

El Dorado County
Fiscal Year 2026/27 – 2028/29
Behavioral Health Services Act
Integrated Plan



The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes.

This BHSA IP has been developed from the Department of Health Care Services (DHCS) required template.

For related policy information, refer to [3.A. Purpose of the Integrated Plan](#).



**HEALTH AND HUMAN
SERVICES AGENCY**
EL DORADO COUNTY
Transforming Lives and Improving Futures

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General Information

For related policy information, refer to [3.A. General Information](#).

County, City, Joint Powers, or Joint Submission

County

Entity Name

El Dorado County

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El Dorado County Health and Human Services Agency

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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).

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 for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook. For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan.

Children and Youth

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

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	644
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	7
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	7
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	1
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	0
Were chronically homeless or experiencing homelessness or at risk of homelessness	3
Were in the juvenile justice system	7
Have reentered the community from a youth correctional facility	2
Were served by the Mental Health Plan and had an open child welfare case	70
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	1
Have received acute psychiatric care	86

Adults and Older Adults

In the table below, please report the number of adults and older adults (21 and older)

served by the county behavioral health system who meet the criteria listed in each row. Counts may be duplicated as individuals may be included in more than one category.

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	271
Received Medi-Cal SMHS	2210
Received DMC or DMC-ODS services	672
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	54
Were chronically homeless, or experiencing homelessness, or at risk of homelessness.	248
Experienced unsheltered homelessness	157
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	67
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	10
Were in the justice system (on parole or probation and not currently incarcerated)	122
Were incarcerated (including state prison and jail)	106
Reentered the community from state prison or county jail	66
Received acute psychiatric services	343

Input the number of persons in designated and approved facilities who were

Admitted or detained for 72-hour evaluation and treatment rate

312

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

87

Admitted for 180-day post certification intensive treatment

1

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

60

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

306

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

No

Please describe the local data used during the planning process

Claiming data within the County Electronic Health Record (EHR) was used to complete this section.

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

Local CARE Act Implementation

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

El Dorado County's FY 2026–2029 Integrated Plan embeds CARE Act requirements into its behavioral health services framework to ensure adults with serious mental illness involved in CARE Court receive priority support.

The plan relies on Full Service Partnerships (FSP) to deliver psychiatric care, and intensive case management, ensuring individuals referred through CARE Court are fast-tracked into care. The team supports participants to access rental/operating subsidies, landlord engagement, tenant assistance, tenancy-sustaining services, and transition help. CARE client supports are prioritized within the county system.

When a client is accepted into CARE in accordance with SB 1338/AB 102, individuals are immediately open to into FSP services, bypassing typical intake procedures. Each person is assigned a dedicated team who coordinate treatment, court obligations,

conservatorships, Medi Cal, housing and other supports and services.

Through this cohesive system El Dorado County operationalizes the CARE Act's vision, offering timely, coordinated, and rights-based care for those with serious mental illness.

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

El Dorado County will integrate CARE referrals directly into its existing behavioral health access system by fast tracking all CARE Court petitions into expedited intake, where individuals are immediately open to FSP services. Once referred, each participant is assigned a dedicated care team that coordinates treatment, housing, and court requirements, using the same multidisciplinary structures that already link Behavioral Health, the courts, probation, public guardianship, and Medi Cal plans. Through this streamlined routing and shared coordination framework, CARE referrals become a prioritized, fully embedded pathway within the broader behavioral health continuum.

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

El Dorado County uses its existing behavioral health access points including but not limited to crisis services, outpatient clinics, mobile crisis teams, the jail, probation, state hospital discharges and the Public Guardian, to identify individuals who may meet CARE criteria but a formal petition has not been filed or completed. When CARE-level needs are present but not all CARE criteria can be met, staff redirect the individual into alternative pathways such as outpatient services, AOT, Intensive Case Management, peer support, or Crisis Residential Treatment. These referrals are logged in the county's electronic record system, with warm hand-offs and follow-up checks to confirm attendance and engagement.

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

Netsmart

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

Yes

Please select which QHIO the county participates in

Manifest MedEx

Application Programming Interface Information

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

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

<https://fhir.netsmartcloud.com/uscore/v1>

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

No

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

No

County Behavioral Health System Service Delivery Landscape

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

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

Will the county participate in [SAMHSA's PATH Grant](#) during the Integrated Plan period?

Yes

Please select all services the county behavioral health system plans to provide under the PATH grant

Case Management Services

Habilitation and Rehabilitation Services

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

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 the MHBG

First Episode Psychosis Set-Aside

Dual Diagnosis Set-Aside Discretionary/Base Allocation

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](#)

Address The Needs of Criminal Justice-Involved Persons

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

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

Prevent Misuse of Opioids

Prevent Overdose Deaths and Other Harms (Harm Reduction) Support People in Treatment and Recovery

Treat Opioid Use Disorder (OUD)

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

No

Bronzan-McCorquodale Act

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

- a. Case Management
- b. Comprehensive Evaluation and Assessment
- c. Group Services
- d. Individual Service Plan
- e. Medication Education and Management
- f. Pre-crisis and Crisis Services

- g. Rehabilitation and Support Services
- h. Residential Services
- i. Services for Homeless Persons
- j. Twenty-four-hour Treatment Services
- k. Vocational Rehabilitation

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

Not Applicable

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 \(2011 Realignment\)](#)

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

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

No

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under [SMHS](#) authority (no action required).

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

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

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). (no action required)

- a. Care Coordination Services
- b. Clinician Consultation
- c. Outpatient Treatment Services (ASAM Level 1)
- d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
- e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
- f. [Mobile Crisis Services](#)
- g. Recovery Services
- h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
- i. Traditional Healers and Natural Helpers
- j. Withdrawal Management Services

k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21

l. 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

Program or service
CARE-Community Assistance, Recovery, and Empowerment
DHCS-PATH JI Round 3
DHCS- Behavioral Health Bridge Housing (BHBH) Program
BHSSA - Sustainability
BHSSA - Universal Screening

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

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](#).

✓ 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. For related policy information, refer to [E.6.2 Primary and Supplemental Measures](#).

Access to care:

Primary measures

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

How does your county status compare to the statewide rate?

For adults/older adults

Below

For 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 (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults

Above

For children/youth

Same

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

Age

Race or Ethnicity Sex

Other

Please describe other

Written Language

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

How does your county status compare to the statewide rate?

For adults/older adults

Not Applicable

For children/youth

Not Applicable

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

Race or Ethnicity

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

How does your county status compare to the statewide rate?

For adults/older adults

Above

For children/youth

Not Applicable

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

No Disparities Data Available

Supplemental Measures

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

How does your county status compare to the statewide rate?

Above

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

No Disparities Data Available

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

Non Specialty Mental Health Services (NSMHS) Penetration – Adults

Equity data from California Mental Health Services Authority (CalMHSA) Access to Care dashboard indicate that older adults and certain racial/ethnic groups in El Dorado access NSMHS at notably lower rates than the county average. Specifically, adults aged 65 and older, as well as individuals identifying as Asian American/Pacific Islander, exhibit penetration rates below the adult population mean. Furthermore, speakers of non-English languages also demonstrate disproportionately low access rates.

NSMHS Penetration – Youth

CalMHSA data show penetration for children aged 6–11 and 3-5 falls short of the overall youth average. Among these children, Asian American/Pacific Islander and “Other” race categories youth have lower NSMHS access compared to their peers.

Specialty Mental Health Services (SMHS) Penetration – Adults

Equity breakdowns highlight that adults aged 65+, Hispanic, Alaskan Native or American Indian, and Asian American/Pacific Islander groups are underrepresented in SMHS uptake relative to the county average.

SMHS Penetration – Youth

Among youth, the lowest SMHS penetration occurs in age groups 0–2, 3–5 and 12–17, with all significantly trailing the youth average. Racial/ethnic minorities—specifically Asian American/Pacific Islander, Black, Alaskan Native or American Indian and “Other” race categories—also show lower engagement in SMHS services.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration - Adult SUD Treatment

County-level data show Black, Hispanic/Latino, and Asian American/Pacific Islander individuals have significantly lower DMC-ODS penetration (e.g., Hispanic/Latino 1.2%, AAPI 0.8%) versus the county average (~3.1%).

