Behavioral Health Services Act 2026 - 2029 Integrated Plan



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2026 - 2029 Integrated Plan Stanislaus County

The Behavioral Health Services Act requires counties to submit three-year Integrated Plans for behavioral health services and outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan.

General Information

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.A. General Information.

County, City, Joint Powers, or Joint Submission	County

Entity Name	Stanislaus County

Behavioral Health Agency Name	Behavioral Health and Recovery Services

Behavioral Health Agency Mailing Address	1601 I St. Ste. 200 Modesto, CA 95354

Primary Mental Health Contact	Ruben Imperial rimperial@stanbhrs.org 2095256225

Secondary Mental Health Contact	Keri Magee kmagee@stanbhrs.org 2096134839

Primary Substance Use Disorder Contact	Ruben Imperial rimperial@stanbhrs.org 2095256225

Secondary Substance Use Disorder Contact	Keri Magee kmagee@stanbhrs.org 2096134839

Primary Housing Interventions Contact	Ruben Imperial rimperial@stanbhrs.org 2095256225

Compliance Officer for Specialty Mental Health Services (SMHS)	Monica Salazar msalazar@stanbhrs.org

Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services	Monica Salazar msalazar@stanbhrs.org

Behavioral Health Services Act (BHSA) Coordinator	Maribel McCarroll mmccarroll@stanbhrs.org

Substance Abuse and Mental Health Services Administration (SAMHSA) liaison	Ruben Imperial rimperial@stanbhrs.org

Quality Assurance or Quality Improvement (QA/QI) lead	Nasrin Safi nsafi@stanbhrs.org

Medical Director	Dr. Bernardo Mora bmora@stanbhrs.org

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).

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.E.2 General Requirements.

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 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 Underage 21**
Received Medi-Cal Specialty Mental Health Services (SMHS)	4650
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	151
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	222
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	31
Accessed the Early Psychosis Intervention	61

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	
Were chronically homeless or experiencing homelessness or at risk of homelessness	000
Were in the juvenile justice system	000
Have reentered the community from a youth correctional facility	000
Were served by the Mental Health Plan and had an open child welfare case	411
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	6
Have received acute psychiatric care	701

Adults and Older Adults

Criteria	**Number of Adults and Older Adults**
Were dual-eligible Medicare and Medicaid members	626
Received Medi-Cal SMHS	5399
Received DMC or DMC-ODS services	3299
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	1076
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	000
Experienced unsheltered homelessness	000
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	000
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	000
Were in the justice system (on parole or probation and not currently incarcerated)	000
Were incarcerated (including state prison and jail)	1321
Reentered the community from state prison or county jail	000
Received acute psychiatric services	1302

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.

Input the number of persons in designated and approved facilities who were	
Admitted or detained for 72-hour evaluation and treatment	1279
Admitted for 14-day and 30-day periods of intensive treatment	205
Admitted for 180-day post certification intensive treatment	5
Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs	2
Please report on 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?
The County utilized internal Electronic Health Record (EHR) SmartCare data where available to complete this section.

For several requested data elements, the County entered "000" to indicate that the data is not currently available within our existing reporting systems, rather than to indicate that no individuals met the criteria. Specifically, certain homelessness, justice-involvement–related, and facility population data elements cannot be fully reported because our EHR system does not currently capture or differentiate between some of the requested categories (e.g., unsheltered homelessness, transitions from unsheltered to sheltered settings, transitions into permanent housing, or justice-involvement status indicators).

In some cases, limited data is collected through manual tracking at the program level however, this information is program-specific and not captured consistently across the entire Behavioral Health and Recovery Services (BHRS) system. For example, within the County's Supportive Services Division, internal tracking identified 156 individuals who moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing) and 21 individuals who transitioned into permanent housing. Because this information reflects only one division and does not represent all BHRS programs, the County entered "000" for these fields to indicate that complete BHRS-wide data is not currently available.

BHRS recognizes the importance of these data elements and will be evaluating opportunities over the next three-year plan period to strengthen EHR infrastructure and improve the ability to capture the required data consistently across BHRS programs. The County will also explore opportunities to strengthen cross-system data coordination with community partners to improve the completeness and reliability of these data elements over time.

Please describe the local data used during the planning process

Where available, the County utilized internal SmartCare reports to estimate service counts and population indicators during the planning process. SmartCare is a semi-statewide electronic health record implemented through CalMHSA that connects 27 California counties to support coordinated behavioral health care and shared data systems. In some instances, the requested indicators did not have exact data field matches within the SmartCare system. As a result, proxy measures and best available data extracts were used, and certain figures may represent slight over- or under-estimates.

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

SmartCare Assessment Mapping IP Portal- Attachment #1

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	SmartCare
County participates in a Qualified Health Information Organization (QHIO)?	Yes
Please select which QHIO the county participates in	Connex

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-calmhsa-provider.ehn-prod.net/fhir/swagger-ui/?page=Location

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

- Yes

Please describe these challenges and concerns

- BHRS has implemented the required Patient Access API and continues to work with CalMHSA and County IT to ensure full alignment with evolving guidance related to API governance and oversight.
- BHRS is currently finalizing internal policies and procedures associated with API management, including processes related to third-party application access review, security considerations, and operational monitoring expectations consistent with applicable BHIN guidance.
- Ongoing implementation and monitoring of API requirements requires coordination between BHRS program areas, County IT, and CalMHSA as the system vendor. Continued collaboration across these entities is ongoing to ensure compliance and support operational oversight of the API environment.

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

- Yes

Please describe these challenges and concerns

ADT Services Not Fully Implemented

- BHRS has access to CalMHSA's interoperability infrastructure, but ADT event

notifications are not yet configured. Activation depends on hospital/partner participation and onboarding beyond CalMHSA's scope. Access to ADT dashboards may require additional subscriptions, and BHRS will allocate the necessary funding through the BHSA Plan to support implementation and ongoing use as needed.

ADT Data Elements Pending Clarification

- BHRS is working with CalMHSA to confirm which ADT data elements will be exchanged via Connex and how they align with DHCS requirements. This review is ongoing. CalMHSA has noted that "supplemental data" may require additional configuration or services. BHRS will continue collaborating with CalMHSA to finalize these elements and will allocate the necessary resources through the BHSA Plan to support full implementation consistent with DHCS requirements.

Provider Directory & Credentialing Limitations

- Real-time ADT routing depends on accurate provider data. BHRS currently updates its directory monthly, and credentialing workflows will be strengthened to support real-time expectations under BHINs. BHRS will continue enhancing these processes as part of its interoperability implementation efforts, supported through resources allocated in the BHSA Plan.

Partner Readiness & Connectivity

- ADT exchange requires hospital/facility participation. BHRS will work with external partners to conduct outreach, establish MOUs, and complete onboarding and data-sharing setup necessary to support ADT exchange and interoperability requirements.

Emerging Requirements: Closed-Loop Referrals

- Authorization

Though not cited in current BHINs, the Department of Healthcare Services (DHCS) is signaling future expectations around care coordination. Closed Loop Referrals/Prior Auth API is option with CalMHSA. BHRS will continue monitoring emerging interoperability expectations and will evaluate implementation of closed-loop referral functionality in coordination with CalMHSA and system partners. BHRS will allocate the necessary funding through the Behavioral Health Services Act (BHSA) plan to support implementation if these capabilities are adopted.

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

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?

- No

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

- No

Community Mental Health Services Block Grant (MHBG)

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

- Yes

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

- Children's System of Care Set-Aside
- Discretionary/Base Allocation
- First Episode Psychosis Set-Aside
- Integrated Services Agency Set-Aside

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

- No

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

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

- Yes

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

- Adolescent/Youth Set-Aside
- Discretionary
- Perinatal Set-Aside
- Primary Prevention Set-Aside

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

- No

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 Misuse of Opioids
- Prevent Overdose Deaths and Other Harms (Overdose Prevention)
- Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids

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).

- Case Management
- Comprehensive Evaluation and Assessment
- Group Services
- Individual Service Plan
- Medication Education and Management
- Pre-crisis and Crisis Services
- Rehabilitation and Support Services
- Residential Services
- Services for Homeless Persons
- Twenty-four-hour Treatment Services
- 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:

- Assertive Community Treatment (ACT)
- Other Programs and Services
    - Collaborative Court
    - CARE Court
    - Reintegration Support Team
    - Therapeutic Behavioral Services

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

- No

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

- Drug Courts
- Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
- Regular and Perinatal Drug Medi-Cal Services
- Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
- 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?

- No

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority

- Adult Residential Treatment Services
- Crisis Intervention
- Crisis Residential Treatment Services
- Crisis Stabilization
- Day Rehabilitation
- Day Treatment Intensive
- Mental Health Services
- Medication Support Services
- Mobile Crisis Services
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Targeted Case Management
- Functional Family Therapy for individuals under the age of 21
- High Fidelity Wraparound for individuals under the age of 21
- Intensive Care Coordination for individuals under the age of 21
- Intensive Home-based Services for individuals under the age of 21
- Multisystemic Therapy for individuals under the age of 21
- Parent-Child Interaction Therapy for individuals under the age of 21
- Therapeutic Behavioral Services for individuals under the age of 21
- Therapeutic Foster Care for individuals under the age of 21
- 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?

- Assertive Community Treatment (ACT)
- Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
- Individual Placement and Support (IPS) Supported Employment
- Peer Support Services

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

- No

Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS)
Select which of the following services the county behavioral health system participates in

- DMC-ODS Program

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

- Care Coordination Services
- Clinician Consultation
- Outpatient Treatment Services (ASAM Level 1)
- Intensive Outpatient Treatment Services (ASAM Level 2.1)
- Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
- Mobile Crisis Services
- Recovery Services
- Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
- Traditional Healers and Natural Helpers
- Withdrawal Management Services
- All Other Medically Necessary Services for individuals under age 21 for individuals under age 21
- Early Intervention for individuals under age 21

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

- Peer Support Services

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

- No

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

- Behavioral Health Student Services Act Rounds 2 and 3
- Behavioral Health Student Services Act Round 4, Category 1
- Behavioral Health Student Services Act Round 4, Category 2
- Community Care Expansion Preservation Program
- Behavioral Health Bridge Housing
- Comprehensive Opioid, Stimulant, and Substance Use Program (COSSUP)
- Felony Incompetent to Stand Trial Diversion Program Grant
- Children's Crisis Continuum Pilot Program
- California Overdose Prevention Network (COPN)
- Department of Rehabilitation
- Substance Abuse Focus Grant

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

Statewide Behavioral Health Goals

All fields must be completed unless marked as optional. You don't need to finish everything at once-your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to, please see 3.E.6 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

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Mark page as complete

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

How does your county status compare to the statewide rate?

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

Adults/Older Adults: Below
Children/Youth: Below

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

- Age
- Race or Ethnicity
- Sex

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

Adults/Older Adults: Above
Children/Youth: Below

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

- Age
- Race or Ethnicity
- Sex

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

Adults/Older Adults: Above
Children/Youth: Below
What disparities did you identify across demographic groups or special populations?

- Race or Ethnicity

Access to care: Supplemental Measure

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?

- No Disparities Data Available

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.

This analysis is based on 2022 data extracted from the CalMHSA Access to Care Power BI dashboard. While this is not the most recent data available, DHCS requires the use of 2022 data for this measure.

SMHS Penetration Rate – Adults
County rate: 2.4%
Groups below the county rate include:

- Adults aged 65+ (1.1%)
- Females (2.1%)
- Hispanic residents (1.4%)
- Asian or Pacific Islander residents (1.3%)
- Other Race/Ethnicity residents (2.2%)

SMHS Penetration Rate – Youth
County rate: 2.6%
Groups below the county rate include:

- Children aged 0–2 (0.4%)
- Children aged 3–5 (1.2%)
- Males (2.5%)
- Asian or Pacific Islander youth (1.0%)
- Hispanic Residents (1.0%)
- Other Race/Ethnicity youth (1.5%)
- Youth with Unknown Race/Ethnicity (2.1%)

NSMHS Penetration Rate – Adults
County rate: 12.9%
Groups below the county rate include:
Age groups:

- 69+ (6.9%)
- 21–32 (12.4%)
- 57–68 (11.8%)

Gender:

- Males (8.8%)

Race/Ethnicity

- Asian or Pacific Islander (7.4%)
- Black (12.7%)
- Other Race/Ethnicity (12.1%)
- Hispanic (11.7%)

Written Language:

- Other non-English (7.2%)
- Vietnamese (5.3%)
- Cambodian (4.9%)

- Arabic (10.4%)
- Farsi (8.9%)
- Spanish (8.9%)

NSMHS Penetration Rate – Youth
County rate: 11.1%
Groups below the county rate include:
Age groups:
- 3–5 (9.7%)
- 6–11 (9.3%)
- 18–20 (10.8%)

Gender:
- Males (11.0%)

Race/Ethnicity:
- Asian or Pacific Islander (8.0%)
- Black (10.4%)
- Hispanic (10.3%)

Written Language:
- Spanish (9.5%)
- Other non-English (7.1%)

DMC-ODS Penetration Rate
County rate: 1.4%
Groups below the county rate include:
- Asian or Pacific Islander residents (0.3%)
- Hispanic residents (0.8%)

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

Stanislaus County Opioid Safety Coalition (SCOSC) Expansion: BHRS will expand the SCOSC to strengthen a coordinated, countywide approach to opioid prevention, harm reduction, and overdose response. Efforts will include enhanced public education, youth prevention strategies, provider training, overdose surveillance, and naloxone distribution. OSF funding will support real-time overdose monitoring infrastructure, multilingual and culturally responsive media campaigns, community-based stipends to support trusted messengers, and expanded naloxone access across high-need areas. Outreach will prioritize Hispanic, Asian/Pacific Islander, and non-English-speaking populations to reduce stigma, promote early help-seeking, increase awareness of available services, and prevent unnecessary crisis system involvement.
Stanislaus Triage, Access, Recovery, and Treatment (START): The START program will function as a centralized, 24/7, no-wrong-door access hub located in Modesto,

designed to streamline entry into substance use disorder and behavioral health services. The selected contractor will provide screening, intake, clinical assessment, crisis intervention, short-term stabilization, care coordination, and referrals to appropriate levels of care regardless of insurance status or payer source. START will serve as a key system entry point, ensuring timely access and reducing fragmentation. The program will incorporate structured transition protocols with County-operated and contracted providers, crisis services, outreach teams, and emergency departments (ED), with a focus on improving post-emergency department follow-up and meeting access and timeliness performance measures.

Justice Diversion & Forensic Access: BHRS will expand justice-involved behavioral health services, adding FACT capacity and integrating JI Peer Support services, to improve diversion and treatment access for individuals involved in the criminal justice system. This includes enhancement of the Reintegration Support, Collaborative Court Behavioral Health Services, Pre-Trial Felony Residential Diversion, Adult Drug Court teams, and Prop 36 coordination. Increased program capacity will support timely screening, assessment, placement into appropriate treatment settings, ongoing monitoring, and coordination across behavioral health, probation, courts, and community providers. Strengthened discharge planning and reentry coordination will improve continuity of care for individuals exiting custody or supervision, with the goal of reducing recidivism and addressing disparities related to incarceration and behavioral health access.

Neighborhood-Based Treatment: The Department identified that while community/cultural-based networks are effective in engaging underserved populations, transitioning individuals from trusted access points into separate treatment teams can create barriers to continuity of care, particularly for culturally and ethnically diverse communities. In response, BHRS will implement a neighborhood-based treatment model that integrates outreach, access, assessment, treatment, and care coordination within trusted community settings. Using an Intensive Community Services framework, multidisciplinary teams will include clinicians, Behavioral Health Specialists, Peer Navigators, and Enhanced Community Health Workers (ECHW) who remain connected to established Promotora and culturally specific community networks. The model will focus on high-need neighborhoods and priority populations, including Latino, Southeast Asian, and LGBTQ+ communities, to reduce service drop-off and strengthen continuity of care.

Outreach & Engagement Expansion: BHRS will expand outreach and engagement services across settings associated with access/continuity gaps, including psychiatric hospitals and emergency departments, street homelessness, and shelter environments. Multidisciplinary teams composed of Mental Health Clinicians, Behavioral Health Specialists, ECHW, and Peer Navigators will focus on care transitions, and linkage to ongoing services. The Behavioral Health Outreach & Engagement (BHOE) Team will support members discharging from hospitals and emergency departments through structured follow-up at 7/30 days. The CARE Team will provide field-based engagement for individuals experiencing homelessness, including those with serious behavioral health needs and high utilization of crisis/ED services. A third dedicated Outreach team will focus on shelter settings. All teams will incorporate substance use disorder screening and intervention as appropriate to support integrated care.

Member Relations & Community Education (MRCE): BHRS will establish an MRCE Program to improve awareness/understanding of Medi-Cal behavioral health services. The program responds to community-identified gaps in knowledge of available services and how to access them. MRCE will conduct outreach through community settings using multilingual materials and bilingual staff. MRCE will provide navigation support, including follow-up through the Access Line. BHRS will leverage existing Promotora

networks and partnerships with community-based, cultural/ethnic organizations to reach underserved populations, including Southeast Asian, Latino, African American, LGBTQ+, and rural communities. Outreach efforts will be targeted to areas with documented disparities in access and utilization.

Crisis Response Team (CRT): BHRS will restructure existing mobile crisis services into a unified Crisis Response Team to provide coordinated responses to mental health and substance use crises. The CRT will respond through the BHRS Crisis Line and the 911 system in partnership with law enforcement and other first responders. BHRS will use data to assess staffing needs and inform 24/7 deployment planning. The CRT will integrate ECHW and Peer Navigators to support culturally responsive engagement, trust building, and ongoing connection to services. The model emphasizes warm handoffs, structured care transitions, and continued field-based follow-up to ensure individuals are successfully linked to outpatient treatment and supportive services following a crisis episode.

Children's Behavioral Health Access Strategy: BHRS will implement a comprehensive children's access strategy focused on early intervention, timely treatment access, family stability, and reduction of unnecessary out-of-home placements. Guided by the AB 2083 Interagency Executive Team, the strategy will strengthen cross-system coordination and accountability across behavioral health, child welfare, probation, education, regional centers, and community partners. Key initiatives include expansion of HFW services, development of a children's crisis continuum, integration of behavioral health services in schools, creation of a System of Care dashboard, and enhanced data sharing and workforce capacity. These efforts aim to improve access, coordination, and outcomes for children and families.

School-Based Initiative: BHRS will partner with school districts to expand on-campus behavioral health services and improve early identification and intervention. Efforts will include supporting districts in maximizing Medi-Cal billing, developing sustainable service models, and exploring integration with county-operated providers and MCP health plans. The Mental Health Workgroup will provide guidance on implementation strategies , and best practices. These initiatives are designed to increase access to care in school settings and reduce downstream involvement with child welfare, juvenile justice, and youth homelessness systems.

High Fidelity Wraparound (HFW) Expansion: BHRS will expand HFW services as a core component of the children's behavioral health system. Expansion will occur through current FSP programs and will include development of infrastructure, workforce capacity, and fidelity monitoring aligned with state standards. Cross-system coordination through the IET will ensure alignment across child serving systems. HFW will prioritize youth with complex behavioral health needs, multi-system involvement, and those at risk of hospitalization, residential placement, or family disruption. HFW will strengthen the continuum of care, improve family stability, and reduce reliance on institutional settings.

Workforce Development: BHRS will expand workforce development efforts through strengthened academic partnerships focused on increasing behavioral health academic capacity, training programs, and internship-to-employment pathways. These strategies are designed to increase the availability of qualified staff, , and support system sustainability across adult and children's services.

Enhanced Community Health Workers (ECHWs): BHRS will implement ECHWs services to improve engagement, care coordination, and cultural responsiveness. A phased implementation will support provider readiness and capacity-building documentation including development of supervision structures, documentation standards, and workflows. ECHWs will be embedded within multidisciplinary treatment

teams to support culturally responsive access services, care coordination, and community support. Medi-Cal billing for ECHW services is anticipated beginning in Fiscal Year 2027–2028 following completion of readiness activities.

Addressing Below-Average Measures: These strategies expand access, strengthen early identification, and reduce disparities to improve SMHS penetration, reduce service drop-offs and reduce delays for underserved populations. Youth initiatives improve access and coordination. Multilingual outreach and navigation reduce engagement disparities, while integrated outreach supports early identification and linkage.

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

- Federal Financial Participation (SMHS, DMC-ODS)
- BHSA Behavioral Health Services and Supports (BHSS)
- Substance Use Block Grant (SUBG)
- Other
    - Opioid Settlement Funds (OSF)

Homelessness: Primary Measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) Department of Housing and Urban Development (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?

- Age
- Race or Ethnicity
- Sex

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

How does your county status compare to the statewide rate? Below

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

- Age
- Gender
- Grade
- 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?

- No Disparities Data Available

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? Below

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

- No Disparities Data Available

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? Above

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

- Age
- Gender
- Race or Ethnicity

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.

This analysis is based on 2024 data extracted from the CalMHSA Homelessness Power BI dashboard. While this is not the most recent data available, DHCS requires the use of 2024 data for this measure.

People Experiencing Homelessness PIT Count

County rate: 37 per 10,000
Groups above the county rate include:
Age groups:

- 35–44 (66)
- 45+ (46)

Gender:

- Males (47)

Race/Ethnicity:

- American Indian or Alaska Native (209)
- Black (134)
- Native Hawaiian or Other Pacific Islander (53)
- Multiple Races (93)
- White (49)

Homeless K–12 Student Enrollment

County rate: 2.6%

Groups above the county rate include:
Grade levels:

- Transitional Kindergarten (2.7%)
- Kindergarten (3.2%)
- Grade 1 (2.9%)
- Grade 2 (3.1%)
- Grade 3 (3.1%)
- Grade 4 (3.2%)
- Grade 5 (2.9%)
- Grade 6 (2.8%)
- Grade 8 (2.7%)

Gender:

- Females (2.6%)

Race/Ethnicity:

- African American (4.8%)
- American Indian or Alaska Native (2.9%)
- Hispanic or Latino (2.8%)
- Two or More Races (3.1%)

Student Groups:

- English Learners (3.8%)
- Migrant students (6.0%)
- Students with disabilities (2.8%)

People Experiencing Homelessness who Accessed Services from COC
County rate: 117 per 10,000
Groups below the county rate include:
Age groups:

- 25–24 (116)
- 18–24 (94)
- 65+ (37)

Gender Identity:

- Cisgender men (114)
- Cisgender women (99)

Race/Ethnicity:

- Asian or Asian American (21)
- Hispanic/Latina/e/o (93)
- White (109)

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)

Over the course of the 2026–2029 Integrated Plan, BHRS will strengthen and explore strategies to address housing and homelessness challenges, guided by community input, operational experience, and local data trends. Stanislaus County BHRS is aligning housing investments with BHSA cross-system homelessness measures by treating housing stability as a core component of the behavioral health system of care. This approach ensures that housing planning, funding, and operations are coordinated with agencies responsible for housing policy and resources, and that BHRS develops the data infrastructure and administrative capacity needed to translate investments into measurable outcomes across programs and service settings. Given uncertainty in long-term behavioral health funding, the sunset of one-time housing resources, and future operational costs associated with recent capital investments, the County is extending its planning horizon to prioritize sustaining existing projects and supporting responsible long-term decision-making.

This strategy reflects the County's understanding that housing functions as both a recovery support and a system-level intervention. Individuals with SMI, SED, or SUD face significant treatment barriers and higher crisis, medical, and justice-system involvement without stable housing. The BHSA housing approach therefore emphasizes cross-agency governance, real-time data, comprehensive housing needs analysis, sustainability of prior investments, integrated funding, strengthened management capacity, and robust outcome monitoring to ensure accountability.

The BHSA Housing & Homelessness Strategy is organized around the following core areas: establishing BHRS-led cross-agency governance; strengthening EHR housing data collection supplemented by internal point-in-time assessments; maintaining a real-time by-name list for prioritization and accountability; completing a behavioral health housing needs and housing-type analysis; aligning all revenue streams so BHSA funds serve as payer of last resort; ensuring continuity for time-limited state-funded projects; strengthening BHRS administrative and management infrastructure; and expanding CARE MDT and BHOE outreach with integrated SUD capability, emergency department coordination, and field-based engagement.

Behavioral Health Housing Collaborative (BHHC): BHRS convened the BHHC to provide structured cross-agency governance for behavioral health housing planning and implementation. Members include City of Modesto Housing and Economic Development, Stanislaus County Community Development, the Housing Authority, Stanislaus County Affordable Housing Corporation, the CoC, CSA Housing & Homeless Services, the CEO's Office, and BHRS. The Collaborative quantifies current and projected housing needs for BHSA priority populations and translates these data into development priorities and funding decisions. It ensures alignment with countywide housing strategies, avoids duplication, and directs resources to BHSA priority populations with a coordinated, countywide perspective. Although distinct from the CoC structure, the BHHC maintains intentional alignment to support a cohesive local housing system.

Housing Data Collection & Internal PIT Assessments: BHRS is strengthening housing data captured in the EHR by establishing policy, administrative guidance, supervisory expectations, and QA processes to ensure routine documentation of housing status. Standardized definitions and data entry fields will clarify whether individuals are experiencing homelessness, instability, transitional housing, or supportive housing and ensure updates are captured over time. These improvements support real-time monitoring and integration of housing metrics into BHSA dashboards and inform operational decision-making. Recognizing that EHR fields cannot capture the full picture of housing instability, BHRS will conduct scheduled internal PIT counts focused on individuals engaged in services. These PIT efforts validate EHR data and provide

additional context on stability, safety, and system-specific service gaps. Together, the EHR and PIT data form the core housing dataset for planning and funding decisions.

Real-Time By-Name List for Housing Prioritization: The strengthened EHR and PIT data will inform a dynamic by-name list of BHRS members needing housing. Updated through routine treatment interactions and PIT validation, the list identifies individuals who are homeless, unstably housed, or at imminent risk. It supports coordinated case conferencing with housing partners, prioritization based on acuity and vulnerability, and tracking of movement from homelessness to stable housing. This operational capability strengthens accountability and aligns daily activities with BHSA homelessness performance measures.

Behavioral Health Housing Needs & Housing-Type Analysis: In compliance with BHSA requirements, the BHHC will conduct a comprehensive housing needs analysis using EHR data, PIT results, and the by-name list. This analysis will quantify current and projected demand over the next three years and compare it to the existing inventory of 307 units and beds (20 emergency, 84 transitional, 189 permanent, and 14 CoC-supported units) plus 68 units in development. While stakeholders have identified priorities such as bridge housing and expanded permanent supportive housing, the analysis will provide an objective evaluation of system needs based on acuity, utilization patterns, and housing status. These findings will guide development priorities, operational investments, and sustainability strategies in alignment with BHSA requirements.

Integrated Funding & Revenue Leveraging Approach: BHRS and the Collaborative will identify available capital, operating, and service funding streams to ensure sustainability. BHSA funds will be used as payer of last resort, maximizing leverage of federal subsidies, vouchers, Medi-Cal specialty behavioral health and DMC revenue, and local/state housing resources. Each proposed project will undergo assessment to ensure BHSA dollars expand—not replace—existing funding streams and that projects align with long-term fiscal and operational feasibility.

Continuity of State-Funded Housing & Infrastructure Projects: Significant housing and infrastructure were developed through time-limited state programs such as BHBH and BHCIP. As these funds sunset, BHRS must ensure operational continuity and prevent loss of newly created capacity. Continuity planning will be incorporated into the BHSA Strategy to address operational needs, subsidy gaps, and long-term sustainability. Projects under consideration include Hope Forward Campus, South Modesto Community Center, CHS Youth Navigation Center, Del Puerto Healthcare site, and Dignity Village expansions. Revenue projections and operating budgets are under development, and the BHSA Plan will be updated as determinations are finalized.

BHRS Administrative & Management Capacity: Rapid expansion of housing investments has increased operational complexity. BHRS is assessing administrative and management capacity to support data coordination, analytics, project oversight, and integrated funding strategies. Additional capacity is required to manage capital, subsidies, services funding, cross-agency partnerships, and outcomes monitoring. Strengthened outcome measurement will track housing stability, engagement, crisis reduction, and other cross-system impacts, supporting strategic resource allocation and communication with policymakers and the community.

Through this strategy, Stanislaus County is building a coordinated framework linking housing development, sustainability, and behavioral health transformation with BHSA homelessness measures. Cross-agency governance, real-time data, by-name lists, needs analysis, integrated funding, sustainability planning, and enhanced administrative infrastructure position BHRS to reduce homelessness among individuals with SMI, SED,

and SUD while improving engagement and long-term recovery outcomes.
Outreach & Engagement System Expansion: BHRS will expand outreach infrastructure across key system touchpoints. The CARE MDT will increase street-level engagement for individuals experiencing homelessness, justice involvement, and high ED utilization, with integrated SUD outreach. The BHOE team will provide post-hospitalization follow-ups, linkage, and ED-based coordination to reduce readmissions and service gaps. Shelter-based outreach will be strengthened by redesignating the Telecare Outreach Team to focus solely on shelters, enabling consistent presence, better relationships with shelter providers, and streamlined referral pathways. Combined with expanded ED and community outreach, these functions strengthen continuity of care from crisis to stabilization.
How These Actions Address Areas Below State Averages: Acuity-based prioritization accelerates placement for adults ages 35–44 and 45+; expanded CARE outreach increases engagement among unsheltered men; disaggregated EHR and PIT data support equity-focused strategies for AI/AN, Black, NHPI, Multi-Race, and White residents; stabilizing parents with SMI/SUD reduces homelessness for TK–6 students; coordinated housing strategies support high-risk school-aged subgroups; expanded shelter and ED-based outreach increases access for ages 18–24 and 65+; field-based engagement strengthens service penetration for Hispanic/Latina/e/o and Asian communities.

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

- BHSA Housing Interventions
- BHSA FSP
- 1991 Realignment
- 2011 Realignment
- Federal Financial Participation (SMHS, DMC/DMC-ODS)

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.

Institutionalization: Primary Measures
How does your county status compare to the statewide rate/average?

Inpatient administrative days (DHCS) rate, FY 2023
Adults/Older Adults: Not Applicable
Children/Youth: Not Applicable

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

- No Disparities Data Available

Institutionalization: Supplemental Measures
How does your county status compare to the statewide rate/average?

Involuntary Detention Rates, FY 2021 – 2022
14-day involuntary detention rates per 10,000: Above
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?

- No Disparities Data Available

Conservatorships, FY 2021 – 2022
Temporary Conservatorships: Above
Permanent Conservatorships: Below
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

Crisis Intervention
For adults/older adults: Above
For children/youth: Above

Crisis Residential Treatment Services
For adults/older adults: Above
For children/youth: Not Applicable

Crisis Stabilization
For adults/older adults: Above
For children/youth: Above

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

- Age
- Race or Ethnicity
- Sex

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

This analysis is based on 2023 data extracted from the CalMHSA Utilization Power BI dashboard. While this is not the most recent data available, the Department of HealthCare Services (DHCS) requires the use of 2023 data for this measure.

SMHS Crisis Utilization – Crisis Intervention for Children and Youth (DHCS), FY 2023
County average: 280.3 minutes
Groups below the county average include:
Age groups:

- 6–11 (186.3)
- 12–17 (263.4)
- 18–20 (235.2)

Race/Ethnicity:

- Hispanic (228.2)
- Asian or Pacific Islander (197.8)
- White (270.8)

Gender:

- Females (252.4)
- Males (241.9)

Primary Written Language:

- English (256.4)
- Spanish (216.4)

SMHS Crisis Utilization – Crisis Intervention for Adults (DHCS), FY 2023
County average: 299.5 minutes

Groups below the county average include:
Age groups:

- 21–32 (277.3)

Race/Ethnicity:

- Asian or Pacific Islander (286.9)
- Hispanic (275.4)

Gender:

- Females (272.4)

Primary Written Language:

- Spanish (229.1)

SMHS Crisis Utilization – Crisis Stabilization for Children and Youth (DHCS), FY 2023
County average: 35.1 hours
Groups below the county average include:
Age groups:

- 12–17 (32.1)
- 18–20 (18.2)

Race/Ethnicity:

- White (23.3)

- Hispanic (19.1)

Gender:

- Males (28.8)
- Females (24)

Primary Written Language:

- English (25.8)

SMHS Crisis Utilization – Crisis Stabilization for Adults (DHCS), FY 2023

County average: 29.2 hours

Groups below the county average include:

Age groups:

- 21–32 (28.7)
- 33–44 (26.7)
- 45–56 (25.3)

Race/Ethnicity:

- White (27.3)
- Hispanic (19.6)

Gender:

- Males (25.4)

Primary Written Language:

- English (27.8)

SMHS Crisis Utilization – Crisis Residential Treatment Services for Adults (DHCS), FY 2023

County average: 28.5 days

Data for the following groups are suppressed due to small denominators or rates below 1.0%:

Age groups:

- 21–32
- 33–44
- 45–56
- 57–68
- 69+

Race/Ethnicity:

- Black
- Hispanic

Institutionalization: Cross-Measure Questions

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

Stanislaus County BHRS does not operate any in-county Mental Health Rehabilitation Centers (MHRCs) or Skilled Nursing Facility–Special Treatment Programs (SNF STPs). While this reflects a lack of locally operated step-down institutional capacity, it is important to note that regional bed availability alone may not fully explain access

challenges. Admission criteria acceptance policies significantly impact placement success and timeliness:

- MHRC Capacity: Stanislaus County maintains zero MHRC beds, compared to a statewide average of 1.5 beds per 10,000 adults with SMI.
- Skilled Nursing Facility (SNF)- Specialized Treatment Program (STP) Capacity: California has approximately 2,200 SNF STP beds statewide, but none are located in Stanislaus County.
- Admission and Placement Barriers: Even when regional bed capacity exists, individuals may face barriers due to restrictive admission practices.
- Impact Indicators: Prolonged inpatient psychiatric stays and delayed discharges due to lack of step-down options.
- Increased emergency department boarding for behavioral health patients.
- High crisis service utilization and unmet need for SMI/SUD treatment, compounded by provider shortages.

These indicators suggest that the primary system challenge may be less about absolute bed counts and more about alignment between patient acuity and facility admission thresholds.

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.

Over the course of the 2026–2029 IP, BHRS will focus on strengthening and aligning strategies to address institutionalization, crisis response, diversion, and cross system integration, guided by community input, local data, and operational experience across partner systems. Stanislaus County is prioritizing reduction of institutional placements by expanding community-based alternatives, improving crisis response, and strengthening linkages between behavioral health, justice, and housing systems. Rising IST placements, increased hospital use, and growing justice involvement among individuals with SMI, SED, and SUD underscore the need for earlier intervention, enhanced diversion, and sustained engagement in community settings. The Institutionalization Reduction Strategy centers on expanding community-based crisis response through the Community Response Team model, integrating behavioral health-led mobile crisis response with law enforcement, EMS, and first responders to ensure coordinated and clinically informed interventions. This model provides timely field-based response during mental health and SUD crises, preventing escalation to hospitalization, incarceration, or long-term institutional care. Complementing crisis response, BHRS is implementing strategies that expand diversion pathways, strengthen community-based treatment capacity, and improve coordination across behavioral health, housing, and justice systems. These include development of a Forensic SOC, continued implementation of CARE Court and justice diversion programs, targeted IST prevention, and expansion of transitional board and care capacity. Collectively, these efforts support earlier intervention, increased diversion, and stronger stabilization options, reducing reliance on institutional settings.

Crisis Response Team Expansion: BHRS is restructuring multiple crisis programs into a unified Community Response Team to provide coordinated responses to 911 calls

involving behavioral health crises. Recent changes in law enforcement protocols have increased the need for behavioral health–led responses, prompting close collaboration to refine joint protocols and clarify responder roles. BHRS is analyzing one year of operational data to determine staffing, deployment, and 24/7 capacity needs to ensure a consistent and reliable crisis response system. BHRS will also expand post-crisis follow-up through the BHOE team, ensuring rapid engagement within 48–72 hours of psychiatric hospitalization, ED visits, or law enforcement encounters to reduce relapse and repeat crisis episodes. Co-location of BHRS navigators and peers in EDs, FQHCs, shelters, and navigation centers will further bridge gaps between crisis intervention and ongoing treatment, supported by START navigation and cross-system coordination. Following the crisis capacity assessment, BHRS will develop a long-term proposal for future BHSA planning and sustainable crisis system design.

Forensics System of Care Development: Stanislaus County, one of the original CARE Court counties, has served approximately 214 individuals with one-time State funding expected to sunset in June 2026. To guide long-term implementation, BHRS created a CARE Court Learning Group composed of justice partners and community stakeholders. The Learning Group identified systemwide challenges affecting justice-involved individuals and recommended improvements including formal MDT structures, clarified roles, shared governance expectations, performance measures, and unified definitions of success to standardize operations. Recommendations also included development of a centralized care coordination system and communication strategies to reduce stigma and improve access to behavioral health services. These findings informed creation of the Forensic System of Care. BHRS is implementing these recommendations, including releasing an RFP for a care coordination software system and updating MOUs to improve information sharing with courts and public safety agencies. A Forensics Governance Workgroup will meet monthly through January 2027 to oversee CARE Court integration,

IST monitoring, Proposition 36, PC 1001.36 diversion, Adult Drug Court, CalAIM Re-Entry coordination, and other justice–behavioral health initiatives that require sustained cross-system alignment.

CARE Court Integration and Sustainability: CARE Court provides a civil pathway connecting individuals with schizophrenia spectrum and psychotic disorders to community-based treatment, housing supports, and care coordination. BHRS partners with the Superior Court, Public Defender, County Counsel, and others to ensure timely access to services and consistent clinical engagement. CARE Court is integrated into the Collaborative Court structure, aligning it with other diversion programs and expanding opportunities to reduce psychiatric hospitalization, conservatorship, homelessness, and justice involvement. As one-time State funding is fully expended, BHRS has incorporated CARE Court into the BHSA plan to sustain operations long-term. CARE Court remains central to the County's strategy to engage, stabilize, and reduce institutional placements among individuals with significant behavioral health needs and will continue to anchor early intervention within the Forensic SOC.

IST Mitigation Strategy: Stanislaus County has experienced increases in IST placements, triggering State penalties under SB 184 and WIC 4336. Although the State increased the County baseline, trends remain near the cap. An executive-level IST Workgroup identified the need for expanded pre-booking, post-booking, and post-release interventions to prevent unnecessary IST referrals and state hospital commitments. BHRS created the Reintegration Support Team and Collaborative Court Behavioral Health Services Team to address these gaps. While IST penalty funds support initial expansion, BHRS recommends continued BHSA funding to sustain these programs as long-term IST prevention infrastructure integrated into the Forensic SOC.

Collaborative Court Behavioral Health Services Team: The Collaborative Court, developed with the Superior Court, DA, Public Defender, Probation, and BHRS, provides a structured setting emphasizing treatment engagement and community-based alternatives to incarceration or hospitalization. The Collaborative Court expands diversion capacity through integrated screening, assessment, engagement, and care coordination, including the Reintegration Support Team, SUD Collaborative Court Team, and DSH-funded PFMHD program. As referrals grow, BHRS will scale these teams into fully staffed multidisciplinary units to support increased demand and ensure reliable treatment engagement support across diversion pathways.

Pre-Trial Felony Mental Health Diversion (PFMHD): Funded through the DSH Diversion and Restoration Project, PFMHD will serve approximately 30 individuals annually as an alternative to State hospital commitment. BHRS is securing a transitional board and care operator for the required residential component, ensuring continuity of care for individuals stepping down from acute or forensic settings.

Proposition 36 and Adult Drug Court Expansion: Since January 2025, roughly 820 Proposition 36 referrals were initially absorbed by the Reintegration Support Team. Growth now requires expanded capacity to maintain IST prevention. Adult Drug Court participation has increased significantly and now requires additional treatment capacity. BHRS is allocating Proposition 36 funding and Opioid Settlement Funds to expand the Adult Drug Court team, support Proposition 36 participants, and relieve pressure on the Reintegration Support Team while sustaining long-term diversion pathways.

Transitional Board and Care Residential Capacity Expansion: BHRS has expanded transitional board and care capacity using BHBH other funding, resulting in a significant net increase in beds. These settings provide stabilization and step-down care for individuals leaving psychiatric hospitals, state hospitals, incarceration, or other institutional settings. With BHBH funds expiring in 2027, BHRS must align BHSA resources to sustain this infrastructure. Updated projections are underway, and long-term strategies will be incorporated into a future BHSA Plan update to protect these essential service placements.

Hope Forward Campus – Children's Crisis Continuum: The Hope Forward Campus in Turlock is the County's primary strategy to reduce institutionalization among youth. Developed through BHCIP funding and the Central Valley Consortium, the campus addresses the lack of local youth psychiatric treatment options. It includes a CSU for up to 24-hour stabilization, a CCRP for short-term residential treatment, a Children's PHF providing inpatient psychiatric capacity, and a Wellness Center offering care coordination, peer support, and family engagement. Additional components include a Family Visitation Unit and linkage to ISFC placements. By consolidating stabilization, residential treatment, inpatient care, and transition services, youth receive timely, coordinated alternatives to out-of-county placements and experience improved continuity of care.

