increased reliance on temporary or contracted staff, and difficulty sustaining fully staffed behavioral health teams.

Together, countywide turnover, housing constraints, and a competitive labor market limit the county's ability to rapidly fill specialized behavioral health positions, expand services, and maintain continuity of care, particularly in rural and remote areas.

How does the county expect workforce needs to shift over the next three fiscal years 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)?

Over the next three fiscal years, Calaveras County anticipates a shift in workforce skills, roles, and deployment to meet new requirements under Behavioral Health Transformation (BHT), including implementation of required and optional evidence-based practices and broader system expectations associated with initiatives such as BH-CONNECT. Workforce needs will emphasize cross-training existing staff, role realignment, and targeted capacity building to support team-based care, outreach and engagement, fidelity to EBPs, and data-informed service delivery.

Rather than significant increases in total staffing, the County will prioritize maximizing existing workforce capacity through expanded use of peer and paraprofessional roles, along with continued coordination with contracted providers and community partners to support service delivery in a rural setting.

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 for 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.

> **Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?**
>
> **Yes**

> **Please explain any actions or activities the county is engaging in to leverage the program**
>
> Calaveras County intends to leverage the Behavioral Health Scholarship Program by monitoring application cycles and encouraging eligible students, trainees, and local providers to apply when opportunities are available. The County will share information with staff, contracted providers, and community partners and will explore opportunities to align scholarship participation with identified workforce needs, particularly in hard-to-recruit clinical and peer support roles.

> **Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?**
>
> **Yes**

> **Please explain any actions or activities the county is engaging in to leverage the program**
>
> The County plans to support use of the Behavioral Health Student Loan Payment Program by promoting the program to eligible behavioral health professionals working in or willing to serve Medi-Cal populations in Calaveras County. As application opportunities arise, the County will assess feasibility and encourage participation as a recruitment and retention strategy for licensed and non-licensed behavioral health positions.

> **Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?**
>
> **Yes**

> **Please explain any actions or activities the county is engaging in to leverage the program**
>
> Calaveras County anticipates leveraging the Behavioral Health Recruitment and Retention Program if and when funding opportunities become available, particularly to address challenges related to rural workforce recruitment and staff retention. The County will evaluate program requirements upon release and consider applying for or supporting participation in components that are feasible and aligned with local workforce needs.

> **Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?**
>
> **Yes**

Please explain any actions or activities the county is engaging in to leverage the program

The County intends to monitor and leverage the Behavioral Health Community-Based Provider Training Program by encouraging participation from community-based providers and partners, particularly those supporting peer services, substance use disorder services, and outreach roles. As opportunities arise, Calaveras County will explore alignment with workforce development needs and training capacity in the local service delivery system.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?

No

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

To address workforce gaps, the County is implementing strategies focused on recruitment, retention, and workforce stability. This includes development of a standardized stipend-based incentive program, with stipends provided at hire and at defined service intervals to support retention and continuity of care across staff classifications.

The County will continue to strengthen clinical supervision, quality assurance, and professional development opportunities to support workforce competency and retention. Additional efforts include exploring flexible staffing models, leveraging blended funding to support key positions, and expanding partnerships with contracted providers, educational partners, and Managed Care Plans to increase workforce capacity.

These efforts are intended to support a stable, trained, and sustainable behavioral health workforce aligned with BHSA requirements and responsive to local rural needs.

SECTION X

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section

Please upload the completed budget template

- Integrated Plan Budget Template Version 3_Calaveras_4th_Revision draft.xlsx

Please upload supporting data

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

Behavioral Health Services and Supports (BHSS)

N/A

Full Service Partnership (FSP)

N/A

Housing Interventions

N/A

Enter date of last prudent reserve assessment

3/1/2026

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

BHSS

N/A

FSP

N/A

Housing Interventions

N/A

SECTION XI

Plan Approval and Compliance

Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template

- Behavioral Health Director Certification-signed.pdf

County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template

- BHSA IP County Administrator certification -signed.pdf

Board of supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section

Please upload the completed Board of supervisor certification template

- BHSA IP BOS CERT..pdf

SECTION XII

Requests

Housing Intervention Funds for Chronically Homeless

What percentage of Housing Intervention Component allocation is the county requesting to use for those who are chronically homeless?