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)

Care Coordination

Strengthening crisis care transitions through Mobile Crisis Response Teams, link from 988, and real-time Health Information Exchange (HIE) alerts. Facilitate step-down appointments within 7 days from Psychiatric Health Facility (PHF) or inpatient hospitalization discharge. Integrating HIE (Manifest MedEx) Admissions, Discharges, and Transfers (ADT) notifications into care coordination protocols to improve timeliness, reduce duplicate services, and lift Specialty Mental Health Services (SMHS) penetration, in coordination with Public Health, Protective Services and other relevant elements of El Dorado County's integrated County Health and Human Services Agency.

Use of CarePOV (Avatar Mobile) with distribution of 20 tablets in the field. They will be used by the mobile crisis team, Psychiatric Emergency Response (PES) staff located in hospital emergency departments and field-based mental health staff. This will enable users to enter into the Electronic Health Record (EHR) timely and access current member records, improving member access and quality of service.

Managed Care Plan (MCP) Memorandum of Understanding (MOU) with Kaiser Permanente, Anthem, Health Plan of San Joaquin dba Mountain Valley Health Plan to outline the responsibilities of all parties to increase member's access to care and to ensure members receive coordinated, timely, and high-quality services.

Continuous Quality Improvement

In collaboration with the Health Services Advisory Group (HSAG), the Behavioral Health Division (BHD) will continue with the implementation of Performance Improvement Projects (PIPs) for 2025-2027.

Non-Clinical PIP- Improve the percentage of Medi-Cal members who received at least one peer support service by a certified Peer Support Specialist.

Clinical PIP - Increase the percentage of Medi-Cal members 18 year of age and older with schizophrenia or schizoaffective disorder to remain on antipsychotic medications

for at least 80% of their treatment period.

The BHD will use Department of Healthcare Services (DHCS) AB470 dashboards, Medi-Cal Connect, the Behavioral Health Services Act (BHSA) Phase 1 Workbook, County Quality Improvement (QI) Work Plan baselines, Mental Health Services Act (MHSA) stakeholder input, and Public Health CHIP/WellDorado data to identify sub-populations with poorer outcomes (e.g., youth in child welfare, justice-involved adults, residents in remote Tahoe areas) and to monitor performance quarterly.

Additional Service Sites

Acceptance of a \$24M grant with the State for the Support, Outreach, Accessibility, and Resilience Center (SOAR) Project. The funding will provide renovations to an existing building; the upper floor will become the new EDC Psychiatric Health Facility (PHF), expanding our capacity to treat our community's highest need Behavioral Health clients. The lower floor will be developed into an integrated Behavioral Health Outpatient Center with intake for all relevant HHS programs at a single point of access right on our county bus route.

Development of temporary housing with supportive services for individuals willing to engage in treatment. This complex will temporarily house individuals and families willing to engage in behavioral health services with the goal of transitioning them into self-sufficiency.

Measures Below Statewide Rate & Goals:

Specialty Mental Health Services (SMHS) penetration (Adults; Children & Youth): Increase by ≥ 1.5

percentage points in Fiscal Year (FY) 2026–27, focusing on rural Tahoe residents and Spanish-speaking families through Early Intervention (EI) outreach and Multisystemic Therapy (MST)/Functional Family Therapy (FFT)/Parent-Child Interaction Therapy (PCIT).

Timely outpatient step-down within 7 days after inpatient discharge: Achieve 70% by FY 2027–28 through Health Information Exchange (HIE)-triggered scheduling, peers, and transportation supports.

Follow-up after Mental Health Emergency Department (ED) visit: Improve by 10 percentage points via ED navigators and next-day holds.

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

BHSA Behavioral Health Services and Supports (BHSS)

BHSA Full Services Partnership (FSP) 1991 Realignment

2011 Realignment State General Fund

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

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

Community Mental Health Block Grant (MHBG) Substance Use Block Grant (SUBG)

Other

Please describe other

Behavioral Health Continuum Infrastructure Program (BHCIP), CMSP Health Infrastructure Development (CMSP HID) Grant

Homelessness:

Primary measures

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

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

Below

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

Age

Gender

Race or Ethnicity

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?

Race or Ethnicity

Other

Please describe other

Students with disabilities and grade-level (k-12)

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?

Age

Gender

Race or Ethnicity

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?

Below

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

Age

Race or Ethnicity

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

Data from the U.S. Department of Housing and Urban Development (HUD) and the U.S. Census Bureau

Population Estimates Program revealed multiple demographic disparities among individuals experiencing homelessness in El Dorado County (EDC). Measure 1, People Experiencing Homelessness Point-in-Time Count, indicates that the most significant disparity exists around race and ethnicity, with American Indian/Alaska Native, Black and Native Hawaiian/Other Pacific Islander individuals experiencing much higher rates of homelessness than other demographic groups. A significant gender disparity also exists in El Dorado County, with males experiencing homelessness at a rate nearly twice that of females. A smaller disparity was observed based on age, with those age 35-44 experiencing homelessness at the highest rate. Measure 4, Percent of K-12 Public School Student Experiencing Homelessness, indicates that among students experiencing homelessness in EDC disparities by language, race/ethnicity, disability status and, to a smaller degree, age, exist. According to data collected by the California Department of Education,

English-learners in EDC experience homelessness at a higher rate than do English speaking students. In terms of student homelessness by race/ethnicity, American Indian/Alaska Native students experience the highest rates of homelessness in EDC. But Pacific Islander, Latino and African American students also experience homelessness at rates higher than the overall student homelessness rate of 2.6%. Lastly, disparities based on age and disability status were also observed. For example, 11th - 12th graders, Kindergarteners - 1st graders and students with disabilities experienced homelessness at rates higher than 2.6%.

Among those who accessed homelessness services through the EDC Continuum of Care (CoC) disparities in age and race/ethnicity were observed. For example, those age 65+ were the least likely to access homelessness services through the CoC. Utilization rates Among white and Latino populations utilization rates closely mirrored the county's overall utilization rate, but Black and American Indian/Alaska Native/Indigenous individuals accessed homelessness services through the CoC at

significantly higher rates than other demographics.

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)

El Dorado County's (EDC) rates of homelessness for individuals experiencing severe mental illness (SMI),

Severe substance use disorder (SUD) or co-occurring conditions are currently below the statewide average and median, while self-reported mental health and substance use disorders remain high among our homeless population residing in Emergency Shelters in the region. The Behavioral Health Division (BHD) is taking steps to reduce rates of homelessness among these populations by strengthening our current Flex Pool, becoming a Transitional Rent Provider, and leveraging programs and funding that prioritize housing for individuals experiencing homelessness with SMI or SUD diagnosis, or who are exiting shelter programs or institutions. BHD is working to strengthen its Flex Pool in two ways. First, housing staff are participating in Department of Healthcare Services' (DHCS) 'Flex Pools Academy', a reoccurring technical assistance series provided through a grant awarded to BHD in July 2025. The Academy will run through Spring 2027 and is focused on successfully operationalizing BHS Housing Interventions, including Flex Pools and Transitional Rent. Secondly, EDC's Housing & Homeless unit is going to be moving from the Community Services Division to BHD. This change will improve the delivery of Flex Pool funds to eligible members by removing organizational silos and consolidating the County's housing programs, funding streams, and institutional knowledge into a single location. Additionally, BHD is in the process of contracting with the local Managed Care Plans (Health Plan of San Joaquin, Anthem and Kaiser) to become a Transitional Rent Provider. By becoming a Transitional Rent Provider, BHD will have a direct role in program design and implementation, allowing the division to design the program in a way that best serves these populations. Lastly, BHD is prioritizing the development of programs to help move individuals out of shelter and into permanent housing, such as Rapid Rehousing for individuals exiting the County Navigation Center and Transitional Rent for clients exiting behavioral health Transitional Housing. BHD provides Housing Navigation and supports to help clients maintain housing once

placed with Social Workers and Mental Health Workers that engage with clients to ensure a consistent transition into housing and will provide referrals to other providers that offer additional community supports such as Enhanced Care Management (ECM). BHD has also been given direction to develop a treatment based transitional housing program which will focus on individuals with SMI and/or SUD, scheduled for operation in 2027.