How These Actions Address Areas Below State Averages: These actions expand diversion, strengthen early identification and linkage, reduce IST commitments, improve crisis-to-care transitions, and target equity gaps among Hispanic, Asian/Pacific Islander, Spanish-speaking residents, youth, and young adults. Enhanced data integration enables real-time disparity monitoring. For youth, the Hope Forward continuum expands local stabilization and treatment capacity, reducing reliance on out-of-county placements while improving step-down transitions.

Data Used to Inform These Initiatives: These initiatives are informed by hospital and ED data, crisis system metrics, BHRS access measures, justice system indicators, 2025 CHA priorities and stakeholder input, and oversight findings from DHCS and BHRS

reports.

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

- 1991 Realignment
- 2011 Realignment
- BHSA Housing Interventions

Justice-Involvement: Primary Measures

2023 How does your county status compare to the statewide rate/average?

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

Adults/Older Adults: Above
Children/Youth: 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? Below

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

- Age
- Race or Ethnicity
- Sex

Incompetent 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

For arrest rates, disparity data were extracted from the CalMHSA Justice-Involvement Power BI Dashboards, which utilizes 2024 data. Data for Adult Recidivism Conviction Rate was sourced from the CDCR convictions dashboard, using 2019-2020 data. While this is not the most recent data available, DHCS requires the use of 2024 data for this measure.

Adult Arrest Rate

County rate: 4,154 per 100,000

Groups above the county rate include:

Age groups:

- 20–29 (5,134)
- 30–39 (7,210)

Gender:

- Males (6,362)

Juvenile Arrest Rate

County rate: 593 per 100,000

Groups above the county rate include:

Gender:

- Males (904)

Overall Population Arrest Rate

County rate: 3,229 per 100,000

Groups above the county rate include:

Race/Ethnicity:

- Black residents (11,622)
- White residents (3,837)

Adult Recidivism Conviction Rate

County three-year recidivism conviction rate: 47.4%

Groups above the county rate include:

Age groups:

- 25–29 (49.2%)
- 30–34 (55.9%)
- 35–39 (50.0%)
- 40–44 (48.6%)

Gender:

- Males (48.5%)

Race/Ethnicity:

- Other Race/Ethnicity (48.6%)
- White (47.6%)
- Hispanic/Latino (47.5%)

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)

Over the course of this 2026–2029 Integrated Plan, BHRS will strengthen and explore strategies to address system challenges, guided by community input and local data. Forensic SOC Development: Over the past year, BHRS engaged in extensive cross-system planning with the Superior Court, District Attorney, Public Defender, Sheriff's Office, Probation, law enforcement, and justice partners to strengthen the County's response to justice-involved individuals with significant behavioral health needs. These efforts were driven by rising IST determinations, increased diversion demand, and recognition that untreated mental health and substance use conditions influence justice involvement. Through structured workgroups, partner engagement, and planning sessions, the County developed a coordinated strategy aligning behavioral health services with the legal system. A central outcome is the Forensic SOC, which organizes diversion, treatment, and reentry services within a structured framework designed to reduce justice involvement and improve outcomes. This strategy also responds to BHSA stakeholder feedback emphasizing stronger reentry navigation and continuity of care for individuals leaving incarceration. The SOC expands programs engaging individuals during incarceration and supporting them following release to improve treatment engagement and reduce relapse, crisis events, and recidivism. BHRS is strengthening warm handoffs, presumptive transfer, and co-location of staff in justice settings to ensure smooth transitions into community-based care.

Sequential Intercept Model Planning Framework: Stanislaus County partners agreed to utilize SIM as the primary planning framework guiding behavioral health integration within the justice system. SIM is an evidence-informed SAMHSA model widely used to improve coordination between behavioral health and criminal justice systems by identifying intercept points where individuals with mental health and SUD needs can be diverted and connected to services. These include community crisis response, law enforcement contact, initial detention and hearings, diversion programs, reentry planning, and community supervision. By examining each intercept, counties identify service gaps, strengthen diversion opportunities, and expand treatment access. Using SIM allows Stanislaus County to take a coordinated approach, ensuring behavioral health interventions are available across the justice continuum and improving collaboration among providers, courts, law enforcement, and corrections.

Forensics System of Care Development: Stanislaus County was among the first cohort

to implement CARE Court. Early implementation revealed broader system challenges affecting diversion, including fragmented referral pathways, inconsistent care coordination, limited data sharing, and need for stronger governance. The CARE Court Learning Group—behavioral health leaders, justice partners, and stakeholders—developed recommendations such as formal MDT structures, clarified roles, shared performance measures, unified success definitions, improved data coordination, and a public awareness strategy. These findings informed development of the SOC model to move the system toward integrated, collaborative operations.

CARE Court Integration and Sustainability: CARE Court provides a civil pathway connecting individuals with untreated schizophrenia spectrum and psychotic disorders to community-based treatment, housing supports and coordinated services. BHRS serves as the clinical lead responsible for assessment, CARE Plans, coordination, and engagement. The program addresses untreated conditions that often lead to cycles of homelessness, hospitalization, incarceration, or conservatorship. CARE Court has operated through partnership with the Superior Court, Public Defender, County Counsel, and others, serving approximately 214 individuals with assessment, treatment planning, and housing linkage. CARE Court is now incorporated into the Collaborative Court structure, allowing participants to be served within a unified diversion framework supported by a dedicated judiciary and coordinated partners. With state funding expiring in June 2026, BHRS incorporated CARE Court into the BHSA plan to ensure long-term sustainability and maintain its role as a core early engagement strategy.

IST Mitigation Strategy: Stanislaus County has experienced some of California's highest IST placement increases. Under SB 184 and WIC 4336, counties exceeding their IST growth baselines incur penalties; Stanislaus paid approximately $4.35 million across FY 22–23 and FY 23–24. Penalty funds are being reinvested into diversion and treatment programs to reduce future IST determinations. While the State increased the baseline from 89 to 108 determinations, IST counts remain near the threshold, reinforcing need for sustained intervention. An executive IST Workgroup identified need to strengthen interventions at pre-booking, post-booking, and post-release stages. BHRS established the Reintegration Support Team and Collaborative Court Behavioral Health Services Team as primary IST mitigation strategies. BHRS recommends ongoing BHSA funding to sustain these programs as long-term prevention infrastructure aligned with BHSA priorities.

Collaborative Court and Diversion Programs: The Collaborative Court within the Superior Court system was developed through partnership with the District Attorney, Public Defender, Probation, and BHRS. It provides a judicial forum to facilitate diversion referrals and coordinate treatment engagement for individuals whose justice involvement is connected to untreated behavioral health conditions. BHRS is expanding behavioral health programs providing screening, assessment, treatment engagement, and care coordination, including the Collaborative Court Behavioral Health Services Team, Reintegration Support Team, SUD Collaborative Court Team, and the PFMHD. These teams collectively support the Collaborative Court and broader SOC.

Collaborative Court BHST: The BHST provides mental health treatment for individuals participating in diversion pathways, functioning as the County's forensic ACT model. It provides psychiatric services, medication management, case management, and treatment engagement for individuals with serious mental illness. As the court becomes fully operational, BHST will expand into a full multidisciplinary team.

Reintegration Support Team: The Reintegration Support Team provides centralized screening, assessment, and navigation for justice-referred individuals. The team conducts psychosocial and SUD evaluations, coordinates referrals to forensic and community

programs, and supports transitions from custody into community care. As Collaborative Court expands, the team will also function as a full treatment screening and navigation unit.

Substance Use Treatment Collaborative Court Team: This team supports SUD diversion pathways through screening, treatment planning, care coordination, and linkage to appropriate SUD treatment. Building on Adult Drug Court, it now supports Proposition 36 and other diversion referrals. BHRS is expanding this program using Opioid Settlement Funds.

Pre-Trial Felony Mental Health Diversion (PFMHD): PFMHD expands diversion capacity by providing residential treatment for individuals with serious mental illness charged with felony offenses who might otherwise be referred to state hospital placement. Developed through the DSH IST Diversion and Community-Based Restoration Initiative, it creates a local alternative.

Community Corrections Partnership Program Integration: BHRS is aligning CCP-funded programs—including CCP FSP and Day Reporting Center SUD services—with the SOC to reduce fragmentation and improve care coordination. BHRS will work with CCP partners to align these programs with diversion, treatment, and reentry infrastructure, ensuring continuity of care, accountability, and efficient use of resources.

Integration with CalAIM Justice-Involved Re-Entry Initiative (JI): The SOC will align with CalAIM JI implementation with the Sheriff's Office and Probation. JI expands Medi-Cal coverage for individuals leaving incarceration and allows services to begin up to 90 days pre-release. BHRS will integrate behavioral health services into JI implementation to support transitions into community programs and ensure continuity of care.

Cross-System Partnerships and Data Sharing: BHRS will explore strengthening partnerships with the Sheriff's Office, Probation, and courts through data-sharing and coordination agreements focused on monitoring diversion, recidivism, and service linkage and refining interventions for subpopulations with poorer outcomes.

How These Actions Address Areas Below State Averages: These actions expand targeted pre-arrest diversion and co-response capacity to reduce arrest rates, particularly among males and adults ages 20–39. Enhanced booking-point screening diverts individuals earlier. Expansion of court-based diversion reduces incarceration and IST trends. Strengthened IST mitigation reduces state hospital commitments. High-intensity in-reach and coordinated reentry planning reduce recidivism among adults 25–44. Expansion of forensic-focused FSP and ACT services improves engagement for high-utilizing adults and TAY. Equity strategies prioritize disproportionately represented populations and expanded data sharing strengthens accountability and targeted intervention.

Data Used to Inform These Initiatives: These initiatives are informed by jail and court data, behavioral health utilization metrics, crisis system data, CHA findings, stakeholder feedback, and DHCS and BHRS oversight indicators.

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

- BHSA FSP
- Federal Financial Participation (SMHS, DMC/DMC-ODS)
- 2011 Realignment

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? Below

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

- Age
- Sex

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.

This analysis is based on 2021-2025 data extracted from the CalMHSA Removal of Children from Home Power BI dashboard. While this is not the most recent data available, DHCS requires the use of 2021-2025 data for this measure.

Open Child Welfare Cases SMHS Penetration Rate (2021)

County rate: 33.9%

Groups below the county rate include:

Age groups:

- 0–2 years (13.7%)
- 3–5 years (29.5%)

Gender:

- Males (33.5%)

Race/Ethnicity:

- Hispanic youth (33.1%)

Youth with a race other than Black, White, or Hispanic (28.3%)
Children in Foster Care Point-in-Time (PIT) Count (2025)
County rate: 259 per 100,000 children
Groups above the county rate include:
Age groups:

- Under 1 year (336 per 100,000)
- 16–17 years (355 per 100,000)
- 18–21 years (342 per 100,000)

Child Maltreatment Substantiations (2024)
County rate: 7.4 per 1,000 children
Groups above the county rate include:
Age groups:

- Under 1 year (22.6%)
- 1–2 years (8.8%)
- 3–5 years (7.9%)

Race/Ethnicity:

- Black youth (22.4%)
- White youth (11.8%)

Gender:

- Females (7.6%)

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.

Over the course of this 2026–2029 Integrated Plan, BHRS will focus on strengthening and exploring strategies to address system challenges, guided by community input and local data. BHRS has undertaken a structured cross-system planning effort to strengthen school-based behavioral health access and increase early treatment to reduce unnecessary removal from home, justice involvement, homelessness, and other impacts of unmet behavioral health needs. In collaboration with the Stanislaus County Office of Education, Community Services Agency, Medi-Cal Managed Care Plans, Probation, Regional Center partners, and community-based providers, BHRS engaged in a year-long process to develop a framework supporting integration of behavioral services in school settings. The Cradle-to-Career MHWG, co-chaired by the Behavioral Health Director and County Superintendent of Schools, developed recommendations informed by CYBHI, the

Community Health Improvement Plan, AB 2083, and BHSA accountability expectations. MHWG planning resulted in efforts to strengthen AB 2083 governance capacity; establish the Cradle-to-Career System of Care Dashboard to guide IET policy and fiscal decisions; and develop a School Mental Health Modeling Guide clarifying strategies for school-based behavioral health integration.

Integrated Governance Structure Supporting BHSA Implementation: Stanislaus County has established an interagency governance structure consisting of the IET, MHWG, and ILT to ensure coordinated planning, oversight, and implementation across systems. The MHWG serves as the primary planning body, the IET as the approving authority, and the ILT as the implementation arm, reinforcing aligned accountability.

Mental Health Working Group (MHWG): The MHWG leads planning for integration of mental health treatment and enhanced care management within school systems. It develops interagency plans, cross-system workflows, and priorities to strengthen coordination and support implementation of HFW and other system reforms. Integrated Executive Team (IET): The IET provides executive oversight, approves plans developed by the MHWG, ensures fiscal and staffing alignment, and finalizes governance decisions. Membership reflects AB 2083 cross-system intent and includes leadership from CSA, BHRS, Probation, SCOE, VMRC, and the Tuolumne Band of Me-Wuk Indians. The IET and ILT will now expand their focus to support BHSA implementation, improving integration and cross-system accountability. Integrated Leadership Team (ILT): The ILT executes approved strategies, oversees day-to-day implementation, advances alignment across partners, and supports ongoing priorities. It operationalizes collaborative agreements to strengthen service access and placement stability for children and youth with complex needs.

AB 2083 Aims and Alignment with BHSA: AB 2083 establishes governance expectations for child-serving agencies to coordinate services, reduce duplication, improve placement stability, and center decision-making around children and families. Stanislaus County's IET–MHWG–ILT structure operationalizes these aims and aligns closely with BHSA requirements emphasizing accountability, performance measurement, equity, and culturally responsive service delivery. MOU provisions related to data sharing and fiscal coordination support BHSA reporting and oversight.

Shared Children's Behavioral Health Data Dashboard: The Stanislaus Cradle-to-Career Dashboard functions as a central governance tool integrating BHSA measures, BHAS indicators, MCP data, child welfare indicators, school metrics, and developmental data. It supports cross-system oversight of access, coordination, and child-level outcomes. Purpose of the Dashboard: It monitors access and service penetration, identifies early warning indicators of instability or placement risk, detects delays in assessment or service initiation, aligns fiscal and programmatic resources, and supports shared decision-making to keep youth safely at home, in school, and outside crisis or institutional systems. Under AB 2083, cross-system delays are governance issues; the dashboard helps the IET identify friction points and assign corrective actions. Priority Lead Measures: Access and Timeliness: MHWG identified lead indicators including ECM enrollment, youth served by BHRS, referral counts, SMHS penetration, inpatient psychiatric utilization, psychiatric holds by payor, chronic absenteeism, and school-based mental health referrals.

Priority Measures, BHSA Accountability, and Performance Oversight: Dashboard measures reflect community priorities across education, child welfare, managed care, and behavioral health. They help determine whether children access treatment early enough and whether services are timely and coordinated. Rising psychiatric holds, inpatient utilization, absenteeism, or declining penetration indicate instability that could

precede removal or crisis involvement. Improvements in ECM enrollment and CFT engagement reflect strengthened stabilization capacity. The IET also reviews BHAS indicators, statewide goals, access and timeliness standards, utilization trends, and BHSA-regulated measures. Quarterly IET review and monthly ILT monitoring ensure both community-developed and state-mandated indicators are reviewed together. When underperformance is identified, the IET examines operational, policy, or fiscal adjustments needed to improve outcomes. This strengthens cross-system coordination and supports proactive system redesign.

Governance and Use of the Dashboard: The dashboard is reviewed quarterly by the IET and ILT, with the MHWG analyzing trends and recommending adjustments. The IET uses findings to identify bottlenecks, monitor placement restrictiveness and crisis trends, assign corrective actions, align funding decisions, and track ICPM implementation. This structured oversight connects BHSA access goals, AB 2083 mandates, and child-level outcomes.

Advancing Removal Prevention Through Data: Shared monitoring enables early intervention before crises result in placement disruption or justice involvement. The dashboard ensures behavioral health access is continuously examined through stabilization, equity, and coordination lenses. Embedding the dashboard within the BHSA Plan ensures transparent, sustained oversight.

School Mental Health Modeling Guide: The C2C MHWG developed the Guide to help LEAs design, expand, and sustain school-based behavioral health services aligned with local need and BHSA expectations. It situates school-based services within MTSS, emphasizing on-campus service delivery, provider integration with school staff, tiered prevention and early intervention, family engagement, and sustainable financing strategies including LEA Medi-Cal, CYBHI, Title funding, and county–education partnerships. The Guide outlines five common school-based mental health approaches and includes a funding matrix summarizing financing streams.

The IET and Superintendent of Schools will provide executive leadership to advance integration strategies across education, health, and behavioral health systems. This governance structure aims to improve early access and prevent unnecessary involvement in child welfare, foster care, justice systems, and youth homelessness. The IET–MHWG partnership supports strategic resource allocation and leverages partnerships with Medi-Cal managed care plans, commercial plans, and other funding mechanisms to maximize impact. Through this structured approach, BHRS seeks to expand access, strengthen sustainability, and improve youth behavioral health outcomes. **High-Fidelity Wraparound Expansion:** HFW is an intensive team-based model supporting children and youth at risk of out-of-home placement, hospitalization, or justice involvement. It convenes natural supports and system partners into one Child and Family Team with a coordinated plan of care. Stanislaus County prioritizes HFW as a central stabilization strategy aligned with AB 2083, ICPM, and BHSA. The Department is expanding HFW beyond child welfare into Children's SOC FSP programs. The ILT leads operational implementation, aligning referral pathways and coordinating across systems, while the IET provides oversight and policy direction. Leadership monitors service timeliness, engagement, stabilization outcomes, and alignment with BHSA performance measures. HFW is positioned as a core intervention within a prevention-oriented, equity-driven strategy supporting family permanency and reducing system penetration.

How These Actions Address Areas Below State Averages: Expanded school-based services improve early access and SMHS penetration for children ages 0–5, males, and Hispanic youth. HFW expansion strengthens stabilization for infants and transition-age youth. Strengthened AB 2083 governance improves coordination and timeliness for

youth with open child welfare cases. Dashboard oversight identifies rising psychiatric holds, inpatient use, and absenteeism early. ICPM implementation improves coordinated planning and reduces fragmentation. Equity strategies target groups with elevated maltreatment substantiation rates. Enhanced care management and CFT processes strengthen culturally responsive stabilization, while LEA Medi-Cal, CYBHI, and managed care financing increase sustainable early intervention access.

Data Used to Inform These Initiatives: These strategies were informed by local assessments, system oversight, and stakeholder engagement. The 2025 CHA identified geographic disparities and unmet youth behavioral health needs, especially in communities with limited school-based service access.

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

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

Untreated Behavioral Health Conditions: Primary Measures

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

How does your county status compare to the statewide rate? 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)

How does your county status compare to the statewide rate? Below

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

- No Disparities Data Available

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?

- Age
- Race or Ethnicity
- Sex

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

This analysis is based on 2023 data extracted from the CalMHSA Untreated Behavioral Health Conditions Power BI dashboard. While this is not the most recent data available, the Department of HealthCare Services (DHCS) requires the use of 2023 data for this measure.

Adults Who Needed Help (2023)
County rate: 51.4%
Groups above the county rate include:
Age groups:

- 25–64 years (57.2%)

Gender:

- Males (65.4%)
- Females (54.8%)

Race/Ethnicity:

- Latino residents (59.5%)
- Residents identifying as Two or More Races (77.2%)

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)

Over the course of this 2026–2029 IP, BHRS will focus on strengthening and exploring strategies to address these challenges, guided by community input and local data.
Untreated Behavioral Health Conditions: BHRS recognizes untreated BH conditions as major drivers of homelessness, justice involvement, ED utilization, and avoidable institutionalization. Stakeholders cited confusion about access, eligibility uncertainty, and the perception treatment is only available in crisis. Navigation barriers and disparities in service penetration among Latino residents, rural communities, older adults, and young children delay engagement and leave MH/SUD untreated. In response, BHRS is implementing a multi-layered strategy that integrates outreach, centralized access, cross-system coordination, housing stabilization, and early intervention for adults and children—reducing untreated conditions, preventing homelessness, and expanding timely care across the continuum.
Member Relations and Community Education: BHRS will explore a Member Relations & Community Education Team to increase awareness of Medi-Cal BH benefits across the lifespan, functioning like member services in commercial/Medi-Cal managed care (education/navigation, not crisis). Staff will attend community events, school functions, civic meetings, and health fairs to provide structured education about covered services and how to access care. Multilingual, culturally responsive materials will reach diverse communities. The team will align with the Access Line for follow-up benefit clarification and navigation. Proactive education will improve help-seeking and reduce delays in

entry.

START Hub: The START hub will serve as a centralized navigation hub for MH/SUD services, a community-centered entry point where individuals, families, and partners connect to care without navigating complex systems. START will offer same-day screening/assessment, navigation, and warm handoffs; short-term supportive engagement; coordination with BHRS crisis/access programs; linkage to medical care, housing, and supports; transportation assistance; and family education/consultation. It reduces barriers by enabling quick access and guided navigation via walk-in, phone, or referral from outreach/community partners. Located in Modesto, START will coordinate with hospitals, FQHCs, shelters, outreach teams, and justice partners to strengthen pathways. Over time, START will anchor a hub-and-spoke model with satellite sites expanding community-based access points across the County.

Targeted Outreach and Engagement: Untreated BH conditions are prevalent among people experiencing homelessness. BHRS is expanding/aligning outreach across hospital, street, and shelter settings to ensure earlier engagement and continuity. Strategies include expanding the CARE multidisciplinary outreach structure with integrated MH/SUD engagement; repurposing the Telecare outreach team for shelter-based outreach countywide; strengthening hospital discharge coordination to reduce discharges into homelessness and improve post-psychiatric hospitalization follow-up; and embedding outreach in encampments/unsheltered areas for screening, assessment, and connection to treatment. These efforts link people earlier to outpatient, MAT, residential, or wraparound services.

Housing Stabilization as a Treatment Strategy: Housing instability exacerbates untreated MH/SUD. BHRS is integrating BH housing analysis/planning through the Behavioral Health Housing Collaborative. Using EHR data, internal PIT counts, and by-name lists, the County is quantifying members needing bridge, transitional, and permanent supportive housing. Stakeholders emphasized interim/bridge housing with integrated BH services for people exiting inpatient units or with high ED utilization. Aligning housing development with verified clinical need prevents cycling between homelessness, crisis services, and institutional care. Housing investments function as clinical stabilization—improving engagement and reducing crisis-driven utilization.

Children and Youth Early Intervention and School-Based Integration: Untreated BH conditions manifest as school disengagement, child welfare involvement, justice contact, and family instability. Through the IET, ILT, and MHWG, BHRS is strengthening governance to align schools, BH, child welfare, and justice partners. Strategies include expanding HFW beyond child welfare, integrating MH treatment and Enhanced Care Management in schools, supporting districts to maximize Medi-Cal billing and leverage recent reforms, and developing a multi-year plan to enhance school-based access and reduce unnecessary system involvement. Embedding early intervention in schools and strengthening accountability prevents escalation to higher-acuity placements or institutional responses.

Justice Diversion: Untreated BH conditions often intersect with justice involvement, particularly among people experiencing homelessness, SUD, and co-occurring MH conditions. BHRS is strengthening diversion pathways so BH needs are addressed via treatment rather than incarceration. With Probation, law enforcement, courts, and governance partners, BHRS is expanding diversion-oriented capacity (outpatient, FSP programs, HFW for youth). These efforts intercept earlier in the justice continuum, provide clinical assessments, and connect participants to structured BH services that stabilize symptoms and reduce recidivism—shifting from punitive responses to treatment-centered interventions aligned with BHSA priorities on homelessness, justice

involvement, and institutionalization risk.

Post-Hospitalization Engagement: Transitions from inpatient psychiatry and EDs are high-risk for disengagement/readmission, especially with untreated/unstable BH conditions. BHRS strengthened the BHOE team to focus on timely post-discharge follow-up and continuity: outreach shortly after discharge, reinforcement of discharge plans, medication coordination, and warm handoffs to outpatient/community supports. This proactive model closes gaps between hospital and community care, supports voluntary reengagement, and decreases avoidable readmissions, improving adherence, outpatient retention, and reducing crisis reliance.

Member Relations and Community Education: BHRS is exploring a Member Relations & Community Education function to address persistent untreated BH conditions. BHSA engagement (stakeholder meetings, consumer/family feedback, surveys, partner input) found ambiguity about BHRS, service availability, eligibility, and how to initiate care. Many delay treatment due to uncertainty or belief services exist only in crisis. Local indicators show lower-than-desired penetration vs statewide benchmarks, access disparities among Latino/rural populations, and reliance on higher-acuity services vs early outpatient engagement—suggesting informational/navigation barriers. BHRS is considering proactive outreach in primary care clinics, shelters, employers, and CBOs: clear service information, access points, culturally/linguistically appropriate materials, and Medi-Cal application assistance. This aims to strengthen early engagement, equitable access, and voluntary self-referrals among lower-utilizing populations. Over time, improved system awareness/BH literacy should reduce untreated BH conditions and crisis-level care.

Anticipated Impact: Collectively, these initiatives reduce untreated BH conditions by addressing informational barriers, access fragmentation, housing instability, and cross-system disconnects. BHRS is building an upstream, equity-driven model integrating outreach, centralized access, housing stabilization, early intervention, and justice diversion. The County anticipates increased outpatient penetration, reduced ED utilization and inpatient readmissions, decreased homelessness among BH members, improved school-based early intervention access, and reduced justice-system cycling. Under BHSA, coordinated investments strengthen early engagement, improve continuity, and ensure individuals are identified, supported, and connected to timely, appropriate treatment.

How These Actions Address Areas Below State Averages: START reduces delays in entry to care and improves FUM-30/FUA-30 follow-up after ED visits. Strengthened post-hospitalization outreach via BHOE improves 30-day follow-up. Member Relations & Community Education improves BH literacy/benefit navigation, targeting adults ages 25–64, males, Latino residents, and people identifying as Two or More Races with higher unmet need. Targeted homelessness outreach and shelter-based engagement identify untreated individuals earlier and connect them to outpatient/MAT services, reducing crisis-driven ED use. Housing stabilization improves engagement/continuity, reducing avoidable ED visits and repeat acute episodes. School-based early intervention and HFW expansion reduce untreated youth BH conditions before crisis/ED use. Justice diversion and reentry coordination engage individuals earlier in the justice continuum, improving outpatient linkage and reducing unmet need. Cross-system data monitoring/oversight enable real-time tracking of follow-up and penetration, supporting targeted improvement where County performance falls below statewide averages.

Data Used to Inform These Initiatives: These strategies are informed by multiple data sources, including findings from the 2025 Community Health Assessment, provider-to-population capacity indicators, County PIT data, BHRS access and follow-up metrics,

stakeholder input from education, health, shelter, and justice partners, and system oversight findings from DHCS and BHRS Annual Updates. These combined data sources highlighted unmet need, access disparities, service gaps, and performance challenges, guiding the development of targeted strategies to strengthen penetration, timeliness, and coordination across the system.

Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal

- BHSA FSP
- 1991 Realignment
- 2011 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
How does your county status compare to the statewide rate/average?

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024
For adults/older adults Below
For children/youth Above

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

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? Above

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

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH), 2022
For the full population measured Above
For adults/older adults Below
For children/youth Below

Overdoses: Supplemental Measures
How does your county status compare to the statewide rate/average?

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022
For the full population measured Above
For adults/older adults Above
For children/youth Below

Prevention And Treatment of Co-Occurring Physical Health Conditions: Primary Measures
How does your county status compare to the statewide rate/average?

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022
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
How does your county status compare to the statewide rate/average?

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
For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications) Below
For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing) Below

Quality Of Life: Primary Measures
How does your county status compare to the statewide rate/average?

Perception of Functioning Domain Score (CPS), 2024
For the full population measured Not Applicable
For adults/older adults Not Applicable
For children/youth Not Applicable

Quality Of Life: Supplemental Measures
How does your county status compare to the statewide rate/average?

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS), 2024
For the full population measured Above

Social Connection: Primary Measures
How does your county status compare to the statewide rate/average?

Perception of Social Connectedness Domain Score (CPS), 2024
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? Below

Suicides: Primary Measures
How does your county status compare to the statewide rate/average?

Suicide Deaths, 2022
For the full population measured Above

Suicides: Supplemental Measures
How does your county status compare to the statewide rate/average?

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022
For the full population measured Above
For adults/older adults Below
For children/youth Above

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.

- Overdoses
- Suicides

Overdoses

Please describe why this goal was selected

- Stanislaus County BHRS selected overdose as an additional BHSA goal based on strong community feedback and clear local data showing that overdose deaths continue to significantly impact the community at a level that exceeds statewide trends. During the countywide BHSA community engagement process, BHRS shared overdose rates, emergency department utilization, and substance related mortality data with residents, service providers, schools, healthcare partners, and community-based organizations. Across sectors, stakeholders consistently identified overdose as a top priority, citing the growing impact of fentanyl, methamphetamine, and polysubstance use on families, youth, and vulnerable adults.
- DHCS preselected 2022 baseline data for this plan, which indicated that Stanislaus County experienced significant increases in opioid-involved and stimulant-involved overdoses, mirroring statewide patterns. Although locally relevant data shows recent improvements in these areas, we are required to use the DHCS 2022 data as the baseline. These improvements strongly support the decision to continue focusing on this goal, as community members emphasized the need for expanded prevention, early intervention, and treatment access, particularly for youth, individuals experiencing homelessness, and people with co-occurring mental health and substance use disorders.
- The County's existing Opioid Safety Coalition, a long standing, multi sector partnership, has already laid the foundation for coordinated overdose prevention efforts, including naloxone distribution, public education campaigns, data sharing, and cross system response planning. Selecting overdose as an additional BHSA goal allows Stanislaus County to align BHSA investments with the work already underway, strengthen the coalition's impact, and respond directly to the community's call for action. This alignment ensures that BHSA resources support evidence-based strategies to reduce overdose deaths, expand access to treatment including medication-addiction treatment, and improve outcomes for populations disproportionately affected by substance use.

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

Stanislaus County's 2024 CHA data show clear disparities in overdose outcomes across demographic groups. These disparities supported the decision to select Overdose as an additional statewide behavioral health goal.

Groups disproportionately impacted include:

Age Disparities:

- Adults aged 25–54 account for the majority of fatal overdoses, with higher rates than other age groups.
- TAY shows emerging risk based on rising substance-related concerns.

Gender Disparities:

- Men represent most overdose deaths, consistent with statewide trends.
- Women experience higher rates of nonfatal substance-related health encounters, indicating different patterns of risk and service utilization.

Race/Ethnicity Disparities:

- Latino residents show disproportionately rising overdose mortality, particularly fentanyl-related deaths.
- White residents continue to experience high rates of methamphetamine-involved overdoses.
- Native American residents, though a small population, have elevated overdose mortality per capita.

Overdose risk is not evenly distributed. Adults 25–54, men, Latino residents, and other identified groups experience disproportionately high overdose mortality and morbidity. These disparities, combined with community input and the work of the Opioid Safety Coalition, strongly support selecting overdose as an Additional Statewide Behavioral Health Goal and prioritizing strategies in the CHIP to reduce overdose-related harm.

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)

Over the 2026–2029 Integrated Plan, BHRS will strengthen and expand coordinated strategies to reduce substance use disorders, prevent overdoses, and improve access to recovery supports. These efforts are shaped by local data, community input, and longstanding cross-system partnerships. Collectively, the initiatives outlined below are designed to identify individuals earlier, reduce structural and cultural barriers to care, and build a comprehensive, community-informed continuum of prevention, treatment, and recovery services.

Substance Use Disorder Treatment, Overdose Prevention, and Recovery Support BHRS is implementing a multifaceted approach spanning community awareness, early intervention, treatment engagement, and system navigation. Key priorities include

expanding community partnerships through the Stanislaus County Opioid Safety Coalition (SCOSC), enhancing mobile outreach teams with integrated SUD and MAT capabilities, strengthening reentry supports for individuals leaving custody, and establishing the START Center as a centralized access point for behavioral health and SUD services. The combined strategies aim to increase early identification, expand access to life-saving harm reduction tools, improve rapid connection to care, and reduce untreated substance use as a driver of preventable overdose deaths.

Stanislaus County Opioid Safety Coalition Expansion: SCOSC is the County's primary organizing body for countywide overdose prevention efforts. Formed in 2018 and jointly led by the Health Services Agency and BHRS, the coalition brings together hospitals, medical providers, schools, public safety agencies, community-based and faith-based organizations, media and business partners, tribal partners, and individuals with lived experience. The coalition uses a data-driven, collaborative approach to ensure a coordinated response across diverse sectors. Regular meetings and specialized workgroups analyze real-time overdose surveillance data, track emerging drug trends such as fentanyl analogs and counterfeit pill activity, and coordinate preventive actions. Monthly data reviews help partners identify geographic hotspots, shifts in drug potency or supply, and spikes in youth-involved overdoses. SCOSC also coordinates timely community alerts with law enforcement and public health to inform the public and partner organizations when trends change. SCOSC leads multilingual public education campaigns emphasizing fentanyl risks, counterfeit pill recognition, safe medication storage and disposal, stigma reduction, and awareness of local treatment resources. Campaigns use radio, social media, print materials, community events, school presentations, and partnerships with youth-serving organizations. Town halls, school forums, and panel discussions provide residents with practical prevention strategies and opportunities to hear from individuals in recovery. SCOSC also collaborates closely with healthcare providers to support safer prescribing practices, increase evidence-based pain management alternatives, expand MAT availability, and strengthen coordination between medical and behavioral health systems. BHRS proposes using Opioid Settlement Funds to enhance SCOSC's analytic capacity, expand campaign reach across diverse neighborhoods, support culturally responsive prevention activities, and increase naloxone availability through coalition-supported distribution events, outreach teams, and partner agencies. Additional staffing will support coalition coordination, ensuring SCOSC remains responsive as drug trends evolve. Through strengthened capacity and expanded partnerships, SCOSC will continue functioning as the County's central hub for prevention and community engagement.

Integration of MAT and SUD Services Into Outreach and Engagement Teams: BHRS will enhance its mobile outreach and field-based engagement teams by embedding specialized SUD treatment expertise, including direct MAT access, creating fully integrated teams capable of engaging individuals in high-risk environments. Outreach teams will prioritize people experiencing homelessness, individuals with co-occurring disorders, and those who have experienced recent overdoses or emergency department encounters. Teams will conduct on-site screenings, brief interventions, naloxone distribution, overdose recognition trainings, and immediate linkage to behavioral health and MAT services. Clinicians and peers will coordinate to facilitate rapid MAT initiation—either mobile or clinic-based—and connect individuals to ongoing treatment, primary care, and recovery resources. Outreach efforts will target shelters, encampments, encampment clusters, libraries, parks, and geographic locations identified through overdose surveillance data. By bringing treatment directly to individuals with limited access to transportation or high mistrust of clinical settings, BHRS will expand early

intervention opportunities and increase retention in care. This approach also supports warm handoffs from emergency departments, psychiatric hospitals, crisis units, and community partners who encounter individuals at heightened overdose risk.

Justice-Involved Reentry Engagement and Overdose Prevention: BHRS will expand targeted reentry efforts for individuals leaving correctional settings, recognizing the high overdose mortality rates seen in the first weeks following release. Working closely with the Sheriff's Office and Probation Department through CalAIM's Justice-Involved Reentry Initiative, BHRS will identify individuals with behavioral health and SUD needs while still in custody and provide pre-release engagement, care planning, and service coordination. Staff will assist with Medi-Cal enrollment or reactivation, conduct pre-release assessments, provide overdose prevention education, supply naloxone upon release, and arrange warm handoffs into community-based behavioral health and MAT programs. The Collaborative Court BHST Team and Reintegration Support Team will ensure continuity of care by providing intensive post-release engagement, coordinating with courts and probation, and supporting adherence to treatment plans. These efforts are designed to reduce relapse and overdose among individuals leaving incarceration, a population that experiences mortality rates significantly above state averages. By ensuring meaningful engagement before release and stable connections to care immediately afterward, BHRS aims to reduce preventable overdose deaths and improve long-term outcomes for justice-involved individuals.

Stanislaus START: Triage, Access, Recovery, and Treatment START will serve as a centralized entry point for behavioral health, mental health, and SUD services across the County. The center will simplify pathways to care by offering same-day screenings, assessments, navigation, and warm handoffs to outpatient, residential, crisis, MAT, and community-based supports. START will also offer short-term supportive engagement for individuals who need stabilization before connecting to long-term care. Services will include navigation assistance, safety planning, transportation support, family education on behavioral health and substance use, and coordination with hospitals, crisis programs, shelters, FQHCs, and outreach teams. START's location in Modesto ensures accessibility, and over time, satellite hubs are planned to expand reach in underserved areas. START is a critical component of overdose prevention efforts, ensuring individuals with untreated SUD or recent overdose experiences can enter services quickly and without navigating complex systems alone.

How These Actions Address Areas Below State Averages: These actions directly address the populations and indicators where Stanislaus County falls below state averages by focusing on groups and communities experiencing the highest overdose burdens. Adults ages 25–54 and men, who represent the majority of local overdose fatalities, benefit from expanded mobile outreach, rapid-access MAT, and START's same-day walk-in model, which together reduce delays in treatment and improve early intervention. Rising fentanyl-related deaths among Latino residents are addressed through bilingual SUD services, the expansion of La Familia's community-based supports, culturally responsive engagement strategies, and multilingual prevention and education campaigns tailored to neighborhood needs. Justice-involved individuals, whose overdose mortality rates exceed state benchmarks, are supported through pre-release MAT initiation, naloxone distribution at release, and intensive follow-up supports designed to stabilize individuals during the first 30 days post-release. Individuals experiencing homelessness and those with co-occurring SMI/SUD are reached through encampment-based outreach, field-based overdose response, and coordinated treatment pathways that reduce missed connections and ensure timely access to care. Additionally,

disaggregated demographic and geographic data guide resource deployment across the county, ensuring Opioid Settlement Funds, SCOSC activities, and prevention strategies are concentrated in the neighborhoods and populations with the highest overdose rates and the greatest need for intervention.

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

- SUBG
- Opioid Settlement Funds

Suicides

Please describe why this goal was selected

- Stanislaus County BHRS selected suicides as an additional BHSA goal based on strong community feedback and clear local data showing that deaths by suicide continue to significantly impact our community at a level that exceeds statewide trends. During the BHSA community engagement process, BHRS shared county level suicide trends, demographic disparities, and crisis service utilization patterns. Community members, including educators, healthcare providers, youth advocates, faith-based leaders, and families identified suicides as a critical area requiring sustained investment, particularly for youth, veterans, LGBTQ+ individuals, and older adults.
- DHCS preselected 2022 baseline data for this plan, which indicates elevated suicide rates in Stanislaus County, consistent with statewide trends. Local data presented during the engagement process highlighted notable increases among transition age youth and middle-aged adults. Community members expressed concern about the intersection of suicide risk with homelessness, substance use, trauma exposure, and limited access to timely behavioral health services. These concerns align with statewide findings but reflect a more acute local need, reinforcing the importance of targeted prevention and early intervention strategies.
- The County's Suicide Prevention Education Coalition (SPEC) has been actively coordinating suicide prevention efforts, including community trainings, post crisis support, school partnerships, and public awareness campaigns. By selecting suicides as an additional BHSA goal, Stanislaus County is building on the existing infrastructure and expertise of SPEC, ensuring that BHSA resources strengthen and expand evidence-based suicide prevention strategies already in motion. This includes enhancing crisis response, increasing access to culturally responsive care, expanding youth focused prevention programs, and improving follow up after crisis events.

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

Stanislaus County's 2024 CHA and County-wide PIT data, combined with strong community feedback, shows persistent and significant disparities in suicide deaths and related behaviors. These findings and community input were central to the County's decision to select suicide as an additional statewide behavioral health goal and prioritize targeted prevention strategies.

Suicide Disparities (Community Health Assessment Data)

Groups disproportionately impacted include:

Age groups:

- Middle-aged adults (35–64) show the highest suicide mortality, linked to isolation and chronic illness.

- Older adults show high suicide mortality.
- TAY show the highest rates of suicide attempts and ED visits for self-harm, despite lower mortality than adults.

Gender:

- Men account for most suicide deaths, consistent with statewide patterns.
- Women account for more suicide attempts and crisis presentations, indicating different risk and help-seeking patterns.

Race/Ethnicity:

- White residents have the highest suicide mortality.
- Latino youth show increasing suicidal ideation and attempts based on youth mental health survey data.
- Native American residents, though a small population, show elevated suicide risk per capita.

Priority Populations:

- Veterans show significantly higher suicide mortality, consistent with statewide and national trends.
- LGBTQ+ youth show elevated suicidal ideation and attempts based on youth mental health indicators.
- Individuals experiencing homelessness have higher suicide risk, supported by PIT data.

Suicide risk in Stanislaus County is concentrated among middle-aged adults, older adults, men, White residents, veterans, LGBTQ+ youth, and individuals experiencing homelessness. These disparities, combined with community input and the work of the SPEC, strongly support selecting suicide as an additional statewide behavioral health goal.

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 Suicides 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)

Over the course of this 2026–2029 Integrated Plan, BHRS will strengthen and expand strategies to address these challenges, guided by local data and stakeholder feedback.