Please select which Housing Interventions exemptions criteria the county meets

SUPPORTING DATA

Please upload supporting data

What is the data source?

Housing Intervention Funds for Capital Development

What percentage of Housing Intervention Component allocation is the county requesting to use for capital development projects?

75

Please select which Housing Interventions exemptions criteria the county meets

- Significant capital development required to meet housing needs of eligible population (e.g., demonstrated lack of existing suitable housing facilities within the county)
- Other funding sources insufficient to address need
- Costs of accessibility improvements exceed 25 percent capital improvement limits

SUPPORTING DATA

Please upload supporting data:

- Part 1 supporting data.pdf

What is the data source?

Evidence of need for housing production

Assertive Community Treatment (ACT)

For counties seeking an exemption to the requirement to include ACT in the county's FSP program

Please select which FSP exemptions criteria the county meets

- Limited workforce (e.g. qualified providers)
- Other hardships

Please provide justification for this FSP exemption request

Calaveras is a rural, mountainous county in the Sierra Nevada foothills, with a total population of just 44,636 residents (DOF, 2025) and an estimated Medi-Cal population of approximately 10,500. As a small county with persistent staffing shortages, limited FSP volume, and an overstretched administrative team, we cannot feasibly implement multiple EBPs to fidelity concurrently without sacrificing our core Medi-Cal obligations and mandated services.

On behalf of Calaveras County Behavioral Health Services, I respectfully submit this correspondence to affirm our county's request for exemption from the Evidence-Based Practice (EBP) requirements outlined under Welfare and Institutions Code (WIC) Section 5887(a)(2). As a small, rural county with a population well under 200,000, Calaveras County faces unique operational, workforce, and fiscal challenges that make implementation of multiple fidelity-based EBPs infeasible.

As implementation moves forward, it is critical that the Department's approach remain aligned with the statutory authority established in WIC Section 5887, which clearly outlines that small counties may seek exemptions from these requirements—without the caveat of meeting additional conditions such as initial fidelity training participation.

Welfare and Institutions Code (WIC) 5887(a)(2) states:

Assertive Community Treatment and Forensic Assertive Community Treatment fidelity, Individual Placement and Support model of Supported Employment, high fidelity wraparound, or other evidence- based services and treatment models, as specified by the State Department of Health Care Services. Counties with a population of less than 200,000 may request an exemption from these requirements. Exemption requests shall be subject to approval by the State Department of Health Care Services. The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association of California on reasonable criteria for those requests and a timely and efficient exemption process.

The Behavioral Health Services Act (BHSA) Policy Manual further clarifies:

For the first Integrated Plan covering FY 2026–2029, all counties, regardless of their size, will be exempt from the EBP fidelity requirements for ACT, FACT, IPS, and HFW. However, counties must begin offering these EBPs by July 1, 2026, and participate in ongoing training, gap analysis, and fidelity review through June 30, 2029.

We are concerned that the Department's current approach requires Calaveras County to participate in ongoing training, technical assistance, and fidelity reviews for all EBPs during the first Integrated Plan period. This expectation is inconsistent with legislative intent under SB 326, which allows small counties the ability to request

exemption from these requirements, and it represents a significant hardship for counties like ours with populations under 200,000. This approach risks diverting scarce local resources away from essential Medi-Cal behavioral health services and other mandated responsibilities.

Under statute, small counties are explicitly authorized to request exemption from any and all EBP requirements under the Full-Service Partnership (FSP) component—including Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Individual Placement and Support (IPS) for Supported Employment.

Calaveras County's Local Context

Calaveras County continues to face longstanding structural challenges that make fidelity implementation of EBPs infeasible, including:

• Severe and Longstanding Workforce Shortages: Calaveras Behavioral Health continues to face chronic, structural staffing shortages. As of October 2024, I remain the department's only licensed supervisory-level staff member. Recruitment is hindered by salary disparities with neighboring counties (e.g., San Joaquin, Stanislaus) and the county's remote location. Persistent vacancies exist across licensed clinician roles, administrative support, housing programs, and critical FSP positions, including ACT and HFW relevant roles. The lack of qualified specialists necessary for evidence-based practice (EBP) implementation makes it extremely challenging to establish and sustain fidelity-based programs, directly affecting service capacity and compliance requirements.