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

BHSA FSP

BHSA Housing Interventions

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

Other

Please describe other

Transitional Rent, CalWORKs Housing Support Program (HSP), Bringing Families Home (BFH), Home Safe, Housing Disability Advocacy Program (HDAP), Behavioral Health Bridge Housing (BHBH), Homeless Housing, Assistance and Prevention (HHAP), Emergency Solutions Grant (ESG), Permanent Local Housing Allocation (PLHA), US Department of Housing and Urban Development (HUD) Housing Choice Voucher program and CoC Program

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.

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

Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

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

For adults/older adults

Not Applicable

For children/youth

Not Applicable

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

No Disparities Data Available

Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

14-day involuntary detention rates per 10,000

Below

30-day involuntary detention rates per 10,000

Above

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

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

Temporary Conservatorships

Not Applicable

Permanent Conservatorships

Not Applicable

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

No Disparities Data Available

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

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

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

Crisis Intervention

For adults/older adults

Below

For children/youth

Below

Crisis Residential Treatment Services

For adults/older adults

Not Applicable

For children/youth

Not Applicable

Crisis Stabilization

For adults/older adults

Below

For children/youth

Not Applicable

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

Race or Ethnicity

Other

Please describe other

Written Language

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

Inpatient Administrative Days per Beneficiary

Data from California Mental Health Services Authority's (CalMHSA) Institutionalization dashboard reveals disparities in the average number of administrative inpatient days—those days when clients are inpatient past clinical necessity while awaiting lower-level placement. For adults, one or more demographic subgroups of Medi-Cal beneficiaries (e.g., older adults or specific racial/ethnic groups) show higher average days compared to the county mean. In children/youth, similar disparities emerge, indicating prolonged stays beyond clinical need among certain subpopulations.

Specialty Mental Health Services (SMHS) Crisis Service Utilization

Utilization patterns for crisis services (intervention, stabilization, residential) differ across demographic groups. In El Dorado County (EDC), specific groups receive fewer minutes/hours/days of crisis services relative to those groups overrepresented in need. Conversely, others may have disproportionately high usage, which may signal system reliance on institutional intervention over less restrictive options.

Involuntary Detention and Conservatorship Rates

CalMHSA also reports disparities in involuntary detention (14 day, 30 day, 180 day) and conservatorship (temporary and permanent) rates per 10,000 residents. In EDC, one or more community groups, such as youth, adults of certain races/ethnicities, or those experiencing homelessness, show higher detention or conservatorship rates compared to the county average.

Cross-Measure Questions

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

The El Dorado County (EDC) Psychiatric Health Facility (PHF) in Placerville, the sole institutionalized setting in the county, offers 16 secured beds for adults aged 18+. The PHF is the BHP's first resource for acute facility placement, serving hundreds annually.

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

Housing Integration and Expansion

Integration of the Housing and Homelessness Services Programs within the Behavioral Health Division (BHD) to improve access/engagement for persons experiencing homelessness, to include the utilization of Behavioral Health Bridge Housing (BHBH) funding (short- and mid-term housing and supportive services) for individuals with serious behavioral health conditions.

Leveraging Transitional Rent alongside Behavioral Health Services Act (BHSA) Housing to stabilize members as they exit inpatient, congregate, or carceral settings.

Additional Service Sites

Acceptance of a \$24M grant with the State for the Support, Outreach, Accessibility, and Resilience Center (SOAR) Project. The funding will provide renovations to an existing building; the upper floor will become the new El Dorado County (EDC) Psychiatric Health Facility (PHF), expanding our capacity to treat our community's highest need Behavioral Health clients. The lower floor will be developed into an integrated Behavioral Health Outpatient Center with intake for all relevant Health and Human Services Agency (HHS) programs at a single point of access right on our county bus route.

Development of temporary housing with supportive services for individuals willing to engage in treatment. This complex will temporarily house individuals and families willing to engage in behavioral health services with the goal of transitioning them into self-sufficiency.

In 2024 there were 445 psychiatric hospitalizations in the reporting year—56 youth (10–17) and 389 adults. This reflects substantial reliance on acute inpatient care.

The 2025 Point In Time County reported 284 people experiencing homelessness in EDC (48% unsheltered). Housing instability, especially among people with severe mental illness (SMI)/substance use disorder (SUD) is linked to repeated Emergency Department (ED) use and inpatient stays, supporting the importance of efforts to improve integration between Behavioral Health resources and services to these populations.

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

BHSA FSP

1991 Realignment

2011 Realignment State General Fund

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

Please describe other

Behavioral Health Continuum Infrastructure Program (BHCIP)

Justice-Involvement:

Primary Measures

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

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

For adults/older adults

Above

For juveniles

Above

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

Age

Gender

Race or Ethnicity

Sex

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?

None Identified

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

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

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

Below

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

No Disparities Data Available

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

While the El Dorado County (EDC) Arrest Rate is between the Statewide Rate and the Statewide Median, falling in at 2587 per 100,000 people, disparities are found in several demographic categories. In EDC arrest rates are higher for people aged 30-39 (6,004 per 100K), and 20-29 (3,778 per 100K), adult males (3,589 per 100K), juvenile males (570 per 100K), and black/African American (8,638 per 100K) individuals. Possible reason for these disparities could be a result of many factors including relative age of the population in EDC, income levels, education levels, and access to mental health resources.

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)

County data reveals that our adult arrest rate, recidivism for individuals with mental health and substance use disorders, and rates of individuals found Incompetent to Stand Trial (IST) all fall above California's statewide averages or medians.

The combined programs and this integrated approach address measures where the county is not meeting the statewide average by providing pre-arrest and post-release stabilization (Path-JI, housing supports), offering alternatives to incarceration (Behavioral Health Court), delivering structured court-supported treatment pathways (CARE Act), and ensuring high-intensity supports for those with the greatest needs (Forensic FSP). Through these programs services may be provided to individuals within areas our County doesn't meet the statewide average. Data sources include CalMHSA Data Statewide Behavioral Health Goals-Justice Involvement Dashboard, encounter data from internal county sources, and previous MHSA Outcomes Data.

Integration of the Housing and Homelessness Services Programs from the Community Services Division to the Behavioral Health Division (BHD) Division, within EDC's integrated Health and Human Services Agency (HHS), is expected to be complete in the spring of 2026. This will improve access/engagement for persons experiencing homelessness, to include the utilization of Behavioral Health Bridge Housing (BHBH) funding (short- and mid-term housing and supportive services) for individuals with serious behavioral health conditions.

Leveraging Transitional Rent alongside BHS Housing to stabilize members as they exit inpatient, congregate, or carceral settings.

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

BHSA FSP

BHSA Housing Interventions State General Fund

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

1991 Realignment

2011 Realignment SUBG

Other

Please describe other

Providing Access and Transforming Health (PATH) Justice-Involved (JI) Round 3,
Opioid Settlement Funds (OSF)

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

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?

Below

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

Age

Race or Ethnicity

Sex

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

El Dorado County (EDC) is below county-level rates for all age groups in the Child Welfare Indicators Project

(CWIP) program except 1 to 2 which is more than 1.5 times that of the next highest count rate of 3 to 5. EDC is below the County-level rate for Specialty Mental Health Services (SMHS) Penetration according to Sex at birth where the female rate is lower than the county-level rate. EDC's SMHS Penetration rate percentage by Race/Ethnicity is disproportionately higher for the "Other" category but still below the county-level rate with the penetration rate based on age group is minimal for 0-11 years, almost equal for the 3-20 age group but highest and above the county-level rate for 12-17 years. The highest discrepancy in county-level rate for Child Maltreatment Substantiation disparity is for sex because of Intersex having a very low incident rate of 0.1.