Suicide Prevention Programs, Services, Partnerships, and Initiatives: This section outlines the County's strategies to strengthen suicide prevention and crisis response across Stanislaus County. These efforts focus on expanding community-based prevention, improving coordination across systems, strengthening crisis intervention and post-crisis follow-up, and increasing the capacity of community partners to identify and respond to suicide risk. Together, these strategies support a comprehensive approach that emphasizes early intervention, community engagement, and coordinated care for individuals experiencing behavioral health crises.

Stanislaus County Suicide Prevention Education Coalition (SPEC) Blueprint for

Action: The Stanislaus County SPEC serves as the county's cross-sector collaborative dedicated to strengthening suicide prevention efforts through coordination, community engagement, and shared leadership. Established in December 2023, SPEC brings together partners from public health, education, healthcare systems, law enforcement, first responders, community-based organizations, and individuals with lived experience. The coalition was formed to create a unified approach to suicide prevention that aligns community resources, strengthens system coordination, and advances prevention strategies across Stanislaus County. SPEC functions as a countywide platform for collaboration, allowing community partners to collectively identify prevention priorities, align initiatives, and develop strategies that address suicide risk across multiple sectors and community settings. The coalition promotes shared accountability for suicide prevention and works to ensure that prevention efforts extend beyond the traditional healthcare system into schools, workplaces, community organizations, and other environments where residents live, learn, and work. A central component of SPEC's work is the Suicide Prevention Blueprint for Action, which outlines a coordinated framework for strengthening suicide prevention infrastructure across the county. The Blueprint was developed through an inclusive and participatory planning process that incorporated community forums, empathy interviews to understand lived experiences, and cross-sector strategy development with community partners. This collaborative design process helped ensure that the Blueprint reflects the perspectives of residents, service providers, and community leaders. The Blueprint identifies several strategic priorities designed to strengthen the county's prevention capacity. These priorities include improving coordination and information sharing across systems, expanding suicide prevention training and community education, activating schools, workplaces, and community organizations as protective environments, strengthening coordination across crisis and behavioral health response systems, centering individuals with lived experience as partners in prevention, and developing cohesive communications strategies that promote awareness and help-seeking. SPEC also prioritizes outreach and prevention strategies focused on populations identified as having elevated risk of suicide, including adult men, youth and young adults, LGBTQ+ individuals, veterans, and residents living in communities experiencing higher suicide rates. These strategies emphasize community-based engagement, culturally responsive education, and strengthening protective factors within local communities. To support coordinated prevention efforts, SPEC has developed a near real-time suicide data monitoring capability that allows coalition partners to track key suicide-related indicators and identify emerging patterns more rapidly. This collaborative data infrastructure supports shared situational awareness among community partners and informs prevention planning across systems. Stanislaus County will continue to expand the capacity of this collaborative data development effort to strengthen real-time monitoring and enhance the ability of community partners to respond proactively to emerging trends. Early implementation efforts under the Blueprint focus on expanding the availability of QPR suicide prevention training across community settings, developing consistent and unified suicide prevention messaging across sectors, and creating a locally tailored suicide prevention resource toolkit for schools, workplaces, healthcare providers, and community organizations. These initiatives are designed to increase community awareness, equip residents with the skills to recognize and respond to suicide risk, and strengthen pathways to support for individuals in crisis. Through the Suicide Prevention Blueprint for Action, SPEC advances a coordinated, community-rooted approach to suicide prevention in Stanislaus County. By strengthening partnerships, expanding community training and education, improving

coordination across systems, and supporting real-time information sharing, the coalition is building a more responsive prevention infrastructure that promotes early intervention and supports residents experiencing crisis.

Crisis Response Team: BHRS will strengthen crisis and post-crisis response pathways to reduce repeat crises and improve continuity of care following psychiatric hospitalization, emergency department visits, and law enforcement encounters. Timely crisis response and effective follow-up are critical components of the County's suicide prevention strategy, ensuring that individuals experiencing behavioral health crises receive immediate support and sustained connection to care. As part of this effort, BHRS is restructuring several community-based crisis response programs into a unified Community Response Team model. This strategy consolidates multiple grant-funded and one-time funded mobile crisis teams into a coordinated program designed to expand the County's capacity to respond to behavioral health emergencies in the community. The Community Response Team model will strengthen field-based responses to both mental health and substance use-related crisis calls originating through the 911 system while improving coordination with law enforcement, emergency medical services, and other first responders. Recent policy adjustments among local law enforcement agencies have increased the need for behavioral health-led field responses to 911 calls involving mental health and substance use crises. Law enforcement partners have implemented updated response protocols related to emergency psychiatric holds and use-of-force considerations, resulting in expanded collaboration with BHRS crisis response teams.

Over the past year, BHRS has worked closely with law enforcement agencies throughout Stanislaus County to refine joint response protocols, clarify roles during behavioral health emergencies, and strengthen coordinated response models between public safety and behavioral health responders. To ensure the Community Response Team program is appropriately scaled, the Department is currently analyzing one year of operational data following the implementation of these law enforcement policy changes. This assessment will help determine the staffing levels, geographic deployment strategies, and service capacity required to provide effective crisis coverage across the County on a 24/7 basis. In addition to mobile crisis response capacity, BHRS will strengthen post-crisis follow-up services to ensure individuals remain engaged in care after a behavioral health emergency. The Behavioral Health Outreach & Engagement (BHOE) Team will expand its role in providing rapid follow-up within 48–72 hours following psychiatric hospitalization, emergency department visits, or law enforcement encounters. The BHOE team will focus on reconnecting individuals to outpatient treatment, coordinating referrals, and supporting continuity of care during the critical period following a crisis event. Co-location of BHRS navigators and peer specialists in emergency departments, FQHCs, shelters, and navigation centers will further reduce gaps between crisis intervention and ongoing treatment. START's centralized navigation team will support appointment scheduling, follow-up monitoring, and data tracking to ensure high-risk individuals remain connected to behavioral health services. Following completion of the Community Response Team capacity assessment, BHRS will develop a long-term mobile crisis response proposal and incorporate recommended staffing and service levels for a update to the BHSA IP. This strategy will support the development of a sustainable community crisis response system capable of providing timely, coordinated behavioral health crisis intervention across Stanislaus County.

How These Actions Address Areas Below State Averages: These actions focus on populations where Stanislaus County falls below state averages by expanding rapid access, targeted outreach, and data-driven resource allocation. Middle-aged and older

adults—especially men with elevated suicide mortality—benefit from START's walk-in services, faster post-hospital follow-up, and strengthened crisis and post-crisis care. Higher suicide rates among White and Native American residents are addressed through culturally responsive outreach and community-based prevention efforts aligned with the County's Blueprint for Action. Rising suicidal ideation among Latino and LGBTQ+ youth is met through expanded school-based services, neighborhood access points, and early-intervention supports. Veterans and individuals experiencing homelessness receive enhanced outreach, increased shelter-based engagement, and improved linkage from crisis encounters to ongoing treatment. Use of the SOC Dashboard and disaggregated data ensures resources are directed to populations and neighborhoods performing below state benchmarks.

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

- SUBG
- Other
    - Opioid Settlement Funds

Community Planning Process

Stakeholder Engagement

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

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

- County outreach through social media County outreach through townhall meetings 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

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

Type of Engagement	Date
Workgroups and committee meetings	12/18/2024
Survey Participation	01/10/2025
Workgroups and committee meetings	04/30/2025
County outreach through social media	04/30/2025
Meeting(s) with county	06/10/2025
Training, education, and outreach related to community planning	09/19/2025
Focus group discussions	10/08/2025
Training, education, and outreach related to community planning	10/15/2025
Focus group discussions	10/17/2025
Focus group discussions	10/20/2025
Focus group discussions	10/21/2025
Meeting(s) with county	10/21/2025
Workgroups and committee meetings	10/27/2025
Focus group discussions	10/28/2025
Focus group discussions	10/31/2025
Training, education, and outreach related to community planning	11/06/2025
Focus group discussions	11/12/2025
Key informant interviews with subject matter experts	11/13/2025
Focus group discussions	11/14/2025
Focus group discussions	11/17/2025
Focus group discussions	11/18/2025
Focus group discussions	11/18/2025
Workgroups and committee meetings	11/19/2025
County outreach through townhall meetings	12/05/2025
County outreach through townhall meetings	12/11/2025
Training, education, and outreach related to community planning	12/12/2025
Training, education, and outreach related to community planning	12/18/2025
Workgroups and committee meetings	12/19/2025

County outreach through townhall meetings	12/19/2025
Focus group discussions	01/06/2026
Focus group discussions	01/08/2026
Focus group discussions	01/09/2026
Training, education, and outreach related to community planning	01/16/2026
Key informant interviews with subject matter experts	01/23/2026

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

Aegis

Stanislaus County Affordable Housing Corporation

Aspiranet

Assyrian Global Network

Behavioral Health Board

CalPride

Center for Human Services

Central Star Behavioral Health

City of Modesto

Creative Alternatives

El Concillo

Grayson Community Center

Health Plan of San Joaquin

Healthnet

Hospice Heart

Veterans in Action

Kaiser

La Familia

MoPride

Modesto Gospel Mission

Modesto Jr. College

NAACP

NAMI

Nirvana Redwood Family Center

Salvation Army

Sierra Vista

Stanislaus Asian American Community Resource

Stanislaus County Aging and Veteran's County Department

Stanislaus County Community Services Agency

District Attorney

Stanislaus County

Probation Department

Stanislaus County Public Health Department

Stanislaus County Union

Stanislaus County Sherriff

Stanislaus Office of Education

Stanislaus Regional Housing Authority

Star Behavioral Health Group

Telecare

Turning Point Community Programs

Valley Mountain Regional Center

Office of Public Defender

Superior Courts Administration & Judges

Promotora Network

What are the five most populous cities in counties with a population greater than 200,000

- City of Modesto

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

- Yes

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

- Yes

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 Integrated Plan was developed through a comprehensive Community Planning Process (CPP) as required under BHSA, engaging diverse stakeholders including Health Plan of San Joaquin, NAMI, NAACP, Stanislaus Office of Education, Modesto Jr. College, law enforcement, housing authorities, and cultural organizations. From Dec 2024 to Jan 2026, input was gathered through focus groups (e.g., Salvation Army and Modesto Gospel Mission for homelessness, Family Support Groups, BHRS Staff Focus Groups), Veterans Collaborative sessions, Advisory Committee meetings, surveys, and community forums. Feedback was analyzed and incorporated into strategies addressing mental health access, housing stability, and culturally responsive services.
- Community strengths included strong provider collaboration, active cultural organizations, and peer support anchors for veterans. Needs focused on affordable housing (including couples options), mobile clinicians, transportation, family involvement in crisis protocols, and workforce strain. Priorities emphasized equity, homelessness prevention, youth and veteran support, and integration of mental health and substance use services. Representative quotes such as “Peer support is key. I trust someone who’s walked in my boots” and “Help by keeping married couples together” illustrate community voices shaping the plan.
- Documentation includes Advisory Committee meeting minutes (Dec 2024–Mar 2026), sign-in sheets, BHSA Priorities Survey summaries, and a comprehensive report of all CPP efforts.

Local Health Jurisdiction

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 Local Health Jurisdiction (LHJ) on the development of the LHJ's recent CHA and/or Community Health Improvement Plan (CHIP)?

- 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

The county engaged with our local health jurisdiction and Medi-Cal managed care plans (MCPs) through collaboration and stakeholder activities in the following ways:

- Collaboration: BHSA staff partnered closely with our LHJ during the development of the CHIP. This included attending planning workshops, contributing behavioral health expertise, and facilitating guided conversations to ensure behavioral health priorities were integrated into the overall strategy.
- Data-Sharing: BHSA supported a comprehensive understanding of community needs and helped align behavioral health indicators with broader health objectives during workshop sessions and discussions.
- Stakeholder Activities: BHSA actively participated in stakeholder engagement sessions organized by the LHJ, offering input on behavioral health trends and challenges. These activities ensured that behavioral health perspectives were represented in community discussions and decision-making processes.

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

- Yes

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+

- Other

During the most recent CHA/CHIP assessment cycle, BHRS did not have finalized

statewide behavioral health goals available for inclusion in the data-sharing process. As a result, those goals were not identified or incorporated at that time.

Was data shared?

- No

Data-Sharing from MCPS and LHJs to Support Integrated Plan (IP) development

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

- Access to Care
- Care Experience
- Engagement in School
- Engagement in Work
- Homelessness
- Institutionalization
- Justice Involvement
- Overdoses
- Prevention of Co-Occurring Physical Health Conditions
- Quality of Life
- Removal of Children from Home
- Social Connection
- Suicides
- Untreated Behavioral Health Conditions

To inform the development of the BHSA IP, Stanislaus County BHRS aligned its CPP with statewide behavioral health goals. While data-sharing from Medi-Cal MCPs and LHJs is encouraged statewide, BHRS proactively provided data on all the identified goals during CPP. This approach ensured transparency and enabled stakeholders to give meaningful feedback on where the county should align its priorities.

Statewide Behavioral Health Goals Addressed During CPP:

- Access to Care – BHRS shared utilization and access barrier data to identify gaps and improve navigation.
- Care Experience – Feedback on warm handoffs, culturally responsive care, and member experience was collected.
- Homelessness – Housing instability and service gaps were highlighted through community engagement.
- Overdoses and Suicides – County-level overdose trends and prevention strategies were presented in coalition meetings.
- Engagement in School and Removal of Children from Home– Insights from the Cradle to Career Mental Health Working Group informed strategies for youth and workforce engagement.
- Institutionalization and Justice Involvement – BHRS provided data on psychiatric

hospitalizations and justice-involved populations to guide CPP discussion.

- Prevention of Co-Occurring Physical Health Conditions – The LJH convened the Behavioral Health Action Work Group to collaborate with cross-sector partners to assess community-based behavioral health capacity, identify service gaps, and advance scalable models such as train-the-trainer and community champion approaches.
- Quality of Life/Social Connection/Untreated Behavioral Health Conditions/Engagement in Work- BHRS shared data and trends in various meetings to collect community feedback on priorities.

Impact of CPP Data Contribution:
By providing data on all these goals during CPP, BHRS enabled stakeholders including community members, advisory committees, and collaborative workgroups, to review trends and give feedback on where alignment with statewide goals was most critical. This feedback directly informed the priorities for the BHSA Integrated Plan and strengthened alignment with CHIP strategies.

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.
- Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.
- Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.

Most Recent CHA, 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?

- Yes

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP (2158 characters)
Stanislaus County BHRS has considered the LHJ most recent CHA and CHIP in preparing its Integrated Plan. StanCo Health is the county's health initiative framework led by the Local Health Jurisdiction (Stanislaus County Health Services Agency – Public Health) to coordinate community health assessment, planning, and implementation of the Community Health Improvement Plan. BHRS actively participates in the StanCo Health

governance and implementation efforts, including the Steering Committee and the Behavioral Health Action Work Group, which supports implementation of the CHIP's behavioral health priority strategies Through this involvement, BHRS aligns behavioral health priorities with county-wide health strategies, ensuring integration across planning processes.

How This Was Considered:

- BHRS is a standing member of the StanCo Health Steering Committee and the Behavioral Health Action Work Group, contributing data, expertise, and strategic input to CHA/CHIP priorities.
- CPP engagement incorporated CHIP-aligned goals such as suicide prevention, and improving access to care, ensuring consistency with county-wide public health improvement strategies.
- Participation in the StanCo Health governance structure, including the Steering Committee, provides a forum for cross-sector coordination that supports BHRS
- The Health Services Agency staff supporting StanCo Health participate in key BHRS community stakeholder meetings to ensure alignment between the CHIP and BHSA IP. These meetings include Mental Health Working Group, Opioid Safety Coalition, and Suicide Prevention Education Coalition.
- The Stanislaus County Health Leadership Council (HLC) is a cross-sector governance body established to advance system alignment, shared accountability, and coordinated implementation of community health priorities across Stanislaus County. Convened by County leadership, the Council brings together executive leaders from behavioral health, public health, hospitals, Medi-Cal managed care plans (MCPs), and key community partners to guide strategy, investment, and performance across the local health system. The HLC supports compliance with the Behavioral Health Services Act (BHSA) by ensuring integrated, cross-sector planning, stakeholder engagement, and alignment of behavioral health investments with broader population health strategies, consistent with state requirements for coordinated, community-driven planning and accountability. The foundational intent of the Stanislaus County Health Leadership Initiative—and the formation of the HLC—is to align historically siloed planning efforts into a unified, community-driven framework. This includes alignment across the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), Hospital Community Health Needs Assessments (CHNAs), CalAIM Population Health Management (PHM) requirements for MCPs, BHSA Integrated Planning, and hospital Community Benefit investments. Through this alignment, the Council reduces duplication, maximizes collective resources, and ensures major health system investments advance shared population health outcomes. By aligning assessment processes, identifying priority populations, and coordinating implementation strategies, the Council strengthens the County's ability to address behavioral health access, homelessness, substance use disorders, and health disparities while advancing a more integrated, person-centered system of care. Within the BHSA framework, the HLC plays a critical role in ensuring behavioral health planning is fully integrated with broader health system initiatives and provides a formal venue to align BHRS investments with MCP population health strategies, hospital community benefit programming, and public health priorities. The Health Leadership Council is intentionally structured to include executive-

level leadership with the authority to align policy, funding, and system-wide strategies. Membership includes leadership from key county agencies such as the Health Services Agency (HSA), Behavioral Health and Recovery Services (BHRS), and the Community Services Agency (CSA), along with Medi-Cal Managed Care Plans, hospital systems, Federally Qualified Health Centers, and community-based partners. To ensure geographic representation and diverse community perspectives, the Council also includes one representative from each of the County's five supervisorial districts.

This collaboration ensures that the BHSA IP reflects shared priorities across behavioral health and public health systems, reducing duplication and maximizing impact.

Medi-Cal Managed Care Plan Community Reinvestment

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

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

- Health Net
- Health Plan of San Joaquin
- Kaiser

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.

Through ongoing discussions between BHRS, LHJ, MCP partners, and other stakeholders involved in the BHSA community planning process, several areas of shared priority have been identified. These discussions reflect alignment between community-identified needs in the County's Integrated Plan and areas where MCP reinvestment strategies may support improved behavioral health outcomes.

Examples of prior collaboration and areas discussed during planning conversations include prior behavioral health workforce development, expansion of Community Health Worker (CHW) programs to improve engagement with underserved populations, interpreter and language access services to reduce barriers to care, and enhanced care coordination and community supports for individuals experiencing homelessness, serious mental illness, or substance use disorders. Partners have also discussed opportunities to strengthen multidisciplinary approaches that support individuals with complex behavioral health needs.

These countywide activities align with MCP-funded benefits and services and reflect BHSA community-identified priorities including workforce development, housing and homelessness interventions, culturally responsive care, and integrated service delivery. Together, they demonstrate a coordinated approach among Stanislaus County, MCPs, and community stakeholders to advance the goals outlined in the county's Integrated Plan.

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 will be released for stakeholder comment

- 04/28/2026

Date the stakeholder comment period will close

- 05/28/2026

Date of behavioral health board public hearing on draft IP is scheduled

- 05/28/2026

Please provide proof of a public posting with information on the public hearing.

- See attachment #4

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.

- www.stanislausmhsa.com

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

- BHRS will be taking the draft IP to public comment on April 28, 2026, and will circulate the plan via public posting, email, committee meetings, local library, and upon request.

Summarize the substantive revisions recommended this stakeholder during the comment period

- No substantive revisions to the FY 2026–2029 BHSA Integrated Plan were recommended during the public comment period that necessitated modification of the Plan. Stakeholder feedback generally expressed support for proposed priorities and implementation strategies while providing recommendations for future program implementation, community engagement, peer support integration, housing services, older adult services, workforce development, and ongoing system improvements. These comments will be considered during implementation and future planning efforts but did not require revisions to the Integrated Plan.

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, indicate N/A.

- N/A

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

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 related policy information, refer to 6.C.2 Securing Medi-Cal Payment.

For SMHS or for integrated SMHS/DMC-ODS contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027

- See Attachment #2

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

- No

Contracted Behavioral Health Services Act 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 and Number of contracted BHSA provider locations

MH services only

- 16

SUD services only

- 0

Both MH and SUD services

- 0

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 DMC-ODS) for SFY 2025-26

MH services only

- 16

SUD services only

- 0

Both MH and SUD services

- 0

All BHSA Provider Locations

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

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

1. Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS? (optional)
    - 57%

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

- 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
- Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and
- 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?

- No

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

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports

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

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General

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

- Children's System of Care (Non-FSP)
- Early Intervention Programs (EIP)
- Workforce, Education and Training (WET)
- Adult and Older Adult System of Care (Non-FSP)
- Outreach and Engagement (O&E)

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

Short-Term Residential Therapeutic Program (STRTP)

Please select the service types provided under Program

- Mental health services

Please describe the specific services provided

The Short-Term Residential Therapeutic Program (STRTP), established on January 1, 2017, through Assembly Bill 403, is a licensed residential program under the California Department of Social Services. STRTPs provide short-term, intensive therapeutic care for youth who cannot safely remain in a family setting. These programs operate 24 hours a day and offer structured supervision and individualized behavioral health services.

STRTPs serve Wards and Dependents of the Court as well as Non-Minor Dependents (NMDs). The purpose of the program is to help youth stabilize and prepare for transition to a less restrictive, family-based environment, typically within six months.

Behavioral health services are delivered through Medi-Cal agreements with BHRS in partnership with local STRTP providers to provide specialized mental health treatments tailored to each youth's needs and STRTPs integrate therapeutic interventions with daily living supports to address behavioral health needs in a structured, supportive environment. Services include:

- Individual and group therapy
- Rehabilitation
- Plan Development

- Intensive care coordination and case management
- Crisis intervention
- Medication support

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

- FY 2026 – 2027: 79
- FY 2027 – 2028: 80
- FY 2028 – 2029: 80

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

Projections for the number of individuals served through the Children's System of Care are based on historical utilization trends and policy changes impacting service responsibility. Specifically, SmartCare BHRS Report 113 shows a decrease in the number of unique individuals served over the past two fiscal years, which serves as the baseline for forecasting. This decline reflects both service utilization patterns and systemic changes.

A key assumption influencing projections is the implementation of AB 1051, which does not directly increase STRTP placements but significantly changes how services and payments are managed for Stanislaus County youth placed in out-of-county STRTPs. Under this legislation, BHRS is no longer responsible for providing or arranging behavioral health services for out-of-county foster youth or Wards placed in Stanislaus County STRTPs. This shift reduces the projected service volume for BHRS and requires close monitoring to assess its impact on access, equity, and outcomes, consistent with BHSA principles.

Forecasting also assumes:

- Stable STRTP bed capacity within the county.
- Continued emphasis on least restrictive settings, aligning with the Integrated Plan's goal of family-based care.
- No significant demographic changes in the Medi-Cal-eligible youth population.
- Penetration rates remain consistent with recent trends unless new initiatives expand access.

These assumptions and data points guide our projections and ensure alignment with the 3-Year IP priorities of access, quality, and outcome monitoring.

Therapeutic Foster Care (TFC)

Please select the service types provided under Program

- Mental health services

Please describe the specific services provided
Therapeutic Foster Care (TFC) is a short-term, intensive, trauma-informed intervention delivered in a family-based setting by a specially trained TFC parent. This service is designed for children and youth with complex emotional and behavioral needs who require frequent, individualized mental health support in a home environment rather than a residential facility.

TFC is available to Medi-Cal eligible children and youth under age 21 who meet medical necessity criteria for SMHS. Services are provided as part of a coordinated care plan developed through the Child and Family Team (CFT), ensuring alignment with the Behavioral Health System of Care principles of family engagement, cultural responsiveness, and least restrictive settings.

TFC includes one or more of the following service components:

- Rehabilitation
- Plan Development
- Intensive care coordination/target case management

The TFC parent, trained in trauma-informed and behavioral health interventions, works daily, up to 7 days per week, including evenings and weekends as medically necessary, to help the child or youth achieve individualized goals and objectives outlined in their treatment plan. These goals focus on improving emotional regulation, social functioning, and overall well-being, while supporting the youth's ability to remain in a family-like home within their community.

TFC functions as an adjunct service, complementing other SMHS interventions such as therapy, intensive care coordination target/case management, medication support and crisis support. By integrating intensive behavioral health strategies into a nurturing family environment TFC promotes stability, permanency, and recovery.

Please provide the projected number of individuals served during the plan period by FY:

- FY 2026 – 2027: 6
- FY 2027 – 2028: 6
- FY 2028 – 2029: 6

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care
Data for the TFC program was obtained through collaboration with contracted Foster Family Agencies (FFAs), which are responsible for recruiting and supporting resource parents trained to provide TFC services. FFAs reported that six homes with trained resource parents were successfully identified and certified to deliver TFC services. This information was validated through provider reports and BHRS contract monitoring.

TFC was recently implemented in Stanislaus County as part of the Children's System of Care continuum of therapeutic services designed to support youth with complex behavioral health needs in a family-based setting. As a newly established service, current

projections are informed by both the initial provider capacity and the anticipated need for a least restrictive, family-centered placement option.

Data reflects the unique requirements of TFC, which combines specialized therapeutic interventions with parenting in a family-based environment. These requirements can create challenges in identifying qualified resource parents. The County will continue to monitor program utilization, service demand, and the needs of youth within the system of care to inform future capacity planning and ensure alignment with BHSA principles of least restrictive care, family engagement, and equity.

Crisis Residential Unit (CRU)- TAY Ages

Please select the service types provided under Program

- Mental health services
- Supportive services
- SUD treatment services

Please describe the specific services provided

The Crisis Residential Unit (CRU) is a voluntary, short-term residential program designed to provide an alternative to hospitalization for individuals experiencing a behavioral health crisis. The program offers a recovery-oriented, environment where members receive intensive support and stabilization services. The standard length of stay is up to 30 days, with the option to extend to a maximum of 90 days based on clinical need and approval. The CRU emphasizes member choice, cultural responsiveness, and community integration, consistent with BHSA principles. The CRU serves individuals who are experiencing serious psychotic episodes or intense emotional distress who might otherwise face hospitalization or incarceration. Priority is given to those at risk of homelessness, hospitalization, or incarceration.

Target populations: TAY: Ages 18–25

Services and Activities include: The CRU provides 24/7 recovery-based treatment options, services and intervention focused on stabilization, recovery, and skill-building. Services include:

- Crisis Intervention & De-escalation: Immediate support to reduce distress and prevent hospitalization.
- Comprehensive Assessment: Physical, psychological, and behavioral health evaluations upon admission.
- Medication Support Services: Psychiatric evaluation and medication management Nursing support for medication administration and monitoring
- Individual and Group Counseling: Evidence-based interventions to promote coping and resilience.
- Substance Use Recovery Services: Integrated rehabilitation and recovery support

For co-occurring disorders.

- Daily Living Skills Training: Members participate in household activities to practice real-world recovery skills, including living and social/interpersonal skills.
- Housing Navigation: Assistance in identifying and accessing permanent housing

resources and community supports.

- Discharge Planning & Linkage: Coordination with outpatient providers, community resources, and support networks to ensure continuity of care.
- Referral for Higher-Level Care: When clinically indicated, referrals for 5150 crisis assessment or inpatient services are facilitated.

Please provide the projected number of individuals served during the plan period by FY:

- FY 2026 – 2027: 9
- FY 2027 – 2028: 9
- FY 2028 – 2029: 10

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

- Projections were based on historical utilization data extracted from SmartCare, the county's EHR system. SmartCare provides accurate counts of unique individuals served, service types, and program-level engagement, which formed the baseline for forecasting.
- Conservative Growth Model: Growth rates were applied incrementally (approximately 3–5% annually) to reflect modest increases in service demand, consistent with historical trends and anticipated system capacity. This approach assumes stable funding, no major expansion of bed capacity, and incremental efficiency improvements through better referral coordination and discharge planning.
- Priority populations (e.g., individuals at risk of hospitalization and/or incarceration) will continue to drive referrals.
- System Integration: Continued collaboration with Mobile Crisis, Behavioral Health, Access, Crisis and Support Line (ACSL) and hospital diversion programs will support steady referral flow without overwhelming capacity.
- These projections align with BHSA principles by emphasizing community-based stabilization, hospital diversion, and continuity of care, while remaining grounded in realistic operational capacity.

Crisis Response Team (CRT) – TAY Ages

Please select the service types provided under Program

- Mental health services
- Supportive services
- SUD services

Please describe the specific services provided

The Crisis Response Team (CRT) is a multidisciplinary team composed of Mental Health Clinicians, Psychiatric Nurses, Behavioral Health Specialists, and Certified Peer Support Specialists, many of whom hold 5150 designation privileges. CRT provides timely, culturally responsive, and community-based crisis intervention to individuals experiencing mental health, substance use, or co-occurring crises, supporting the BHSA goals of early intervention, equity, and integrated care. SUD services include crisis evaluations, screening and linking to SUD treatment.

Operating 24/7, CRT responds to hospitals for crisis evaluations, diversion planning, and safe discharge coordination, helping ensure continuity of care and preventing unnecessary institutionalization. CRT prioritizes language access and cultural responsiveness, offering bilingual Spanish services and interpreter support for other languages. For children and youth, CRT works closely with parents, guardians, and caregivers to restore stability and promote resilience, consistent with federal and state laws governing consent and confidentiality.

CRT also supports system integration by providing 5150 training and guidance for BHRS staff, contractors, and hospital partners. The team collaborates closely with the County's 24/7 Access Line to conduct live risk assessments and determine appropriate care pathways, ensuring "No Wrong Door" access and timely engagement in services.

Over the three-year BHSA IP period, BHRS will strengthen and expand the CRT model by consolidating several grant-funded and one-time funded mobile crisis programs into a coordinated Community Response Team structure. This approach will expand field-based behavioral health crisis response capacity and strengthen coordination with law enforcement, emergency medical services, hospitals, and other first responders. The enhanced CRT model will increase the County's ability to respond to behavioral health-related 911 calls, provide rapid community-based intervention, and connect individuals to ongoing behavioral health services and post-crisis supports.

To ensure the program is appropriately scaled to meet community needs, BHRS will analyze operational data related to crisis call volume, response patterns, and geographic coverage to inform staffing levels, deployment strategies, and service capacity. This data-informed approach will guide the continued development of a sustainable mobile crisis response system that improves access to behavioral health care and ensures individuals experiencing behavioral health crises receive timely, coordinated support in the least restrictive setting.

The CRT will strengthen continuity of care and improve engagement among culturally and ethnically diverse populations through the integration of ECHWs and Peer Navigators, creating a supportive service pathway beyond the initial crisis response by providing culturally responsive engagement and trust building. These services will emphasize coordinated care transitions from CRT into outpatient treatment teams and supportive services through warm handoffs, structured follow-up, and ongoing field-based engagement.

Please provide the projected number of individuals served during the plan period by FY:

- FY 2026 – 2027: 883
- FY 2027 – 2028: 927
- FY 2028 – 2029: 974

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

The county projected the number of individuals served through the Children's System of Care using historical utilization data from the SmartCare system, specifically the

BHRS_113 Unique Clients Served report and BHRS_153 Program Services report. Fiscal Year 2024–2025 was selected as the baseline year because it reflects recent service trends and program capacity. To estimate future utilization, the county applied a 5% annual growth rate, based on historical patterns, anticipated population growth, and expanded outreach efforts under CalAIM and BHSA strategic initiatives. This assumption supports planning for increased engagement and access to care, consistent with BHSA's goals of early intervention and equity.

Adult and Older Adult System of Care - Non-FSP Program

Crisis Residential Unit (CRU)- Adults/Older Adults
Please select the service types provided under Program

- Mental health services
- Supportive services
- SUD treatment services

Please describe the specific services provided

The Crisis Residential Unit (CRU) is a voluntary, short-term residential program designed to provide an alternative to hospitalization for individuals experiencing a behavioral health crisis. The program offers a recovery-oriented, environment where members receive intensive support and stabilization services. The standard length of stay is up to 30 days, with the option to extend to a maximum of 90 days based on clinical need and approval. The CRU emphasizes member choice, cultural responsiveness, and community integration, consistent with BHSA principles. The CRU serves individuals who are experiencing serious psychotic episodes or intense emotional distress who might otherwise face hospitalization or incarceration. Priority is given to those at risk of homelessness, hospitalization, or incarceration.

Target populations: Adults: Ages 26–59
Services and Activities include:

- The CRU provides 24/7 recovery-based treatment options, services and intervention focused on stabilization, recovery, and skill-building. Services include:
- Crisis Intervention & De-escalation: Immediate support to reduce distress and prevent hospitalization.
- Comprehensive Assessment: Physical, psychological, and behavioral health evaluations upon admission.
- Medication Support Services: Psychiatric evaluation and medication management Nursing support for medication administration and monitoring
- Individual and Group Counseling: Evidence-based interventions to promote coping and resilience.
- Substance Use Recovery Services: Integrated rehabilitation and recovery support

For co-occurring disorders.

- Daily Living Skills Training: Members participate in household activities to practice real-world recovery skills, including living and social/interpersonal skills.
- Housing Navigation: Assistance in identifying and accessing permanent housing

resources and community supports.

- Discharge Planning & Linkage: Coordination with outpatient providers, community resources, and support networks to ensure continuity of care.
- Referral for Higher-Level Care: When clinically indicated, referrals for 5150 crisis assessment or inpatient services are facilitated.

Please provide the projected number of individuals served during the plan period by FY:

- FY 2026 – 2027: 42
- FY 2027 – 2028: 44
- FY 2028 – 2029: 45

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

- Projections were based on historical utilization data extracted from SmartCare, the county's EHR system. SmartCare provides accurate counts of unique individuals served, service types, and program-level engagement, which formed the baseline for forecasting.
- Conservative Growth Model: Growth rates were applied incrementally (approximately 3–5% annually) to reflect modest increases in service demand, consistent with historical trends and anticipated system capacity. This approach assumes stable funding, no major expansion of bed capacity, and incremental efficiency improvements through better referral coordination and discharge planning.
- Priority populations (e.g., individuals at risk of hospitalization and/or incarceration) will continue to drive referrals.
- System Integration: Continued collaboration with Mobile Crisis, Behavioral Health, Access, Crisis and Support Line (ACSL) and hospital diversion programs will support steady referral flow without overwhelming capacity.
- These projections align with BHSA principles by emphasizing community-based stabilization, hospital diversion, and continuity of care, while remaining grounded in realistic operational capacity.

Crisis Response Team (CRT)- Adults/Older Adults

Please select the service types provided under Program

- Mental health services
- Supportive services
- SUD services

Please describe the specific services provided

The Crisis Response Team (CRT) is a multidisciplinary team composed of Mental Health Clinicians, Psychiatric Nurses, Behavioral Health Specialists, and Certified Peer Support Specialists, many of whom hold 5150 designation privileges. CRT provides timely, culturally responsive, and community-based crisis intervention to individuals

experiencing mental health, substance use, or co-occurring crises, supporting the BHSA goals of early intervention, equity, and integrated care. SUD services include crisis evaluations, screening and linking to SUD treatment.

Operating 24/7, CRT responds to hospitals for crisis evaluations, diversion planning, and safe discharge coordination, helping ensure continuity of care and preventing unnecessary institutionalization. CRT prioritizes language access and cultural responsiveness, offering bilingual Spanish services and interpreter support for other languages The CRT will strengthen continuity of care and improve engagement among culturally and ethnically diverse populations through the integration of ECHWs and Peer Navigators, creating a supportive service pathway beyond the initial crisis response by providing culturally responsive engagement and trust building. These services will emphasize coordinated care transitions from CRT into outpatient treatment teams and supportive services through warm handoffs, structured follow-up, and ongoing field-based engagement.

CRT also supports system integration by providing 5150 training and guidance for BHRS staff, contractors, and hospital partners. The team collaborates closely with the County's 24/7 Access Line to conduct live risk assessments and determine appropriate care pathways, ensuring "No Wrong Door" access and timely engagement in services.

Over the three-year BHSA IP period, BHRS will strengthen and expand the CRT model by consolidating several grant-funded and one-time funded mobile crisis programs into a coordinated Community Response Team structure. This approach will expand field-based behavioral health crisis response capacity and strengthen coordination with law enforcement, emergency medical services, hospitals, and other first responders. The enhanced CRT model will increase the County's ability to respond to behavioral health-related 911 calls, provide rapid community-based intervention, and connect individuals to ongoing behavioral health services and post-crisis supports.

To ensure the program is appropriately scaled to meet community needs, BHRS will analyze operational data related to crisis call volume, response patterns, and geographic coverage to inform staffing levels, deployment strategies, and service capacity. This data-informed approach will guide the continued development of a sustainable mobile crisis response system that improves access to behavioral health care and ensures individuals experiencing behavioral health crises receive timely, coordinated support in the least restrictive setting.

Please provide the projected number of individuals served during the plan period by FY:

- FY 2026 – 2027: 957
- FY 2027 – 2028: 1005
- FY 2028 – 2029: 1055

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.

The county projected the number of individuals served through the Adult and Older Adult

System of Care using historical utilization data from the SmartCare system, specifically the BHRS_113 Unique Clients Served report and BHRS_153 Program Services report. Fiscal Year 2024–2025 was selected as the baseline year because it reflects recent service trends and program capacity. To estimate future utilization, the county applied a 5% annual growth rate, based on historical patterns, anticipated population growth, and expanded outreach efforts under CalAIM and BHSA strategic initiatives. This assumption supports planning for increased engagement and access to care, consistent with BHSA's goals of early intervention and equity.

24/7 Mobile Crisis Services

Please select the service types provided under Program

- Mental health services
- Supportive services
- SUD services

Please describe the specific services provided

CRT provides mobile crisis services across community settings, including homes, schools, workplaces, and public spaces, to reduce reliance on emergency departments and inpatient facilities. CRT delivers rapid assessment, de-escalation, short-term stabilization, and linkage to ongoing supports, with interventions typically lasting 24 to 96 hours. Through BHRS's contracted provider, Telecare, 24/7 crisis response is available countywide, offering immediate, multidisciplinary intervention in the least restrictive environment. Services are person-centered and culturally responsive, with involvement of family and natural supports when appropriate and full compliance with privacy and minor-consent laws.

As BHRS strengthens its crisis continuum, multiple crisis response programs are being consolidated into a unified Community Response Team model. This restructuring enhances coordination with 988, 911, law enforcement, emergency medical services, and community providers, increasing the County's capacity to respond to behavioral health emergencies and improving timely access to field-based crisis care.

Under the BHSA framework, the CRT will transition into a fully integrated, sustainable, and data-driven crisis response system. Planned enhancements include expanded service capacity, consistent operating standards, shared technology platforms, and improved clinical specialization across youth, adult, and co-occurring substance use crises. The future model will operate as a comprehensive 24/7 field-based continuum with stronger interoperability between crisis lines, dispatch systems, mobile teams, first responders, and community treatment providers.

Through BHSA investments, the Community Response Team will evolve into a modern, equitable, and community-centered crisis response system that increases stabilization in the least restrictive setting, reduces avoidable hospitalizations and justice-system involvement, and ensures that all residents receive timely, coordinated behavioral health care where and when crises occur.

The CRT will strengthen continuity of care and improve engagement among culturally and ethnically diverse populations through the integration of ECHWs and Peer Navigators,

creating a supportive service pathway beyond the initial crisis response by providing culturally responsive engagement and trust building. These services will emphasize coordinated care transitions from CRT into outpatient treatment teams and supportive services through warm handoffs, structured follow-up, and ongoing field-based engagement.

Please provide the projected number of individuals served during the plan period by FY:

- FY 2026 – 2027: 1693
- FY 2027 – 2028: 1778
- FY 2028 – 2029:1867

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

The county projected the number of individuals served through the Adult and Older Adult System of Care using historical utilization data from the SmartCare system, specifically the BHRS_113 Unique Clients Served report and BHRS_153 Program Services report. Fiscal Year 2024–2025 was selected as the baseline year because it reflects recent service trends and program capacity. To estimate future utilization, the county applied a 5% annual growth rate, based on historical patterns, anticipated population growth, and expanded outreach efforts under CalAIM and BHSA strategic initiatives. This assumption supports planning for increased engagement and access to care, consistent with BHSA's goals of early intervention and equity.

Early Intervention Programs

Program or service name

- *Center for Human Services School Behavioral Health Integration (SBHI)*

Which of the three components of EI are included as part of the program or service

- Treatment Services and Supports: Other

Other:

The Early Intervention (EI) Program is a key element of the BHSA EI component, designed to identify and address behavioral health needs early in life to prevent escalation and promote long-term wellness. This program serves children, youth, and transitional-age individuals (0–21), with a focus on those from unserved and underserved communities and schools.

Target Population:

- Individuals experiencing early signs of a mental health or substance use disorder, including those newly identified in the behavioral health system or with limited prior engagement in services
- Families facing barriers to care due to socioeconomic, cultural, or geographic factors.

Service Model:

- Recovery-oriented interventions that emphasize resilience, family engagement, and culturally responsive care.

Services include:

- Individual and group therapy
- Rehabilitation
- Plan Development
- Intensive care coordination and target case management
- Crisis intervention
- Medication support

BHSA Alignment:

- Equity and Access: Prioritize underserved populations and reduce disparities.
- Early Action: Intervene before conditions worsen, promoting resilience and stability.
- Whole-Person Care: Trauma-informed, culturally competent, and strength-based services.
- Outcome-Driven: Support recovery and reduce long-term system involvement.