• Insufficient Population Size: With a small and widely dispersed population, there are too few eligible Medi- Cal beneficiaries meeting EBP criteria to sustain fidelity models or dedicated teams. Our FSP-eligible population at any given time averages 30–35 individuals, which is not enough to build fidelity-consistent teams for ACT/FACT, IPS, and HFW simultaneously. Requiring all three EBPs would result in fragmented, under-capacity teams that cannot deliver services. Effectively. For example, the minimum caseload for an ACT or FACT team far exceeds the total number of individuals meeting criteria within our county. • Fiscal Constraints: Calaveras County operates within an extremely limited behavioral health budget. Requiring counties to allocate funds toward EBP-specific positions, training, or fidelity reviews for programs that cannot be sustained would redirect resources away from critical local programs, including crisis services, outpatient treatment, and housing supports.

• Limited Administrative and Training Capacity: Existing staff manage multiple programs and caseloads, leaving little capacity for the extensive training and data collection requirements tied to EBP fidelity. This would exacerbate workforce burnout and turnover, particularly in a system already stretched to maintain Medi-Cal service delivery.

Requiring small, frontier counties such as Calaveras to engage in fidelity-related technical assistance for programs we cannot feasibly sustain will accelerate workforce exhaustion and undermine service continuity for our most vulnerable residents. Despite our small size, Calaveras County is held to the same audit, compliance, and reporting standards as large counties. Our entire Behavioral Health administrative team is made up of only a few individuals, many of whom wear multiple hats — program oversight, contract management, utilization review, QA/QI, policy, fiscal tracking, and clinical supervision. Adding fidelity training, data collection, monitoring, and documentation across 3–4 EBPs is not feasible with our current staff. The burden is disproportionately high compared to counties with more robust infrastructures. • Prior Implementation Experience and Local Adaptation:

Calaveras County previously attempted to implement Individual Placement and Support (IPS) to fidelity when our Medi-Cal and FSP populations were slightly higher. Even under those more favorable conditions, we were unable to meet the fidelity caseload thresholds or maintain the staffing infrastructure required. Fidelity staffing roles such as

employment specialists could not be sustained in isolation, and over time, we had to shift to a more flexible model — as we often do across programs — in order to best meet the needs of our members.

Today, our Supported Employment programming continues in a form that closely mirrors the intent of IPS, while remaining scalable for our size and workforce. We maintain data, assign a case manager to support employment-focused clients, and periodically include a part-time peer. The case manager partners regularly with Mother Lode Job Training to connect clients to job readiness classes, soft skills training, and other vocational supports.

Our current model is outcomes-oriented, client-centered, and community-based, and demonstrates our commitment to the spirit of IPS. However, we simply cannot maintain a fidelity-bound IPS team in parallel with ACT/FACT and HFW, especially given our workforce and resource constraints.

Additionally, while we appreciate DHCS' creation of Centers of Excellence (COEs) to support statewide EBP implementation, our engagement to date indicates a lack of dedicated rural behavioral health expertise within existing COEs. This absence of rural adaptation limits the relevance and practicality of fidelity models for small counties.

Requested Actions

In light of these challenges, Calaveras County Behavioral Health Services respectfully requests that DHCS immediately align its implementation approach with statutory intent and:

• Allow small counties (population <200,000) to request outright exemptions for EBP implementation and associated fidelity training beginning July 1, 2026.

• Clarify that participation in training and fidelity activities for EBPs is optional for small and frontier counties.

• Continue to provide technical assistance and flexible training opportunities for counties that voluntarily choose to explore adapted EBP implementation models.

Without this adjustment, Calaveras County will be forced to expend limited time and resources attempting to meet requirements that are structurally unachievable, diverting focus from mandated services and placing additional strain on a fragile workforce.

Calaveras County appreciates the Department's recognition of the unique challenges faced by rural and frontier counties and looks forward to continued collaboration to ensure implementation that aligns with statute and is operationally feasible.