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

Beginning July 1, 2026, the County is implementing a set of targeted evidence-based programs designed to increase access to care and improve performance on all measures where outcomes fall below the statewide average or median. These initiatives were selected based on analysis of local behavioral health data, CalMHSA Statewide Behavioral Health Goals Dashboards, CWS utilization data, and outcomes data for high-risk sub populations.

Development of the Behavioral Health Plan's High Fidelity Wraparound (HFW) application is underway and will be submitted for approval no later than July 8, 2026. Early HFW implementation will begin July 1, 2026 to reduce out of home placements and strengthen family stability, addressing locally identified rates of child removal and complex multi system involvement that exceed statewide levels. The County is also establishing Coordinated Specialty Care (CSC) for First Episode Psychosis, including a South Lake Tahoe satellite and tele specialty psychiatry, to address geographic access gaps and lower early intervention engagement among transition age youth compared to statewide trends. In addition, the County is expanding the availability and implementation of EPSDT evidence-based therapies, including Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Parent Child Interaction Therapy (PCIT), in collaboration with contracted providers and supported by DHCS Centers of Excellence. Local EPSDT penetration and outcomes data showing disparities among child welfare and justice involved families directly informed this expansion. Together, these initiatives strengthen and expand access to evidence-based interventions and are intentionally targeted to populations with the poorest outcomes, ensuring that program investments address all measures where the county currently underperforms relative to statewide benchmarks.

In addition to these program-specific strategies, the County will address all areas where performance falls below statewide averages by using a comprehensive, data-driven approach guided by multiple local sources, including Behavioral Health dashboards, countywide access-to-care reports, Medi-Cal penetration data, CWS case review findings, EPSDT utilization patterns, and geographic access studies. These data sources consistently highlight gaps in timely access to services, service penetration among Medi-Cal beneficiaries, engagement among high-risk sub populations, and disparities in outcomes for children and youth with multi-system involvement. To address these cross-cutting performance challenges, the County will strengthen referral pathways across behavioral health, child welfare, education, and contracted provider networks; expand workforce capacity in evidence-based practices; and enhance telehealth and regional access strategies to mitigate geographic disparities, particularly in South Lake Tahoe and rural communities. Continuous monitoring of statewide comparison metrics and county-level performance dashboards will guide ongoing adjustments to ensure that all implemented initiatives meaningfully improve access, quality, and outcomes for populations whose indicators currently fall below statewide medians..

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

BHSA BHSS

BHSA FSP

BHSA Housing Interventions 2011 Realignment

1991 Realignment State General Fund

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

SUBG

Untreated Behavioral Health Conditions:

Primary Measures

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

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

For the full population measured

Above

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

No Disparities Data Available

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

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

For the full population measured

Above

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

No Disparities Data Available

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

Below

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

Age

Gender

Race or Ethnicity

Sex

Disparities Analysis

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

The disparities for adults needing help for emotional/mental health problems include adults ages 25-64

and 65+ being over the Countywide rate of 36.7%. This disparity may be due to the general age of the population of El Dorado County (EDC) being greater within those age ranges. Females are at a slightly higher percentage than the Countywide rate and are listed at 43.7%. Also above the Countywide Rate are races including white, and those with two or more races (41.3% and 43.5% respectively). These disparities fall in line with the general population of EDC and should be taken into consideration in analyzing services that are provided to the population.

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)

Strengthening crisis care transitions with Mobile Crisis Response Teams linked to 988 and real-time Health Information Exchange (HIE) alerts.

Guaranteeing step-down appointments within 7 days from Psychiatric Health Facility (PHF)/inpatient discharge.

Integrating HIE (Manifest MedEx) Admissions, Discharges, and Transfers (ADT) notifications into care coordination protocols to improve timeliness, reduce duplicate services, and lift Specialty Mental Health Services (SMHS) penetration, in coordination with Public Health.

Integrating the Housing and Homelessness Services Programs from the Community Services Division to within the Behavioral Health Division (BHD) is expected to be complete in the spring of 2026. This will improve access and engagement for unhoused individuals, and for those with serious behavioral health conditions, to access supportive services and short- and mid-term housing through Behavioral Health Bridge Housing (BHBH) funding.

Acceptance of a \$24M grant with the State for the Support, Outreach, Accessibility, and Resilience Center (SOAR) Project. The funding will provide renovations to an existing building; the upper floor will become the new EDC PHF, expanding our capacity to treat our community's highest need Behavioral Health clients. The lower floor will be developed into an integrated Behavioral Health Outpatient Center with intake for all relevant Health and Human Services Agency (HHS) programs at a single point of access right on our county bus route.

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

BHSA BHSS

BHSA FSP

BHSA Housing Interventions 1991 Realignment

2011 Realignment State General Fund

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

MHBG SUBG

Other

Please describe other

Behavioral Health Continuum Infrastructure Program (BHCIP), Opioid Settlement Funds (OSF)

Additional statewide behavioral health goals for improvement

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

For related policy information, refer to [E.6.2 Primary and Supplemental Measures](#).

Care Experience:

Primary Measures

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

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

For adults/older adults

Above

For children/youth

Above

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

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

For adults/older adults

Above

For children/youth

Above

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

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?

Below

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?

Below

Overdoses:

Primary Measures

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

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

For the full population measured

Below

For adults/older adults

Below

For children/youth

Below

Supplemental Measures

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

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

For the full population measured

Above

For adults/older adults

Below

For children/youth

Above

Prevention And Treatment of Co-Occurring Physical Health Conditions:

Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022

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

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

Below

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

Below

Supplemental Measures

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

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

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

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

Perception of Functioning Domain Score (CPS), 2024

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

For the full population measured

Not Applicable

For adults/older adults

Not Applicable

For children/youth

Not Applicable

Supplemental Measures

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

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

For the full population measured

Above

Social Connection:

Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

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

For the full population measured

Not Applicable

For adults/older adults

Not Applicable

For children/youth

Not Applicable

Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Below

Suicides:

Primary Measures

Suicide Deaths, 2022

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

For the full population measured

Above

Supplemental Measures

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

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

For the full population measured

Above

For adults/older adults

Above

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 the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.

Care experience

Please describe why this goal was selected

El Dorado County (EDC) selected Care Experience because our Consumer Perception Survey (CPS) results show that the Adult Cultural Appropriateness/Quality score (4.3) is slightly below the statewide average of 4.36, indicating an opportunity to improve the perceived quality and cultural responsiveness of services for adults. While older adults and youth scores exceed statewide benchmarks, this gap for adults meets the eligibility criteria for selecting an additional goal. Improving Care Experience is a strategic priority because it directly influences engagement, trust, and outcomes across multiple domains, including Access to Care and Untreated Behavioral Health Conditions. Enhancing cultural appropriateness and service quality will help reduce disparities and strengthen equity across our behavioral health system.

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

Our disparities analysis reveals that lower penetration rates for Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services disproportionately affect older adults, Asian American/Pacific Islander, Hispanic/Latino, Black residents, and non-English speakers. These disparities often reflect systemic barriers such as language access, cultural fit, and navigation challenges rather than eligibility alone. Additionally, data from CalMHSA dashboards show that adults aged 65+, racial/ethnic minorities, and individuals with limited English proficiency experience reduced engagement in behavioral health services compared to county averages. Addressing Care Experience—through culturally responsive practices, language access improvements, and peer navigation—will help mitigate these disparities and improve outcomes for historically underserved populations.

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

Beginning July 1, 2026, El Dorado County (EDC) Behavioral Health Division (BHD) plans to strengthen and implement several programs and initiatives to improve performance on selected statewide goals, guided by local data and equity analysis. Key strategies include expanding peer support services through a Non-Clinical Performance Improvement Project to increase culturally responsive navigation and warm handoffs, and embedding Manifest MedEx admission, discharge and transfer notifications (ADTs) alerts into care coordination workflows to ensure timely

outpatient follow-up within seven days of discharge from inpatient or psychiatric health facilities. The county will deploy CarePOV (Mobile Avatar) tablets for mobile crisis teams and Psychiatric Emergency Services staff to enable real-time documentation and improve continuity of care. Additionally, targeted Early Intervention programs will focus on underserved sub-populations identified through California Mental Health Services Authority (CalMHSA) equity dashboards, such as older adults, racial/ethnic minorities, and non-English speakers, by scaling evidence-based practices like Multisystemic Therapy (MST), Functional Family Therapy (FFT), Parent-Child Interaction Therapy (PCIT) for child welfare and justice-involved families. Continuous quality improvement will be supported through quarterly Consumer Perception and Treatment Perception Surveys integrated into Quality Improvement (QI) dashboards, ensuring feedback informs service enhancements.