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

- No

Please describe intended outcomes of the program or service:

BHRS is currently in the planning phase. As implementation begins, BHRS will utilize Centers of Excellence (COEs), BHSA resources, and CalMHSA technical assistance, while adhering to DHCS requirements under BHSA, the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), and the EPSDT timeline. Implementation activities will include staff training, development of policies and procedures, and roll out of the implementation plan.

Intended outcomes:

- Equity and Access: Increase service utilization among unserved and underserved children and youth by reducing barriers through school-based and community settings, ensuring culturally responsive and trauma-informed care.
- Early Action: Detect and address behavioral health needs before they escalate, resulting in fewer crises, reduced psychiatric hospitalizations, and improved long-term mental health stability.
- Whole-Person Care: Strengthen resilience and recovery by providing individualized, family-centered interventions that improve emotional regulation, coping skills, and overall well-being.
- System Impact: Decrease future involvement in child welfare, juvenile justice, and intensive behavioral health services by intervening early and supporting recovery.
- Educational and Social Outcomes: Improve school attendance, academic performance, and social engagement by stabilizing behavioral health challenges.
- Advancing Equity: Reduce disparities in behavioral health outcomes for high-risk

populations, including homeless youth, justice-involved youth, and those with trauma histories.

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 projected number of individuals served during the plan period by FY:

- FY 2026-2027: 1141
- FY 2027-2028: 1255
- FY 2028-2029: 1380

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

To estimate the projected number of individuals served by the SBHI Early Intervention Program for the next three fiscal years, we utilized historical service data from SmartCare BHRS Report 113, which tracks unique individuals served annually. Over the past two fiscal years, the program demonstrated consistent growth in service volume, reflecting increased outreach, school-based integration, and demand within underserved communities.

- Baseline Data: The most recent fiscal year's actual service count was used as the starting point.
- Growth Rate: A 10% annual growth rate was applied to the baseline, based on observed trends in prior years and anticipated program expansion efforts.
- Assumptions: Continued Demand Growth: Increased awareness and integration within schools will sustain a 10% annual growth rate.
- Stable Funding and Staffing: Program capacity will expand proportionally to meet projected demand.
- No Major Policy or System Disruptions: Assumes no significant changes in eligibility, funding, or external factors that would reduce access.
- Referral Patterns Remain Consistent: Schools will continue to be the primary referral source, supported by community partnerships.

Program or service name

- *BHRS Children's Early Intervention (CEI)*

Which of the three components of EI are included as part of the program or service

- Treatment Services and Supports: Other

Other

BHRS CEI program focuses on children and youth who are new to the behavioral health system including those with a first-time diagnosis or minimal prior engagement. Services are intended to be individualized to focus on reducing barriers to care.

Target Population:

- Individuals experiencing early signs of a mental health or substance use disorder, including those newly identified in the behavioral health system or with limited prior engagement in services
- Families facing barriers to care due to socioeconomic, cultural, or geographic factors.

Service Model:

- Recovery-oriented interventions that emphasize resilience, family engagement, and culturally responsive care.

Services include:

- Individual and group therapy
- Family Counseling
- Rehabilitation
- Plan Development
- Intensive care coordination and targeted case management
- Crisis intervention
- Medication support
- Supportive Services- including Parent Partners and Peer Navigators

BHSA Alignment:

- Equity and Access: Prioritize underserved populations and reduce disparities.
- Early Action: Intervene before conditions worsen, promoting resilience and stability.
- Whole-Person Care: Trauma-informed, culturally competent, and strength-based services.
- Outcome-Driven: Support recovery and reduce long-term system involvement.

Please indicate if the program or service includes EBPs or CDEPs from the predefined DHCS biennial list for EI programs

- No

Please describe intended outcomes of the program or service

BHRS is currently in the planning phase. As implementation begins, BHRS will utilize Centers of Excellence (COEs), BHSA resources, and CalMHSA technical assistance, while adhering to DHCS requirements under BHSA, the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT), and the EPSDT timeline. Implementation activities will include staff training, development of policies and procedures, and roll out of the implementation plan, which is anticipated to begin in mid-2026.

- Multisystemic Therapy (MST)
- Functional Family Therapy (FFT)
- Parent-Child Interaction Therapy (P-CIT)

Below are interventions that are utilized as it is not an exhausted list:

- Motivational Interviewing

Intended outcomes:

- Equity and Access: Increase service utilization among unserved and underserved children and youth by reducing barriers through school-based and community settings, ensuring culturally responsive and trauma-informed care.
- Early Action: Detect and address behavioral health needs before they escalate, resulting in fewer crises, reduced psychiatric hospitalizations, and improved long-term mental health stability.
- Whole-Person Care: Strengthen resilience and recovery by providing individualized, family-centered interventions that improve emotional regulation, coping skills, and overall well-being.
- System Impact: Decrease future involvement in child welfare, juvenile justice, and intensive behavioral health services by intervening early and supporting recovery.
- Educational and Social Outcomes: Improve school attendance, academic performance, and social engagement by stabilizing behavioral health challenges.
- Advancing Equity: Reduce disparities in behavioral health outcomes for high-risk populations, including homeless youth, justice-involved youth, and those with trauma histories.

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 projected number of individuals served during the plan period by FY:

- FY 2026-2027: 434
- FY 2027-2028: 477
- FY 2028-2029: 524

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

Based on the increase in the number of unique individuals served over the past two fiscal years, as reported in the SmartCare BHRS Report 113, we are projecting a 10% growth in service volume for each upcoming fiscal year.

Program or service name

- *Behavioral Health Wellness Center*

Which of the three components of EI are included as part of the program or service

- Outreach
- Access and Linkage: Referrals

Please indicate if the program or service includes EBPs or CDEPs from the predefined DHCS biennial list for EI programs

- No

Please describe intended outcomes of the program or service
The Behavioral Health Wellness Center (BHWC) serves as a community-based early intervention resource designed to promote wellness, recovery, and social connection for individuals living with serious mental illness or co-occurring disorders. The BHWC provides a safe, welcoming, and stigma-free environment where members can accesspeer-driven supports before symptoms escalate to crisis or hospitalization.

Through peer support specialists and community engagement, the BHWC fosters resilience and recovery by offering opportunities for skill-building, social inclusion, and mutual support. Members participate in wellness and rehabilitative activities, including self-help groups, life skills training, and culturally responsive peer support. These services help individuals strengthen coping strategies, reduce isolation, and maintain stability in the community, key goals of early intervention under BHSA.

The BHWC also conducts outreach and engagement at community locations such as Modesto Gospel Mission, Turlock Gospel Mission, BHRS housing sites, schools, and local events. Outreach extends to surrounding cities including Oakdale, Patterson, and Turlock, ensuring equitable access to early intervention services across Stanislaus County.

Target Population: TAY: Ages 18–25; Adults: Ages 26–59; Older Adults: Ages 60+
The BHWC offers a variety of peer-led groups and activities that promote recovery and prevent symptom escalation, including:

- Self-help and wellness groups: Self-esteem, life skills, men's/women's groups, co-occurring support, LGBTQ+ group, Spanish peer support group
- Creative and social activities: Sewing group, music group, movie group
- Individual peer support: One-on-one sessions to provide guidance, encouragement, and linkage to community resources

These services are voluntary, culturally responsive, and recovery-oriented, supporting individuals in maintaining stability and reducing the likelihood of crisis or hospitalization.

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

- Yes

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program
Community-Based Wellness and Peer Support for Adults and TAY
The BHWC is included as an additional priority because it addresses a critical gap in early intervention for individuals living with serious mental illness or co-occurring disorders who are at risk of crisis or hospitalization. While not part of the standard Early Intervention priorities focused on children and youth, BHWC provides preventive, recovery-oriented support that align with BHSA goals of promoting wellness, reducing disparities, and preventing escalation of behavioral health needs. BHWC offers: Peer-driven support through self-help groups, life skills training, and culturally responsive peer support. Social inclusion activities to reduce isolation and foster resilience. Individual peer support sessions for guidance and linkage to housing, employment, and community resources. Outreach and engagement across Stanislaus County, ensuring equitable access for TAY, adults, and older adults. The county identified BHWC as an

additional priority because: It prevents symptom escalation and hospitalization, reducing long-term system involvement. It advances equity by providing culturally responsive, voluntary services in a stigma-free environment. It fills a gap for adults and older adults who are not served under standard EI programs focused on children/youth. Metrics for Measuring Effectiveness To demonstrate impact, the following metrics will be tracked: Engagement and Participation Number of individuals served by age group (TAY, adults, older adults) Attendance in peer-led groups and activities Recovery and Stability Outcomes Reduction in psychiatric hospitalizations or crisis interventions among participants Self-reported improvements in wellness, coping skills, and social connectedness Equity and Access Outreach contacts and engagement in underserved areas (e.g., Modesto Gospel Mission, rural cities) Participation in culturally responsive groups (e.g., Spanish peer support, LGBTQ+ group).

Please provide the projected number of individuals served during the plan period by FY:

- FY 2026 – 2027: 419
- FY 2027 – 2028: 436
- FY 2028 – 2029: 453

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

BHRS established its baseline projections using program-level data sources from the Behavioral Health Wellness Center, including sign-in logs, outreach contact logs, one-to-one peer support appointment records, and monthly service summaries. These sources were used to estimate participation across community-based activities and outreach efforts conducted through the Wellness Center. Individuals were deduplicated across onsite and outreach activities to ensure accurate counts and avoid double counting.

This approach reflects BHSA priorities by capturing engagement in community-based and culturally responsive settings and emphasizing early outreach and connection to behavioral health supports. Projections also consider historical participation trends and current program capacity.

The County is currently exploring opportunities to enhance data capture within its EHR system, SmartCare, to improve consistency in tracking participation, service utilization, and linkages to care. As EHR data capture capabilities are expanded, BHRS will continue monitoring participation trends and refining projections to support equitable access and outcome-driven planning.

Program or service name

- Behavioral Health Access, Crisis and Support Line

Which of the three components of EI are included as part of the program or service

- Outreach
- Access and Linkage: Screening

Please indicate if the program or service includes EBPs or CDEPs from the

predefined DHCS biennial list for EI programs

- No

Please describe intended outcomes of the program or service

The Behavioral Health ACSL is a toll-free, 24/7 live line that serves as the primary entry point for BHRS, supporting BHSA's strategic goals of early intervention, equitable access, and integrated care. Behavioral Health ACSL provides timely screening, linkage, and support to prevent escalation of behavioral health concerns and promote recovery.

- Early Identification and Engagement: Behavioral Health ACSL staff conduct initial screenings for mental health and substance use needs, verify eligibility, and connect individuals to the appropriate level of care within BHRS systems including Adult, TAY, Children, SUD, and Crisis services. This process ensures early identification and intervention, reducing barriers and aligning with CalAIM's "No Wrong Door" approach.
- Crisis and Support Services: Behavioral Health ACSL functions as a 24/7 crisis line, offering real-time emotional support, de-escalation, and coping strategies. When higher-level intervention is needed, ACSL partners with mobile crisis teams and clinicians to provide immediate, community-based response. Support calls also link individuals to essential resources such as housing, food, and peer support, addressing social determinants of health and promoting stability.
- Equity and Language Access: Behavioral Health ACSL provides bilingual staff and utilizes Language Line services to ensure care is delivered in the caller's preferred language, advancing BHSA's commitment to culturally responsive and equitable services.

By serving as a centralized access point, Behavioral Health ACSL helps individuals engage in care early, navigate complex systems, and receive coordinated services that support recovery and resilience.

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 projected number of individuals served during the plan period by FY:

- FY 2026 – 2027: 1817
- FY 2027 – 2028: 1890
- FY 2028 – 2029: 1965

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

Projections were developed using historical utilization data from the SmartCare system, specifically the BHRS_113 Unique Clients Served report and BHRS_153 Program Services report. Fiscal Year 2024–2025 served as the baseline year for estimating service demand. To project future utilization, the county applied a 5% annual growth rate, which reflects anticipated population growth, increased outreach efforts, and expanded access under early intervention initiatives. This assumption aligns with historical trends and strategic goals to improve engagement and reduce barriers to care.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

Program Name

- *Coordinated Specialty Care- First Episode Psychosis (CSC-FEP) operated by Sierra Vista Life Path*

Please describe the program or service

The Lasting Independence Family Empowerment (LIFE) Path Early Psychosis Intervention (EPI) program supports individuals aged 14-25 years of age experiencing early symptoms of psychosis through culturally responsive treatment, education, and connection to behavioral health and community resources. The program focuses on empowering individuals and their families to build hope and maintain stability through early identification, engagement in services, and coordinated support. Staff play a pivotal role in supporting recovery by advocating for members and family members, facilitating communication between treatment providers and families, and often serving as a liaison between hospitals and outpatient programs to ensure continuity of care during critical transition periods.

In conjunction with direct services for individuals experiencing early psychosis, the Coordinated Specialty Care- First Episode Psychosis (CSC for FEP) program provides education, support, and navigation services for families whose loved ones are experiencing the early stages of psychosis. The program educates families about the signs and symptoms associated with the onset of psychosis and assists them in accessing and navigating behavioral health services. Family members receive guidance and support as they cope with the illness of a loved one, helping strengthen engagement in treatment and long-term recovery outcomes. The program also collaborates with community partners to increase awareness of early psychosis, provide education on early warning signs, and expand outreach to underserved populations.

Through the BHSA requirements, the County will strengthen and expand the LIFE Path CSC for FEP for ages beyond 14-25. The enhanced program will emphasize early identification and rapid engagement in treatment, coordinated team-based care, family education and support, and connections to supportive services that promote recovery and long-term stability. Outreach and community education efforts will continue to focus on improving recognition of early psychosis and reducing barriers to care so individuals experiencing first episode psychosis can access services as early as possible. Through these efforts, the program will strengthen access to coordinated, evidence-based behavioral health services and support recovery-oriented outcomes for individuals and families experiencing early psychosis.

Review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the BH-CONNECT EBP Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county below.

**DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. 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. These projections are not binding and are for planning purposes.*

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	106
Number of Uninsured Individuals	9

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	12.75
Number of Teams Needed to Serve Total Eligible Population	3

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, 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	4	7	13
Total Number of Teams	1	2	3

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

- Yes

Please list other funding sources

- To ensure robust and sustainable funding for our CSC-FEP program, we will leverage Medi-Cal Federal Financial Participation.

Outreach and Engagement (O&E) Program

Program Name

- *Assisted Outpatient Treatment*

Please describe the program or service

The Assisted Outpatient Treatment (AOT) program serves individuals with SMI who meet strict legal criteria and often experience symptoms that impair their ability to recognize the need for care. The primary goal of AOT is to engage individuals in voluntary, community-based behavioral health services and reduce barriers to treatment through intensive outreach and coordination. Court-ordered treatment is used only when necessary to facilitate access to care and support safety.

In alignment with BHSA principles of equity, access, and whole-person care, the AOT program focuses on timely linkage to appropriate BHRS programs, prioritizing the least restrictive and most clinically appropriate interventions.

Through collaboration with qualified referring parties, the AOT team conducts targeted outreach and engagement and completes comprehensive assessments for adults and transitional aged youth to evaluate eligibility, engagement level, and risk factors. AOT staff work closely with BHRS treatment teams to support sustained engagement, monitor progress, and continually assess whether court involvement remains necessary.

This approach reflects BHSA's commitment to voluntary participation whenever possible, family engagement, and culturally responsive care.

Target Population: TAY: 18–25; Adults: 26–59; Older Adults: 60+

Services and Activities include:

- Case management and care coordination
- Brief therapy and psychoeducation
- Mental health assessments and risk evaluations
- Psychosocial rehabilitation to build coping skills
- Linkages to housing, benefits, and community resources
- Referrals to medical care and Enhanced Care Management
- Warm hand-offs to treatment teams for continuity of care
- Referrals and admission to Behavioral Health Bridge Housing
- Outreach in hospitals, homeless encampments, and shelters
- Provision of basic needs (clothing, food, hygiene kits, pet supplies) to address members' immediate needs while fostering trust, stability, and ongoing engagement
- Transportation assistance for access to treatment and supports

By integrating trauma-informed practices, whole-person care, and cross-system collaboration, AOT advances the 3-Year IP goals of improving access, reducing disparities, and achieving better outcomes for individuals with the most complex needs.

Please provide the projected number of individuals served during the plan period by FY:

- FY 2026 – 2027: 80
- FY 2027 – 2028: 84
- FY 2028 – 2029: 88

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

Projections for the number of individuals served through the AOT team were based on historical utilization data from SmartCare, current program capacity, and anticipated outreach expansion efforts.

Program Name:

- *Behavioral Health Outreach and Engagement*

Please describe the program or service

The Behavioral Health Outreach and Engagement (BHOE) team provides outreach, engagement, care coordination, and linkage services to unserved and underserved adults and transitional age youth who may need or request specialty behavioral health services but are not currently connected to outpatient treatment. BHOE will primarily support individuals transitioning from psychiatric hospitals and emergency departments (EDs), serving as a key County strategy to strengthen connections to care following ED visits and inpatient psychiatric stays. Through structured follow-up and coordinated care transition processes, the program is intended to improve performance on FUM-7 and FUM-30 measures while strengthening continuity of care. Consistent with BHSA principles and the County's 3-Year Integrated Plan priorities, BHOE is designed to reduce barriers to care, improve timely access to services, and promote equitable engagement in ongoing behavioral health treatment.

Program Structure

BHOE operates through two integrated program tracks:

• Community Outreach and Linkage Services

- Engages individuals referred through county departments, community partners, the County Access Center, ED settings, and the Assisted Outpatient Treatment (AOT) program.
- Provides behavioral health screening, case management, system navigation, and linkage to specialty mental health and substance use disorder (SUD) services.
- Connects individuals who do not meet specialty mental health criteria to managed care plans and community-based resources.
- Maintains engagement as clinically appropriate to support successful connection to ongoing care.

• Inpatient and ED Care Transition Services

- Serves adults and transitional age youth presenting in emergency departments or placed on involuntary psychiatric holds in local or out-of-county inpatient psychiatric facilities.
- Initiates discharge planning in coordination with hospital providers and facilitates pre-discharge linkage to outpatient care, including scheduling follow-up appointments when possible.
- Provides intensive post-discharge outreach and care coordination to ensure continuity of care and reduce gaps in service.

Core Services and Activities

Services are delivered by a multidisciplinary team of Behavioral Health Specialists, Clinicians, Peer Specialists, and Family Advocates using a whole-person, trauma-informed approach, including:

- Mental health assessments and brief therapeutic interventions
- Case management and psychosocial rehabilitation
- Peer support and family engagement
- Warm hand-offs to outpatient treatment teams and community providers
- Linkages to specialty mental health, SUD treatment, medical care, and Enhanced Care Management

- Referrals to Behavioral Health Bridge Housing and other supportive housing resources
- Outreach in emergency departments, hospitals, shelters, encampments, and community settings
- Basic needs support and transportation assistance to reduce barriers to engagement

Structured Follow-Up and Care Transition Protocols
To strengthen continuity of care following ED visits and hospitalizations, the County will implement standardized BHOE protocols that include:

- Rapid post-discharge outreach, with initial contact within 24–72 hours
- Coordinated outpatient hand-offs, including pre-scheduled appointments and direct communication with receiving providers
- Structured 7-day and 30-day follow-up aligned with FUM-7 and FUM-30 measures
- Peer and Enhanced Community Health Worker (ECHW) navigation supports to address engagement barriers
- Ongoing monitoring and engagement until individuals are successfully linked to and participating in ongoing care

These protocols are coordinated with START, Crisis Response Teams, ED partners, homeless outreach, and justice system programs to ensure a consistent, countywide approach to access, referral, and follow-up.

Target Population

- Transitional Age Youth (18–25)
- Adults (26–59)
- Older Adults (60+)

System Impact
Through its role in outreach and care transitions, BHOE will:

- Improve timely access to outpatient behavioral health services following ED visits and inpatient stays
- Increase FUM-7 and FUM-30 follow-up rates
- Reduce avoidable hospital readmissions and repeat ED utilization
- Strengthen engagement among populations with historically low access to care
- Improve continuity of care for individuals experiencing homelessness and those with complex behavioral health needs

Please provide the projected number of individuals served during the plan period by FY:

- FY 2026 – 2027: 1723
- FY 2027 – 2028: 1792
- FY 2028 – 2029: 1864

Please describe any data or assumptions the county used to project the number of individuals served through O&E programs
Projections for the number of individuals served through the BHOE team were based on historical utilization data from SmartCare, current program capacity, and anticipated

outreach expansion efforts.

Data Sources and Methodology:

- SmartCare Reports provided unduplicated counts of adults and older adults served in BHOE and related outreach programs over the past two fiscal years.
- Baseline Trends: FY 2023–2024 actuals and FY 2024–2025 estimates were analyzed to establish a starting point for projections.
- Program Capacity: Current staffing levels and outreach coverage informed assumptions about service reach.
- Community Need: Referrals from hospitals, shelters, and encampments, as well as county demographic data, were considered to estimate demand among unserved and underserved populations.

County Workforce, Education, and Training (WET) Program

Program Name

- *Continuing Education Program*

Please select which of the following categories the activity falls under

- Continuing Education

Please describe efforts to address disparities in the Behavioral Health workforce

The Behavioral Health Workforce Development Department provides a comprehensive Continuing Education (CE) Program designed to support staff in meeting licensure, certification, and competency requirements across MH, SUD, and Peer Support disciplines. As an approved CE provider for CAMFT, ACE, the Board of Registered Nursing, all three Alcohol and Other Drug (AOD) certifying bodies (CCAPP, CADTP, CAADE), and Peer Support Specialist continuing education, the department offers a wide range of high-quality trainings accessible to staff across the system of care.

- CAMFT (California Association of Marriage and Family Therapist) Continuing Education Program
- ACE (Association for Continuing Education) Provider Program
- Board of Registered Nursing Continuing Education Program
- AOD Continuing Education Programs (CCAPP, CADTP, CAADE)
    - California Consortium of Addiction Programs and Professionals (CCAPP)
    - California Association of DUI Treatment Programs (CADTP)
    - California Association for Alcohol/Drug Educators (CAADE)
        - Peer Support Specialist Continuing Education Program

Staff receive paid CE time annually, reducing barriers to participation and ensuring equitable access to required coursework. Offerings include Law & Ethics, Trauma-Informed Care, Clinical Supervision, Motivational Interviewing, Cultural Humility, crisis intervention topics, SUD specialty trainings, and skill-building workshops relevant to diverse service settings. Trainings are scheduled throughout the year and strategically

selected based on regulatory requirements, workforce data, and program needs. This program ensures that staff maintain up-to-date knowledge, remain compliant with professional standards, and continue developing evidence-based skills necessary for providing effective, member-centered care.

The CE Program actively advances equity and supports a more culturally responsive and representative behavioral health workforce. Many CE offerings focus on culturally informed practice, including cultural humility, working with LGBTQ+ communities, serving immigrant and refugee populations, addressing systemic barriers, and understanding trauma through a cultural lens. These trainings enhance staff capacity to provide appropriate services to underserved populations. By offering CE programs across multiple credentialing pathways, including MH clinicians, nurses, SUD counselors, and Peer Support Specialists, the program expands access to advancement opportunities for individuals from varied educational backgrounds and those with lived experience. The inclusion of paid CE hours reduces financial and workload barriers that disproportionately impact early-career professionals and staff from low-income or marginalized communities.

Additionally, CE content is reviewed to ensure alignment with state initiatives aimed at reducing disparities in behavioral health outcomes. This approach promotes greater equity in training access, clinical competence, and workforce development across the entire system of care.

Program Name:

- *Behavioral Health Internship and Student Placement Program*

Please select which of the following categories the activity falls under

- Internship and Apprenticeship Programs

Please describe efforts to address disparities in the Behavioral Health workforce

The Behavioral Health Internship and Student Placement Program provides structured opportunities for students to explore and develop careers in behavioral health. For high school students, the program hosts a Summit featuring panelists and discussions designed to introduce behavioral health career pathways, highlight workforce needs, and foster interest in the field. For undergraduate and graduate students, interns are placed in clinical, peer support, counseling, and administrative roles across MH and SUD programs, gaining hands-on experience and exposure to community events and outreach activities. The program offers individualized supervision, group supervision, and advanced clinical oversight for interns at the college and graduate level. Internal staff also have access to clinical supervision opportunities for professional growth. Career development is supported through workshops, mentoring, and networking opportunities, helping students develop the knowledge and skills necessary for a successful behavioral health career.

The Internship and Student Placement Program is designed to reduce barriers and

expand access to behavioral health careers for students from diverse and historically underrepresented backgrounds. Recruitment emphasizes cultural, racial, and linguistic diversity, ensuring that interns reflect the communities they will serve. For high school students, the Summit provides early exposure to the field, fostering interest among students who may not have prior awareness of behavioral health careers. College and graduate-level internships include culturally responsive supervision, equity-focused training, and mentorship to prepare staff to serve diverse populations effectively. Partnerships with local and regional schools strengthen the homegrown workforce and promote continuity of culturally competent care in underserved communities.

Program Name:

- *Clinical Supervision for Behavioral Health Staff*

Please select which of the following categories the activity falls under

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

Please describe efforts to address disparities in the Behavioral Health workforce

The Workforce Development and Training Department provides supervision and mentorship to all levels of staff, including interns, early-career professionals, and licensed clinicians. Services include individual and group supervision, advanced clinical consultation, and guidance on professional development. Supervision ensures staff apply evidence-based practices, maintain compliance with policies and regulations, and develop skills needed to deliver high-quality behavioral health services. Supervisors provide structured support, including regular check-ins, performance feedback, and opportunities for skill-building in clinical and administrative areas. This approach helps staff gain confidence, improve job performance, and progress toward professional licensure or career advancement.

Supervision emphasizes culturally responsive practices and equity, ensuring that staff from diverse backgrounds receive the guidance needed to succeed. By providing support to staff across all levels, including those from historically underrepresented communities, the department fosters a diverse and capable workforce. Supervision also promotes retention and development of staff who reflect the cultural and linguistic backgrounds of the populations served, enhancing access to culturally competent care for the community.

Program Name:

- *Workforce Development & Training Department*

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
The Workforce Development and Training Department provides a comprehensive range of services to support staff at all levels, including professional development, onboarding, evidence-based practice (EBP) training, career pathway development, and workforce mentoring. The department has expanded significantly, growing from 4 to 15 staff and increasing training offerings from 55 to over 160 sessions annually. These trainings span clinical skills, cultural competence, leadership, and community engagement, ensuring staff are equipped to deliver high-quality, member-centered care. The department also supports interns, provides supervision guidance, and developed a Trainee position to create structured learning opportunities for early-career staff, strengthening the pipeline of future behavioral health professionals.uA component of the department's workforce strategy is the Loan Repayment Program (LRP), which provides targeted support to staff applying for loan repayment opportunities through CalMHSA and the California Department of Health Care Access and Information (HCAI). Workforce Development staff offer technical assistance with eligibility requirements, application processes, documentation, and timelines, while also preparing staff to meet service obligations tied to loan repayment awards. This effort increases access to financial incentives that reduce student loan burden and supports retention in hard-to-fill and high-demand positions.u
Together, these workforce development initiatives strengthen recruitment, retention, and overall workforce capacity. The department integrates equity-focused strategies to reduce barriers for individuals from low-income backgrounds and communities historically underrepresented in higher education and behavioral health professions. By expanding trainee and internship opportunities, supporting career pathways, and connecting diverse staff to financial supports like loan repayment, the department promotes a workforce that reflects the cultural, linguistic, and lived experiences of the communities served. These efforts improve service accessibility, cultural responsiveness, and continuity of care for underserved populations.

In addition, BHRS is actively strengthening partnerships with local universities and colleges to expand behavioral health academic program capacity. Current data indicate that workforce challenges are driven not only by recruitment gaps, but by limited educational capacity, with many qualified applicants unable to enroll due to restricted program slots. To address this bottleneck, BHRS collaborates with academic institutions and behavioral health providers to expand internship and practicum placements, which are critical to program growth. By increasing training opportunities and strengthening the education-to-employment pipeline, BHRS is advancing long-term workforce sustainability and ensuring a steady flow of qualified professionals into the local behavioral health system.cc

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

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

Table 16. Estimated Number of Individuals Eligible for Full-Service Partnership Services

Total Adult FSP Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	2001
Number of Uninsured Individuals	229
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	846

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

Input the estimates provided to the county in the table below

ACT Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	314
Number of Uninsured Individuals	36

FACT Eligible Population (ACT with Justice-System Involvement)	**Estimates**
Number of Medi-Cal Enrolled Individuals	157
Number of Uninsured Individuals	18

ACT/FACT Practitioners and Teams Needed	**Estimates**

Number of Practitioners Needed to Serve Total Eligible Population	60
Number of Teams Needed to Serve Total Eligible Population	6

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 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	60	60	60
Total Number of Teams	6	6	6

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

Input the estimates provided to the county in the table below

FSP ICM Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	1530
Number of Uninsured Individuals	175

FSP ICM Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	70
Number of Teams Needed to Serve Total Eligible Population	14

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 Practitioners	70	70	70
Total Number of Teams	14	14	14

High Fidelity Wraparound (HFW) Eligible Population
Input the estimates provided to the county in the table below

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	566
Number of Uninsured Individuals	73

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	212
Number of Teams Needed to Serve Total Eligible Population	4

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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	47	75	75
Total Number of Teams	9	15	15

Individual Placement and Support (IPS) Eligible Population
Input the estimates provided to the county in the table below

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	2828
Number of Uninsured Individuals	331

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	197.5
Number of Teams Needed to Serve Total Eligible Population	79

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	4	7	14
Total Number of Teams	2	3.5	7

FSP Program Overview
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
The answer depends on how the county ultimately structures the ACT/FACT teams and the IPS program. For example, if ACT/FACT operate as a single program versus standalone programs, practitioner responsibilities may differ. Similarly, the degree to which IPS housing and employment specialists are dedicated solely to IPS or whether they will also support ACT/FACT functions, will affect whether they provide more than one EBP.

Our goal is for each practitioner to provide only one EBP. However, there may be occasions when cross-coverage is necessary. These details are still being finalized as part of our planning process.

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports
Stanislaus County BHRS employs a whole-person, trauma-informed approach across its Full-Service Partnership (FSP) programs and broader BHSA initiatives. This approach is grounded in the principles of person-centered care, cultural responsiveness, and family engagement, ensuring that services address behavioral health needs alongside social determinants such as housing, employment, and community integration.

Whole-Person Care
FSP teams operate under the "Whatever It Takes" philosophy, providing flexible, individualized supports across multiple life domains:

- Housing stability through navigation, landlord engagement, and tenancy support.
- Employment and education assistance, including Individual Placement and Support (IPS) for vocational goals.
- Physical health integration via linkages to primary care and Enhanced Care Management.
- Social connection and community integration through peer-led groups and culturally specific resources.

Trauma-Informed Practices
All FSP programs embed trauma-informed principles:

- Staff receive training in Trauma-Informed Care, Motivational Interviewing, and culturally responsive engagement.
- Services prioritize safety, trust, and empowerment, reducing traumatization and promoting resilience.
- Interventions are delivered in least restrictive settings, often in homes or community locations, to minimize stress and stigma.

Partnership with Families and Natural Supports

- Family advocates and peer specialists are integral to FSP teams, ensuring lived experience informs care.
- HFW and CFT meetings occur regularly, incorporating caregivers and natural supports into treatment planning.
- For youth and families, BHRS expands school-based behavioral health services and collaborates with child welfare and juvenile justice systems to strengthen family functioning and prevent unnecessary out-of-home placements.
- For adults, engagement includes peer support networks, culturally affirming community organizations, and linkage to mutual aid groups (AA, NA, LGBTQ+ resources).

Evidence-Based and Culturally Responsive Services

- FSP programs implement ACT for individuals with complex needs and evaluate implementation of Forensic ACT services for members with justice involvement.
- Services are tailored to cultural and linguistic needs, with targeted outreach to underserved populations such as Latino, LGBTQ+, and rural communities.
- Workforce development initiatives focus on recruiting bilingual/bicultural clinicians and peers, reinforcing equity and trust.

Continuous Engagement and Flexibility

- BHRS offers a tiered continuum of care, allowing members to move between levels without losing connection to their treatment team.
- Engagement strategies extend beyond program closure, including access to wellness centers, housing supports, and peer-led activities to sustain recovery.

Through FSP programs and system-wide initiatives, Stanislaus County BHRS delivers integrated, trauma-informed, and culturally responsive care that actively involves families and natural supports. This approach promotes recovery, reduces disparities, and strengthens community-based solutions for individuals with the most complex behavioral health needs.

Please describe the county's efforts to reduce disparities among FSP participants
Stanislaus County BHRS is committed to equity-driven, whole-person care within its FSP programs. Guided by the BHSA principles, our efforts to reduce disparities among FSP

participants focus on access, cultural responsiveness, and outcome equity for populations historically underserved or experiencing poor behavioral health outcomes.

Data-Driven Identification of Disparities

- BHRS uses SmartCare system data, DHCS penetration rates, and local Community Health Assessment findings to identify gaps in access and outcomes by race/ethnicity, language, age, gender identity, and geography.
- Priority populations include Latino residents, LGBTQ+ individuals, rural communities, justice-involved adults, and youth in child welfare.

Culturally Responsive and Linguistically Appropriate Services

- FSP teams integrate bilingual/bicultural clinicians and peer specialists to address language and cultural barriers.
- Staff receive ongoing training in cultural humility, trauma-informed care, and equity-focused engagement, ensuring services are affirming and inclusive.

Family and Natural Support Engagement

- Peer and family advocates with lived experience strengthen trust and reduce stigma, particularly for communities historically marginalized.

Targeted Outreach and Engagement

- BHRS deploys BHOE and CARE Teams to reach individuals in high-need areas, including homeless encampments, shelters, and rural communities.
- Outreach strategies emphasize relationship-building, overdose prevention, and culturally tailored messaging to engage those disconnected from traditional services.

Integration of Social Determinants of Health

- FSP programs provide housing navigation, employment support, and transportation assistance, addressing structural barriers that disproportionately impact underserved populations.
- Partnerships with schools, justice system, MCPs, and community-based organizations ensure coordinated care for youth, families, and adults with complex needs.

Continuous Monitoring and Quality Improvement

- BHRS tracks engagement, timeliness, and outcomes by demographic group to identify disparities and adjust strategies.
- Equity metrics are incorporated into Quality Improvement Plans (QIP) and reviewed quarterly to ensure accountability.

Through data-driven planning, culturally responsive practices, family engagement, and integrated supports, Stanislaus County BHRS actively works to reduce disparities among FSP participants. These efforts align with BHSA priorities for equity, access, and whole-person care, ensuring that individuals with the most intensive behavioral health needs

receive services that are inclusive, effective, and recovery-oriented.

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

- Access to care
- Institutionalization
- Justice involvement
- Homelessness
- Untreated behavioral health conditions
- Care experience

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

Stanislaus County BHRS provides a comprehensive, recovery-oriented system of care to ensure individuals enrolled in FSP ICM remain actively engaged throughout their treatment journey. Our approach is grounded in the "whatever it takes" philosophy, emphasizing flexibility, person-centered planning, and integrated supports across multiple life domains.

Continuum of Care and Flexibility

BHRS utilizes a tiered model of care to match service intensity to member needs, allowing individuals to transition seamlessly between levels without losing connection to their treatment team.

- Assertive Community Treatment: For members requiring intensive, day-to-day support, including 24/7 crisis intervention. Services may occur several times per day, multiple days per week, delivered in the community to reduce barriers and promote engagement.
- Intensive Case Management: Members who require intensive but less frequent services, typically on a weekly basis, delivered in outpatient or community settings, will be served in Intensive Case Management (ICM) programs under BHSA. These programs are designed to ensure that members transitioning from ACT receive a structured level of care that balances flexibility with comprehensive support. ICM focuses on maintaining engagement, promoting stability, and addressing individualized needs through coordinated interventions in the community. By transitioning these members to ICM, we aim to provide a more sustainable model of care that emphasizes recovery-oriented practices while optimizing resources for those who need consistent, yet less frequent, intensive services.
- Wellness / Step-Down Level: For members who have stabilized and require lower-intensity support, such as medication management and monthly check-ins as they are transitioned to a managed care or community provider.

At every level, ongoing assessment of functioning ensures individuals receive the appropriate intensity of care. This flexibility allows members to move up or down as needed while maintaining relationships with a consistent team, critical for engagement

and trust.

Wraparound Services Across Life Domains
The BHST employs BHSA-designated Evidence-Based Practices (EBPs) to provide comprehensive psychosocial rehabilitation. These practices extend beyond symptom reduction and include coordinated support across key life domains such as mental health, medication management, housing, social connections, employment, education assistance, and substance use treatment. Grounded in Whole-Person care and social determinants of health principles, BHST services promote long-term recovery and community integration. Counties implementing these EBPs through the BHSA are required to maintain fidelity to each model and utilize established pathways—including Full-Service Partnership (FSP) and Behavioral Health Services and Supports (BHSS)—to ensure equitable, high-quality care.

Comprehensive Clinical and Recovery Services
FSP ICM teams provide a full array of clinical and rehabilitative services to promote engagement and recovery:

- Individual therapy and psychosocial rehabilitation.
- Case management and linkage to community resources.
- Medication support and monitoring.
- Crisis prevention and intervention.
- Group therapy and skill-building groups.
- Linkage to SUD treatment, including ASAM-based screening and referrals for MAT.
- Connection to community-based supports such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), LGBTQ+ resources, and other culturally responsive services.

Housing and Social Support
Stable housing is a cornerstone of recovery. BHRS prioritizes housing interventions for FSP members who are homeless or at risk, providing housing navigation, landlord engagement, and tenancy support. Social connection is reinforced through peer-led wellness groups, community activities, and family engagement.

Peer and Family Support
Peer support specialists and family advocates are integral to the FSP model. Their lived experience fosters trust, reduces stigma, and enhances engagement. Peer-led groups and community-based activities promote resilience and recovery.

Employment Support Services
BHRS offers supported employment for individuals with psychiatric disabilities, providing on-the-job coaching, job placement, and retention support. Additional services include education assistance, vocational training, and career development, helping members achieve meaningful roles in the community.

Integrated Care and Collaboration
Engagement is sustained through collaboration with primary care providers, SUD

programs, and community organizations. Care coordination ensures that individuals receive whole-person care, addressing physical health, behavioral health, and social determinants.

Through flexible levels of care, wraparound supports, and integrated recovery-oriented services, BHRS ensures that individuals receiving FSP ICM remain engaged throughout their treatment journey. This approach aligns with BHSA priorities for person-centered, culturally responsive, and community-based care, promoting stability, resilience, and long-term recovery.

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

Stanislaus County BHRS recognizes that ongoing engagement is essential for recovery and stability, particularly for members with complex behavioral health needs. While we provide ongoing engagement required under EBPs, including ACT, FACT, FSP ICM, HFW, and IPS, we also provide additional engagement strategies that go beyond the core requirements of these models. These enhancements reflect our commitment to whole-person care, cultural responsiveness, and community integration, consistent with BHSA priorities. BHRS invests in proactive outreach to unserved and underserved individuals, even before or outside of formal EBP enrollment.

Outreach and Engagement Beyond EBP Enrollment

The BHOE team conducts community-based outreach to individuals who may only access episodic or crisis care.

- BHOE staff build trust through culturally responsive engagement, develop individualized intervention plans, and connect individuals directly to treatment and supportive services.
- This approach ensures that people who might otherwise fall through the cracks are engaged early and linked to appropriate care.

Coordination Across Systems

Beyond EBP requirements, BHRS emphasizes cross-system collaboration to address the full spectrum of member needs:

- Coordination with primary care providers for integrated physical and behavioral health.
- Collaboration with substance use treatment programs, housing agencies, and social service organizations.
- Linkage to community-based supports, including mutual aid groups (AA, NA), LGBTQ+ resources, and culturally specific organizations.
- This integrated approach reduces fragmentation and promotes sustained engagement.

Wraparound Services Across Life Domains

The BHST employs BHSA-designated Evidence-Based Practices (EBPs) to provide

comprehensive psychosocial rehabilitation. These practices extend beyond symptom reduction and include coordinated support across key life domains such as mental health, medication management, housing, social connections, employment, education assistance, and substance use treatment. Grounded in Whole-Person care and social determinants of health principles, BHST services promote long-term recovery and community integration. Counties implementing these EBPs through the BHSA are required to maintain fidelity to each model and utilize established pathways—including Full-Service Partnership (FSP) and Behavioral Health Services and Supports (BHSS)—to ensure equitable, high-quality care.

The Behavioral Health Services team (BHST)/Core Treatment Model (CTM) model doesn't just treat symptoms, it aims for psychosocial rehabilitation and coordination across life domains: mental health, medication, housing, social supports, employment and education supports, substance use treatment. These services reflect a whole-person philosophy, addressing social determinants of health and promoting long-term recovery.

Flexible Levels of Care with Continuity
With the three levels of care, BHRS allows members to "step down" as their needs change, while staying within the same BHST team. This preserves therapeutic relationships and supports long-term engagement. Once members have stabilized and no longer meet criteria for SMHS, program staff ensure timely linkage to local managed care or community-based providers, as appropriate.

After closing from an FSP program
BHRS members can continue to stay connected to our housing, and employment programs for ongoing linkage and support. Members can also continue to participate in groups and individual services at the Behavioral Health Wellness Center.