SUPPORTING DATA

Please upload supporting data

- Calaveras Request .docx

Please select the data source

- Other

Please describe

Formal EBP exemption request for Counties with Population Under 200,000

Forensic Assertive Community Treatment (FACT)

For counties seeking an exemption to the requirement to include FACT in the county's FSP program

Please select which FSP exemptions criteria the county meets

- Limited workforce (e.g. qualified providers)
- Other hardships

Please provide justification for this FSP exemption request

Calaveras is a rural, mountainous county in the Sierra Nevada foothills, with a total population of just 44,636 residents (DOF, 2025) and an estimated Medi-Cal population of approximately 10,500. As a small county with persistent staffing shortages, limited FSP volume, and an overstretched administrative team, we cannot feasibly implement multiple EBPs to fidelity concurrently without sacrificing our core Medi-Cal obligations and mandated services.

On behalf of Calaveras County Behavioral Health Services, I respectfully submit this correspondence to affirm our county's request for exemption from the Evidence-Based Practice (EBP) requirements outlined under Welfare and Institutions Code (WIC) Section 5887(a)(2). As a small, rural county with a population well under 200,000, Calaveras County faces unique operational, workforce, and fiscal challenges that make implementation of multiple fidelity-based EBPs infeasible.

As implementation moves forward, it is critical that the Department's approach remain aligned with the statutory authority established in WIC Section 5887, which clearly outlines that small counties may seek exemptions from these requirements—without the caveat of meeting additional conditions such as initial fidelity training participation.

Welfare and Institutions Code (WIC) 5887(a)(2) states:

Assertive Community Treatment and Forensic Assertive Community Treatment fidelity, Individual Placement and Support model of Supported Employment, high fidelity wraparound, or other evidence- based services and treatment models, as specified by the State Department of Health Care Services. Counties with a population of less than 200,000 may request an exemption from these requirements. Exemption requests shall be subject to approval by the State Department of Health Care Services. The State Department of Health Care Services shall collaborate with the California State Association of Counties and the County Behavioral Health Directors Association of California on reasonable criteria for those requests and a timely and efficient exemption process.

The Behavioral Health Services Act (BHSA) Policy Manual further clarifies:

For the first Integrated Plan covering FY 2026–2029, all counties, regardless of their size, will be exempt from the EBP fidelity requirements for ACT, FACT, IPS, and HFW. However, counties must begin offering these EBPs by July 1, 2026, and participate in ongoing training, gap analysis, and fidelity review through June 30, 2029.

We are concerned that the Department's current approach requires Calaveras County to participate in ongoing training, technical assistance, and fidelity reviews for all EBPs during the first Integrated Plan period. This expectation is inconsistent with legislative intent under SB 326, which allows small counties the ability to request exemption from these requirements, and it represents a significant hardship for counties like ours with populations under 200,000. This approach risks diverting scarce local resources away from essential Medi-Cal behavioral health services and other mandated responsibilities.

Under statute, small counties are explicitly authorized to request exemption from any and all EBP requirements under the Full-Service Partnership (FSP) component—including Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Individual Placement and Support (IPS) for Supported Employment.

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• Insufficient Population Size: With a small and widely dispersed population, there are too few eligible Medi- Cal beneficiaries meeting EBP criteria to sustain fidelity models or dedicated teams. Our FSP-eligible population at any given time averages 30–35 individuals, which is not enough to build fidelity-consistent teams for ACT/FACT, IPS, and HFW simultaneously. Requiring all three EBPs would result in fragmented, under-capacity teams that cannot deliver services. Effectively. For example, the minimum caseload for an ACT or FACT team far exceeds the total number of individuals meeting criteria within our county. • Fiscal Constraints: Calaveras County operates within an extremely limited behavioral health budget. Requiring counties to allocate funds toward EBP-specific positions, training, or fidelity reviews for programs that cannot be sustained would redirect resources away from critical local programs, including crisis services, outpatient treatment, and housing supports.

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Medi-Cal service delivery.

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Calaveras County previously attempted to implement Individual Placement and Support (IPS) to fidelity when our Medi-Cal and FSP populations were slightly higher. Even under those more favorable conditions, we were unable to meet the fidelity caseload thresholds or maintain the staffing infrastructure required. Fidelity staffing roles such as employment specialists could not be sustained in isolation, and over time, we had to shift to a more flexible model — as we often do across programs — in order to best meet the needs of our members.