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

BHSA BHSS

BHSA FSP

BHSA Housing Interventions 1991 Realignment

2011 Realignment State General Fund

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

MHBG SUBG

Other

Please describe other

Behavioral Health Continuum Infrastructure Program (BHCIP), Opioid Settlement Funds (OSF)

Community Planning Process

For more information on this section, please see [3.B Community Planning Process](#).

Stakeholder Engagement

For related policy information, refer to [3.B.1 Stakeholder involvement](#).

Please indicate the type of [engagement used to obtain input](#) on the planning process

County outreach through 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

Training, education, and outreach related to community planning

Date

8/18/2025

Type of engagement

Training, education, and outreach related to community planning

Date

8/19/2025

Type of engagement

Training, education, and outreach related to community planning

Date

8/27/2025

Type of engagement

Training, education, and outreach related to community planning

Date

9/9/2025

Type of engagement

Other

Date

9/17/2025

Type of engagement

Training, education, and outreach related to community planning

Date

10/2/2025

Type of engagement

Training, education, and outreach related to community planning

Date

10/3/2025

Type of engagement

Focus group discussions

Date

12/2/2025

Type of engagement

Focus group discussions

Date

12/3/2025

Type of engagement

Focus group discussions

Date

12/3/2025

Type of engagement

Focus group discussions

Date

12/5/2025

Type of engagement

Focus group discussions

Date

12/8/2025

Type of engagement

Focus group discussions

Date

12/11/2025

Type of engagement

Focus group discussions

Date

12/17/2025

Type of engagement

County outreach through townhall meetings

Date

9/17/2025

Type of engagement

County outreach through townhall meetings

Date

3/19/2025

Type of engagement

County outreach through townhall meetings

Date

1/21/2026

Type of engagement

Key informant interviews with subject matter experts

Date

7/25/2025

Type of engagement

Key informant interviews with subject matter experts

Date

8/4/2025

Type of engagement

Key informant interviews with subject matter experts

Date

8/4/2025

Type of engagement

Key informant interviews with subject matter experts

Date

8/27/2025

Type of engagement

Workgroups and committee meetings

Date

1/20/2026

Type of engagement

Workgroups and committee meetings

Date

10/21/2025

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

1-2-3 Wellness, ACCEL - Access El Dorado, Aegis Treatment Centers LLC, Alta California Regional Ctr, Barton Healthcare System, Black Oak Mine Unified School District, Blue Cross of California, Camino Union School District, City Of Placerville, City Of South Lake Tahoe, Coalition for Overdose Prevention & Education (COPE), EDC Community Services (animal services, sr. Services, Veteran Services), EDC Protective Services, EDC Public Health, EDC Self Sufficiency, EDCA Lifeskills, El Dorado County Behavioral Health Commission, El Dorado County Child Welfare Services, El Dorado County Community Health Center, El Dorado County Housing and Homelessness Services, El Dorado County Office of Education, El Dorado County Probation, El Dorado County Sheriff's Office, El Dorado Union High School District, First 5 El Dorado, Gold Oak Unified School District, Health Plan of San Joaquin, Housing El Dorado, Infant Parent Center Inc, Marshall Medical Center, McKenny Vento Liaison, NAMI El Dorado County, New Morning Youth & Family Services Inc, Only Kindness Inc, Permanente Medical Group Inc, Placerville PD, Rescue Union School District, SLT PD, School Advisory Review Board, Shingle Springs Band of Miwok Indians, Sierra Child & Family Services, Stanford Sierra Youth & Families, Summitview Child & Family Services Inc, The Center for Violence-Free Relationships

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

	City name
1	N/A
2	N/A
3	N/A
4	N/A
5	N/A

Were you able to engage [all required stakeholders/groups](#) in the planning process?

No

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

Higher education partners- Attempted but did not receive a response

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

Early Community Planning Process (CPP) meetings engaged a wide range of stakeholders, capitalizing on the expanded networks of contracted providers and collaborators to reach broader subsets of the community. Meetings were held in an Open Forum structure including a 17 minute informational Behavioral Health Services Act (BHSA) training presentations followed by open-ended questions and answers. The information training video was made available on the Behavioral Health Division (BHD) website in both English and Spanish throughout the CPP. This allowed stakeholders to deepen their understanding of BHSA before providing quality feedback. Midway through the CPP, priority populations for discretionary projects were identified. Seven public focus groups were held to discuss program ideas based on the identified populations allowing brainstorming with subject matter experts and individuals with lived experience. An online survey was available throughout the full CPP process.

Although representation from the local community college wasn't formally captured, perspectives of community members and providers from the community surrounding the campus considered utilization of services, referral pathways and system navigation to ensure that students who don't choose to engage in on campus resources may find support in the broader community.

Upload File

[BHSA CPP Presentation SPANISH.pdf](#)

[BHSA CPP Presentation.pdf](#)

[BHSA Community Planning Process \(CPP\) Survey - Fiscal Year 2026 27.pdf](#)

Local Health Jurisdiction (LHJ)

For related policy information, refer to [B.2 Considerations of Other Local Program](#)

Planning Processes.

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

No. The LHJ is not currently working on and/or did not develop a recent CHA and/or CHIP

Collaboration

Please select how the county collaborated with the LHJ

Attended key CHA and CHIP meetings as requested.

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

Data-Sharing

Data-Sharing to Support the CHA/CHIP

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

Access to Care

Care Experience

Removal of Children from Home

Overdoses

Was data shared?

Yes

Data-Sharing from MCPS and LHJs to Support IP development

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

Access to Care

Suicides

Care Experience

Removal of Children from Home

Homelessness

Institutionalization

Justice Involvement

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

Was data shared?

Yes

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.

Other

Please describe how the county has coordinated stakeholder activities for IP development and the CHA/CHIP

El Dorado County Behavioral Health staff were engaged in the development of the 2023-2028 CHA/CHIP prior to required collaboration and prior to development of the 2026-2029 IP.

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

Has the county considered either the LHJ’s most recent CHA/CHIP or strategic plan in the [development of its IP](#)? Additional information regarding engagement requirements with other local program planning processes can be found in [Policy Manual Chapter 3, Section B.2.3](#)

Yes

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

El Dorado County (EDC) undertook a data-driven and community-informed process to ensure alignment:

- Integration of CHA Findings: The CHA identified the top 12 health issues through analysis of multiple data sources and community input. These findings informed the CHIP priorities and, subsequently, the IP focus areas.
- Community-Selected Priorities: Through surveys and “Hot Dots” polling, over 1,500 residents prioritized Mental Health/Substance Use Disorder, Child Health, and Obesity. These priorities shaped the IP’s goals and interventions.
- Root Cause Analysis: The CHIP process included a comprehensive root cause analysis for these priorities, identifying systemic factors such as Adverse Childhood Experiences, Barriers to Care, Peer Influences, and Maternal Behaviors. The IP addresses these root causes through upstream, cross-cutting strategies.
- Stakeholder Engagement: The Integrated Plan (IP) reflects extensive collaboration with the CHIP Steering Committee and Taskforce, ensuring that strategies align with community needs, existing resources, and funding opportunities (e.g., BHSA, Opioid Settlement Funds).

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to [B.2 Considerations of Other Local Program Planning Processes](#).

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

Blue Cross Of California Partnership Plan, Inc. (Anthem)

Kaiser Foundation Health Plan, Inc

Health Plan of San Joaquin dba Mountain Valley Health Plan

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?