High Fidelity Wraparound Enhancements
Ongoing engagement in HFW involves consistent, strengths-based collaboration with youth, families, and their support teams through regular CFT meetings, typically every 30–35 days. Facilitators maintain active communication, update strengths inventories quarterly, and adapt care plans to reflect evolving needs and cultural values. Natural supports are continually invited and engaged, and successes are celebrated to reinforce progress. Coaching and supervision help ensure fidelity to the model, while engagement gradually shifts toward building family self-sufficiency as they prepare for transition out of HFW.

In addition to implementing required EBPs, BHRS provides enhanced engagement strategies that include proactive outreach, integrated care coordination, wraparound supports, and culturally responsive practices. These efforts align with BHSA priorities for person-centered, recovery-oriented, and community-based care, ensuring that individuals remain connected, supported, and empowered throughout their journey toward wellness.

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.)

Stanislaus County BHRS will comply with the required FSP levels of care by maintaining a multilevel, flexible care model that ensures individuals receive services matched to their clinical and functional needs. This approach is grounded in CalAIM principles and aligns with BHSA priorities for person-centered, recovery-oriented care.

Multilevel Care Model

BHRS offers three distinct levels of care within the FSP framework, allowing members to transition seamlessly as their needs change while maintaining continuity with their treatment team. Members are placed in levels of care depending on their needs: Utilizing the LOCUS as part of the CALAIM Assessment to determine the best level of care need for the individual member. Utilization of the levels of care will continue:

- ACT: For members requiring intensive, day-to-day support, including 24/7 crisis intervention. Services may occur multiple times per day, several days per week, delivered in the community to reduce barriers and promote engagement.
- ICM: For members needing intensive but less frequent services, typically weekly, provided in outpatient or community settings.
- Wellness / Step-Down Level: For members who have stabilized and require lower-intensity support, such as medication management and monthly check-ins, while transitioning to a lower level of care, as appropriate.

This tiered structure ensures flexibility and responsiveness, preserving therapeutic relationships and supporting long-term engagement.

Assessment and Level-of-Care Determination

BHRS uses the Level of Care Utilization System (LOCUS) as part of the CalAIM assessment process to determine the most appropriate level of care for each adult member.

- Members seeking services are screened using the Adult Medi-Cal Screening Tool.
- Those scoring 6 or above receive a scheduled mental health assessment to determine eligibility for SMHS.
- Based on assessment outcomes, members are assigned to the appropriate level of care.
- Members who do not meet SMHS criteria are linked back to their MCP by the Care Coordination Team (CCT), ensuring no one is left without support.

Existing and Expanded Capacity

Stanislaus County currently operates two internal FSP programs and contracts with additional providers to deliver FSP services.

- FACT services are being developed to support individuals involved in the legal and justice systems, providing specialized engagement and coordination.
- BHRS will continue to evaluate the need to transition teams to levels of care where clinically indicated and stand up new FSP teams as needed to meet demand and comply with BHSA requirements.

Cross-System Collaboration

- BHRS works closely with other counties, pre-release in-custody programs, and the Public Defender's Office to schedule assessments for individuals returning to the community.
- This proactive approach ensures continuity of care for justice-involved individuals and reduces risk of disengagement.
- BHRS maintains an open-door policy, allowing walk-ins to be screened and linked to appropriate services either BHRS or MCP, based on screening results.

Through a tiered, flexible care model, standardized assessment processes, expanded ACT and FACT capacity, and strong cross-system collaboration, Stanislaus County BHRS will fully comply with required FSP levels of care. This approach ensures timely access, continuity, and engagement for individuals with the most intensive behavioral health needs, consistent with BHSA priorities for integrated, person-centered care.

In addition to the core services described above, Stanislaus County BHRS will include the following team-based services within its FSP programs. These services reflect BHSA priorities for flexibility, integrated care, and recovery-oriented supports:

Team-Based Services

- Transportation Assistance: To reduce barriers and ensure access to appointments, community activities, and essential services.
- Housing Support: Dedicated housing specialists assist with securing and maintaining stable housing for individuals experiencing or at risk of homelessness.
- Employment Services: Employment specialists provide vocational training, job placement, and retention support, including IPS services.
- Peer and Family Support: Peer support specialists and family advocates offer lived-experience guidance, trust-building, and culturally responsive engagement.
- Integrated Care Coordination: Linkage to primary care providers, ECM, and SUD treatment, including mutual aid groups and MAT.
- Wellness and Recovery Activities: Group participation, skill-building, and wellness center services to promote resilience and social inclusion.
- 24/7 Crisis Support: Immediate access to crisis intervention and stabilization services for individuals at the ACT level of care.

BHRS FSP Team Structure:

- TBHST – 1 ACT level team, 1 ICM level team, 1 Wellness team
- Turning Point BHST Team 1 - 1 ACT level team, 1 ICM level team, 1 Wellness team
- Turning Point BHST Team 2 - 1 ACT level team, 1 ICM level team, 1 Wellness team
- Turning Point BHST Team 3 – 1 ACT level team, 1 ICM level team
- Telecare BHST Team 1 - 1 ACT level team, 1 ICM level team, 1 Wellness team
- Telecare BHST Team 2 - 1 ACT level team, 1 ICM level team, 1 Wellness team
- Telecare BHST Team 3 - 1 ACT level team, 1 ICM level team
- Telecare BHST Team 4 - 1 ACT level team, 1 ICM level team
- Telecare BHST Team 5 - 1 ACT level team, 1 ICM level team

- Telecare TAY BHST- 1.5 ACT level teams, 1.5 ICM teams
- Central Star BHST- 1 ACT level team, 1 ICM level team
- Central Star- 3 HFW Team

This structure ensures coverage across all levels of care, allowing members to transition seamlessly while maintaining continuity with their treatment team. It also reflects BHSA's emphasis on multidisciplinary, community-based, and culturally responsive services.

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

Stanislaus County BHRS will include outreach activities and other recovery-oriented services as part of its FSP program. While outreach and engagement are core components of EBPs such as ACT, FACT, IPS, and HFW. BHRS goes beyond these requirements by implementing community-based, culturally responsive strategies aligned with BHSA priorities for access, equity, and person-centered care.

Key Features of Our Approach:

- Community-Based Outreach Teams: Dedicated BHOE and CARE Teams, along with contracted providers, conduct proactive outreach in shelters, high-need neighborhoods, and rural areas to connect unserved and underserved individuals to care.
- Engagement Beyond Initial Contact: FSP teams prioritize relationship-building and trust through flexible, frequent contact in community settings, ensuring sustained engagement throughout recovery.
- Specialized Outreach for High-Risk Populations: Targeted strategies for individuals in custody, psychiatrically hospitalized, or justice-involved, including discharge planning and reentry support.
- Continuous Engagement Philosophy: Open-door policy and adaptive engagement methods to maintain connection even during periods of instability.
- Recovery-Oriented Supports: Housing navigation, employment assistance, transportation, peer and family advocacy, and linkage to culturally affirming community resources.

These enhancements reflect BHSA principles of whole-person care, cultural responsiveness, and integrated supports, ensuring individuals are not only connected to services but remain engaged in their recovery journey.

Primary SUD FSPs

- No

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

Describe the outreach activities the county will engage in to enroll individuals

living with significant behavioral health needs into the county's FSP program
Stanislaus County BHRS prioritizes proactive outreach and sustained engagement as foundational strategies for connecting individuals to care and supporting recovery. While outreach and engagement are core components of EBPs such as ACT, FACT, IPS, and HFW, BHRS goes beyond these requirements by implementing community-based, culturally responsive approaches that align with BHSA priorities for access, equity, and person-centered care.

Community-Based Outreach Teams
BHRS operates dedicated BHOE and CARE Teams, along with a contracted provider outreach team, to reach individuals who are unserved or underserved.

- These teams are frequent local shelters, community programs, and high-need areas, ensuring visibility and accessibility.
- Outreach staff build trust through consistent presence, culturally responsive engagement, and individualized intervention planning, connecting individuals to treatment and supportive services.

Engagement Beyond Initial Contact
Once individuals are connected to a BHST, engagement efforts continue as a relationship-building process between case managers and members.

- Staff prioritize rapport and trust, recognizing these as essential for long-term engagement and recovery.
- For members at the ACT level of care, engagement is even more intensive due to the complexity and severity of their illness. Teams provide frequent, flexible contact in community settings to reduce barriers and maintain connection.

Specialized Outreach for High-Risk Populations
BHRS extends outreach and engagement to individuals who are:

- In custody or psychiatrically hospitalized, focusing on rapport building and discharge planning to ensure continuity of care post-release.
- BHRS is collaborating with Justice-involved individuals, through collaboration with FACT teams, Public Defender's Office, and pre-release programs, to facilitate smooth transitions back into the community.
- BHRS is working with the justice involved partners to establish FACT services for members with justice involvement, ensuring smooth transitions back into the community.

Continuous Engagement Philosophy
Engagement is not a one-time event, it is an ongoing process that adapts to the member's needs and circumstances. BHRS teams maintain an open-door policy, allowing walk-ins to be screened and linked to appropriate services. This flexibility ensures that members remain connected even during periods of instability.

Through community-based outreach teams, intensive engagement strategies, and specialized support for high-risk populations, Stanislaus County BHRS goes beyond EBP requirements to ensure individuals are not only connected to care but remain engaged throughout their recovery journey. These efforts reflect BHSA priorities for access,

cultural responsiveness, and integrated care, promoting stability, resilience, and long-term wellness.

Other recovery-oriented services

- Yes

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

Stanislaus County BHRS implements the FSP model using the guiding principle of "Whatever the member needs, whatever it takes." This philosophy ensures that individuals with the most intensive behavioral health needs receive flexible, comprehensive, and person-centered services that go beyond traditional treatment. Our approach aligns with BHSA priorities for whole-person care, cultural responsiveness, and community integration.

Comprehensive, Wraparound Supports

FSP teams provide services across multiple life domains to address the complex needs of members:

- Transportation assistance to reduce barriers to care and promote community participation.
- 24/7 service availability, including crisis intervention and support, ensuring members have access whenever needed.
- Community-based engagement, meeting members where they are, at home, in shelters, or other community settings, to foster trust and continuity.

Multidisciplinary Team Approach

FSP teams include a broad range of professionals and supports:

- Peer support specialists build trust and reduce stigma through lived experience.
- Housing support specialists to assist with securing and maintaining stable housing.
- Employment specialists to provide vocational training, job placement, and retention support.
- Psychiatrists and psychiatric nurses for medication management and clinical oversight.
- Linkage to primary care providers (PCPs) and ECM providers for integrated physical and behavioral health care.
- Doc-to-Doc consultation to ensure seamless coordination between medical and behavioral health providers.

Social and Community Integration

FSP services extend beyond clinical care to help members build natural supports and community connections:

- Assistance in creating a social support system through community groups and culturally responsive resources.
- Linkage to SUD treatment, including mutual aid groups such as AA and NA, and

referrals for MAT.
- Opportunities for group participation and wellness activities to promote recovery, resilience, and social inclusion.

By implementing a "Whatever It Takes" philosophy, Stanislaus County BHRS ensures that FSP members receive individualized, flexible, and comprehensive supports that address clinical, social, and environmental needs. This approach reflects BHSA priorities for person-centered, recovery-oriented care, promoting stability, empowerment, and long-term wellness.

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

The Adult Medication clinics provide psychiatric medication evaluation, prescribing, and management to support individuals experiencing severe mental health conditions. This team works within multidisciplinary treatment programs with the Adult System of Care, Forensics System of Care, and Substance Use Disorder System of Care ensuring that medication services are integrated with each member's overall treatment plan. These services are delivered by a team of licensed psychiatrists, psychiatric nurse practitioners, psychiatric registered nurses, and behavioral health specialists. This team provides ongoing monitoring, adjustments, and support to ensure that prescribed medications are safe and effective in reducing mental health symptoms.

The Adult Medication Clinic serves members 18 years and older, with Serious Mental Illness who have Stanislaus County Medi-Cal, meet criteria for Specialty Mental Health Services who are enrolled in one of BHRS's treatment programs.

Psychiatric Appointments
A licensed prescriber—psychiatrist or psychiatric nurse practitioner—evaluates each member's mental health needs and prescribes medication when appropriate.

Medication Management
Prescribers monitor the effectiveness of prescribed medications and make necessary adjustments. This may include follow-up appointments or communication between visits to support ongoing progress.

Monitoring, Evaluation, and Administration
Psychiatric Registered Nurses (RNs) track symptom progress, assess for potential health concerns, monitor vital signs and physiological indicators, ordering labs, evaluating results, along with providing psychoeducation on mental health diagnosis, symptoms, and medication side effects. The RNs also administer long-acting injectable medications as prescribed.

Coordination of Care
The medication team collaborates closely with the member's treatment team to promote consistency and alignment across all behavioral health and recovery services as well helps to connect to additional resources and supports as needed.

Stand-Alone Medication Services
Provide ongoing medication management and limited case coordination for adult members who have completed treatment team goals but continue to need specialty mental health psychiatric medication services. This includes members transitioning to their primary care physician (PCP) or those whose PCP is unable to assume psychiatric medication management or provide long-acting injectable medications.

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
Stanislaus County BHRS incorporated a robust community stakeholder advisory process to ensure the unique needs of eligible children and youth were central to the development of the county's FSP program. This process reflects BHSA priorities for community engagement, cultural responsiveness, and data-driven planning.

Stakeholder Engagement
BHRS convened CPP sessions and stakeholder advisory meetings that included:

- Families, caregivers, and youth with lived experience to provide firsthand perspectives on barriers and needs.
- Education partners, child welfare representatives, juvenile justice stakeholders, and community-based organizations serving children and youth.
- Cultural and linguistic representatives ensure services are responsive to diverse populations.
- These sessions focused on identifying gaps in access, cultural considerations, and strategies for engagement and retention.

Review of Local Data
BHRS analyzed county-level data on:

- Children's mental health prevalence, service utilization patterns, and unmet needs.
- Disparities among racial/ethnic groups, LGBTQ+ youth, and youth involved in child welfare or juvenile justice systems.
- Hospitalization and crisis service trends for youth, highlighting areas for early intervention.

Incorporation of Evidence and Best Practices
The planning process included review of research and statewide guidance on effective FSP models for youth, including:

- HFW for youth with complex needs.
- Integration of peer and family advocates to strengthen engagement.
- Strategies for school-based and community-based linkage to reduce barriers.

Through stakeholder engagement, data analysis, and evidence-based planning, BHRS

ensured that the FSP program reflects the unique needs of children and youth. This collaborative process aligns with BHSA priorities for inclusive planning, equity, and recovery-oriented care, resulting in services that are family-driven, culturally responsive, and community-based. Here's how you can provide individual responses for each population, improved through the lens of BHSA and incorporating your stakeholder engagement efforts.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Stanislaus County BHRS considered the unique needs of LGBTQ+ children and youth through targeted stakeholder engagement and collaborative planning.

- We partnered with the LGBTQ+ Community Collaborative during our CPP to gather feedback on barriers, cultural responsiveness, and service gaps.
- Input from LGBTQ+ stakeholders informed strategies such as inclusive language in service delivery, staff training on gender identity and sexual orientation, and linkage to affirming community resources.
- BHRS also reviewed local data and statewide best practices to ensure FSP services are safe, affirming, and accessible for LGBTQ+ youth.

In the child welfare system:
BHRS engaged child welfare stakeholders, caregivers, and youth advocates during CPP sessions to identify the unique needs of children and youth involved in child welfare.
Feedback emphasized the importance of trauma-informed care, family engagement, and coordination with child welfare agencies. BHRS incorporated these recommendations into FSP design by including family partners, wraparound supports, and cross-system collaboration with child welfare and juvenile justice programs.

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:
In developing the county's FSP for older adults, Stanislaus County BHRS engaged in multiple activities to ensure their unique needs were addressed:

- Data Review & Needs Assessment: Analyzed demographic and utilization data to identify older adults with high medical complexity, co-occurring behavioral health conditions, and risk factors such as isolation and housing instability.
- Stakeholder Engagement: Conducted focus groups and listening sessions with older adults, caregivers, and community partners (including senior centers and advocacy groups) to understand barriers and priorities.
- Cross-System Collaboration: Established linkages to Central Valley PACE (Program of All-Inclusive Care for the Elderly) and WellBe Health for integrated medical and behavioral health support; partnered with PCPs and medical providers to ensure continuity of care.
- Enhanced Care Coordination: Implemented ECM linkage and Doc-to-Doc consultations between behavioral health clinicians and medical staff to address complex health needs.

- Placement & Transition Planning: Coordinated with SNFs, rehab facilities, and housing programs for older adults requiring medical stabilization or long-term care.
- Ongoing Consultation: Provided ongoing consultation with medical staff to adapt behavioral health interventions for older adults with chronic conditions, as needed.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+):
In developing the county's FSP for LGBTQ+ adults, the behavioral health system engaged in the following activities to address their unique needs:

- Data Review & Needs Assessment: Analyzed demographic and service utilization data to identify disparities in access and outcomes for LGBTQ+ individuals.
- Stakeholder Engagement: Partnered with LGBTQ+ community organizations and advocates through presentations, listening sessions, and surveys to gather input on barriers and priorities.
- Culturally Responsive Services: Incorporated LGBTQ+-affirming practices into treatment teams, including dedicated support groups and staff training on cultural competency.
- Linkages & Access Supports: Established connections to LGBTQ+ community programs and services, provided transportation assistance to these resources, and ensured safe and inclusive environments for care.
- Ongoing Collaboration: Maintained partnerships with LGBTQ+ organizations for consultation and resource sharing to continuously improve service delivery.

In, or are at risk of being in, the justice system:
In developing the county's FSP for adults who are in, or at risk of being in, the justice system, the behavioral health system engaged in the following activities:

- Data Review & Needs Assessment: Analyzed local jail booking data, probation reports, and behavioral health utilization trends to identify gaps in care for justice-involved individuals.
- Stakeholder Engagement: Collaborated with justice partners including probation, public defenders, and community-based reentry programs and incorporated feedback from individuals with lived experience to inform program design.
- Cross-System Coordination: Established regular communication and joint planning with justice/legal partners to align behavioral health treatment with court requirements and reentry timelines.
- Reentry Support & Advocacy: Provided advocacy through letter writing, attending court hearings, and supporting members during legal proceedings; offered transportation to court and treatment appointments.
- Continuity of Care: Maintained collateral contact with incarcerated individuals and those preparing for release to ensure seamless transition into community-based services.
- Integrated Services: Developed strategies to address housing, employment, and behavioral health needs post-release, reducing recidivism and promoting recovery.

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

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

Existing Programs for Assertive Field-Based SUD Treatment Services: Targeted outreach

Program Name:

- *Outreach Teams: BHOE, CARE, Telecare O & E, Care Coordination Team*

Program description
Community-Based Behavioral Health Outreach and Engagement (BHOE, CARE, and Telecare O&E)
Stanislaus County BHRS operates community-based outreach and engagement teams, including the BHOE Team, CARE Team, and Telecare Outreach and Engagement services, to identify and connect individuals who are unserved or underserved by traditional behavioral health systems. These teams provide field-based engagement in community settings such as shelters, encampments, community programs, and other high-need areas.

Through consistent presence and culturally responsive engagement, staff build trust with individuals experiencing mental health and substance use challenges. Teams conduct screening, provide brief interventions, and facilitate connection to behavioral health, substance use disorder treatment, housing supports, and other community resources. The program prioritizes individuals experiencing homelessness, high crisis utilization, or barriers to accessing clinic-based services, ensuring timely linkage to ongoing care and supportive services.

DMC-ODS Care Coordination Team: The Stanislaus County Behavioral Health and Recovery Services DMC-ODS Care Coordination Team supports individuals receiving services within the DMC-ODS by ensuring timely access to appropriate levels of substance use disorder treatment and facilitating continuity of care across providers and systems.

The team works closely with contracted treatment providers, behavioral health programs, medical providers, and community partners to coordinate assessments, treatment placement, and transitions between levels of care. Care coordinators assist individuals with navigating the treatment system, removing barriers to engagement, and maintaining connection to services during critical transitions such as hospital discharge, residential treatment completion, or reentry from institutional settings. This coordinated approach promotes treatment retention, improves system navigation, and supports long-term recovery outcomes.

Current funding source: The outreach teams currently are funded through a braid of FFP, BHSA, and SUBG

BHSA changes to existing programs to meet BHSA requirements

To meet BHSA requirements, the county will implement the following changes to existing programs:

- Integrate substance use treatment into all outreach teams and overall service philosophy
- Policy and Structural Updates: Revise policies to clearly differentiate operational responses and resource allocation for individuals with mild SUD versus those with BHSA-qualified moderate/severe SUD, ensuring compliance with BHSA eligibility criteria.
- Expanded Target Populations: Incorporate additional priority groups identified through BHSA, including youth at risk of juvenile justice involvement, re-entry from correctional facilities, child welfare involvement, or risk of institutionalization; and adults at risk of justice involvement, re-entry from correctional facilities, and those impacted by SB 43.
- Program Re-Envisioning: Develop and implement SUT pathways to care that are low barrier, and tailored to the needs of these populations, emphasizing assertive engagement and integrated care.
- Alignment of Funding and Policy: Reconcile SUBG priority population mandates with BHSA target populations, updating policies to ensure consistency and equity.
- Workforce Development: Provide comprehensive training for All outreach providers and assess what tools they may need including reconfiguring EHR access, and other requirements Performance Monitoring: Establish robust monitoring, auditing, and data collection systems to track engagement, service delivery, and outcomes, ensuring accountability and continuous quality improvement.

Expected timeline of operation: The county is currently assessing the resources needed to establish all requirements for this team throughout the integrated implementation period. This includes hiring consultants to assess infrastructure needs, policy development, program design, workforce preparation, and alignment with BHSA service expectations. This work also depends on comprehensive stakeholder engagement and the incorporation of culturally responsive practices.

Monitoring, auditing, and data collection processes will be developed in phases. While the timeframe for full automation has not yet been determined, the county is committed to building systems that support accurate performance measurement and compliance with BHSA requirements.

Existing Programs for Assertive Field-Based SUD Treatment Services: Mobile-Field Based Programs

- Not Applicable

Existing Programs for Assertive Field-Based SUD Treatment Services: Open-access clinics

Program Name

- *Stanislaus Recovery Center – Evaluation & Medication Access Clinic (EMAC)*

Program description: The EMAC program provides low threshold, open-access, walk-in services offering same day evaluation and initiation of FDA approved medications for substance use disorders (excluding methadone). Individuals may receive standalone medication services without being required to participate in additional treatment, reducing barriers to care for those seeking rapid access to MAT. EMAC also provides assessment, care coordination, counseling, family therapy, recovery support, crisis intervention, and ASAM WM1 ambulatory withdrawal management for individuals experiencing mild withdrawal symptoms. All services are culturally responsive and designed to meet the needs of BHSA priority populations, including individuals experiencing homelessness, those at risk of justice involvement, and persons with co-occurring conditions.

Aligned with BHSA goals of timely access, integration, and equity, EMAC incorporates the county's Open Access Scheduling initiative. This scheduling model supports same-day access to assessments and treatment initiation across the outpatient network and the DMC-ODS continuum. The program removes scheduling barriers, improves engagement, and ensures equitable entry points for individuals seeking services.

To support systemwide implementation of Open Access Scheduling, EMAC participates in BHSA-driven activities including:

- Working with county-convened stakeholder groups to guide rollout across network providers.
- Aligning program workflows with the county's comprehensive Open Access implementation plan.
- Training provider staff in Open Access protocols and evidence-based scheduling practices.
- Coordinating with the Access Line to support same-day scheduling requests.
- Integrating real-time availability into EHR scheduling functions.
- Reflecting Open Access requirements in Behavioral Health Plan subcontracts and

practice guidelines.
- Monitoring performance metrics such as timeliness to outpatient services, narcotic treatment services, and time-to-first medication dose.

Current funding source: The EMAC program is funded through leveraging Drug Medi-Cal billing.

BHSA changes to existing programs to meet BHSA requirements

To meet BHSA requirements, the program will maintain and enhance the following service components:

- Stand-Alone Medication Services: Provide outpatient access to all FDA-approved medications for SUD treatment (excluding methadone), ensuring low-threshold entry and member choice. Individuals may receive medication without being required to participate in other treatment services, reducing barriers to care.
- Comprehensive Support Services: Offer assessment, care coordination, individual and group counseling, family therapy, patient education, recovery services, SUD crisis intervention, and withdrawal management to support holistic recovery.
- Ambulatory Withdrawal Management (ASAM WM-1): Deliver outpatient withdrawal management without extended on-site monitoring for individuals experiencing mild withdrawal symptoms, requiring daily or less-than-daily supervision.
- Integration and Accessibility: Align services with BHSA principles by ensuring culturally responsive care, reducing disparities, and prioritizing access for BHSA target populations, including individuals at risk of justice involvement, those experiencing homelessness, and persons with co-occurring conditions.
- Community Collaboration: Strengthen partnerships with behavioral health, medical providers, and community organizations to promote continuity of care and integrated service delivery.

Expected timeline of operation

The program currently provides open access for both Stand-Alone MAT and ASAM WM-1 withdrawal management services.

- Implementation Timeline: These services are fully operational and will continue to be enhanced to align with BHSA requirements, including expanded outreach to priority populations, integration of culturally responsive practices, and strengthened care coordination.
- Future Enhancements: Additional activities such as workforce training, policy updates, and development of monitoring and data collection systems will be implemented by December 2026 to ensure compliance with BHSA performance and reporting standards.

New Programs for Assertive Field-Based SUD Treatment Services: Targeted Outreach

- Not Applicable

New Programs for Assertive Field-Based SUD Treatment Services: Mobile-Field Based Programs

Program Name

- *Assertive-Field Based Substance Use Treatment (SUT) Program (RFP)*

Program Description: This intensive, mobile program will provide substance use treatment for individuals experiencing unstable housing, frequent crises, or transportation barriers. The multidisciplinary team meets clients wherever they are—homes, shelters, streets, encampments—and accepts referrals from outreach teams, mobile crisis units, and homeless services. Beyond traditional outreach, the program delivers individualized counseling, connection to MAT prescribers, relapse prevention supports, care coordination, and recovery services, with the goal of initiating treatment, reducing crisis utilization, meeting members where they are at, and promoting long-term stability and recovery curated to individual needs rather than traditional in-clinic prescriptive service level treatment.

Planned funding: The program will be funded through Drug Medi-Cal/Opioid Settlement Funds

Planned operations: The Assertive Field-Based SUT Program will operate as an intensive, mobile treatment service designed to engage individuals experiencing substance use disorders who face barriers to traditional clinic-based care, including unstable housing, transportation insecurity, and frequent crisis system involvement. Services will be delivered directly in community settings such as homes, shelters, streets, and encampments to initiate treatment and support recovery in real-world environments.

Deployment Model: The team will accept referrals from outreach teams, mobile crisis programs, homeless services providers, and other community partners. Staff will proactively engage individuals in community settings and provide rapid connection to treatment services when readiness is identified.

Staffing Structure: The multidisciplinary team will include substance use counselors, case managers, peer support specialists, and coordination with MAT prescribers who can initiate or manage medication-assisted treatment.

Service Scope: Provide assertive, field-based substance use treatment including individualized counseling, harm reduction and relapse prevention supports, care coordination, and linkage to MAT services. The program will focus on initiating treatment, stabilizing individuals, and supporting recovery pathways tailored to individual needs rather than relying on traditional clinic-based service models.

Integration with Existing Systems: Coordinate closely with existing outreach teams to transition individuals from engagement activities into active treatment services. Collaborate with EMAC to support individuals identified in emergency and medical settings who require immediate linkage to substance use treatment, and coordinate with the START Office to ensure individuals interacting with crisis response systems can be

rapidly connected to field-based treatment and recovery supports.

Technology & Communication: Utilize secure mobile technology to support field documentation, care coordination, and real-time communication with MAT prescribers and partnering programs.

Quality & Outcomes: Focus on improving engagement in substance use treatment, reducing crisis and emergency system utilization, and supporting long-term recovery and stability. Program performance will be monitored through data tracking on engagement rates, treatment initiation, referral follow-through, and reduced crisis system involvement.

Expected timeline of implementation:
The County plans to initiate an RFP and procurement process to support this program, with the goal of launching services by Winter 2026 or Spring 2027.

New Programs for Assertive Field-Based SUD Treatment Services: Open-Access Clinic

Program Name:

- *Stanislaus Triage, Access, Recovery, and Treatment (START)*

Program description: The START center will serve as a centralized behavioral health navigation hub designed to improve access to mental health and SUD services across Stanislaus County. START will function as a community-centered entry point where individuals, families, and community partners can connect to care without needing to navigate complex behavioral health systems. The program will provide same-day screenings and assessments, navigation services, and warm handoffs to appropriate behavioral health treatment providers. Additional services will include short-term supportive engagement, coordination with BHRS crisis and access programs, linkage to medical care, housing, and other supportive services, and transportation assistance to help individuals access treatment throughout the County. START will also provide education and consultation for families seeking to better understand behavioral health conditions and available treatment options.

START is intended to remove barriers to care and ensure that when individuals seek help—whether through a direct visit, a phone call, or a referral from outreach or community partners—they are connected to services quickly and effectively. The program will be strategically located in Modesto and will coordinate closely with hospitals, FQHCs, shelters, outreach teams, and justice system partners to strengthen pathways into care. Over time, the START Center is intended to serve as the foundation for a broader hub-and-spoke access model, with potential satellite locations expanding community-based access points across Stanislaus County and strengthening coordinated access to behavioral health care throughout the region.

Planned funding: OSF and Drug Medi-Cal FFP

Planned operations: The START Center will function as a 24-7 open access centralized behavioral health navigation hub accepting walk-ins, phone inquiries, and referrals from community partners including hospitals, Federally Qualified Health Centers, outreach teams, shelters, justice system partners, and BHRS crisis and access programs. Individuals will receive same-day screening and navigation support to rapidly connect them to appropriate mental health and substance use disorder treatment services.

Staffing Structure: The START Center will be staffed by a multidisciplinary team including behavioral health clinicians, substance use counselors, case managers, peer support specialists, and care navigators. Staff will work collaboratively with BHRS programs and community providers to facilitate assessments, service planning, and coordination of care.

Service Scope: Services will include same-day screenings, behavioral health assessments, care navigation, short-term supportive engagement, and warm handoffs to treatment providers. Staff will assist individuals and families in understanding available services and support connections to mental health treatment, substance use disorder care, housing resources, medical care, and other supportive services. Transportation assistance will be available to help individuals attend appointments and access services throughout the County.

Integration with Existing Systems: The START Center will coordinate closely with BHRS crisis and access programs, outreach teams, hospitals, FQHCs, shelters, and justice system partners to strengthen pathways into care and ensure timely connections to services. The program will serve as a central coordination point to support individuals identified through crisis response, community referrals, or direct access to the START Center.

Technology & Communication: Staff will utilize secure electronic systems to document screenings, coordinate referrals, and communicate with BHRS programs and community providers. These systems will support real-time care coordination and help track service connections across the behavioral health system.

Quality & Outcomes: The program will focus on improving timely access to behavioral health services, reducing barriers to care, and strengthening coordinated pathways into treatment. Program performance will be monitored through data tracking on access timelines, referral completion, successful linkage to services, and reduced delays in behavioral health treatment engagement.

Expected timeline of implementation

The County plans to initiate an RFP and procurement process to support this program, with the goal of launching services by Winter 2026 or Spring 2027.

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

Stanislaus County BHRS currently provides same-day access to MAT, Monday through Friday through Open Access Scheduling at Stanislaus Recovery Center's Evaluation and Medication Access Clinic and Stand-Alone Medication Services. Outpatient MAT is available by appointment seven days per week via Recover Medical Group, a telehealth provider, and daily by appointment through Narcotic Treatment Programs.

To meet estimated population needs before July 1, 2029, the county will expand MAT availability to 24/7 access by:

- Leveraging Opioid Settlement Funding to enhance County Crisis Services programs and integrate MAT initiation into mobile and field-based teams.
- Utilizing federal Drug Enforcement Administration telemedicine flexibilities to enable real-time prescribing outside traditional clinic hours.
- Expanding DMC-ODS contracts to include providers with seven-day operational capacity for prescribing MAT.
- Partnering with emergency departments, bridge programs, and community MAT providers to ensure same-day initiation and closed-loop referrals for continuity of care.

Gap Assessment Approach

The county will conduct a comprehensive gap analysis by comparing current MAT capacity to projected needs using:

- Drug Medi-Cal timeliness metrics for outpatient, stand-alone, and Narcotic Treatment Programs.
- HEDIS measures related to treatment initiation and engagement.
- Public health and overdose surveillance data, including California Opioid Overdose Dashboard and local accidental poisoning and alcohol-related mortality rates.
- Estimated population needs data to identify service gaps and inform resource allocation.

Continuous monitoring will ensure compliance with BHSA standards for timely access, equity, and quality of care.

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

- Contract directly with MAT providers in the County
- Operate MAT clinics directly
- Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS) Medi-Cal
- Leverage telehealth model(s) Partner with neighboring counties

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

The county has not yet engaged in formal collaboration with neighboring counties on MAT initiatives; however, we recognize the value of regional alignment and shared learning. As part of our BHSA 3year plan, we intend to explore partnership opportunities with Merced County and San Joaquin County, our two adjacent DMC-ODS counties. These

partnerships would support consistency in service delivery, strengthen regional approaches to MAT access, and help inform local implementation through shared best practices and guidance. Working with Merced and San Joaquin Counties would further promote alignment with BHSA priorities related to equity, access, and coordinated systems of care.

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

- Buprenorphine
- Methadone
- Naltrexone
- Other
    - All Food and Drug Administration approved medications for the treatment of SUD

Housing Interventions

Planning

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

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System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are 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 Housing Inventory Count (HIC) to inform responses to this question.

Housing Type	**Gap**
Supportive housing	Medium
Apartments, including master-lease apartments	Medium
Single and multi-family homes	Medium
Housing in mobile home communities	Large
(Permanent) Single room occupancy units	Large
(Interim) Single room occupancy units	Large
Accessory dwelling units, including junior accessory dwelling units	Large
(Permanent) Tiny homes	Medium
Shared housing	Medium
(Permanent) Recovery/sober living housing, including recovery-oriented housing	Medium
(Interim) Recovery/sober living housing, including recovery-oriented housing	Medium
Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)	Medium
License-exempt room and board	Large
Hotel and Motel stays	Small
Non-congregate interim housing mode	Medium
Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)	Medium
Recuperative Care	Medium
Short-Term Post-Hospitalization housing	Large
(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units	Medium
Peer Respite	Medium

Permanent rental subsidies	Small
Housing supportive services	Small

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 (*

Beyond BHSA funding, Stanislaus County BHRS leverages a variety of local, state, and federal resources, partnerships, and programs to expand housing supply and improve access for members eligible under BHSA:

Local Partnerships and Programs

- Stanislaus Affordable Housing Corporation (STANCO)
  - Provides transitional and permanent supportive housing for individuals with mental health disabilities in partnership with Stanislaus County BHRS. STANCO manages over 250 units and offers property management and tenant success programs.
- Dignity Village Modesto
  - A Behavioral Health Bridge Housing (BHBH) project offering 42 interim housing units with wraparound behavioral health services. Developed through a public-private partnership between Stanislaus County, City of Modesto, and DignityMoves, funded by a $3.4 million grant from California DHCS.
- Stanislaus Equity Partners (STEP)
  - Collaborates with BHRS and local agencies to create tiny home villages, Accessory Dwelling Units (ADUs), and permanent supportive housing projects like James Street Apartments, funded by Project Homekey (California HCD) with $1.7M investment.
- City of Modesto Measure H
  - A voter-approved local sales tax generating approximately $39 million annually, with allocations for homelessness initiatives including bridge housing. Recent investments include $3 million for tiny homes and infrastructure, including $527,000 for Grace Gardens, a pilot site with 12 tiny homes offering transitional housing and wraparound services.

State-Level Resources

- CalHFA MHSA Housing Program
  - Administered by the California Housing Finance Agency, this program funds long-term supportive housing for individuals with serious mental illness. Stanislaus County has used this program for projects like Bennett Place and Kestrel Ridge.
- Project Homekey
  - State initiative providing capital for converting properties into permanent supportive housing for homeless individuals with behavioral health needs. Stanislaus County has successfully attracted Homekey funding for local projects.
- Homeless Housing, Assistance, and Prevention (HHAP) Program
  - Stanislaus County received $22.6 million across HHAP funding rounds

(2019–2025) to support housing and homelessness reduction efforts, including behavioral health populations.

Data Sharing and Coordination

- Continuum of Care Partnerships
    - Stanislaus County participates in the Modesto/Stanislaus CoC, which coordinates housing resources, data sharing, and service integration for homeless individuals with behavioral health needs.

Stanislaus County BHRS is exploring opportunities to increase available housing with state programs (CalHFA MHSA Housing, Project Homekey, HHAP), and local partnerships (STANCO, STEP, DignityMoves, Measure H). These efforts include interim housing, permanent supportive housing, rental assistance, and innovative housing models to ensure BHSA-eligible members have access to safe, affordable housing integrated with behavioral health services.

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?

Stanislaus County BHRS has initiated a Behavioral Health Housing Collaborative, to being the planning process in collaboration with local housing partners and a consultant. The purpose of this effort is to:

- Understand the needs of BHRS members experiencing homelessness.
- Identify existing non-BHSA resources available in the community.
- Determine the gap in housing supply for BHSA-eligible individuals.

This foundational work will guide future decisions on how BHSA housing interventions can best support and complement other resources. The collaborative is in the early stages, and no specific strategies have been finalized. The Behavioral Health Housing Collaborative is focused on building a clear understanding of needs, resources, and gaps before determining next steps. This approach ensures that any future BHSA housing interventions are strategically aligned with community resources and designed to strengthen the continuum of housing supports for BHSA-eligible members.

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

Stanislaus County BHRS promotes permanent housing placement and long-term retention for individuals receiving BHSA Housing Interventions through a structured, performance-driven approach that combines clear expectations, coordinated services, and ongoing system improvement.

To actively promote housing placement, BHRS intends to embed specific, measurable goals for housing placements into provider contracts, including expectations for outreach, engagement, and timelines from referral to housing. These contracts emphasize Housing First, low-barrier access, and prioritize rapid connection to permanent housing resources. Providers are supported by dedicated BHRS staff who offer in-kind assistance with housing navigation, landlord engagement, and coordination with community partners through the Behavioral Health Housing Collaborative.

To strengthen housing retention, BHRS intends to s also incorporating retention benchmarks into contracts, such as targets for maintaining housing at 6- and 12-month intervals. Providers are required to deliver ongoing tenancy supports, including case management, behavioral health services, and crisis response, to help individuals remain stably housed. BHRS is further aligning service expectations to ensure that supports are flexible, person-centered, and responsive to changing needs over time.

In addition, the county is utilizing system-level monitoring and continuous quality improvement processes, including regular data tracking and performance reviews, to ensure accountability and identify areas for enhancement. Engagement with specialized consultants will further refine strategies by identifying gaps, strengthening service models, and recommending evidence-based practices to improve both placement rates and long-term housing stability.

BHRS is also adopting a philosophy in attempting to invest in PSH partnership by investing in capital funds, subsidies and in-kind housing retention staff support.

Together, these efforts promote a consistent, accountable, and outcomes-focused system that not only increases access to permanent housing but also ensures individuals have the supports needed to remain housed.

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)?
Stanislaus County BHRS is engaged in foundational activities to support housing stability for BHSA-eligible members, including:

- Providing supportive services such as case management, housing navigation, and behavioral health care for members residing in permanent housing settings through existing BHRS programs.
- Collaborating with local housing partner like STANCO to connect members to available permanent housing resources.

While these activities help link members to housing resources, BHRS recognizes the need for a comprehensive strategy for permanent supportive housing (PSH). To address this, BHRS has launched the Behavioral Health Housing Collaborative. This initiative will focus efforts on:

- Assessing the needs of BHRS members who require PSH.
- Identifying existing PSH resources and supports in the community.
- Determining gaps in PSH availability and retention supports.

BHRS will return in future annual updates to share findings and outline specific strategies informed by this gap analysis. This approach ensures that any actions taken are data-driven, responsive to identified needs, and aligned with community resources.

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
Currently, Stanislaus County BHRS provides clinical and supportive behavioral health

services through existing programs that serve individuals in housing settings, including case management, mental health treatment, and linkage to community supports. These services are offered to eligible members residing in permanent housing or transitional housing settings through BHRS outpatient programs and FSPs.

As the Behavioral Health Housing Collaborative reviews existing services, BHRS will work with partners to develop recommendations for ensuring all housing intervention settings provide access to clinical and supportive services.

BHRS will return in future annual updates to share findings and outline specific strategies informed by this gap analysis. This approach ensures that any actions taken are data-driven, responsive to identified needs, and aligned with community resources, creating a sustainable continuum of housing and behavioral health supports.

Eligible Populations

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

Stanislaus County BHRS connects members to housing resources through existing processes and partnerships, including:

Coordinated Entry System (CES)

BHRS participates in the Modesto/Stanislaus Continuum of Care's CES, which serves as an access point for individuals experiencing homelessness. Through CES, BHRS can identify and prioritize individuals with behavioral health needs for housing interventions.