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Our current model is outcomes-oriented, client-centered, and community-based, and demonstrates our commitment to the spirit of IPS. However, we simply cannot maintain a fidelity-bound IPS team in parallel with ACT/FACT and HFW, especially given our workforce and resource constraints.

Additionally, while we appreciate DHCS' creation of Centers of Excellence (COEs) to support statewide EBP implementation, our engagement to date indicates a lack of dedicated rural behavioral health expertise within existing COEs. This absence of rural adaptation limits the relevance and practicality of fidelity models for small counties.

Requested Actions

In light of these challenges, Calaveras County Behavioral Health Services respectfully requests that DHCS immediately align its implementation approach with statutory intent and:

• Allow small counties (population <200,000) to request outright exemptions for EBP implementation and associated fidelity training beginning July 1, 2026.

• Clarify that participation in training and fidelity activities for EBPs is optional for small and frontier counties.

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Without this adjustment, Calaveras County will be forced to expend limited time and resources attempting to meet requirements that are structurally unachievable, diverting focus from mandated services and placing additional strain on a fragile workforce.

Calaveras County appreciates the Department's recognition of the unique challenges faced by rural and frontier counties and looks forward to continued collaboration to ensure implementation that aligns with statute and is operationally feasible.

SUPPORTING DATA

Please upload supporting data

- Calaveras Request .docx

Please select the data source

- Other

Please describe

Formal EBP exemption letter for Counties with Populations Under 200,000

Individual Placement and Support (IPS) Supported Employment

For counties seeking an exemption to the requirement to include IPS in the county's FSP program Please select which FSP exemptions criteria the county meets

- Limited workforce (e.g. qualified providers)
- Other hardships

Please provide justification for this FSP exemption request

Calaveras is a rural, mountainous county in the Sierra Nevada foothills, with a total population of just 44,636 residents (DOF, 2025) and an estimated Medi-Cal population of approximately 10,500. As a small county with persistent staffing shortages, limited FSP volume, and an overstretched administrative team, we cannot feasibly implement multiple EBPs to fidelity concurrently without sacrificing our core Medi-Cal obligations and mandated services.

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Requested Actions

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Without this adjustment, Calaveras County will be forced to expend limited time and resources attempting to meet requirements that are structurally unachievable, diverting focus from mandated services and placing additional strain on a fragile workforce.

Calaveras County appreciates the Department's recognition of the unique challenges faced by rural and frontier counties and looks forward to continued collaboration to ensure implementation that aligns with statute and is operationally feasible.

SUPPORTING DATA

Please upload supporting data

- Calaveras Request .docx

Please select the data source

- Other

Please describe

Formal EBP exemption letter for Counties with Populations under 200,000.

Data Suppression Notice:

Values marked with "" have been suppressed per DHCS de-identification standards. Counts between 1–10 are displayed as "<11"

GET CONNECTED

How to Reach Us

Calaveras County Behavioral Health Services serves residents of all ages across the county. You do not need a diagnosis or a referral to call and ask a question.

24-Hour Crisis Support

TOLL-FREE, 24/7

(800) 499-3030

LOCAL, 24/7

(209) 754-3239

NATIONAL LIFELINE

Call or text 988

If you or someone you know is in immediate danger, call 911. Crisis staff answer these lines every day of the year, including nights, weekends, and holidays.

MAIN LINE

(209) 754-6525

Appointments, referrals, and general questions.
Monday–Friday, 8:00 a.m.–5:00 p.m.

TOLL-FREE ACCESS

(800) 499-3030

Free from anywhere in Calaveras County and beyond. Also the 24-hour crisis line.

FAX

(209) 754-6534

For records and provider correspondence.

MENTAL HEALTH CLINIC

891 Mountain Ranch Road,
Building N
San Andreas, CA 95249

Walk-ins welcome during business hours.

MAILING ADDRESS

Calaveras County Behavioral Health Services
509 East St. Charles Street
San Andreas, CA 95249

ONLINE

behavioralhealth.calaverasgov.us
mentalhealth.calaverasgov.us

Calaveras County Behavioral Health Services · Behavioral Health Services Act Integrated Plan, Fiscal Years 2026–2029 · Approved by the California Department of Health Care Services.
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