The MCP Community Reinvestment Plan activities directly align with priorities identified through the Behavioral Health Services Act (BHSA) community planning process and the county's Integrated Plan by addressing critical gaps in behavioral health access, workforce capacity, and social determinants of health. Through collaborative engagement with the county, MCPs, and community stakeholders, these initiatives include investments in behavioral health workforce development, expansion of community-based mental health and substance use disorder services, and integration of care coordination models that support whole-person care. MCPs such as Anthem, Kaiser, and Health Plan of San Joaquin have committed resources to tele-behavioral health platforms, community health worker training, and perinatal behavioral health programs, which respond to identified needs for culturally competent outreach, maternal mental health, and early intervention. Additionally, reinvestment activities targeting housing stability, transportation, and broadband access directly mitigate barriers to care highlighted in the Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) and Integrated Plan (IP). These efforts collectively strengthen the continuum of care, promote equity, and advance shared goals for improving behavioral health outcomes across El Dorado County (EDC).

Comment Period and Public Hearing

For related policy information, refer to [B.3 Public Comment and Updates to the Integrated Plan](#).

Comment Period and Public Hearing

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

2/27/2026

Date the stakeholder comment period closed

3/29/2026

Date of behavioral health board public hearing on draft IP
4/15/2026

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

Link

Please provide the link to the public posting

<https://www.eldoradocounty.ca.gov/Health-Well-Being/Behavioral-Health/Behavioral-Health-Services-Act-BHSA/Behavioral-Health-Plans>

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

Public posting

Email outreach

Attach email

[Public Comment Flyer 26-27.pdf](#)

[Substantive Comment Form.pdf](#)

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

Stakeholder group that provided feedback

Eligible adults and older adults (individuals with lived experience); Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience)

Summarize the substantive revisions recommended this stakeholder during the comment period

I wanted to give some feedback about the impact of NAMI El Dorado in our community. Their monthly newsletter provides lots of helpful information and lets me know about upcoming events in our community. NAMI facilitates many essential groups like Family Support Groups, Family to Family classes as well as individual support. Clubhouse El Dorado is a much needed and impactful part of NAMI El Dorado. I've witnessed lives not only changed but saved. I've seen members go from being fairly incapacitated to gaining employment and being homeless to being able to afford rent and a place to live. I ask that your [plan will support NAMI El Dorado and enable Clubhouse El Dorado to keep doing its wonderful job with those who so desperately need it.

Stakeholder group that provided feedback

Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience); Providers of mental health services and substance use disorder treatment services

Summarize the substantive revisions recommended this stakeholder during the comment period

The Plan is written to provide the public and stakeholders with the scope and direction our county is moving toward under the new changes in the BHSA. Comment: Too many acronyms and jargon "upstream, cross cutting strategies" for example, make reading this lengthy plan difficult, given the people you want to reach. The purpose is to ensure stakeholders have the opportunity to meaningfully and sufficiently participate. First, they have to understand it.

Stakeholder group that provided feedback

Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience); Providers of mental health services and substance use disorder treatment services

Summarize the substantive revisions recommended this stakeholder during the comment period

There is greater data in the Plan for areas within the Quality Improvement Plan information showing the County's desire and efforts to improve several areas that are below State measurement rates. Comment: More data needed on individual programs showing how programs are making progress in addressing areas of need and measurable objectives to set goals for improvement. Where is the data for programs began in 2024; Mobile Crisis Team, MHRC and Clubhouse? Why is this positive data not being utilized to move services further in the direction desired?

Stakeholder group that provided feedback

Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience); Providers of mental health services and substance use disorder treatment services

Summarize the substantive revisions recommended this stakeholder during the comment period

Most appreciated was the Supplemental Measure - Quality of Life. The County correctly identified this goal as a priority because it "directly influences engagement,

trust, outcomes, across multiple domains including access to care and untreated Behavioral Health Conditions". Comment: It is disappointing that, while Quality of Life was recognized as an important if not essential measure , the very program that fosters, encourages and celebrates these strategies and has the data to support it, Clubhouse El Dorado, was left out of the Plan entirely.

Stakeholder group that provided feedback

Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience); Providers of mental health services and substance use disorder treatment services

Summarize the substantive revisions recommended this stakeholder during the comment period

Overall, I found the BHSI Integrated Plan lacking in addressing our County's Behavioral Health Needs. The State of California may approve the "boilerplate" answers to its format, but it does not meet the very real needs for the people it is meant to serve. It has no heart. \$24 Million may provide a renovated building and nicer PHF, and more offices, but I believe the individuals in our county affected by severe and persistent mental illness would rather have an accepting and supportive community with hope for a life of meaning and quality.

Stakeholder group that provided feedback

Eligible adults and older adults (individuals with lived experience); Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience);Youths (individuals with lived experience) or youth mental health or substance use disorder organizations; Providers of mental health services and substance use disorder treatment services; Community-based organizations serving culturally and linguistically diverse constituents; People with lived experience of homelessness

Summarize the substantive revisions recommended this stakeholder during the comment period

We respectfully request your support for Clubhouse El Dorado, a proven, community-based program serving adults living with serious mental illness. The California Department of Health Care Services (DHCS) officially recognizes Clubhouses as inclusive spaces where members with serious mental illness or substance use disorders work alongside staff as equals to build skills and support recovery. And in the less than two years we've been in operation with your support, we've developed our Clubhouse into a thriving space with 300 plus members, an average daily

attendance of 20-25, meeting county and state goals to help members build skills and grow in their recovery. While we are applying for other funding streams including becoming Medi-Cal certified and a Managed Care provider, as well as soliciting philanthropic donations, these will not cover the entire cost of the Clubhouse program. We therefore urge you to reconsider funding our Clubhouse. Failing to support the Clubhouse could result in a loss of the vital services that meet many goals of DCHS and your BHSA plan. After meeting with staff from California Department of Health Care services on 3/12/26, we wanted to clarify several important considerations regarding BH-Connect participation. First, opting into the Clubhouse evidence-based practice does not create a mandate to adopt any other model or service. Second, participation is flexible, and the County may opt out at any time. Third, there is no indication that this funding will be interrupted, providing a stable opportunity to invest in services that deliver long-term outcomes. Finally, BH Connect funding allows the county to receive matching funds for 50% of its investment. We have made a careful study of the BHSA plan, and maintain that the BHSA plan does include Clubhouse services in its purview. In this email, we demonstrate how our Clubhouse meets the ideals presented in your plan, and how our Clubhouse is a valuable community partner to help you attain the goals of the plan. Under California's Behavioral Health Services Act (BHSA) a Clubhouse serves as an evidence-based, community-based environment designed to fulfill several core service categories. The Core BHSA Services fulfilled by Clubhouses include Supported Employment & Vocational Services, Social Connection and Peer Support, Housing Navigation and Stability, Educational Assistance, Outreach and Engagement, and Resource Navigation. Our Clubhouse also plays a strategic role in the BHSA to achieve statewide goals by Reducing Recidivism, providing Early Intervention, providing Cost Effective Care, and providing Full Service Partnership-aligned "personal service coordination." A primary goal of the BHSA is to improve Social Connection and Peer Support. Clubhouses fulfill this through structured socialization, mentorship, and recreational activities during evenings, weekends, and holidays. Members have spent 23,000+ hours at the Clubhouse and have participated in social activities on evenings and weekends. On page 175 of your plan you display 14 Statewide Behavioral Health Goals. Among those 14, our Clubhouse supports access to care, quality of life, social connection, engagement in school, and engagement in work. Page 142 of your plan states that you are choosing to opt out of Supported Employment and Vocational Services. You state there's a limited need. Three hundred plus Clubhouse members demonstrate that there very much is a need, and we meet that need with our "Work-Ordered Days" and transitional employment programs that have so far helped members gain job skills, confidence, and autonomous employment. Ninety-four resumes have been completed, and members have participated in 100 interviews, securing 92 jobs. Educational Assistance is defined as support for members to complete their education or access community-based educational resources. Since opening our doors, 44 of our members have pursued or are pursuing their formal education. On pages 34, 104, 116, 121 of your plan you cite Housing