Collaboration with Community-Based Organizations (CBOs)

BHRS works closely with local housing providers and CBOs such as STANCO, STEP, Turning Pont Community Programs, and others to refer individuals to available housing programs and supportive services.

Internal Screening and Referral Processes

BHRS programs, including FSPs and outpatient services, screen members for housing needs and make referrals to housing resources when appropriate.

Future Planning Through the BHRS Housing Continuum

As the Behavioral Health Housing Collaborative reviews existing processes, BHRS will work with partners to develop recommendations for ensuring all housing intervention settings provide access to clinical and supportive services.

BHRS will return in future annual updates to share findings and outline specific strategies informed by this gap analysis. This approach ensures that identification, screening, and referral processes are data-driven, coordinated, and aligned with community resources, creating a seamless pathway to housing for BHSA-eligible individuals.

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

BHRS has established the Behavioral Health Housing Collaborative (BHHC) to provide structured, cross-agency governance for the development of a comprehensive Behavioral Health Housing Plan. The planning process begins with strengthening the department's data infrastructure to ensure accurate, timely, and actionable information on housing need. BHRS is enhancing homelessness and housing status reporting within its SmartCare electronic health record by improving data quality, consistency, and timeliness. In parallel, the department is investing in the utilization and capacity of the Homeless Management Information System (HMIS), including the development of workflows and policies to improve data collection, integration, and reporting for BHRS members. Together, these efforts create a reliable, real-time dataset that serves as the foundation for identifying housing needs and informing planning decisions.

Building on this data foundation, the BHHC will conduct a comprehensive assessment of the number and types of housing and residential supports needed for members currently engaged in treatment across all systems of care. Within this broader effort, BHRS is placing a specific focus on the Children and Youth System of Care, particularly BHSA priority populations including justice-involved youth. The department will conduct an internal point-in-time count within the Children and Youth System of Care, including transitional age youth, to identify individuals and families experiencing homelessness or housing instability while engaged in treatment. This targeted analysis will capture both the scope of need and the types of housing interventions required, informing the development of youth-specific housing strategies across the full range of housing programs and types.

Finally, the BHHC will align these identified needs with development priorities, investment strategies, and available funding resources. This includes assessing capital financing opportunities for new units and facilities, as well as identifying sustainable funding streams to support ongoing operating subsidies and services. Through this phased, data-driven approach—data strengthening, needs assessment, and resource alignment—BHRS will develop a coordinated, countywide housing strategy that integrates the needs of children, youth, and families into a unified framework designed to prevent homelessness, reduce system involvement, improve placement stability, and support long-term behavioral health outcomes.

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

BHRS has established the BHHC to provide structured, cross-agency governance for development of a comprehensive Behavioral Health Housing Plan. Consistent with BHSA CPP requirements, BHRS has incorporated targeted stakeholder engagement, including collaboration with the county's two largest LGBTQ+ community-based organizations, to gather input on housing needs, service gaps, and culturally responsive strategies to inform BHSA planning and development.

The planning process begins with strengthening the department's data infrastructure to ensure accurate, timely, and actionable information on housing need. BHRS is enhancing

homelessness and housing status reporting within its SmartCare electronic health record by improving data quality, consistency, and timeliness. In parallel, the department is expanding utilization of the Homeless Management Information System (HMIS), including development of workflows and policies to improve data collection, integration, and reporting for BHRS members. Together, these efforts establish a reliable, near real-time dataset to inform housing planning and decision-making.

Building on this foundation, the BHHC will conduct a comprehensive assessment of the housing and residential support needs of members across all systems of care. This includes a focused analysis of BHSA priority populations, with specific attention to LGBTQ+ individuals and youth. Within the Children and Youth System of Care, BHRS will conduct an internal point-in-time count, including transitional age youth, to identify those experiencing homelessness or housing instability while engaged in treatment. This analysis will identify both the scope of need and the types of housing interventions required, supporting development of targeted, culturally responsive housing strategies.

Finally, the BHHC will align identified needs with development priorities, investment strategies, and available funding resources. This includes evaluating capital development opportunities and identifying sustainable funding for operating subsidies and supportive services. Through this phased, data-driven approach, data strengthening, needs assessment, and resource alignment, BHRS will develop a coordinated, countywide housing strategy that advances equitable access to housing, reduces homelessness and system involvement, improves placement stability, and supports long-term behavioral health outcomes, including for LGBTQ+ populations.

In the child welfare system

BHRS has established the BHHC to provide structured, cross-agency governance for the development of a comprehensive Behavioral Health Housing Plan. The planning process begins with strengthening the department's data infrastructure to ensure accurate, timely, and actionable information on housing need. BHRS is enhancing homelessness and housing status reporting within its SmartCare electronic health record by improving data quality, consistency, and timeliness. In parallel, the department is investing in the utilization and capacity of the Homeless Management Information System (HMIS), including the development of workflows and policies to improve data collection, integration, and reporting for BHRS members. Together, these efforts create a reliable, real-time dataset that serves as the foundation for identifying housing needs and informing planning decisions.

Building on this data foundation, the BHHC will conduct a comprehensive assessment of the number and types of housing and residential supports needed for members currently engaged in treatment across all systems of care. Within this broader effort, BHRS is placing a specific focus on the Children and Youth System of Care, particularly BHSA priority populations including children and families involved in the child welfare system. The department will conduct an internal point-in-time count within the Children and Youth System of Care, including transitional age youth, to identify individuals and families experiencing homelessness or housing instability while engaged in treatment. This targeted analysis will capture both the scope of need and the types of housing interventions required, informing the development of youth-specific housing strategies across the full range of housing programs and types.

Finally, the BHHC will align these identified needs with development priorities, investment strategies, and available funding resources. This includes assessing capital financing opportunities for new units and facilities, as well as identifying sustainable funding streams to support ongoing operating subsidies and services. Through this phased, data-driven approach—data strengthening, needs assessment, and resource alignment—BHRS will develop a coordinated, countywide housing strategy that integrates the needs of children, youth, and families into a unified framework designed to prevent homelessness, reduce system involvement, improve placement stability, and support long-term behavioral health outcomes.

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

BHRS has established the Behavioral Health Housing Collaborative (BHHC) to provide structured, cross-agency governance for the development of a comprehensive Behavioral Health Housing Plan. The planning process begins with strengthening the department's data infrastructure to ensure accurate, timely, and actionable information on housing need. BHRS is enhancing homelessness and housing status reporting within its SmartCare electronic health record by improving data quality, consistency, and timeliness. In parallel, the department is investing in the utilization and capacity of the Homeless Management Information System (HMIS), including the development of workflows and policies to improve data collection, integration, and reporting for BHRS members. Together, these efforts create a reliable, real-time dataset that serves as the foundation for identifying housing needs and informing planning decisions.

Building on this data foundation, the BHHC will conduct a comprehensive assessment of the number and types of housing and residential supports needed for members currently engaged in treatment across all systems of care. Within this broader effort, BHRS is placing a specific focus on adult priority populations, including older adults. The department will conduct targeted internal point-in-time assessments to identify adults experiencing homelessness or housing instability while engaged in treatment. This analysis will capture both the scope of need and the types of housing interventions required, informing the development of population-specific housing strategies across the full range of housing programs and types.

Finally, the BHHC will align these identified needs with development priorities, investment strategies, and available funding resources. This includes assessing capital financing opportunities for new units and facilities, as well as identifying sustainable funding streams to support ongoing operating subsidies and services. Through this phased, data-driven approach—data strengthening, needs assessment, and resource alignment—BHRS will develop a coordinated, countywide housing strategy that integrates the needs of adult priority populations into a unified framework designed to reduce homelessness, improve stability, and support long-term behavioral health outcomes.

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

BHRS has established the BHHC to provide structured, cross-agency governance for the development of a comprehensive Behavioral Health Housing Plan. The planning process begins with strengthening the department's data infrastructure to ensure accurate, timely, and actionable information on housing need. BHRS is enhancing homelessness and housing status reporting within its SmartCare electronic health record by improving data quality, consistency, and timeliness. In parallel, the department is investing in the utilization and capacity of the Homeless Management Information System (HMIS), including the development of workflows and policies to improve data collection, integration, and reporting for BHRS members. Together, these efforts create a reliable, real-time dataset that serves as the foundation for identifying housing needs and informing planning decisions.

Building on this data foundation, the BHHC will conduct a comprehensive assessment of the number and types of housing and residential supports needed for members currently engaged in treatment across all systems of care. Within this broader effort, BHRS is placing a specific focus on adult priority populations, including individuals who are in or at risk of involvement with the justice system. The department will conduct targeted internal point-in-time assessments to identify adults experiencing homelessness or housing instability while engaged in treatment. This analysis will capture both the scope of need and the types of housing interventions required, informing the development of population-specific housing strategies across the full range of housing programs and types.

Finally, the BHHC will align these identified needs with development priorities, investment strategies, and available funding resources. This includes assessing capital financing opportunities for new units and facilities, as well as identifying sustainable funding streams to support ongoing operating subsidies and services. Through this phased, data-driven approach—data strengthening, needs assessment, and resource alignment—BHRS will develop a coordinated, countywide housing strategy that integrates the needs of adult priority populations into a unified framework designed to reduce homelessness, improve stability, and support long-term behavioral health outcomes.

In underserved communities

BHRS has established the BHHC to provide structured, cross-agency governance for the development of a comprehensive Behavioral Health Housing Plan. Consistent with BHSA CPP requirements, BHRS has conducted targeted community engagement to inform planning and development, including direct outreach within shelters and service settings to gather input from individuals experiencing homelessness and other underserved communities. These efforts prioritize elevating lived experience and community voice to better understand barriers to housing access, service gaps, and opportunities to improve housing supports.

The planning process begins with strengthening the department's data infrastructure to ensure accurate, timely, and actionable information on housing need. BHRS is enhancing homelessness and housing status reporting within its SmartCare electronic health record by improving data quality, consistency, and timeliness. In parallel, the department is expanding utilization of the Homeless Management Information System (HMIS), including development of workflows and policies to improve data collection, integration, and reporting for BHRS members. Together, these efforts create a reliable, near real-time dataset to inform housing planning and decision-making.

Building on this data foundation, the BHHC will conduct a comprehensive assessment of the number and types of housing and residential supports needed for members across all systems of care. Within this effort, BHRS will focus on adult priority populations, including individuals from underserved communities. The department will conduct targeted internal point-in-time assessments to identify adults experiencing homelessness or housing instability while engaged in treatment. This analysis will capture both the scope of need and the types of housing interventions required, informing development of population-specific and culturally responsive housing strategies.

Finally, the BHHC will align identified needs with development priorities, investment strategies, and available funding resources. This includes assessing capital financing opportunities for new units and facilities and identifying sustainable funding for operating subsidies and supportive services. Through this phased, data-driven approach—data strengthening, needs assessment, and resource alignment—BHRS will develop a coordinated, countywide housing strategy designed to reduce homelessness, improve housing stability, and support long-term behavioral health outcomes for adult priority populations.

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?

Stanislaus County BHRS maintains active coordination with the Modesto/Stanislaus Continuum of Care (CoC) to support timely identification, referral, and placement of BHSA-eligible individuals into Housing Intervention services.

BHRS participates in CoC meetings to ensure alignment of housing and behavioral health strategies, as well as ongoing collaboration with community-based providers.
BHRS coordinates closely with the CoC's Homeless Management Information System (HMIS) lead entity to strengthen data integration, referral tracking, and system transparency. Current efforts include the development of standardized workflows to support the referral of BHRS members, as well as exploration of designating a dedicated HMIS staff resource to support all BHRS housing programs, regardless of funding source. This approach is intended to ensure consistent data entry, improve timeliness of referrals, and enhance the County's ability to monitor housing outcomes and system performance. BHRS utilizes CES as a primary access point for housing resources and prioritization. Through this process, individuals engaged in BHRS services who are experiencing homelessness are assessed, prioritized, and referred to appropriate housing interventions based on vulnerability and behavioral health needs. In parallel, BHRS operates internal referral pathways to identify and connect eligible clients to housing services, with coordination occurring between clinical teams, housing providers, and CES partners.. .As part of BHSA implementation and alignment with CalAIM initiatives, BHRS will evaluate if current CES and referral processes need updating to ensure integration of Housing Interventions within the broader behavioral health continuum of care. This includes identifying opportunities to streamline referrals, reduce duplication, and ensure that behavioral health clients are effectively connected to housing resources.

Coordination efforts are documented through participation in CoC meetings, HMIS data

reporting, and internal tracking systems. BHRS will continue to use these mechanisms to monitor referral patterns, assess system effectiveness, and inform ongoing improvements. Future updates to the Integrated Plan will include data-driven outcomes and any enhancements to coordination and referral processes.

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
Stanislaus County BHRS actively collaborates with the Modesto/Stanislaus CoC through participation in regular CoC meetings. These meetings allow BHRS to share updates on behavioral health programs, discuss challenges, and ensure coordination for individuals experiencing homelessness. BHRS staff work closely with CoC to ensure regular updates on communicated on homelessness-related issues and concerns.

Public Housing Agency
BHRS leadership regularly meets with the Stanislaus Regional Housing Authority to discuss processes, upcoming initiatives, and opportunities for collaboration. These meetings help align housing resources such as Section 8 Housing Choice Vouchers and other rental assistance programs with BHRS services. BHRS staff also assist members in navigating application processes and maintaining housing stability.

The Behavioral Health Housing Collaborative will evaluate current coordination with the Housing Authority and explore deeper integration, such as prioritization agreements for BHSA-eligible members, joint planning for PSH, and leveraging federal housing programs alongside BHSA resources. Recommendations will be informed by gap analysis and shared in future updates.

MCPs
BHRS regularly meets with MCPs to align behavioral health services with Medi-Cal initiatives, including ECM and Community Supports. These meetings focus on improving care coordination, addressing challenges, and identifying opportunities to integrate housing supports with behavioral health services.

Through the Behavioral Health Housing Collaborative, BHRS will explore strategies to connect MCP housing-related benefits with BHSA Housing Interventions. This may include joint case conferencing, shared care plans, and formal agreements to ensure members receive comprehensive housing and behavioral health support. Specific strategies will be developed after the needs and gaps analysis and shared in future updates.

ECM and Community Supports Providers
BHRS collaborates with CBOs that provide ECM and Community Supports through regular meetings to discuss coordination, challenges, and opportunities. These

partnerships help link BHSA-eligible members to housing navigation, tenancy supports, and behavioral health services.

The Behavioral Health Housing Collaborative will assess how these partnerships can be strengthened to ensure housing interventions are fully integrated with ECM and Community Supports. Potential strategies may include co-location of services, shared referral systems, and joint training for staff to improve coordination. Recommendations will be included in future annual updates.

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

BHRS engages with county agencies such as child welfare, public health, and social services through regular collaborative meetings to discuss processes, upcoming initiatives, and opportunities for improvement. BHRS also created a Behavioral Health Housing Collaborative, which brings together leaders from behavioral health organizations to share best practices and address system-level challenges.

The Behavioral Health Housing Collaborative includes housing partners and prospective PSH developers to ensure BHSA Housing Interventions align with local housing development efforts. Future strategies will focus on leveraging these partnerships to expand housing options, integrate behavioral health supports, and create sustainable housing solutions for BHSA-eligible individuals. These strategies will be informed by the gap analysis and shared in future annual updates.

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?

Stanislaus County BHRS has experience partnering on supportive housing projects funded through Project Homekey, such as the James Street Apartments, which provide permanent supportive housing for members with behavioral health needs. BHRS also delivers onsite behavioral health and navigation services at Dignity Village Modesto, a Behavioral Health Bridge Housing site, demonstrating our ability to integrate services within housing settings. BHRS maintains ongoing collaboration with local developers and operators involved in Homekey projects, such as UP Holdings/RH Community Builders, positioning the county to interface with supportive housing sites on services and referral pathways.

To build on this foundation, BHRS has launched the Behavioral Health Homelessness Continuum of Care initiative, which will:

- Assess member needs for supportive housing
- Map existing resources, including Homekey and the new Homekey+ program, and identify operational and service gaps
- Develop recommendations on where BHSA resources (services, flexible funds) can be braided with Homekey/Homekey+ capital to close local housing gaps for BHSA-eligible individuals

BHRS is currently in the exploration phase. The Behavioral Health Housing Collaborative will complete a needs and gap analysis before recommending specific strategies. BHRS will return in future annual BHSA updates with detailed plans informed by this analysis.

This approach ensures that coordination with Homekey+ and supportive housing providers is data-driven, collaborative, and aligned with community resources, ultimately expanding permanent housing opportunities for BHSA-eligible members.

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. 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.

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?

Based on current capacity and prior-year performance, Stanislaus County BHRS expects to serve approximately 64 unique individuals annually with rental subsidies through BHSA Housing Interventions. Last calendar year, BHRS supported 64 unique individuals in transitional housing with 36 funded units of interim rental housing.

In addition, BHRS will begin funding permanent housing subsidies in FY 2026–2027 as rental subsidy resources continue to become scarce. The exact number of permanent units is still being finalized.

BHRS also operates a Permanent Supportive Housing (PSH) project, Jenny's Place, which includes 25 units. Due to the shortage of vouchers, these 25 units will be dedicated to BHRS members and supported through BHSA Housing Interventions. Furthermore, BHRS is preparing for the development of 24 new PSH units under the El Capitan Project, which will also be funded with rental subsidies.

As these projects come online and begin serving participants, BHRS will continue to monitor utilization rates and provide updated projections on the total number of individuals served annually.

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

- 49

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

- 64

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?

Currently, Stanislaus County BHRS uses the Fair Market Rent (FMR) system as the basis for estimating rental subsidies. This calculation considers local FMR rates and adjusts for member-specific factors such as income contributions. However, there are variables that make projections challenging, including unpredictable member income levels and landlords who charge rents above FMR. As part of our housing continuum planning process, BHRS will review these methodologies to identify gaps and develop strategies for more accurate forecasting of both total rental subsidies and the number of individuals served in interim and permanent housing settings.

For which setting types will the county provide rental subsidies?

- Time Limited Interim Settings: Non-congregate interim housing models
- Non-Time Limited Permanent Settings: Supportive Housing

Will this Housing Intervention accommodate family housing?

- Yes

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

Transitional (Interim) Housing:
BHRS funds 36 units of interim housing that provide short-term, supportive accommodations for members transitioning from homelessness to permanent housing. These homes, managed in partnership with Stanislaus County Affordable Housing Corporation (StanCo), offer structure, behavioral health treatment support, housing navigation, and access to education and skill-building services. This intervention helps members stabilize while actively working toward long-term housing solutions.

Permanent Housing Subsidies:
Due to a countywide shortage of vouchers and other rental subsidy resources, BHRS is expanding the use of BHSA funding to support Permanent Supportive Housing (PSH) interventions where no other resources are available.
– Jenny's Place: A BHRS-affiliated PSH project with 25 units, all of which will be dedicated to BHRS members and supported through BHSA Housing Interventions.
– El Capitan PSH Development: A new PSH project that will include 24 units funded with BHSA rental subsidies upon completion.

As these PSH projects come online and begin housing members, BHRS will evaluate

utilization rates and revise the projected number of individuals served with permanent housing subsidies in future Annual Updates.

To ensure the strategic allocation of BHSA Housing Interventions funding, BHRS has established the Behavioral Health Housing Collaborative. This collaborative assesses the housing needs of BHSA-eligible members, identifies existing housing resources that can be leveraged, and determines where BHSA investments are most needed to fill gaps. This coordinated approach ensures effective planning and strengthens housing stability across the full continuum of care.

In addition, the Department is collaborating with other housing partners to fund additional permanent supportive housing units.

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?

- Tenant-based
- Project-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

Stanislaus County BHRS has initiated a Behavioral Health Housing Collaborative designed to address homelessness among BHRS members and ensure access to stable housing. Current efforts focus on assessing needs, identifying existing resources, and quantifying gaps for BHRS members experiencing homelessness. Future strategies will leverage partnerships to expand housing options, integrate behavioral health supports, and create sustainable housing solutions for BHSA-eligible members. These strategies will be informed by the gap analysis conducted within this initiative and shared in future annual updates to ensure transparency, accountability, and continuous improvement.

Framework Priorities:

- Assess the current housing needs of BHRS members experiencing homelessness.
- Identify existing housing resources available for these members.
- Quantify the gap between need and available units.
- Develop strategies to close this gap using BHSA housing interventions and leveraging other funding sources.
- Identifying a Portfolio of Units
- Comprehensive Housing Inventory: BHRS will create a centralized inventory of housing units, including:
- Units secured through partnerships with housing developers and landlords.
- Existing non-BHSA housing resources available
- Gap Analysis: Using consultant-led data analysis, BHRS will determine the number and type of units needed to meet demand and prioritize high-need populations.

Collaborative Partnerships Include

- County Housing Authority & CoC: Align BHSA placements with affordable housing programs and HUD-funded resources.
- Community-Based Organizations: Partner with providers offering supportive housing and wraparound services.
- Health Plans & Managed Care: Coordinate housing supports under CalAIM and other initiatives.
- Ongoing Monitoring & Strategy Development
- BHRS will maintain a Housing Collaborative to:
    - Monitor housing availability and utilization.
    - Adjust strategies based on emerging needs.
    - Identify new funding opportunities and partnerships.

Future BHSA annual updates will provide progress reports, updated strategies, and measurable outcomes to ensure alignment with BHSA goals and continuous improvement.

Total number of units funded with BHSA Housing Interventions per year

- 85

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

BHRS is currently in the exploration phase. The Behavioral Health Housing Collaborative will complete a needs and gap analysis before recommending specific strategies. BHRS will return in future annual BHSA updates with detailed plans informed by this analysis.

Operating Subsidies (Chapter 7, Section C.9.2)

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

- 611

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

Stanislaus County will utilize BHSA Housing Intervention funding to provide operating subsidies for recovery residences (also known as sober living environments) that support individuals with substance use and co-occurring behavioral health conditions who are engaged in treatment services. Recovery residences provide safe, structured, alcohol- and drug-free environments that promote recovery through peer support, accountability, and connection to recovery services.

These homes serve as an important component of the county's behavioral health continuum by providing stable housing that supports individuals with behavioral health needs in achieving recovery and stability.

Use of BHSA Housing Interventions Funding
BHSA Housing Intervention funds will be used to support the operational costs of recovery residences, which may include:

- Subsidizing the cost of operating sober living homes serving individuals with behavioral health and substance use disorders
- Supporting house management, staffing, and program oversight
- Maintaining safe and recovery-oriented living environments (utilities, maintenance, and property operations)
- Increasing the availability of recovery housing beds for individuals transitioning from treatment, homelessness, or institutional settings

Interim Housing and Permanent Housing Development

In addition to the interventions described above, Stanislaus County will allocate BHSA Housing Intervention operating subsidies funding toward both time-limited interim housing and non-time-limited permanent housing options. Investing in both categories allows the county to assess system needs and strategically expand the housing continuum for individuals experiencing homelessness who are served by BHRS. Funding will support the development and expansion of interim housing opportunities that provide stabilization and engagement in services, as well as permanent housing solutions that promote long-term housing stability and recovery...By investing across crisis stabilization, interim housing, and permanent housing, the county is strengthening a housing continuum that supports individuals at different stages of recovery and housing stability while reducing homelessness, crisis system utilization, and institutional placements for individuals with behavioral health conditions.
Short-Term Time-Limited Motel Stays

Through a contract with Community Housing and Shelter, Stanislaus County provides 1- to 3-day motel stays for BHSA-eligible individuals experiencing a housing crisis or who require short-term stabilization as part of a behavioral health treatment plan. Motel stays are utilized by multiple treatment teams within the Adult System of Care (ASOC) and serve as an immediate intervention when individuals lack safe housing or are exiting crisis situations. Each placement includes an established exit plan and connection to behavioral health services, case management, and longer-term housing resources. These placements serve as a temporary stabilization option while individuals are assessed and connected to appropriate housing and treatment supports.

Peer Respite Program – Turning Point Community Programs (Garden Gate)

The Turning Point Community Programs Garden Gate Respite Program provides up to 28 days of short-term residential respite services in two homes with a total of 11 beds for individuals experiencing behavioral health crises. The program follows a harm-reduction and recovery-oriented model, offering food, clothing, and safe shelter while connecting individuals to behavioral health assessments, treatment services, housing resources, and case management. Referrals primarily come from BHRS treatment teams and local law enforcement partners. The respite program serves as an alternative to hospitalization or incarceration, providing stabilization in a supportive peer-driven environment.

For which setting types will the county provide operating subsidies?

- Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including

recovery-oriented housing
- Non-Time Limited Permanent Settings: Supportive housing
- Time Limited Interim Settings: Hotel and motel stays
- Time Limited Interim Settings: Peer Respite
- Time Limited interim Settings: Non-congreate interim housing models

Will this be a scattered site initiative?
- Yes

Will this Housing Intervention accommodate family housing?
- No

Total number of units funded with BHSA Housing Interventions per year
- 115

Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units
- Not Applicable

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
- 75

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Stanislaus County BHRS operates a comprehensive Housing Support Services program designed to expand access to safe, stable housing for members experiencing homelessness who are engaged in behavioral health services. This intervention addresses social determinants of health by reducing housing insecurity and promoting recovery-oriented care. The program focuses on landlord engagement and risk mitigation to increase housing inventory and reduce barriers for individuals with complex behavioral health needs.

Activities include:
- Proactive outreach and relationship-building with landlords, property managers, and housing providers to foster trust and reduce stigma.
- Financial incentives and risk mitigation strategies funded through BHSA Housing Interventions, including holding fees, double security deposits, and reimbursement for eligible costs such as unit damages, missed rent, or other

tenancy preservation expenses encourage participation and reduce financial risk.
- Ongoing support and problem-solving for landlords and tenants to maintain housing stability and prevent evictions.
- Support staff-led engagement and education efforts to strengthen partnerships with housing providers.
- Implement performance monitoring to track housing retention, landlord participation rates, and outcomes for individuals meeting chronic homelessness criteria.

All BHSA-eligible members who are homeless or at-risk, have access to housing navigation, case management, and peer support services to ensure successful tenancy and long-term stability. These efforts directly increase housing inventory, promote equity, and improve behavioral health outcomes for priority populations.

Total number of units funded with BHSA Housing Interventions per year

- 0

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

The purpose of these funds is to expand housing opportunities for individuals engaged in behavioral health services by reducing barriers and increasing landlord participation, whereby increasing the inventory of units for eligible members.

The county's Housing Support Services program includes:

- Landlord Outreach and Engagement: Building relationships with property owners and managers to foster trust, reduce stigma, and encourage participation in housing programs.
- Risk Mitigation and Financial Incentives: Offering holding fees, double security deposits, and reimbursement for eligible costs such as unit damages, missed rent, or other tenancy preservation expenses. These funds are flexible and applied as needed to support housing stability, rather than being allocated to a fixed number of units.
- Ongoing Support: Providing problem-solving assistance to landlords and tenants to maintain housing stability and prevent evictions.

These strategies are designed to increase overall housing inventory and reduce systemic barriers, rather than being linked to a predetermined unit count. By focusing on landlord engagement and risk mitigation, the county ensures that individuals with complex behavioral health needs have greater access to safe, stable housing.

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

- 75

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

BHRS Participant Assistance Funds aims to remove financial and practical barriers that prevent members from accessing and maintaining stable housing. These supports are rooted in individualized assessments and prioritize participants engaged in behavioral health services, including those who are chronically homeless or experiencing complex behavioral health challenges.

Specific uses of BHSA Housing Interventions funding for participant assistance funds include:

- Covering essential costs required to secure housing, such as application fees, credit report fees, security and utility deposits, rental or utility arrears, and storage fees.
- Assisting with obtaining critical documents (e.g., identification, Social Security cards, birth certificates) necessary for housing applications.
- Supporting tenancy success for individuals with pets by covering pet deposits or related fees.
- Promoting successful move-ins and housing retention through additional supports such as transportation, food, hygiene items, and basic household furnishings (beds, tables, chairs, cleaning supplies, and other essentials) to establish a safe and stable home environment.

These services are delivered in coordination with case management and housing navigation to ensure participants receive comprehensive support tailored to their needs.

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

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

- 75

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

BHRS provides Housing Transition Navigation Services and Tenancy Sustaining Services to assist individuals experiencing or at risk of homelessness, including those who are chronically homeless and living with behavioral health challenges, in obtaining and maintaining stable housing. These services are delivered through the Behavioral Health Housing Support Services program and are tailored to each participant through individualized housing assessments and support plans.

Housing Transition Navigation Services include:

- Locating and securing housing units, completing rental applications, and obtaining vital documents.
- Advocating with landlords and educating participants on Fair Housing protections and reasonable accommodations.
- Coordinating access to housing resources such as vouchers, deposits, and community supports.
- Preparing participants for move-in, ensuring units meet safety and habitability standards, and arranging non-medical transportation for housing search and relocation.

Tenancy Sustaining Services focus on long-term housing stability by:

- Providing ongoing case management and skill-building for communication with landlords and adherence to lease requirements.
- Offering early intervention when housing is at risk, including crisis planning and conflict resolution.
- Supporting budgeting and financial management, and connecting participants to behavioral health, medical, and community supports.
- Coordinating with property managers to prevent evictions and reduce housing instability.

Through these services, BHRS aims to reduce homelessness, shorten housing search timelines, increase housing retention, and promote recovery-oriented housing stability for individuals with significant behavioral health needs. These efforts align with BHSA priorities by addressing social determinants of health, promoting equity, and improving measurable outcomes for housing and behavioral health integration.

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

- 296

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

The Community Assessment, Response, and Engagement (CARE) program is a multidisciplinary initiative delivering whole-person, community-based care for individuals with the most complex behavioral health needs. The team includes behavioral health professionals, criminal justice partners, and social service providers who collaborate to ensure timely access to treatment, equitable service delivery, and coordinated support aligned with BHSA principles.
Target Population: TAY (18–25), Adults (26–59), and Older Adults (60+) who often experience:

- SMI
- High-risk health and safety behaviors
- Vagrancy-related criminal justice involvement
- Severe SUDs
- Barriers to accessing or accepting traditional services

These individuals are frequently unserved or underserved, making proactive outreach and engagement a central focus of the program.

Program Approach: CARE uses a trauma-informed, culturally responsive model to meet individuals where they are, in the community, hospitals, homeless encampments, or shelters. The goal is to increase meaningful engagement and support individuals in transitioning from declining services to participating in recovery-oriented care. The program emphasizes least restrictive settings, family involvement, and cross-system collaboration.

CARE provides a comprehensive array of services addressing behavioral health, physical health, and social determinants of health, including:

- Case management and care coordination to support individualized recovery plans
- Behavioral health screening and assessments to determine appropriate levels of care
- Brief therapy and psychoeducation to address immediate concerns
- Psychosocial rehabilitation to build coping skills and improve functioning
- Linkages to housing, benefits, and social supports
- Referrals to medical care and Enhanced Care Management for integrated needs
- Warm hand-offs to treatment teams to ensure continuity of care
- Transportation assistance to improve access to services

The CARE Program advances BHSA goals by:

- Expanding access for individuals with the highest barriers to care
- Reducing disparities among unserved and underserved populations
- Integrating behavioral health, physical health, and social supports
- Promoting recovery through trauma-informed, culturally responsive practices
- Strengthening collaboration across behavioral health, criminal justice, and social service systems

Through coordinated, community-based care, CARE increases engagement, reduces avoidable hospitalizations and justice involvement, and improves long-term outcomes for individuals with complex needs.

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?

- 1

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

- *El Capitan, a Permanent Supportive Housing Project*

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):

- 48

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

- 48

Total number of units funded with Housing Interventions funds only

- 0

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
Stanislaus County BHRS is allocating $500,000 in BHSA Housing Intervention funds to support a portion of the El Capitan project's capital development and infrastructure. This funding is not tied to a specific number of units because it will cover shared site improvements and essential systems such as utilities, fire safety, and ADA compliance that enable future housing units and behavioral health service spaces.

The investment is intended to leverage other funding sources, accelerate project readiness, and ensure long-term habitability and safety. While not directly linked to unit

construction, these improvements are critical to bringing housing online for individuals with behavioral health challenges and integrating behavioral health services on-site.

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)

- 07/31/2026

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)

- $373,062

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 City of Modesto did not need to use the "By-Right" provisions provided by State for the administrative approval for this project as it falls under the "Negligible Impact" provision and therefore an already permitted development as designed.

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?

- N/A

Anticipated number of individuals served per year

- N/A

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)

Stanislaus County anticipates utilizing BHSA Housing Interventions funding to support the continuation of certain housing programs currently funded through time-limited sources, including Behavioral Health Bridge Housing (BHBH), once those funds are no longer available. One example includes Dignity Village, an interim housing project supported through BHBH funding that provides temporary housing and supportive services for individuals experiencing homelessness who have behavioral health needs. As BHBH funding sunsets, BHSA Housing Interventions funding may be used beginning in 2027 to help sustain projects such as Dignity Village and ensure continued access to interim housing for individuals served by BHRS.

In addition, BHRS is establishing a Behavioral Health Housing Collaborative to assess the county's behavioral health housing continuum, identify housing gaps, and evaluate the effectiveness and sustainability of existing housing programs. This collaborative effort will inform decisions regarding which programs should be continued, expanded, or developed to meet the housing needs of individuals with behavioral health conditions. Funding allocated to interim housing within the BHSA plan will allow the county flexibility to support existing projects, such as Dignity Village, while also responding to identified housing gaps and investing in the development of a broader housing pipeline for individuals experiencing homelessness who are served by BHRS.

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?

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care
- Day Habilitation
- Transitional Rent

None of the above

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

- Housing Transition Navigation Services
  - No
- Housing Deposits
  - No
- Housing Tenancy and Sustaining Services
  - No
- Short-Term Post-Hospitalization Housing
  - No
- Recuperative Care
  - No
- Day Habilitation
  - No
- Transitional Rent
  - No

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)?

Stanislaus County BHRS will utilize the developed Behavioral Health Housing Collaborative to examine and strengthen processes for connecting Medi-Cal members to

housing-related Community Supports offered by MCPs, including Transitional Rent. Through this initiative, BHRS will:

- Assess Current Processes: Review existing referral pathways, eligibility confirmation practices, and coordination mechanisms between BHRS, MCPs, and housing partners.
- Identify Gaps and Opportunities: Determine where improvements are needed to streamline referrals, reduce barriers, and ensure timely access to Community Supports.
- Develop Strategies: Work with MCPs, housing partners, and community-based organizations to design strategies that integrate behavioral health supports with housing services, including leveraging Transitional Rent as a bridge to permanent housing.
- Commit to Continuous Improvement: Findings and strategies will be shared in future annual updates, reflecting progress, lessons learned, and new approaches to improve member outcomes.
- Align with CalAIM Goals: Ensure strategies are consistent with DHCS guidance for Community Supports and Enhanced Care Management, while coordinating with local housing systems and the Coordinated Entry System.

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

Stanislaus County BHRS and MCPs currently maintain a strong collaborative relationship, meeting regularly to review contracts, Memorandums of Understanding (MOUs), and address system challenges. This coordination ensures MCPs are informed about BHRS's contracted provider network for Housing Interventions and that referral pathways remain clear and effective.

Looking ahead, this collaboration will be further strengthened through the new Behavioral Health Homelessness Continuum of Care initiative, which will introduce enhanced coordination strategies. As these strategies emerge, BHRS will continue to share updates and maintain transparency with MCPs and community partners. This approach ensures alignment with CalAIM Community Supports and BHSA priorities, promoting integrated housing solutions and reducing barriers for BHSA-eligible and Medi-Cal members.

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)?

- Yes

Please describe the county behavioral health system's coordination efforts to align network development

Stanislaus County BHRS and MCPs maintain a strong, ongoing collaboration to align network development for housing-related services. We meet regularly with MCP representatives and housing partners to review contracts, MOUs, share provider network information, and address system challenges. These meetings will continue under the new Behavioral Health Housing Collaborative initiative, ensuring enhanced coordination and alignment with BHSA Housing Interventions and CalAIM Community Supports.

BHRS and MCPs will continuously evaluate coordination efforts to identify opportunities for improvement, such as reducing duplication, expanding provider participation, and strengthening integration between behavioral health and housing supports. Updates on network alignment strategies and progress will be reported back through annual updates, ensuring transparency, accountability, and responsiveness to emerging needs.

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?

Stanislaus County BHRS has established processes to ensure Medi-Cal members with significant behavioral health conditions do not experience gaps in housing or behavioral health services once MCP housing benefits are exhausted, to the extent resources are available. These processes include:

- Ongoing Coordination with MCPs: BHRS and MCPs meet regularly to review contracts, MOUs, and system challenges. This collaboration will continue under the Behavioral Health Homelessness Continuum of Care initiative to strengthen alignment and proactively plan for transitions before MCP housing benefits end.
- Proactive Monitoring and Transition Planning: Through the Housing Continuum Collaborative, BHRS tracks members receiving MCP housing supports and initiates transition planning early to avoid service disruptions. This includes identifying alternative housing resources and supports before benefits expire.
- Leveraging Multiple Funding Streams: BHRS aligns BHSA Housing Interventions with MCP Community Supports and other resources such as CoC, HUD, and CalAIM flex-pool funding to sustain housing stability beyond time-limited benefits.
- Integration with Behavioral Health Services: Members continue to receive specialty mental health and substance use disorder services through BHRS providers regardless of housing benefit status, ensuring continuity of clinical care.
- Continuous Evaluation and Reporting: BHRS evaluates coordination efforts for network alignment and reports progress and emerging strategies in annual updates to maintain transparency and accountability.

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.

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?

- No

Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?

- No

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

- Not Applicable

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

Workforce Strategy

Maintain an Adequate Network of Qualified and Culturally Responsive Providers
The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:
1. Maintains and monitors a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and
2. Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.
3. The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.

Does the county intend to adopt this recommended approach for BHSA-funded providers that 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)?

- 14%

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates

- Other qualified Provider
- Registered Nurse
- Psychiatrist

Please describe any other key workforce gaps in the county

The County identified five positions with the greatest vacancy rates: Behavioral Health Specialist II, Mental Health Clinician II, Psychiatric Nurse II, Clinician Technician, and Psychiatrist.

However, the available dropdown options in Question 3 did not fully align with the County's internal classifications. As a result, the County selected the closest comparable categories available, Registered Nurse, Psychiatrist, and Other Qualified Professional, to best represent these high-vacancy roles. Positions such as Behavioral Health Specialist II, Mental Health Clinician II, and Clinician Technician do not have direct equivalents within the dropdown menu and were therefore captured under "Other Qualified Professional."

In addition to these critical vacancies, the county faces broader workforce gaps that impact service delivery and the ability to meet Behavioral Health Transformation (BHT) and BH-CONNECT requirements.

Key challenges include:

- Specialized Skills Shortages: Limited availability of staff trained in evidence-based practices and culturally responsive care, which are essential for implementing new models of integrated and equitable care.
- Pipeline Limitations: Educational and training programs do not consistently prepare graduates for specialized behavioral health roles, creating delays in filling critical positions.
- Licensure Barriers: Extended timelines for obtaining required licenses and certifications hinder rapid onboarding of qualified candidates.
- Retention and Burnout: High turnover and burnout rates among clinical staff exacerbate gaps and disrupt continuity of care.
- Geographic Distribution: Uneven distribution of professionals across the county, particularly in rural and underserved areas, limits access to services.

To address these challenges, the county will continuously evaluate workforce needs

throughout the three-year integrated plan period. This includes monitoring recruitment and retention trends, assessing emerging gaps related to BHT and BH-CONNECT implementation, and identifying new skill requirements as evidence-based practices expand. Data from service delivery, stakeholder feedback, and workforce analytics will inform mid-course adjustments and responsive strategies such as targeted training, partnerships with educational institutions, and flexible staffing models.

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, workforce needs will shift significantly due to BHT and BH-CONNECT requirements. The county anticipates increased demand for classifications that support evidence-based practices and integrated, equity-focused care models. This includes clinicians trained in EBPs, care coordinators, peer support specialists, and culturally responsive providers. Workforce gaps will be compounded by turnover and uneven distribution of professionals, while educational pathways often lack specialized behavioral health training. Additionally, the time required for licensure and certification will continue to delay meeting workforce needs. To address these challenges, strategies must focus on expanding training pipelines, accelerating onboarding for specialized roles, and supporting retention through career development and flexible staffing models.

Address Workforce Gaps

If the county is planning to leverage the BH-CONNECT workforce initiative to address workforce gaps including FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?

- No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?

- No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?

- No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?

- No

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

In addition to the efforts outlined under BHSA BHSS Workforce, Education, and Training, the county will continuously evaluate workforce needs throughout the three-year integrated plan period. This includes ongoing assessment of emerging gaps related to BHT and BH-CONNECT implementation, monitoring recruitment and retention trends, and identifying new skill requirements as evidence-based practices and equity-focused care models expand. The county will leverage data from service delivery, stakeholder feedback, and workforce analytics to inform mid-course adjustments and develop responsive strategies. These may include targeted training, partnerships with educational institutions, and flexible staffing models as needs evolve. Our approach is iterative and adaptive to ensure alignment with transformation goals and community priorities.