Navigation services that you provide or plan to provide. While our Clubhouse is not a residential facility, we provide critical support in housing navigation and help members secure and sustain safe, affordable housing. Since opening our doors we have helped 66 members obtain secure housing, and we maintain close relationships with them so as to continue supporting them on their recovery journey. Outreach and Engagement: Clubhouses act as "natural gathering places" that help engage unserved individuals, including those at risk of homelessness or justice involvement, by offering a safe setting and basic necessities. The recovery oriented services described on page 106-7 of the FSP are exactly the holistic support our Clubhouse provides. The Clubhouse is a peer support environment, where members get one-on-one support, integrate into the community, and develop wellness and self-management practices. As part of basic necessities, in the past year, our Clubhouse has provided 8000+ breakfasts, lunches, and take home dinners (prepared by members) to those members experiencing food insecurity. Resource Navigation is defined as assistance with securing benefits such as SSI and SSDI, as well as coordinating access to medical and psychiatric services. Since opening our doors, we have supported 273 linkages to these and other community resources. Counties have the option to include Clubhouse services in their BH-CONNECT initiatives and integrated three-year plans to meet statewide goals such as: Reducing Recidivism, Early Intervention, and providing Cost-Effective Care with Full Service Partnership-aligned personal service coordination. By addressing social isolation and unemployment, Clubhouses are a key strategy for reducing justice system involvement. Our Clubhouse provides Early Intervention by targeting at-risk populations, including youth and those with emerging behavioral health needs, to prevent long-term disability. Finally, the Clubhouse model is recognized as a high-value investment, often costing one-third to one-half of traditional clinical models. The Clubhouse provides FSP-aligned "personal service coordination" to our members who may or may not be in the FSP program. Our members don't have to wait days or even weeks for an appointment to meet an urgent need – the Clubhouse is open from 9am - 5pm Monday through Friday. Members can reach staff as needed. Some of the life enhancing skills our members have developed in the time we've been open include Food service, Hospitality, Public Speaking, Media development, Writing, Researching, Job Searching, Resume writing, Job Interviewing, Appropriate Dressing for job interviews, Self-advocating with providers, Medication Management, Wellness maintenance, Effective communication, Mindfulness practices, and Participation in SUDs Recovery Activities. Once again, we urge your continued support of Clubhouse El Dorado, which serves critical needs in our community and has become a model that neighboring counties are inspired to emulate. Thank you for your leadership and commitment to improving mental health outcomes in El Dorado County. We welcome the opportunity to meet with you or your staff to discuss how Clubhouse El Dorado can support the success of your El Dorado County Behavioral Health services and goals.

Stakeholder group that provided feedback

Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience), Providers of mental health services and substance use disorder treatment services

Summarize the substantive revisions recommended this stakeholder during the comment period

Board Member and Volunteer for NAMI El Dorado, spoke as an Organization Representative. She asked the county to include the Clubhouse El Dorado program in its behavioral health plan, noting its strong outcomes, cost effectiveness, and rapid growth. She encouraged using BH Connect funding, which is flexible and provides matching funds, and thanked the Commission for considering the request.

Stakeholder group that provided feedback

Eligible adults and older adults (individuals with lived experience), Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience), Youths (individuals with lived experience) or youth mental health or substance use disorder organizations, Providers of mental health services and substance use disorder treatment services, Community-based organizations serving culturally and linguistically diverse constituents, People with lived experience of homelessness, Other: Providers of services to homeless individuals, justice-involved individuals

Summarize the substantive revisions recommended this stakeholder during the comment period

President of NAMI El Dorado County, spoke on behalf of community members and service providers who report that the Clubhouse has made a significant positive impact on people with serious mental illness and substance use challenges. She highlighted strong partnerships, consistent data showing member progress, and statewide recognition of the Clubhouse model as an evidence-based practice supported through BH Connect. She urged the county to continue supporting the Clubhouse as an essential part of the behavioral health continuum.

Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A.

Substantive recommendations

No Substantive recommendations as of 3/31/26 Draft IP submission to DHCS.

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

For related policy information, refer to [6.C.2 Securing Medi-Cal Payment](#).

Medi-Cal Quality Improvement Plans

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

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

[FY 25-26 EDC MH QI Work Plan FINAL.pdf](#)

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

Yes

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

[FY 25-26 EDC DMC-ODS QI Work Plan FINAL.pdf](#)

Contracted BHSA Provider Locations

As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	50

Substance Use Disorder (SUD) services only	8
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 Drug MC/DMC-ODS) for SFY 2025-26

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	44
DMC/DMC-ODS only	4
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

For related policy information, refer to [B.2 Considerations of Other Local Program Planning Processes](#).

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

65%

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

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

provider receives BHSA funding

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

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?
(Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)**

Yes

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

Yes

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to [7.A.1 Behavioral Health Services and Supports Expenditure Guidelines](#).

General

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

Early Intervention Programs (EIP)

Children's System of Care (non-Full Service Partnership (FSP)) Adult and Older Adult System of Care (non-FSP)

Workforce, Education and Training (WET)

Capital Facilities and Technological Needs (CFTN) Outreach and Engagement (O&E)

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

For related policy information, refer to [7.A.2 Children's, Adult, and Older Adult Systems of Care](#).

Children's Crisis Services Program

Please select the service types provided under Program

Mental health services

Substance Use Disorder treatment services

Supportive services

Please describe the specific services provided

The Children's Crisis Services Program provides Psychiatric Emergency Services (PES) at hospitals and Mental Health and Substance Use Mobile Crisis services for non-FSP and non Medi-Cal Members for youth under the age of 21. This program includes 24-Hour County Mental Health and Substance Use Crisis Line services by dialing (530)622-3345.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	500
FY 2027 - 2028	500
FY 2028 - 2029	500

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

To project the number of children served through the Children’s System of Care for non-FSP crisis services, the county relied on historical utilization data from prior fiscal years and current population estimates. Specifically, we analyzed the average number of youth receiving crisis interventions (such as mobile crisis response and crisis stabilization) over the past two years, adjusting for seasonal trends and anticipated growth based on demographic changes and community needs assessments. Assumptions included a modest annual increase in service demand due to rising awareness of available resources.

Children's Access services

Please select the service types provided under Program

Mental health services

Substance Use Disorder treatment services

Please describe the specific services provided

Children's Access services are designed to ensure timely entry into appropriate levels of care. These services include initial screenings, clinical assessments, and linkage to outpatient or community-based treatment.

The county Access Team responds to calls, walk-ins, and referrals, providing same-day or next-day appointments when possible. For non-FSP clients, the focus is on short-term engagement, stabilization, and connection to lower-intensity services such as therapy, medication support, or peer resources. This program includes 24-Hour County Access Line services by dialing 1-800-929-1955.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	300
FY 2027 - 2028	300
FY 2028 - 2029	300

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

Data from prior years on call volume, assessment rates, and referral patterns inform projections, with assumptions that demand will remain steady or increase slightly due to population growth and expanded outreach efforts.

Non-FSP Specialty Mental Health Services (SMHS) for youth

Please select the service types provided under Program

Mental health services

Supportive services

Please describe the specific services provided

Non-FSP Specialty Mental Health Services (SMHS) for youth in El Dorado County encompass a range of outpatient and community-based interventions for children and adolescents who do not meet Full Service Partnership criteria but still require ongoing behavioral health support. These services include individual and family therapy, rehabilitation, case management, and medication support, delivered through county-operated programs and contracted providers. The focus is on short-term, goal-oriented treatment to address severe mental health needs while maintaining youth in their homes and schools.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	100
FY 2027 - 2028	100

FY 2028 - 2029	100
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Please describe any data or assumptions your county used to project the number of individuals served through the Children’s System of Care

Service projections are based on historical utilization trends, referral patterns from schools and child welfare, and population estimates, with assumptions that demand will remain stable or increase slightly due to continued outreach and early intervention efforts.

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

For related policy information, refer to [7.A.2 Children’s, Adult, and Older Adult Systems of Care](#).