Budget and Prudent Reserve

Budget and Prudent Reserve

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
- Full-Service Partnership
- Housing Interventions

Enter date of last prudent reserve assessment

- 05/08/2026

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
- FSP
- Housing Interventions

Local Review of the BHSA Integrated Plan

A BHSA advisory committee meeting was held on April 28, 2026. During this meeting, advisory committee members received a detailed presentation of the draft Three-Year BHSA Integrated Plan for Fiscal Years 2026–2029. The draft Integrated Plan was also presented in various community and stakeholder settings. Details regarding these meetings and the comments received are documented in the log below.

Public comments were solicited through a comment form included at the end of the draft Integrated Plan and were accepted through the following methods:

- Fax: (209) 653-0391
- U.S. Mail to the address listed above
- Email: bhsa@stanbhrs.org
- Telephone: (209) 525-6247
- Online through the public comment form

The draft Three-Year BHSA Integrated Plan for Fiscal Years 2026–2029 was made available for a 30-day public review period beginning April 28, 2026. A public hearing was subsequently held by the Behavioral Health Board on May 28, 2026. Notification of the public review period and access to copies of the draft Integrated Plan were provided through the following methods:

- Posting on the County's MHSA website: www.stanislausmhsa.com
- Distribution of paper copies to Stanislaus County Public Libraries
- Electronic notification to all BHRS service sites, including a link to www.stanislausmhsa.com
- Email notification to BHSA Advisory Committee members, Behavioral Health Board members, and other community stakeholders informing them of the public review period and instructions for obtaining a copy of the draft Integrated Plan
- Publication of public notices in newspapers throughout Stanislaus County. The notices included information on accessing the draft Integrated Plan online and requesting a copy of the document by telephone.

A public hearing was conducted by the Stanislaus County Behavioral Health Board on May 28, 2026, at 5:30 p.m. at 1130 12th Street, Modesto, California 95354. Community stakeholders were invited to attend and provide input. The public comment period concluded on May 28, 2026. Feedback and questions received during the public comment period are documented in the BHRS Public Comment Log.

Following the completion of the public review and comment process, the draft Three-Year BHSA Integrated Plan for Fiscal Years 2026–2029 was presented to the Stanislaus County Board of Supervisors on June 16, 2026. The meeting was held in the Board Chambers, Basement Level, 1010 10th Street, Modesto, California 95354.

Public Comment Log

The following table represents all comments received by stakeholders and community members during the Public Comment period between April 28, 2026, and May 28, 2026. The Table also notes any revisions made to the draft Three-Year BHSA Integrated Plan for Fiscal Years 2026–2029.

Comment/ Feedback Provided By	Date Comment/ Feedback Received	Comment/ Feedback/Page Number	County Response
Public Comment Form	During public comment	It is disheartening to see Project Hope (PH) lose funding, as they provide vital in-home therapy and case management to older adults throughout Stan County. PH helps overcome transportation barriers that prevent a vulnerable population from accessing essential services, especially as they face the challenges of aging and may no longer be able to drive safely within their community. Older adults are at greater risk due to fixed incomes, which makes paying for co-pays difficult and potentially threatens their housing, electricity, or gas services. Beyond therapeutic and case management support, PH offers companionship through its friendly visitors program, helping those who no longer drive combat loneliness. This program relies on dedicated volunteers who visit socially isolated elderly individuals. Extensive research from organizations like the American Psychological Association, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and World Health Organization shows that loneliness and social isolation significantly increase the risk of early death, dementia, heart disease, stroke, type 2 diabetes, and depression. One may wonder what causes feelings of loneliness and social isolation among the elderly. Often, it is not the individual's fault but rather a result of circumstances such as the loss of family members, a partner, friends, neighbors, or physical limitations that come with aging. As I reflect while writing this letter, I recognize that before working with this population, I knew little about the needs	No changes to the Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.

		and barriers elderly adults face daily. Throughout my journey, I've learned how to become an ally to them and ensure they receive the services they deserve—just as we would want for our grandparents, parents, aunts, uncles, and someday, ourselves. Please do not let this valuable program come to an end at the Department of Aging and Veterans Services. Thank you for your time.	
Public Comment Form	During public comment	As the Local Level Entity (LLE) for Cal Voices, the Help is Hope Foundation appreciates the opportunity to provide feedback on the FY 2026-2029 BHSA Integrated Plan. We provide specialized peer-led support and advocacy for adults (18+) in Stanislaus County who are experiencing the intersection of homelessness, recent justice involvement, substance use disorders, and mental health challenges. We strongly support the County's commitment to expanding the continuum of care, specifically the Forensic System of Care and the proposed Housing Interventions. For the populations we serve—many of whom face significant barriers to stability—clinical services alone are often insufficient. We advocate for the integration of Consumer-Operated Services to serve as a critical bridge. Peer support is uniquely effective in engaging adults who have struggled with incarceration and housing instability, providing the non-judgmental, lived-experience connection required for long-term recovery and success. As the County moves toward implementing these 3-year goals, we urge the Department to ensure that peer-run organizations are included in the implementation strategies for forensic and housing programs. Maintaining open communication with local peer organizations is essential to ensuring that these services remain culturally responsive and truly accessible to the vulnerable adult populations we serve. We look forward to partnering with the Department to bridge these systemic gaps.	No changes to the Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.
Public Comment Form	During public comment	As a Board Member of the Help is Hope Foundation and a working Peer Support Specialist, I am providing feedback on	No changes to the Integrated Plan. The comment has been

		the FY 2026-2029 BHSA Integrated Plan from the perspective of the front lines. I work daily with adults (18+) who are navigating the intersections of homelessness, past justice involvement, and substance use. While the County's plan is comprehensive, the most significant barrier to service is often a lack of trust in formal clinical systems. From my experience, the only way to effectively reach and retain this population is through "peer-led" bridges. I strongly urge the County to prioritize funding and operational support for peer-run organizations that provide trauma-informed, non-clinical outreach. We know from experience that when our clients are engaged by peers who share their lived experience, they are more likely to successfully transition into housing and forensic support programs. I ask that the Department view local peer-run organizations as essential partners in executing the community outreach goals described in this plan.	acknowledged and will be considered in ongoing Department planning activities.
Public Comment Form	During public comment	ASK #1 — Include Help Is Hope as an FSP Provider or Subcontracted FSP Peer Support Partner Over 2,200 Stanislaus County adults are eligible for FSP services, and the plan's own FSP model requires peer support specialists across all ACT, FACT, ICM, and HFW teams. Help Is Hope formally requests that BHRS either contract directly with us as an FSP sub provider, or require all FSP prime contractors to subcontract a defined percentage of peer support hours to community-based, peer-led nonprofits. True partnership means partnering with organizations already embedded in the community — not replicating that work on a county payroll. ASK #2 — Require Lived Experience and Community-Based Hiring in Peer Support Roles The plan deploys 177+ peer support practitioners across FSP programs. If all roles go to county employees or large contractors, BHSA dollars will build a workforce that lacks genuine community credibility. We ask BHRS to require that all peer support roles be filled by individuals with certified lived experience, that a minimum percentage	No changes to the Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.

		of peer support hours be contracted to community-based nonprofits, and that procurement structures allow peer-led organizations to compete without clinical licensure. ASK #3 — Designate and Fund Peer-Led Nonprofits as Trusted Messengers People in encampments, active addiction, and reentry do not engage because a county employee handed them a brochure. They engage because someone they already trust showed up. Help Is Hope's staff are neighbors and people in recovery — that credibility cannot be manufactured from a job posting. We ask BHRS to create a contracted Trusted Messenger pathway with clear deliverables and billing codes, and to include Trusted Messenger contracting in the START Center RFP (Winter 2026/Spring 2027). ASK #4 — Create a CBO Contracting Pathway Without Clinical Licensure Requirements Current procurement standards require clinical licensure — even for non-clinical peer outreach and navigation. This structurally excludes peer-led nonprofits and contradicts BHSA's own equity mandate and commitment to CDEPs. We ask BHRS to create a tiered CBO contracting framework that pays qualified nonprofits for peer outreach, navigation, harm reduction, and basic needs services without requiring clinical licensure. Who We Are — Why We Qualify Help Is Hope is already doing this work: CalAIM Community Supports and ECM provider in Stanislaus, Merced, and San Joaquin Counties Certified Medi-Cal Peer Support Specialists with lived experience in homelessness, substance use, and incarceration Services include peer support, WRAP planning, crisis navigation, shelter/encampment outreach, basic needs, and warm hand-offs 24/7 AI-assisted navigation platform	

		and walk-in services at 140 Calaveras Ave, Modesto Actively pursuing full Medi-Cal provider enrollment ahead of the July 1, 2027 billing requirement We are not asking to be handed a contract. We are asking for a fair opportunity to compete for work we already perform. We respectfully request a direct meeting with BHSA Policy Planning staff and BHRS contracts leadership to discuss FSP subcontracting and peer support partnership pathways.	
Public Comment Form	During public comment	I am a student in a program that focuses on community health and social awareness. I want to share my thoughts on the Behavioral Health Services Act planning process. There are three areas that I think are really important: Crisis Services and System Transformation, Family and Youth-Focused Services, and Older Adult Behavioral Health. What I have seen in my community is that people in crisis are often met by police officers not mental health professionals which can make things worse. I have seen this happen. It is clear that these people need care and understanding not punishment. This is why I think we need to change the way we respond to crises. I also have friends who are struggling with stress and anxiety. They do not know where to turn for help. If we can provide support for young people and their families, it can make a big difference. I have also seen adults in my family struggle with loneliness and mental health issues, and it is clear that we need a system that is more compassionate and accessible to all ages.	No changes to the Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning to expand Crisis Response Services.
Behavioral Health Board Members	05/20/2026	County Behavioral Health System Overview. Page 5&6 - Why are we at 000 in some the numbers? 8 questions on the table in Children and Youth	The Department does not currently have the capacity to accurately report these data elements. However, the BHSA Integrated Plan includes strategies intended to strengthen the Department's data reporting capabilities.
Behavioral Health Board Members	05/20/2026	When is the County going to start counting kids? Or get the numbers from the school districts? – BHRS is currently working with appropriate partners to capture the data required for all populations we currently have a gap in data, that includes youth/children.	The BHSA Integrated plan includes strategies to increase the department's capacity to collect and report on children experiencing homelessness.

		Are we checking HMIS and putting them at the top of the list for housing?	
Behavioral Health Board Members	05/20/2026	Are we working with the Center for Human Services and YNC for these kids?	County does fund services at the Center for Human Services' Youth Navigation Center (YNC).
Behavioral Health Board Members	05/20/2026	Do we currently have a contract with the hospitals?	The Department does have contracts with the in-county psychiatric hospital, Doctor's Behavioral Health Center, and the local Psychiatric Health Facility and is developing MOUs with local medical hospitals.
Behavioral Health Board Members	05/20/2026	Who do we have MOUs with? Are you looking at some the smaller community non-profits or organizations that do the work?	The Department currently contracts with smaller nonprofit organizations and considers a variety of provider types when developing services and implementing programs.
Behavioral Health Board Members	05/20/2026	What does the Bronzan McCorquodale Act Do? Is there any way we can get a presentation on it?	The Bronzan–McCorquodale Act established California's county-based public mental health system and designated counties as the local mental health authority responsible for planning, administering, and overseeing community mental health services. Enacted as part of the 1991 Mental Health Realignment, the Act shifted significant responsibility for behavioral health services from the State to counties while providing dedicated funding to support these programs.
Behavioral Health Board Members	05/20/2026	Are specialty services going into every program and treatment team?	The Department, as the County's Behavioral Health Plan, serves as the provider of Specialty Mental Health Services. BHRS programs and services are organized to ensure individuals have timely access to, and support in navigating, the Specialty Mental Health Services system of care.
Behavioral Health Board Members	05/20/2026	Care Transitions What referral services do you use to send care of peers to other providers? How long do you follow them after hand off?	When a member no longer meets BHRS criteria for Specialty Mental Health Services, the program utilizes Department of Healthcare Services (DHCS)

		Do you go with them on their first visit with the new provider?	transition-of-care processes to facilitate a referral to the member's Managed Care Plan for ongoing behavioral health services. BHRS supports members throughout this care coordination process to help with the transition and continuity of care. In addition, members may be referred to peer support and recovery-oriented services, including Wellness Center programs and other community-based supports, as appropriate to their needs. If the member requests, the referring treatment staff may accompany the member on their first appointment.
Behavioral Health Board Members	05/20/2026	Statewide Behavioral Health Goals What are the 14 goals?	The 14 statewide priority goals are: Care Experience, Access to Care, Prevent and Treat Co-Occurring Physical Health Conditions, Quality of Life, Social Connection, Engagement in School, Engagement in Work, Suicide, Overdose, Untreated Behavioral Health Conditions, Homelessness, Institutionalization, Justice Involvement, and Removal of Children from Home.
Behavioral Health Board Members	05/20/2026	Where can we get the workbook?	The link below is to the BHSA Policy Manual https://policy-manual.mes.dhcs.ca.gov/
Behavioral Health Board Members	05/20/2026	Priority Statewide Behavioral Health Goals for Improvement Will there be questions on LGBTQ+ folks? They are considered a special population in California. Will you have all Community Partners take in all this information?	Yes, the county did engage with LGBTQ+ population as part of the Community Planning Process. The Department has incorporated feedback received through engagement with LGBTQ+ community stakeholders into its planning and service development efforts. The Department also maintains a Behavioral Health Equity Committee (BHEC), which helps inform equity-focused initiatives, identifies opportunities to reduce

			disparities, and supports efforts to improve access to culturally responsive behavioral health services for underserved populations. The Department will continue to share information, resources, and best practices with behavioral health providers to strengthen their capacity to provide culturally responsive services and improve access, engagement, and outcomes for LGBTQ+ individuals.
Behavioral Health Board Members	05/20/2026	What are the non-specialty mental health services for BHRS and Community Partners? (Page 16) are Medi-cal MCP services that are administered by our MCPs in Stanislaus County.	The Department does not administer or directly provide Non-Specialty Mental Health Services (NSMHS). These services are administered by Medi-Cal Managed Care Plans through separate provider networks.
Behavioral Health Board Members	05/20/2026	What are BHRS plans to get more information from the people who are having a hard time getting access to care? Has the dashboards you guys used show any improvement in getting people access to care? How long does it take them to get this care? If at all (Page 17)	Page 17 of the Access Disparity Analysis identifies several populations whose utilization of behavioral health services falls below the statewide average. To address these disparities, the Department has incorporated a range of programs, services, and strategies within the BHSA Integrated Plan that are specifically designed to improve access, engagement, and service utilization among the populations identified as experiencing below-average access to care. The Department will continue to use data and community input to inform ongoing efforts to reduce disparities and improve equitable access to services.
Behavioral Health Board Members	05/20/2026	When will your START hub be opening? Will this program be Drop in or Referral? or both? What are the qualifications for it? (Pages 18-21)	The Department is currently in the planning phase of the START Hub and anticipates releasing a Request for Proposals (RFP) in the near future. As a result, a final opening date has not yet been established.

			The program is anticipated to serve individuals through both walk-in access and referrals from healthcare providers, partner agencies, and community-based organizations. While final program requirements are still under development, the START Hub is intended to serve community members seeking substance use disorder treatment services regardless of their ability to pay, insurance status, or payer source, including individuals who are uninsured.
Behavioral Health Board Members	05/20/2026	Homeless Data - are we going to keep LGBTQ+ people numbers and data in this area? Are we going to get it put in the HMIS system?	The Department will continue to collect all required LGBTQ+ demographic and outcome data. The BHSA Integrated Plan includes strategies to increase the Department's capacity to improve data collection, integration, analysis, and reporting through systems such as HMIS and other applicable data sources and reporting platforms.
Behavioral Health Board Members	05/20/2026	Is the BHRS going to get a seat on CSOC?	There is not a plan for BHRS to join the Community System of Care (CSOC) at this time.
Behavioral Health Board Members	05/20/2026	What is the standard amount of time you spend with each client and how long do they stay with their programs? (Page 28)	Service intensity and the amount of time spent with each member are individualized and vary based on the member's unique clinical needs, goals, and level of care.
Behavioral Health Board Members	05/20/2026	Are we up to standard with the number of beds that we need for the county this size? Adult and children?	No response provided. The question lacks sufficient specificity to provide an accurate response.
Behavioral Health Board Members	05/20/2026	Why are we only listing males in the adult arrest rates? Can we get the amount of females and juveniles too? (Page 34)	The primary and secondary measures for the statewide goals were established by DHCS and could not be modified by BHRS. Although the required reporting measures are standardized statewide, the Department has data on all populations included in the dataset and uses this information to support local planning and equity-focused initiatives.

Behavioral Health Board Members	05/20/2026	Additional Statewide Behavioral Health Goals for Improvement Where are we getting the school numbers from? Is it our numbers? Do we get information from the school mental health professionals? (Page 47)	Per DHCS guidance, the Department must use data from California Health Kids Survey.
Behavioral Health Board Members	05/20/2026	County - Selected Statewide Population Behavioral Health Goals What is BHRS doing to get the Education and Information out the groups and other organizations that need the information?	The Department provides education and information through ongoing outreach, community partnerships, stakeholder engagement activities, public meetings, and collaboration with local organizations to ensure behavioral health resources and services are accessible to priority populations and the broader community.
Behavioral Health Board Members	05/20/2026	How are we going to help people that are in the justice system that don't get Medi-Cal?	The Department currently provides in-reach services and facilitates access to behavioral health treatment for individuals incarcerated in the local county jail. Funded through Community Corrections Partnership (CCP) resources, the program supports both insured and uninsured individuals by connecting them to appropriate behavioral health services and treatment prior to and following release
Behavioral Health Board Members	05/20/2026	When will the SPEC Blueprint Plan go to the BOS?	The Department paused presentation of the Suicide Prevention Education Coalition (SPEC) Blueprint to the Board of Supervisors pending DHCS approval of the BHSA Integrated Plan. With approval of the Integrated Plan now received, the Department is reviewing the Blueprint to ensure alignment with the approved BHSA strategies and priorities before presenting it to the Board of Supervisors for consideration.
Behavioral Health Board Members	05/20/2026	When will the START team go operational? How many teams will there be? How many on a team?	The Department is currently in the planning phase of the START program and anticipates releasing a Request for Proposals (RFP) in the near future. While the final program design has not

			been finalized, the program is intended to be adequately staffed to provide access to substance use disorder treatment services 24 hours per day, seven days per week. The START program is being designed as a payer-agnostic access point, serving individuals seeking substance use disorder treatment regardless of insurance status or payer source, including Medi-Cal beneficiaries, privately insured individuals, and those who are uninsured.
Behavioral Health Board Members	05/20/2026	County Contracted Behavioral Health Services Act Locations Why do we not have any locations for only SUD? And any for Dual Diagnosis?-	The locations identified in this section reflect services funded through the BHSA. While no locations are designated exclusively for substance use disorder (SUD) services under BHSA funding, BHRS provides SUD treatment services through other funding sources and service delivery systems.
Behavioral Health Board Members	05/20/2026	What is the Behavioral Health Housing Collaborative? Who are the other organizations involved in this project? How do I get involved in this?	The Behavioral Health Housing Collaborative, including its purpose, structure, and planned projects, is described in detail on page 23 of the Integrated Plan. Please contact BHRS administration for information on how to get involved in the Behavioral Health Housing Collaborative.
Behavioral Health Board Members	05/20/2026	Where can I get the DHCS flex pool TA Resource Guide?	DHCS website- Flexible Housing Subsidy Pools – Technical Assistance Resource
Behavioral Health Board Members	05/20/2026	Work Force Strategy Where can I get the Policy Manual?	The county has a posted manual Stanislaus County Workforce DevelopmentStanislaus County Workforce Development
Behavioral Health Board Members	05/20/2026	Where is the list of Equity/Compliance trained providers? (Page 153)	The Department does not maintain a specific list of providers who have completed this training. However, County policy requires that all County-operated and contracted providers complete a

			minimum of eight hours of cultural competency training annually. Compliance with this requirement is incorporated into the County's provider and workforce expectations to support culturally responsive service delivery.
Behavioral Health Board Members	05/20/2026	Build Workforce to Address Statewide Behavioral Goals Are we in line with the state? Are we higher or lower? What are we doing to get or recruit people to work for the County? (Page 154)	The Department's workforce strategy is outlined in the Workforce Strategy section of BHSA Integrated Plan. That section includes workforce data, identifies key workforce challenges, and describes the Department's strategies and planned investments to recruit, retain, develop, and support the behavioral health workforce needed to meet community needs.
Behavioral Health Board Members	05/20/2026	Quality Assessment & Performance Improvement (QAPI) Program Does this plan include all the QIC's or it only for this plan? Where do you get the information?	Per DHCS guidance, only the current year's Quality Improvement Plan (QIP) is required to be posted. The QIP can be accessed on the BHRS website under the Quality Assessment section: Quick Links – Behavioral Health and Recovery Services – Stanislaus County
Behavioral Health Board Members	05/20/2026	How do the partners submit information to be tracked? (Page 5)	Stanislaus County Individuals interested in obtaining information related to the development of the QIP or providing input may contact the BHRS Administration Office at (209) 525-6225.
Public Comment Form	During public comment	1.) Within the support planned for clients categorized as “severe populations”, it is recommended to create a space, providing both community support and peer support where healing individuals can learn, reintegration skills and create community to establish a healthy support system for sustainability. 2.a) When expanding scope for input sake, consider ways to invite and include individuals who are not associated with established groups such as the “justice involved” non-profit. 2.b) Improved access is imperative for	Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.

		this large group of individuals between the ages of 33 and 54 years of age who are not married, do not have children, and are in need of support. This group is similar to transitional-aged youth and are in need of similar support because their life skills were stunted due to trauma and other circumstances found within the category of "severe populations." These individuals (ages 33-54) continue to be overlooked, yet they are the largest population identified on page 51 of the BHSA 2026-29 Integrated Plan to be impacted by overdoses. Moreover, stabilizing this group can generate peer support for possible TAY mentorship. 3.) As a support for employment, implement strategies to better inform and equipped community leaders/organizations to receive clients who are being transitioned out from the severe population status and reintegrating into the community. 4.) As a way to strengthen treatment capabilities and as a workforce strategy, advocate for group sessions to be created for those re-stabilizing so there is a safe space to practice new skills before fully reintegrating into community— this serves as a way to improve functioning and reduce impairment. 5.) Ensure equitable mental health support for school based services. The lower the income and the higher the need, then the higher the mental health support to be provided to those schools and greater service expansion to guardians.	
StanC2C Mental Health Working Group	05/07/2026	Discussion focused on key behavioral health initiatives, including the development of the START program to support individuals experiencing homelessness and substance use disorders, expansion of crisis response services through increased school and community partnerships, and continued planning for the Hope Forward Campus in collaboration with neighboring counties. Participants emphasized the importance of leadership, governance, and accountability to sustain system improvements. Additional discussion highlighted BHRS's stable budget outlook, opportunities to strengthen community awareness and engagement,	Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.

		and challenges related to managed care plan reimbursement processes, including the need for improved communication, feedback mechanisms, and reduced administrative barriers.	
Suicide Prevention Education Coalition (SPEC) Meeting	05/08/2026	Presented overview of the Draft Integrated Plan- No questions received	No changes to Plan.
StanC2C Steering Committee	05/08/2026	Discussion focused on key behavioral health initiatives, including the development of the START program to support individuals experiencing homelessness and substance use disorders, expansion of crisis response services through increased school and community partnerships, and continued planning for the Hope Forward Campus in collaboration with neighboring counties. Participants emphasized the importance of leadership, governance, and accountability to sustain system improvements. Additional discussion highlighted BHRS's stable budget outlook, opportunities to strengthen community awareness and engagement, and challenges related to managed care plan reimbursement processes, including the need for improved communication, feedback mechanisms, and reduced administrative barriers.	Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.
Safety Opioid Coalition Meeting	05/14/2026	Presented overview of the Draft Integrated Plan- No questions received	No changes to Plan.
BHB Public Hearing	05/28/2026	Putting money in good place however what if people want to continue to be homeless or do drug. Is there a cut off?	Members generally have the right to choose whether to participate in behavioral health and housing services. The Department's role is to make services available, reduce barriers to access, and continue engaging individuals when they are ready for support. Recovery can take time, and services are designed to meet people where they are while respecting personal choice
BHB Public Hearing	05/28/2026	Peer Art Recovery stated they can go into various community settings to help BHRS spread message of services as at times residents do not trust county and CBO can provide message in a better way.	The Department recognizes the important role of community-based organizations and will continue to partner with CBOs, when appropriate, to support outreach, engagement, and awareness of behavioral health services.
BHB Public Hearing	05/28/2026	Will FRC's continue to operate?	Family Resource Centers (FRC) are operated by

			several community-based organizations. Questions regarding the operations, services, or activities of a specific Family Resource Center should be directed to the organization responsible for operating that center.
BHB Public Hearing	05/28/2026	Veteran Helping Veterans- Presentation didn't include information on how veterans will be helped.	The Department is currently working with a collaborative of veteran stakeholders to develop recommendations for inclusion in the next BHSA Integrated Plan update.
BHB Public Hearing	05/28/2026	Comment on how under MHSA, PEI work allowed communities to do the work of prevention and this is not allowed under BHSA and the county needs to find a way to continue this work.	Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.
BHB Public Hearing	05/28/2026	CalPride Stanislaus- This organizations has connections to many county resources and when individuals come in they feel more comfortable seeking help there and getting appropriate referrals. They to are also seeing veterans.	Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.
BHB Public Hearing	05/28/2026	SAACR has been an increase in the veterans they are helping.	Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.
BHB Public Hearing	05/28/2026	What was missing in presentation was how county will be helping the special education population. Statistics were provided on how this population has grown.	Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.
BHB Public Hearing	05/28/2026	Comment on how the county has not mentioned how they will use the money that should be coming to counties under the California approved WET plan according to a community member.	Integrated Plan. The comment has been acknowledged and will be considered in ongoing Department planning activities.

Plan Approval and Compliance

For more information on this section, please see 3.A.1 Reporting Period.

Behavioral Health Director Certification

- To be uploaded once signed with final

County Administrator or Designee Certification

- To be uploaded once signed with final

Board of Supervisor Certification

- To be uploaded once signed with final

BHSA Integrated Plan Acronyms

Acronym	Definition
AA	Alcoholics Anonymous
ACSL	Access, Crisis and Support Line
ACT	Assertive Community Treatment
AOD	Alcohol and Other Drug
AOT	Assisted Outpatient Treatment
API	Application Programming Interfaces
ASAM	American Society of Addiction Medicine
ASOC	Adult System of Care
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHAS	Behavioral Health Accountability Set
BHBH	Behavioral Health Bridge Housing
BHDS	Behavioral Health Delivery System
BHEC	Behavioral Health Equity Committee
BHHC	Behavioral Health Housing Collaborative
BHIN	Behavioral Health Information Notice
BHOATR	Behavioral Health Organized Access and Treatment Reform
BHOE	Behavioral Health Outreach & Engagement
BHRS	Behavioral Health and Recovery Services
BHSA	Behavioral Health Services Act
BHSS	Behavioral Health Services and Supports
BHST	Behavioral Health Services team
BHT	Behavioral Health Transformation
BHWC	Behavioral Health Wellness Center
BMA	Bronzan-McCorquodale Act
BRFSS	Behavioral Risk Factor Surveillance System
CAADE	California Association for Alcohol/Drug Educators
CADTP	California Association of DUI Treatment Programs
CARE	Community Assessment, Response, and Engagement
CCAPP	California Consortium of Addiction Programs and Professionals
CCT	Care Coordination Team
CDCR	California Department of Corrections and Rehabilitation
CDE	California Department of Education
CDPH	California Department of Public Health
CE	Continuing Education
CEI	Children's Early Intervention
CES	Coordinated Entry System
CFT	Child and Family Team
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
CHIS	California Health Interview Survey
CHKS	California Health Kids Survey
CHW	Community Health Worker

COPN	California Overdose Prevention Network
COSSUP	Comprehensive Opioid, Stimulant, and Substance Use Program
CPP	Community Planning Process
CPS	Consumer Perception Survey
CRT	Crisis Response Team
CRU	Crisis Residential Unit
CSA	Community Services Agency
CSC	Coordinated Specialty Care
CSC-FEP	Coordinated Specialty Care- First Episode Psychosis
CTM	Core Treatment Model
CWIP	Child Welfare Indicators Project
DHCS	Department of Healthcare Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DSH	Department of State Hospitals
EBP	Evidence-based practice
ECHW	Enhanced Community Health Workers
ECM	Enhanced Care Management
ED	Emergency Departments
EHR	Electronic Health Record
EI	Early Intervention
EIP	Early Intervention Programs
EMAC	Evaluation & Medication Access Clinic
EPI	Early Psychosis Intervention
EPSDT	Early Periodic Screening Diagnostic Treatment
FACT	Forensic Assertive Community Treatment
FFS	Fee-For-Service
FFT	Functional Family Therapy
FMR	Fair Market Rent
FSP	Full Service Partnership
FUA-30	Follow-Up After Emergency Department Visit for Substance Use Disorder
FUM-30	Follow-Up After Emergency Department Visits for Mental Illness
FY	Fiscal Year
HCAI	Health Care Access and Information
HFW	High Fidelity Wraparound
HHAP	Homeless Housing, Assistance, and Prevention
HIC	Housing Inventory Count
HLC	Health Leadership Council
HMIS	Homeless Management Information System
HSA	Health Services Agency
HUD	Department of Housing and Urban Development
ICM	Intensive Case Management
IET	Integrated Executive Team
IET-INI	Initiation of Substance Use Disorder Treatment
ILT	Integrated Leadership Team

IP	Integrated Plan
IPS	Individual Placement and Support
IST	Incompetent Stand Trial
JBCT	Jail Based Competency Treatment
JI	Justice-Involved
LHJ	Local Health Jurisdiction
LIFE	Lasting Independence Family Empowerment
LOCUS	Level of Care Utilization System
LRP	Loan Repayment Program
MAT	Medications for Addiction Treatment
MH	Mental Health
MHBG	Mental Health Services Block Grant
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHWG	Mental Health Working Group
MRCE	Member Relations & Community Education
MST	Multisystemic Therapy
NA	Narcotics Anonymous
NSMHS	Non-Specialty Mental Health Services
NTP	Narcotics Treatment Program
OSF	Opioid Settlement Funds
P-CIT	Parent-Child Interaction Therapy
PATH	Projects for Assistance in Transition from Homelessness
PCP	Primary Care Physician
PFMHD	Pre-Trial Felony Mental Health Diversion
PHM	Population Health Management
PIP	Performance Improvement Projects
PIT	Point-in-Time
PSH	Permanent Supportive Housing
QAPI	Quality Assessment & Performance Improvement
QI	Quality Improvement
QIC	Quality Improvement Committee
QIP	Quality Improvement Plan
QMT	Quality Management Team
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration
SBHI	School Behavioral Health Integration
SCOSC	Stanislaus County Opioid Safety Coalition
SFY	State Fiscal Year
SMHS	Specialty Mental Health Services
SNF	Skilled Nursing Facility
SOC	System of Care
SPEC	Suicide Prevention Education Coalition
STANCO	Stanislaus Affordable Housing Corporation
START	Stanislaus Triage, Access, Recovery, and Treatment
STEP	Stanislaus Equity Partners
STP	Specialized Treatment Program

STRTP	Short-Term Residential Therapeutic Program
SUBG	Substance Use Prevention, Treatment, and Recovery Services Block Grant
SUD	Substance Use Disorder
SUT	Substance Use Treatment
TA	Technical Assistance
TFC	Therapeutic Foster Care
TPS	Treatment Perception Survey
WET	Workforce, Education and Training

SmartCare Assessment Mapping IP Portal- Attachment #1

SmartCare Assessment BHSA IP Indicator Mapping - County BH System Overview

From IP: 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.*

Indicator	SmartCare Value (FY 24/25)	Smart Care Access Instructions	Publicly Available Value	Time Period for Public Value	Publicly Available Value Source	Public Source Access Notes
Received Medi-Cal Specialty Mental Health Services (SMHS)	**4,650**	BHRS 113 Service Area: MH Age Group: 0-20 Billable	**2,741**	FY 22/23	The Child and youth MHS demographic AB470 dashboard	Data is stratified by demographic category only. However, BHPs can calculate the total number of beneficiaries served by summing totals across demographic groups (i.e., total beneficiaries served = male beneficiaries + female beneficiaries).
Received at least one SUD individual PEI service						
Received DMC-ODS services	**222**	BHRS 113 Service Area: DMC Program Type: all types starting with SUD Age Group: 0-20 Billable	**162**	FY 22/23	Substance Use Disorder Drug Medi-Cal and Drug Medi-Cal Organized Delivery System	SUD Drug Medi-Cal and Drug Medi-Cal Organized Delivery System Penetration Rate Dashboard Data only available for FYs 2022–23; scroll to Figure 5 -Used DMC-ODS (not DMC)
Received MH and SUD services from MHP and DMC-ODS plan	**31**	BHRS 113: First filter for MH only in service area. Then filter for SUD only. Then filter for both. Use equation: MH only + SUD only - (MH or SUD filters). Age Group: 0-20				
Accessed the Early Psychosis Intervention Plus Program	**61**	BHRS 113 billiable only 4356 -LIFE Path Medication Clinic 5617- SVCFS - LIFE Path Treatment 5619- SVCFS - LIFE Path Engagement 5621- SVCFS - LIFE Path Referrals/After Care Ages: under 20				
Were chronically homeless or experiencing homelessness or at risk of homeless	**0**	BHRS 113 Program: 2202 Age Group: 0-20	**2,932**	FY 24/25	2024-25 Homeless Student Enrollment by Dwelling Type State Report	NOTE: Value reflects total unhoused population, not subset who were served by Behavioral Health
Were in the juvenile justice system	**0**	BHRS 101 Age: Children (0-17 yrs) Status: Active Flag: Probation, Distinct Client Count	**401**	FY 23/24	Office of Youth and Community Resoration (OYCR) - County Plans	NOTE: Value reflects total justice-involved population, not subset who were served by Behavioral Health 2025 Stanislaus County Plan: pg. 4 - Total number of youth booked
Have reentered the community from a youth correctional facility	**0**	BHRS 101 Age: Children (0-17 yrs) Status: Active Flag: Probation, Distinct Client Count	**6**	FY 23/24	Office of Youth and Community Resoration (OYCR) - County Plans	NOTE: Value reflects total justice-involved population, not subset who were served by Behavioral Health 2025 Stanislaus County Plan: pg. 5 - Total commitments minus # youth currently serving commitment in SYTF
Were served by the Mental Health Plan and had an open child welfare case	**411**	BHRS 113 Program: 1602, 1604, 1611 Service Area: MH Age Group: 0-20	**466**	FY 21/22	BHSA indicator Children And Youth With An Open Child Welfare Case Specialty Mental Health Services (SMHS) Performance Dashboard	-Navigate to the first dashboard labeled "Demographics – SMHS Penetration Rates". Click on the arrow on the left of the screen and select one value per filter: CA Geography: Select the county of interest. Fiscal Year: Select [most recently available year]. Demographic Category: Select "All" or a specific age range. The dashboard defaults to the "Pen Rate" tab; select the "SMHS1" tab to view the number of beneficiaries who had at least one visit.
Were served by the DMC-ODS plan and had an open child welfare care	6	BHRS 113 - billiable Program: 1502, 1503 Service Area: DMC Age Group: 0-20 Total = 6				
Have received acute psychiatric care	**701**	FY 24/25: Distinct count of children/youth ages 0-20 who received acute psychiatric care (aka received at least one Crisis Assessment; count does not include Mobile Crisis Assessment) = 701				



Quality Assessment & Performance Improvement (QAPI) Program -Attachment #2

Quality Improvement (QI) Program Description and Work Plan

Stanislaus County Behavioral Health and Recovery Services

2025-2026

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Quality Improvement (QI) Program Description 2025-2026

Overview

The Quality Improvement Program (QIP) encompasses the quality improvement activities of the Stanislaus County Behavioral Health and Recovery Services (BHRS) Department, including Medi-Cal Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS). The QAPI and Workplan serve as the foundation of Stanislaus County BHRS to continuously improve the quality of treatment and services provided to its members including strategies to ensure access to coordinated and culturally responsive care for members with co-occurring behavioral health needs.

The Quality Management Team (QMT), on behalf of the Behavioral Health Plan, oversees the program to ensure compliance with quality improvement requirements related to service delivery. The QIP aims to identify, monitor and address quality of care issues through a structured and continuous improvement process to ensure that services meet established regulatory and clinical standards. QMT shall evaluate the impact and effectiveness of its QAPI Program annually and update the Program as necessary.

Quality is assessed in terms of access, satisfaction, continuity, and quality care, with specific expectations for each area that are tracked through an ongoing improvement plan.

The QIP is multidisciplinary, involving providers, consumers, family members of consumers, and BHRS staff responsible for care management, quality assurance, and administration. Consumer and family input is actively sought as it is considered essential for achieving quality of care.

Continuous improvement principles the program follows:

- Prioritize the needs and experiences of the member
- Involve those closest to the issue in problem-solving
- Implement data-driven process improvement strategies
- Leverage both quantitative and qualitative insights
- Employ a holistic, systematic approach to improvements

Vision

Our vision is to continue to be a leader in behavioral health and to be recognized for excellence in our community, state, and nation.

Mission

In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote our community's capacity to achieve wellness, resilience and recovery outcomes.

Quality Improvement Program Structure

Stanislaus County BHRS is responsible for establishing, maintaining, and supporting an effective QIP, as delegated by the State Department of Health Care Services (DHCS) for Medi-Cal members. The BHRS QMT ensures that the program meets the standards and goals set by the delegating authority.



ROLES DEFINED

Executive Leadership Team – This team includes the Behavioral Health Director, Medical Director, Associate Director of Clinical Operations, and Assistant Directors. This team serves as the oversight for all BHRS activities. They report to both the County CEO and the Board of Supervisors.

SLT - This team includes the Behavioral Health Director, all BHRS Senior Leaders, and the Executive Assistant to the Behavioral Health Director. They are scheduled to meet weekly and are responsible for ensuring all QI activities are established, maintained, and supported.

Behavioral Health Plan – The plan is responsible for plan functions for the Mental Health and DMC-ODS Plan, ensuring implementation of applicable regulatory and contractual requirements.

QMT –Monitors and ensures accountability for all Quality Improvement (QI) efforts and receives regular reports on their progress and reviews recommendations to take to SLT. The team includes SLT leaders, clinical system of care (SOC) Quality Improvement Committee (QIC), Medication Monitoring Team, Process Improvement Projects (PIP) Committee Lead, and Behavioral Health Equity Committee (BHEC) Lead and other key staff.

Medication Monitoring Team – This team is responsible for the QI activities related to medication management functions of BHRS. The team is supervised by the Medical Director and the BH Plan Administrative Chief (or designee) and is composed of UM clinical staff.

PIPs – PIP Committees are formed and facilitated by the Quality Services Manager when processes needing improvement across divisions are identified. PIPs must follow the framework and structure provided by the Health Services Advisory Group in adherence to DHCS and federal regulations.

QIC – Each clinical system of care of BHRS participates in a QIC. The QICs oversee the overall program effectiveness and the performance of its delivery systems. They are comprised of division staff, senior leaders, providers from the network, and members/their family members. Each QIC reviews and develops an annual action plan led by the Chair and Co-Chair of the committee. Each QIC meets at least ten times each year.

BHEC – This committee is responsible for overseeing BHRS cultural competence initiatives and ensuring adherence to DHCS Cultural Competence Plan requirements. It is comprised of division staff, senior leaders, providers, and members/their family members. The BHE Manager also participates in all other QI Committees to evaluate culturally responsive care. BHEC meets at least ten times a year.

QI Program Process and Evaluations

The QIP adopts the concept of continuous process improvement with a systematic framework. This process is employed to identify important aspects of care and service through focused audits and evaluations. This process involves a continuous feedback loop, which should be completed as efficiently as possible. Elements of the process are:

1. Define and clarify the problem.
2. Analyze potential contributing factors.
3. Identify solutions, utilizing cross-functional collaboration where applicable.
4. Select the most effective option(s).
5. Implement the solution(s).
6. Establish a timeline for reassessment.
7. Evaluate data to assess the solution(s) effectiveness.
8. Based on the results of the data analysis:
    a. If problem is resolved, establish a monitoring plan to prevent recurrence.
    b. If unresolved, repeat the process until the issue is addressed.

The QIP follows accepted industry standards for gathering, sorting and analyzing information. Each indicator of key processes is operationally defined, i.e., measurable. Other evaluations may be initiated as the result of information gathered from ongoing monitoring, through surveys, audits, and/or analysis of complaints and grievances. Whenever possible, results will be presented quantitatively as well as qualitatively.

Communication/structure throughout the QI Program that aids in the continuous quality improvement efforts includes (but is not limited to):

1. QIC chairs are members of the QMT and present routine reports to the QMT on the activities of their respective QICs.
2. Each QIC will complete and submit to the QMT an annual report on evaluations and accomplishments for the year and recommended focuses for the next fiscal year that aligns with the QI work plan.
3. The Quality Services Manager supports the Plan Administrators in completing the evaluations of the overall BHRS QI work plan.

4. Members and their families will meaningfully participate in the quality improvement process at all levels of the organization.
5. Performance will be measured, and the results will be used to develop corrective actions, improve processes, and set goals.
6. Improvements will be documented, analyzed, and monitored.

Expected Performance Outcomes

The QI Work Plan is a living document that will establish methods of monitoring and measuring QI outcomes and will be updated as necessary. Results of these activities will be reported to QMT to be utilized in process improvement activities at least quarterly. This process will include measures established by other regulatory agencies. The expected outcomes are as follows:

1. Service capacity exists to meet the needs of members.
2. Members can access a continuum of services within the scope of their benefits in a timely, geographically convenient, culturally, linguistically, age and clinically appropriate manner.
3. Services provided are evaluated for medical necessity and appropriateness.
4. Members and family members are satisfied with services.
5. Grievances are processed according to regulatory standards.
6. Clinical and service outcomes are achieved, including improved functioning and symptom management through the Core Treatment Model (CTM).
7. Ensure authorization decisions meet required standards, including:
    a. Written policies and procedures for initial and continuing service authorizations, as outlined in Title 42, CFR, Section 438.210(b)(1).
    b. Mechanisms to ensure consistent application of review criteria and consultation with the requesting provider when needed, as stated in Title 42, CFR, Section 438.210(b)(2).
    c. Service denial or modifications (in amount, duration, or scope) must be made by a healthcare professional with appropriate expertise, per Title 42, CFR, Section 438.210(b)(3).
    d. Authorization decisions must comply with the timelines in Title 42, CFR, Section 438.210(d), and notices of action must be provided within the timeframes in Title 42, CFR, Section 438.404(c).

Quality Improvement Work Plan: 2025-2026

Overview

The QI Work plan outlined in this document involves an agency-wide commitment to quality improvement initiatives. Consistent with requirements outlined in the Integrated Contract, each system of care and/or division will develop an action plan specific to the functions of their respective systems.

Our Mental Health Services Act (MHSA) programs are fully implemented. We continue our efforts to integrate the essential elements of MHSA into every facet of our organization while we plan our future implementation of Behavioral Health Services Act (BHSA) in the FY 2026-2027. In addition, BHRS has remained fully invested in implementing integrated quality improvement initiatives that focus on improving both DMC-ODS and SMHS programs.

Involvement in developing, monitoring, reporting, and action planning for the QI Work Plan is multi-faceted. It includes consumer and family member involvement along with staff, providers, and administrators. Each team/group in the QI Program Structure is invested in the QI Work Plan and remain active contributors and owners.

Quality Improvement Work Plan: 2025-2026 Goals and Objectives

1. Service Capacity and Accessibility		
Goal	Conduct monitoring to assess the accessibility of SMHS and DMC-ODS services to ensure adequate access for all members.	
Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
1. Track the provision of services to children, youth, and adult Medi-Cal/Uninsured members by service type and location, comparing it to service demand.	Ensure resources are appropriately allocated for member access.	TBD
Evaluation of Data FY 2025-2026	TBD	TBD
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
2. Maintain a 24/7 telephone line providing: • Information in members' preferred language • Accessing SMHS and DMC-ODS services • Grievance/complaint support • Guidance for urgent conditions	Maintain a 24/7 toll-free number that members may call seeking access to SMHS and/or DMC-ODS services.	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	
Responsible Partners	SOC QIC's	
Evaluation Methods/Tools	Compliance Monthly Test Calls, SSRS Reports, MHSA Data, BHEC Data	
Regulations	*42 CFR § 438.206(b)(1); BHIN 24-020; BHIN 23-018; BHIN 22-019; DHCS External Quality Review (EQR) Requirements; Integrated Behavioral Health Contract, Exhibit A (Attachments 5, 7, & 8)*	

2. Timeliness Standards of Access		
Goal	Conduct monitoring on the timeliness of referrals and services following initial assessments or requests to improve on overall timeliness standards.	
Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
1. Members are offered a timely appointment for: • Outpatient Non-Urgent Non-Psychiatric SMHS • Outpatient Services – Outpatient SUD Services • SUD Residential	Offered an appointment within 10 business days of request for services	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
2. Members are offered a timely Follow Up Appointment for: • Non-urgent Follow-Up Appointment for DMC-ODS services with non-physician • Non-urgent Follow-Up Appointment for SMHS	Offered a follow-up appointment within 10 business days of the prior appointment	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
3. All urgent appointments for SMHS and DMC-OD are offered timely.	48 hours without PA 96 hours with PA	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
4. Members requesting Opioid Treatment services are offered a timely appointment.	Within 3 business days of request	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
5. Evaluate program specific data regarding average number of days from initial member contact to completed SUD assessment.	Not specified	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
6. Number of days from first service following initial request or agreement to services.	Not specified	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
7. Monitor the number/percentage of no-shows for initial SUD assessment.	Not specified	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
8. Members discharging from psychiatric hospitalization are given a timely outpatient appointment.	Within 7 Days After Discharge	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
9. Members are offered a timely appointment for psychiatric services.	Offered an appointment within 15 business days of request for services	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Responsible Partners	SOC QICs
Evaluation Methods/Tools	OEM Reports
Regulations	*BHIN 25-013, HCS 1367.03(a)(5)(H); 28 CCR section 1300.67.2.2(c)(5)(H)*

3. Member Satisfaction			
Goal	Monitor member satisfaction to improve the quality of care, division operations, and effectiveness of services provided.		
Objective		**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
1. Utilize the Treatment Perception Survey for DMC-ODS and SMHS to assess member and family satisfaction, identify areas for improvement, and develop a plan to address and monitor key areas of focus for the upcoming fiscal year, as necessary.		Survey clients annually for satisfaction	TBD
Evaluation of Data FY 2025-2026	TBD		
QI Action Plan	TBD		

Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
2. Evaluate the volume of member grievances, appeals, and State Fair Hearings and ensure they are being resolved in accordance with regulated time frames.	Grievances – 30 days Appeals – 30 days Expedited appeals – 72 hours Evaluating at least annually	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
3. Identify and address quality of care issues by reviewing and analyzing trends from incident reports.	Unusual occurrences to be reported to DHCS within 24 hours. Evaluating at least annually	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
4. Resolve member requests to change service providers are resolved within regulated time frames.	Evaluate requests at least annually	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	
Responsible Partners	Quality Services, Risk Management, SOC QICs	
Evaluation Methods/Tools	Symplr Reporting, ABGAR, Consumer Perception Survey, Treatment Perception Survey	
Regulations	*42 C.F.R. § 438.242(a) & 438.416(a); 9 C.C.R. § 1810.376; MHSUDS IN 18-010E, BHIN 24-020; BHIN 24-009; BHIN 24-026*	

4. Credentialing and Monitoring of Providers			
Goal	Perform database checks in accordance with State and Federal regulations, ensuring compliance with provider credentialing and monitoring standards.		
Objective		**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
1. Establish and require adherence to a uniform credentialing and recredentialing policy that addresses all clinical providers.		A documented process be implemented and followed	TBD
Evaluation of Data FY 2025-2026	TBD		
QI Action Plan	TBD		

Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
2. Ensure all applicable licensed staff are enrolled in the DHCS Provider Application and Validation for Enrollment (PAVE) portal.	All licensed staff be enrolled in PAVE	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Responsible Partners	Human Resources
Evaluation Methods/Tools	HR Personnel Reports
Regulations	*42 C.F.R. part 438.214; BHIN 18-019; BHIN 24-023; 9 C.C.R section 1810.435(a)*

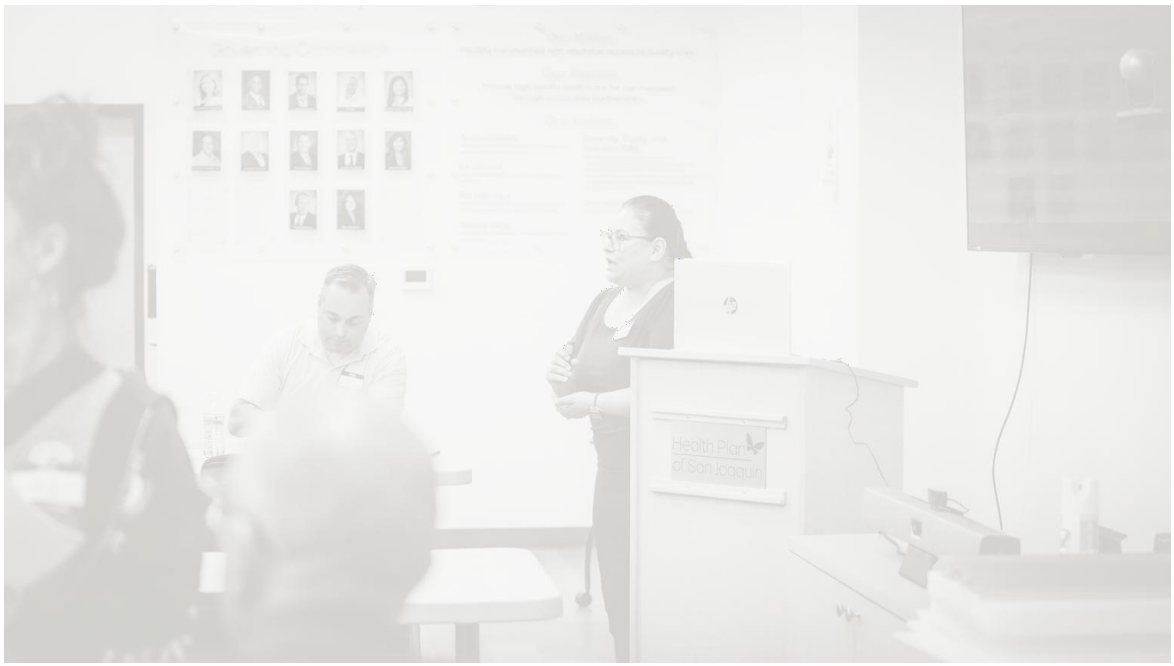
5. The Service Delivery System's Clinical Integrity & Safety			
Goal	Monitor the safety and effectiveness of clinical practices in both SUD and SMHS programs.		
Objective		**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
1. Audit medication practices under the supervision of a licensed prescriber or dispenser to ensure regulatory prescriber and documentation practices.		Medication monitoring shall occur at least once annually	TBD
Evaluation of Data FY 2025-2026	TBD		
QI Action Plan	TBD		

Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
2. Assess the effectiveness of existing strategies aimed at reducing avoidable hospitalizations and implement additional measures, if needed, to further minimize overutilization.	Monitoring of avoidable hospitalizations shall occur	TBD
Evaluation of Data FY 2025-2026	TBD	
QI Action Plan	TBD	

Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
3. Monitor the average residential length of stay to ensure it is within the 30-day guideline.	Length of stays shall be monitored with a focus on a 30-day goal	TBD
Evaluation of Data FY 2025-2026		
QI Action Plan		
Responsible Partners	Medication Monitoring Team, SOC QIC's	
Evaluation Methods/Tools	MD/RN Audits, QIC Monitoring	
Regulations	*42 C.F.R. § 438.330(b)(3); BHIN 23-065; 42 USC 1396 (A)(30-33), 42 CFR 456.2-456.6*	

6. Performance Improvement Projects (PIPs)			
Goal	Conduct PIPs that contribute to meaningful improvement.		
Objective		**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
1. Conduct two PIPs designed to achieve quality improvement in clinical and member outcomes. An evaluation and intervention of the PIPs shall be properly documented.		One clinical and non-clinical PIP be conducted annually and proper External Quality Review tools be completed.	TBD
Evaluation of Data FY 2025-2026	TBD		
QI Action Plan	TBD		
Responsible Partners	PIP Committees, Quality Services Manager		
Evaluation Methods/Tools	HSAG EQR PIP Tools		
Regulations	*42 C.F.R. § 438.330*		

7. Behavioral Health Accountability Set (BHAS)			
Goal	Implement targeted quality improvement strategies to increase performance on at least two BHAS measures where the plan was below Minimum Performance Level (MPL).		
Objective		**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**
1. Improve performance on Follow-Up After Emergency Department Visit for Mental Illness (FUM), Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA), and Pharmacotherapy for Opioid Use Disorder (POD)		Demonstrate at least a 5% improvement for each measure performance from Measurement Year (MY) 2024	TBD
Evaluation of Data FY 2025-2026	TBD		
QI Action Plan	TBD		
Responsible Partners	Behavioral Health Equity Manager		
Evaluation Methods/Tools	CalMHSA HEDIS, BHQIEP Plan		
Regulations	BHIN 24-004		



Stanislaus County
Behavioral Health and Recovery Services Behavioral Health Services Act

Community Planning Process Comprehensive Report-Attachment #3

Executive Summary

The Behavioral Health Services Act (BHSA) requires counties to implement a Community Planning Process (CPP) under SB 326 to ensure meaningful stakeholder engagement, transparency, and alignment with statewide goals. The CPP informs the BHSA Integrated 3-Year Plan, draft due March 31, 2026, final due June 30, 2026, and supports readiness for Behavioral Health Organized Access and Treatment Reform (BHOATR) by January 2028.

Purpose of CPP:

- Gather input from priority populations: individuals experiencing homelessness, families, culturally diverse communities, veterans, and youth.
- Ensure community voices shape priorities, funding allocations, and performance goals.

Timeline & Methods:

- Dec 2024 – Jan 2026: Focus groups, advisory committees, staff sessions, leadership collaboratives, equity committee meetings, surveys, and community presentations.
- Activities included Salvation Army, Modesto Gospel Mission, Family Support Groups, BHRS Staff Focus Groups, Veterans Collaborative, Leadership Collaborative, and community forums, and community surveys.

Connection to BHSA Integrated Plan:

- CPP findings inform the draft Integrated Plan
- CPP findings inform the public comment and final submission by June 30, 2026.
- CPP ensures alignment with statewide performance goals and integrates emerging priorities such as overdose and suicide prevention based on community feedback.

Community Participation Summary

Stanislaus County BHRS conducted extensive engagement to ensure diverse community representation and meaningful stakeholder input.

- 171 individuals in shelter focus groups (Priority: Homelessness)
- 72 veterans in veteran focus groups (Priority: Veterans)
- 123 behavioral health experts (System stakeholders)
- 174 participants in community partner sessions (Families, diverse communities)
- 99 survey participants (Community prioritization)
- 122 participants in community information sessions (General outreach)

Estimated Reach: 761 participant instances; approximately 500–600 unduplicated individuals.

Alignment with DHCS CPP Requirements includes engagement of priority populations, multiple methods, and both qualitative and quantitative data

Engagement Narratives

Salvation Army Focus Groups

Dates: October – November 2025
Objectives: Identify service gaps and continuity issues for individuals experiencing homelessness.
Key Themes:

- Housing solutions should include couples options
- On-site mental health services and resources at shelters are needed
- Transportation and benefits navigation support is needed
- Provide more awareness and education to community on resources
- Face-to-face communication preferred over phone referrals, a phone number is not sufficient
- Shelter staff need training on for mental health resources and how to connect

Representative Quotes:

- "Take education and outreach on BHRS to the community, hospitals, churches, parks."
- "Help by keeping married couples together."
- "We need more information on how to connect to services."
- "We need to better trained shelter staff on how to connect us to community services."

Modesto Gospel Mission

Dates: October – November 2025
Objectives: Identify service gaps and continuity issues for individuals experiencing homelessness.
Key Themes:

- Mobile clinicians and on-site assessments at shelter sites
- Warm handoffs between programs
- Dignity-centered basic needs support
- No faith in process, prefer to have screening in person
- BHRS to create more tools for community to use such as user-friendly applications to keep track of appointments, case managers, and medications

Representative Quotes:

- "Better promotion to provide better encouraging reason to reach out to seek help"
- "I get lost in communication and referrals, too many referrals and no services"
- "Make outreach service / workers more accessible and communicate process"

Family Members Support Group

Dates: October – November 2025
Objectives: Engage caregivers
Key Themes:

- More family advocates embedded in treatment teams
- Youth consent barriers are delaying access
- Family members need to have a say in loved one's treatment as they have firsthand knowledge
- Crisis protocols and family involvement should be updated

Representative Quotes:

- "Crisis line must talk with families because they don't"
- "For parents, we need more support groups and flexible hour."

BHRS Staff Focus Groups

Dates: December 2025
Objectives: Gather staff input
Key Themes:

- More peer navigators at first contact for members
- Human-answered Access Line and warm handoffs
- Mobile/rural outreach and flexible hours

- Lower caseloads and burnout prevention
- MH–SUD integration and ACT fidelity
- Documentation relief

Representative Quotes:

- "Warm handoffs need improvement- call before referring"
- "Bring back Substance Use Navigators in hospitals for fast linkage"
- "Add more peer support staff"
- "Lower caseloads"

Behavioral Health Leadership Collaborative

Dates: October 2025 - ongoing
Objectives: Align behavioral health leadership on statewide goals; map challenges and solutions.
Key Themes:

- Referral and transition gaps
- Workforce shortages and prescriptive contracting
- SmartCare/documentation burdens
- Align efforts across counites to reduce organization burden
- Solutions such as shared referral system, interagency referrals, warm handoffs, universal credentialing, contract flexibility

Representative Quotes:

- "We need a shared referral system and real-time collaboration to prevent members from falling through the cracks"

Veterans Community Collaborative

Dates: September 2025 – ongoing
Objectives: Capture veteran-specific needs
Key Themes:

- Navigation overload ("too many phone numbers and no direction)
- Peer support as trust anchors, need more of
- Family education on trauma/PTSD
- Housing stability and BHRS–VA collaboration

Representative Quotes:

- "Peer support is key. I trust someone who's walked in my boots."
- "Families need to understand PTSD, it's not just about me, it's about us."

BHSA Priorities Survey (Narrative)

Dates: Dec 2024 – September 2025
Objectives: Identify top priorities for BHSA Integrated Plan.
Key Themes:
• Reduce access barriers.
• Expand housing supports.
• Enhance TAY SUD services.
• Address workforce strain and language equity.

Advisory Committee Meetings

Dates: 12/18/2024, 04/30/2025, 10/27/2025, 11/19/2025, 12/19/2025, 03/2026
Objectives: Governance and stakeholder review.
Key Themes:

- Evening cadence for accessibility
- English with Spanish materials
- Agendas and slide ties per CPP plan
- Provided updates on all components of Integrated Plan, county updates, plans, and gathered feedback for Integrated Plan

County Meetings: Community Feedback on Performance Goals (Overdose & Suicide)

Stanislaus Cradle to Career Mental Health Working Group, Behavioral Health Equity Committee, Opioid Safety Coalition, and Suicide Prevention Education Coalition

Dates: October 2025- ongoing
Objectives: Provide BHSA updates, gather input, and share BHSA data

Attachment #4- Public Notice (Email)

BHSA Draft 2026-2029 Integrated Plan - Public Comment Period Notice

Summarize

Reply | Reply All | Forward

Mon 4/27/2026 11:01 AM

BB BHRS - BHSA
To

BHSA FY 2026-2029 Final Draft Integrated Plan.pdf
2 MB

Hello,

Public comment for the Stanislaus County Behavioral Health Services Act (BHSA) Draft 3-Year Integrated Plan Fiscal Year 2026–2029 will begin tomorrow, April 28, 2026, and continue through May 28, 2026.

The draft plan may be viewed online at www.stanislausmhsa.com. Printed copies may also be requested by contacting the BHSA Policy Planning office at (209) 525-6247 or by writing to Stanislaus County Behavioral Health and Recovery Services – BHSA, 1130 12th Street, Suite B, Modesto, CA 95354.

Members of the public are invited to review the document and submit comments during the Public Comment Period. Comments must be received by 5:00 PM on May 28, 2026, and may be submitted in any of the following ways to be considered:

- Faxed to (209) 653-0391
- Sent via U.S. mail to the address above
- Sent via email to bhsa@stanbhrs.org
- Provided by calling (209) 525-6247
- Submitted online here: BHSA 3-Year Draft Integrated Plan Public Comment Form
- Public Comment Listening Session April 28, 1:00 PM, at Behavioral Health and Recovery Services, 1130 12th Street, Suite C, Room 16, Modesto, CA 95354

A public hearing on the draft plan will be held at the Stanislaus County Behavioral Health Board Meeting on May 28, 2026, from 5:30 PM to 6:30 PM at Behavioral Health and Recovery Services, 1130 12th Street, Suite C, Room 16, Modesto, CA 95354.

All stakeholders are encouraged to participate.

Thanks,
BHRS BHSA Planning Team

References
1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.
2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.
3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.
4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.
5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).
6. W&I Code § 5892, subdivision (b)(2).
7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development.
8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Table One: Behavioral Health Care Continuum Projected Expenditures									
	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (Year One)	Total Projected Expenditures On Adults and Older Adults (Year Two)	Total Projected Expenditures On Adults and Older Adults (Year Three)	Total Projected Expenditures on Children/Youth (under 21) (Year One)	Total Projected Expenditures on Children/Youth (under 21) (Year Two)	Total Projected Expenditures on Children/Youth (under 21) (Year Three)	Projected Individuals to be Served Annually (May be duplicated) Eligible Adults and Older Adults	Projected Individuals to be Served Annually (May be duplicated) Eligible Children/Youth (under 21)
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 784,959.00	$ 824,207.00	$ 865,417.00	$ 96,867.00	$ 101,710.00	$ 106,796.00	235	29
Early Intervention Services	☑	$ -	$ -	$ -	$ 250,000.00	$ 262,500.00	$ 275,625.00	0	151
Outpatient Services	☑	$ 32,365,341.00	$ 33,983,611.00	$ 35,682,792.00	$ 117,309.00	$ 123,173.00	$ 129,332.00	2927	31
Intensive Outpatient Services	☑	$ 1,989,161.00	$ 2,088,619.00	$ 2,193,050.00	$ 72,333.00	$ 75,950.00	$ 79,747.00	110	4
Crisis and Field-Based Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0
Residential Treatment Services	☑	$ 10,961,498.00	$ 11,509,573.00	$ 12,085,051.00	$ 116,612.00	$ 122,442.00	$ 128,564.00	376	4
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0
Mental Health (MH) Services									
Primary Prevention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0
Early Intervention Services	☑	$ 6,172,132.00	$ 6,480,739.00	$ 6,804,775.00	$ 10,960,880.00	$ 11,508,924.00	$ 12,084,370.00	1496	979
Outpatient and Intensive Outpatient Services	☑	$ 41,753,626.00	$ 43,841,308.00	$ 46,033,373.00	$ 24,171,833.00	$ 25,380,426.00	$ 26,649,447.00	4967	4130
Crisis Services	☑	$ 8,328,334.00	$ 8,744,751.00	$ 9,181,989.00	$ 2,514,062.00	$ 2,639,765.00	$ 2,771,754.00	1907	1032
Residential Treatment Services	☑	$ 21,229,717.00	$ 22,291,203.00	$ 23,405,763.00	$ 3,764,036.00	$ 3,952,238.00	$ 4,149,850.00	588	69
Hospital and Acute Services	☑	$ 20,130,177.00	$ 21,136,685.00	$ 22,193,519.00	$ 8,138,009.00	$ 8,544,910.00	$ 8,972,156.00	1286	393
Subacute and Long-Term Care Services	☑ ☑	$ 14,882,385.00	$ 15,626,504.00	$ 16,407,829.00	$ -	$ -	$ -	104	0
Housing Services (MH + SUD)									
Housing Services	☑	$ 14,917,053.00	$ 15,612,907.00	$ 16,343,552.00	$ 24,909.00	$ 26,154.00	$ 27,462.00	730	12
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 173,514,383.00	$ 182,140,107.00	$ 191,197,110.00	$ 50,226,850.00	$ 52,738,192.00	$ 55,375,103.00	14726	6834

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures (Year One)**	**Total Projected Expenditures (Year Two)**	**Total Projected Expenditures (Year Three)**
Capital Infrastructure Activities	$ 1,585,000.00	$ 787,500.00	$ 826,875.00
Workforce Investment Activities	$ 597,088.00	$ 597,088.00	$ 597,088.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 33,260,934.00	$ 34,923,980.00	$ 36,670,179.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 5,991,423.00	$ 6,290,994.00	$ 6,605,543.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 41,434,445.00	$ 42,599,562.00	$ 44,699,685.00

Table Three: Projected Annual Expenditures by County BH Funding Source			
	Total Annual Projected Expenditures (Year One)	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
BHSA	$ 43,775,000.00	$ 43,775,000.00	$ 43,775,000.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 23,331,438.00	$ 24,031,381.00	$ 24,752,322.00
2011 Realignment (Public Safety Realignment)	$ 28,424,979.00	$ 28,879,778.00	$ 29,341,855.00
State General Fund	$ 9,100,000.00	$ 9,373,000.00	$ 9,654,190.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 130,950,000.00	$ 134,878,500.00	$ 138,924,855.00
Projects for Assistance in Transition from Homelessness (PATH)	$ -	$ -	$ -
Community Mental Health Block Grant (MHBG)	$ 3,468,645.00	$ 3,468,645.00	$ 3,468,645.00
Substance Use Block Grant (SUBG)	$ 2,681,873.00	$ 2,762,329.00	$ 2,845,199.00
Commercial Insurance	$ 50,000.00	$ 50,000.00	$ 50,000.00
County General Fund	$ 4,265,327.00	$ 4,265,327.00	$ 4,265,327.00
Opioid Settlement Funds	$ 8,500,000.00	$ 8,500,000.00	$ 8,500,000.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 135,732.00	$ -	$ -
Other state funding (including DSH funding)	$ 4,418,777.00	$ 3,000,000.00	$ 3,000,000.00
Other county mental health or SUD funding	$ 6,073,907.00	$ 14,493,901.00	$ 22,694,505.00
Other foundation funding	$ -	$ -	$ -
Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**
Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 265,175,678.00	$ 277,477,861.00	$ 291,271,898.00
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 223,741,233.00	$ 234,878,299.00	$ 246,572,213.00
Auto-validation: Table 2: Other County Expenditures	$ 41,434,445.00	$ 42,599,562.00	$ 44,699,685.00

Table Four: BHSA Transfers				
	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Year Two Component Allocation (dollars)	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Year Three Component Allocation (dollars)	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
BHSA Transfers Year One Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ 5,656,489.00	$ 6,599,237.00	$ 6,599,237.00	$ 18,854,963.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -
BHSA Transfers Year Two Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
BHSA Transfers Year Three Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00

Funding Transfer Request Allocations			
Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)			
Base Component (Year One)	**Housing Intervention Percentage (Year One)**	**Housing Intervention Funds (Year One)**	
Base Percentage and Funding	30%	$ 12,475,875.00	
Percentage Reduced	0%	$ -	
Percentage Added	0%	$ -	
New Housing Interventions Base Percentage (auto-populated)	30%	$ 12,475,875.00	
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**	
Base Percentage and Funding	35%	$ 14,555,188.00	
Percentage Reduced	0%	$ -	
Percentage Added	0%	$ -	
New FSP Base Percentage (auto-populated)	35%	$ 14,555,188.00	
Transferred To/From	**Behavioral Health Services and Support Percentage (Year One)**	**Behavioral Health Services and Support Funding (Year One)**	
Base Percentage and Funding	35%	$ 14,555,188.00	
Percentage Reduced	0%	$ -	
Percentage Added	0%	$ -	
New BHSS Base Percentage (auto-populated)	35%	$ 14,555,188.00	

Funding Transfers (Year One)				
	Housing Intervention (Year One) (1)	**Full-Service Partnership (Year One)**	**Behavioral Health Services and Support (Year One)**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)			
Base Component (Year Two)	**Housing Intervention Percentage (Year Two)**	**Housing Intervention Funds (Year Two)**	
Base Percentage and Funding	30%	$	12,475,875.00
Percentage Reduced	0%	$	-
Percentage Added	0%	$	-
New Housing Interventions Base Percentage (auto-populated)	30%	$	12,475,875.00
Transferred To/From	**Full Service Partnership Percentage (Year Two)**	**Full Service Partnership Funds (Year Two)**	
Base Percentage and Funding	35%	$	14,555,188.00
Percentage Reduced	0%	$	-
Percentage Added	0%	$	-
New FSP Base Percentage (auto-populated)	35%	$	14,555,188.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Two)**	**Behavioral Health Services and Support Funding (Year Two)**	
Base Percentage and Funding	35%	$	14,555,188.00
Percentage Reduced	0%	$	-
Percentage Added	0%	$	-
New BHSS Base Percentage (auto-populated)	35%	$	14,555,188.00

Funding Transfers (Year Two)				
	Housing Intervention (Year Two) (1)	**Full-Service Partnership (Year Two)**	**Behavioral Health Services and Support (Year Two)**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)			
Base Component	**Housing Intervention Percentage (Year Three)**	**Housing Intervention Funds (Year Three)**	
Base Percentage and Funding	30%	$	12,475,875.00
Percentage Reduced	0%	$	-
Percentage Added	0%	$	-
New Housing Interventions Base Percentage (auto-populated)	30%	$	12,475,875.00
Transferred To/From	**Full Service Partnership Percentage (Year Three)**	**Full Service Partnership Funds (Year Three)**	
Base Percentage and Funding	35%	$	14,555,188.00
Percentage Reduced	0%	$	-
Percentage Added	0%	$	-
New FSP Base Percentage (auto-populated)	35%	$	14,555,188.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Three)**	**Behavioral Health Services and Support Funding (Year Three)**	
Base Percentage and Funding	35%	$	14,555,188.00
Percentage Reduced	0%	$	-
Percentage Added	0%	$	-
New BHSS Base Percentage (auto-populated)	35%	$	14,555,188.00

Funding Transfers (Year Three)				
	Housing Intervention (Year Three) (1)	**Full-Service Partnership (Year Three)**	**Behavioral Health Services and Support (Year Three)**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

MHSA Transfers to BHSA				
MHSA Component	**Available Unspent BHSA Funds**	**Transferred to Housing Intervention**	**Transferred to Full-Service Partnership**	**Transferred to Behavioral Health Services and Support**
CSS	$ 154,851.00	$ 154,851.00	$ -	$ -
PEI	$ 9,400,653.00	$ 2,801,416.00	$ 6,599,237.00	$ -
Encumbered INN	$ 3,600,000.00	$ -	$ -	$ 3,600,000.00
Unencumbered INN	$ 4,502,847.00	$ 2,700,222.00	$ -	$ 1,802,625.00
WET	$ 1,196,612.00			$ 1,196,612.00
CFTN	$ -			$ -
Total (auto-populated)	$ 18,854,963.00	$ 5,656,489.00	$ 6,599,237.00	$ 6,599,237.00

Excess Prudent Reserve to BHSA Components	
Transfer from Prudent Reserve to BHSA Component Allocation	**Amount**
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 500,000.00
Local Prudent Reserve Maximum (2)	$ 8,176,956.00
Excess Prudent Reserve Funding that must be transferred	**$ (7,676,956.00)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References
1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.
2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).
3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.

Table Five: BHSA Components			
	Total Housing Interventions Funding (Year One)	**Total Housing Interventions Funding (Year Two)**	**Total Housing Interventions Funding (Year Three)**
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 12,475,875.00	$ 12,475,875.00	$ 12,475,875.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 12,475,875.00	$ 12,475,875.00	$ 12,475,875.00

Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ 2,000,000.00	$ 2,000,000.00	$ 2,000,000.00	$ 1,000,000.00	$ 1,000,000.00	$ 1,000,000.00
Operating Subsidies	$ 1,369,630.00	$ 1,369,630.00	$ 1,369,630.00	$ 2,415,000.00	$ 2,487,450.00	$ 2,562,074.00
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 2,934,083.00	$ 2,934,083.00	$ 2,934,083.00	$ -	$ -	$ -
Operating Subsidies	$ 1,058,630.00	$ 1,058,630.00	$ 1,058,630.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ 750,000.00	$ 750,000.00	$ 750,000.00	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 750,000.00	$ 750,000.00	$ 750,000.00	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 2,240,219.00	$ 2,240,219.00	$ 2,240,219.00	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ 873,313.00	$ 873,313.00	$ 873,313.00	$ 1,887,421.00	$ 1,944,044.00	$ 2,002,365.00
Capital Development Projects	$ 500,000.00	$ 500,000.00	$ 500,000.00	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 12,475,875.00	$ 12,475,875.00	$ 12,475,875.00	$ 5,302,421.00	$ 5,431,494.00	$ 5,564,439.00

Housing Interventions Transfer Information	Year One	Year Two	Year Three
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Administrative Information	**Year One**	**Year Two**	**Year Three**
Housing Interventions Component Admin Expenses	$ -	$ -	$ -
Total Housing Interventions Expenditures (auto-populated)	$ 12,475,875.00	$ 12,475,875.00	$ 12,475,875.00
Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 6,244,163.00	$ 6,244,163.00	$ 6,244,163.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 311,000.00	$ 311,000.00	$ 311,000.00
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	4.0%	4.0%	4.0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	50.0%	50.0%	50.0%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	7.0%	7.0%	7.0%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	468	468	468
Eligible Adults/Older Adults	875	875	875
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References
1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.
2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.
3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.
4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.
5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).
6. W&I Code § 5892, subdivision (b)(2).
7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development.
8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Table Six: BHSA Components			
	Total Full Service Partnership (FSP) Funding (Year One)	**Total Full Service Partnership (FSP) Funding (Year Two)**	**Total Full Service Partnership (FSP) Funding (Year Three)**
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 14,555,188.00	$ 14,555,188.00	$ 14,555,188.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 14,555,188.00	$ 14,555,188.00	$ 14,555,188.00

Full Service Partnership Category (1)										
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)**	**Projected Expenditures - Federal Financial Participation (Year One)**	**Projected Expenditures - Federal Financial Participation (Year Two)**	**Projected Expenditures - Federal Financial Participation (Year Three)**	**Projected Expenditures - All Other Funding Sources (Year One)**	**Projected Expenditures - All Other Funding Sources (Year Two)**	**Projected Expenditures - All Other Funding Sources (Year Three)**
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 8,220,850.00	$ 8,220,850.00	$ 8,220,850.00	$ 10,725,468.00	$ 11,047,232.00	$ 11,378,649.00	$ 177,633.00	$ 182,962.00	$ 188,451.00
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 44,805.00	$ 44,805.00	$ 44,805.00	$ 854,385.00	$ 880,017.00	$ 906,417.00	$ 1,773,677.00	$ 1,826,887.00	$ 1,881,694.00
FSP Intensive Case Management	$ 4,167,305.00	$ 4,167,305.00	$ 4,167,305.00	$ 8,284,352.00	$ 8,532,883.00	$ 8,788,869.00	$ 52,780.00	$ 54,363.00	$ 55,994.00
High Fidelity Wraparound	$ 105,105.00	$ 105,105.00	$ 105,105.00	$ 734,700.00	$ 756,741.00	$ 779,443.00	$ 1,263,112.00	$ 1,301,005.00	$ 1,340,035.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 255,923.00	$ 255,923.00	$ 255,923.00	$ -	$ -	$ -	$ 390,954.00	$ 402,683.00	$ 414,763.00
Assertive Field-Based Initiation for SUD Treatment Services	$ 72,100.00	$ 72,100.00	$ 72,100.00	$ 986,619.00	$ 1,016,218.00	$ 1,046,704.00	$ 702,481.00	$ 723,556.00	$ 745,262.00
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ 1,689,100.00	$ 1,689,100.00	$ 1,689,100.00	$ 3,308,112.00	$ 3,407,356.00	$ 3,509,576.00	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 14,555,188.00	$ 14,555,188.00	$ 14,555,188.00	$ 24,893,636.00	$ 25,640,447.00	$ 26,409,658.00	$ 4,360,637.00	$ 4,491,456.00	$ 4,626,199.00

FSP Transfer Information	Year One	Year Two	Year Three
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -
FSP Administrative Information	**Year One**	**Year Two**	**Year Three**
FSP Component Admin Expenses	$ -	$ -	$ -
Total Full Service Partnership Expenditures (auto-populated)	$ 14,555,188.00	$ 14,555,188.00	$ 14,555,188.00
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	872	872	872
Eligible Adults/Older Adults	2363	2363	2363
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References
1. W&I Code § 5892, subdivision (a)(2)(A) states 35% of BHS funds distributed to counties shall be used for Full Service Partnership Programs.
2. May be bundled or un-bundled depending on county BH-CONNECT opt-in.

Table Seven: BHSA Components			
	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	**Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)**	**Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)**
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 14,555,188.00	$ 14,555,188.00	$ 14,555,188.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 14,555,188.00	$ 14,555,188.00	$ 14,555,188.00

Behavioral Health Services and Supports Category (1)									
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)**	**Projected Expenditures - Federal Financial Participation (Year One)**	**Projected Expenditures - Federal Financial Participation (Year Two)**	**Projected Expenditures - Federal Financial Participation (Year Three)**	**Projected Expenditures - All Other Funding Sources (Year One)**	**Projected Expenditures - All Other Funding Sources (Year Two)**	**Projected Expenditures - All Other Funding Sources (Year Three)**
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ 2,558,022.00	$ 2,558,022.00	$ 2,558,022.00	$ 1,488,926.00	$ 1,533,594.00	$ 1,579,602.00	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 2,289,526.00	$ 2,289,526.00	$ 2,289,526.00	$ 8,055,758.00	$ 8,297,431.00	$ 8,546,354.00	$ 397,112.00	$ 409,025.00	$ 421,296.00
Early Intervention Expenditures	$ 9,089,522.00	$ 9,089,522.00	$ 9,089,522.00	$ 2,086,760.00	$ 2,146,363.00	$ 2,207,754.00	$ 529,696.00	$ 545,587.00	$ 561,955.00
Coordinated Specialty Care for First Episode Psychosis	$ 536,911.00	$ 536,911.00	$ 536,911.00	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ -	$ -	$ -
All Other EI Expenditures	$ 8,552,611.00	$ 8,552,611.00	$ 8,552,611.00	$ 1,986,760.00	$ 2,046,363.00	$ 2,107,754.00	$ 529,696.00	$ 545,587.00	$ 561,955.00
Outreach and Engagement	$ 461,874.00	$ 461,874.00	$ 461,874.00	$ 5,150.00	$ 5,305.00	$ 5,464.00	$ 9,068.00	$ 9,340.00	$ 9,620.00
Workforce Education and Training (WET)	$ 156,244.00	$ 156,244.00	$ 156,244.00	$ -	$ -	$ -	$ 440,844.00	$ 440,844.00	$ 440,844.00
Dedicated BHSA WET funds	$ 156,244.00	$ 156,244.00	$ 156,244.00	$ -	$ -	$ -	$ 440,844.00	$ 440,844.00	$ 440,844.00
Dedicated MHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 14,555,188.00	$ 14,555,188.00	$ 14,555,188.00	$ 11,636,594.00	$ 11,982,693.00	$ 12,339,174.00	$ 1,376,720.00	$ 1,404,796.00	$ 1,433,715.00

BHSS Prudent Reserve Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -
BHSS Administrative Information	**Year One**	**Year Two**	**Year Three**
BHSS Component Admin Expenses	$ -	$ -	$ -
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 14,555,188.00	$ 14,555,188.00	$ 14,555,188.00
Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 5,644,044.00	$ 5,644,044.00	$ 5,644,044.00
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	93.1%	93.1%	93.1%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	62.1%	62.1%	62.1%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	1667	1667	1667
Eligible Adults/Older Adults	2813	2813	2813
Projected BHSS Funds transferred to WET or CF/TN	**Year One**	**Year Two**	**Year Three**
BHSS transfer to WET	$ 156,244.00	$ 156,244.00	$ 156,244.00
BHSS transfer to CF/TN	$ -	$ -	$ -
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
Estimated MHSA WET Funds	$ 1,196,612.00	$ 1,196,612.00	$ 1,196,612.00
Estimated MHSA CF/TN Funds	$ -	$ -	$ -
MHSA "Encumbered" INN	$ 3,600,000.00	$ 3,600,000.00	$ 3,600,000.00

References
1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).
2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.
3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.
4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.
5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ -	$ -	$ -
Total Projected County Integrated Plan Annual Planning Expenditures	$ 2,188,750.00	$ 2,188,750.00	$ 2,188,750.00
New and Ongoing Administrative Costs	$ -	$ -	$ -
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 43,775,001.00	$ 43,775,001.00	$ 43,775,001.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	0.0%	0.0%	0.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	5.0%	5.0%	5.0%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

References
1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 500,000.00
Local Prudent Reserve Maximum (1)	$ 8,176,956.00
Excess Prudent Reserve Funds (auto-populated)	$ (7,676,956.00)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -
References	
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).	

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	Full-Service Partnerships	Behavioral Health Services and Supports	Total
Year One				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00

BHSA Funding Summary (Year One)				
	Housing Interventions (Year One)	Full Service Partnerships (Year One)	Behavioral Health Services and Supports (Year One)	Year One Totals
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year One	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00

BHSA Funding Summary (Year Two)				
	Housing Interventions (Year Two)	Full Service Partnerships (Year Two)	Behavioral Health Services and Supports (Year Two)	Year Two Totals
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year Two	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00

BHSA Funding Summary (Year Three)				
	Housing Interventions (Year Three)	Full Service Partnerships (Year Three)	Behavioral Health Services and Supports (Year Three)	Year Three Totals
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year Three	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 12,475,875.00	$ 14,555,188.00	$ 14,555,188.00	$ 41,586,251.00

BHSA Plan Admin Expenses				
Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	$ -	$ -	$ -	$ -
Total Projected County Integrated Plan Annual Planning Expenditures	$ 2,188,750.00	$ 2,188,750.00	$ 2,188,750.00	$ 6,566,250.00
Total Projected New and Ongoing Administrative Expenditures	$ -	$ -	$ -	$ -

Table Ten: BHSA Funding Summary (auto-populated)