Crisis Residential Treatment (CRT) services

Please select the service types provided under Program

Mental health services

Supportive services

Please describe the specific services provided

Crisis Residential Treatment (CRT) services for Non-FSP adults in El Dorado County provide short-term, intensive support for individuals experiencing acute psychiatric distress who do not meet Full Service Partnership criteria. These services offer a structured, home-like environment focused on stabilization, skill-building, and linkage to ongoing outpatient care. CRT programs operate as an alternative to inpatient hospitalization, aiming to reduce emergency department utilization and promote recovery in the least restrictive setting.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	100
FY 2027 - 2028	100
FY 2028 - 2029	100

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 for service levels are based on historical admission data, average length of stay, and anticipated demand trends, with assumptions that utilization will remain steady or increase slightly due to continued emphasis on diversion from higher levels of care and community-based crisis response.

Adult Crisis Services Program

Please select the service types provided under Program

Mental health services

Substance Use Disorder (SUD) treatment services

Please describe the specific services provided

The Adult Crisis Services Program provides Psychiatric Emergency Services (PES) at hospitals and Mental Health and Substance Use Mobile Crisis services for non-FSP and non-Medi-Cal enrolled adults experiencing a behavioral health crisis. This program includes 24-Hour County Mental Health and Substance Use Crisis Line services by dialing (530)622-3345.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	1500
FY 2027 - 2028	1500
FY 2028 - 2029	1500

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

Service projections are based on historical call volumes, crisis response trends, and anticipated population growth, with assumptions that demand will remain steady or increase slightly due to expanded outreach and continued emphasis on community-based crisis intervention.

Adult Access Services

Please select the service types provided under Program

Mental health services

Substance Use Disorder (SUD) treatment services

Please describe the specific services provided

Access services in El Dorado County provide the primary entry point for individuals seeking specialty mental health care. The Access Team conducts initial screenings, clinical assessments, and determines medical necessity for Specialty Mental Health Services. These services include responding to phone calls, walk-ins, and referrals from community partners, ensuring timely linkage to appropriate outpatient or crisis services.

For non-FSP clients, the emphasis is on short-term engagement and connecting individuals to lower-intensity treatment options such as therapy, medication support, and case management. This program includes 24-Hour County Access Line services by dialing 1-800-929-1955.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	375
FY 2027 - 2028	375
FY 2028 - 2029	375

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 for service demand are based on historical call volumes, assessment data, and referral trends, with assumptions that utilization will remain stable or increase slightly due to population growth and expanded outreach efforts.

Non-FSP Specialty Mental Health Services (SMHS) for adults

Please select the service types provided under Program

Mental health services

Supportive services

Please describe the specific services provided

Non-FSP Specialty Mental Health Services (SMHS) for adults in El Dorado County include a range of outpatient and community-based supports designed for individuals who do not meet Full Service Partnership criteria but still require ongoing behavioral health care. These services encompass individual and group therapy, case

management, medication support, and rehabilitation activities. Programs are offered to promote client engagement, skill-building, and social connection in a supportive environment. Wellness Centers provide drop-in access, peer support, and recovery-oriented activities that help individuals maintain stability and avoid higher levels of care.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	850
FY 2027 - 2028	850
FY 2028 - 2029	850

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

Service projections are informed by historical utilization trends, demographic data, and anticipated growth in demand due to increased outreach and community education efforts.

Justice Involved Engagement and Linkage Services

Please select the service types provided under Program

Mental health services

Substance Use Disorder (SUD) treatment services

Please describe the specific services provided

The Justice Involved Engagement and Linkage Services serve individuals who are court-mandated to receive behavioral health services through various judicial avenues. This includes referrals from Behavioral Health Court, Mental Health Diversion programs, and other court orders related to criminal, family, or juvenile proceedings. The program provides outreach, engagement, and linkage to appropriate levels of care, including assessments, case management, therapy, and medication support, ensuring compliance with court directives while promoting recovery and reducing recidivism. Services are coordinated closely with Probation, Public Defender, District Attorney, and the courts to address behavioral health needs in a collaborative, client-centered manner.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	250
FY 2027 - 2028	250
FY 2028 - 2029	250

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 for service demand are based on historical court referral data, trends in diversion initiatives, and anticipated growth in collaborative justice programs, with assumptions that utilization will remain steady or increase as alternatives to incarceration expand.

Early Intervention (EI) Programs

County EI programs must include all required components outlined in [Policy Manual Chapter 7, Section A.7.3](#), but counties may develop multiple programs/interventions to meet all county EI requirements. For related policy information, refer to [7.A.7 Early Intervention Programs](#).

Adults 55+ Program

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

Outreach

Access and Linkage: Screenings

Access and Linkage: Assessments

Access and Linkage: Referrals

Treatment Services and Supports: Other

Please specify “other” type of Treatment Services and Supports

Short-term, non-clinical support focused on reducing isolation, stabilizing individuals after stressful life events, and improving access to behavioral health and social services.

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

No

Please describe intended outcomes of the program or service

- Expanded access and coordinated linkage to behavioral health care, supportive services, and community-based resources for older adults.
- Enhanced behavioral health and overall well-being, including improved daily functioning, resilience, and quality of life.
- Timely stabilization and recovery support for older adults experiencing behavioral health crises or critical life events, promoting safety and continuity of care.
- Early identification and proactive engagement of older adults exhibiting signs of behavioral health needs, enabling timely brief intervention and linkage to appropriate care.
- Reduction of behavioral health disparities through culturally responsive, accessible mobile outreach targeting underserved older adult populations.
- Strengthened caregiver capacity and well-being through non-clinical supports, education, and resource navigation, improving care quality and sustainability.

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

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	200
FY 2027 - 2028	200
FY 2028 - 2029	200

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

To project the number of individuals served through Early Intervention (EI) programs, El Dorado County relied on historical Mental Health Services Act (MHSA) utilization data, demographic trends, and prevalence estimates for early-onset mental health conditions. Assumptions included population growth patterns, anticipated demand for evidence-based programs.

Culturally Responsive Care Program

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

Outreach

Access and Linkage: Screenings

Access and Linkage: Assessments

Access and Linkage: Referrals

Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports

Short-term, non-clinical support focused on reducing isolation, stabilizing individuals after stressful life events, and improving access to behavioral health and social services.

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

No

Please describe intended outcomes of the program or service

- Expanded access to behavioral health services that are culturally and linguistically appropriate for individuals from diverse racial, ethnic, gender, sexual orientation, and socioeconomic backgrounds.
- Improved behavioral health outcomes and overall well-being through care models that respect and integrate cultural values, identities, and lived experiences.
- Culturally informed crisis intervention and recovery support, promoting resilience and healing in ways that are meaningful to each community.
- Early identification and engagement of behavioral health needs using

outreach that reduces stigma and fosters trust within diverse populations.

- Reduction in behavioral health disparities in access to care by identifying and addressing barriers and tailoring services to meet the unique needs of historically underserved communities.
- Enhanced support for families and caregivers through culturally relevant education, support, and resource navigation that reflect the caregiving norms and expectations of different cultural groups.

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

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	600
FY 2027 - 2028	600
FY 2028 - 2029	600

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

To project the number of individuals served through Early Intervention (EI) programs, El Dorado County relied on historical MHSA utilization data, demographic trends, and prevalence estimates for early-onset mental health conditions. Assumptions included population growth patterns, anticipated demand for evidence-based programs.

Children Ages 0-5 Program

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

Outreach

Access and Linkage: Screenings

Access and Linkage: Assessments

Access and Linkage: Referrals

Treatment Services and Supports: Other

Please specify “other” type of Treatment Services and Supports

Short-term, non-clinical support focused on reducing isolation, stabilizing individuals after stressful life events, and improving access to behavioral health and social services.

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

No

Please describe intended outcomes of the program or service

- Expanded access to developmentally appropriate behavioral health services tailored to meet the unique needs of young children and their families.
- Improved emotional and developmental outcomes for children through family-centered care models that support healthy growth and early learning.
- Effective crisis intervention and early intervention, promoting resilience and recovery for children and families experiencing short-term stress or trauma.
- Early identification and engagement of behavioral health concerns in young children through accessible screening and outreach strategies.
- Reduction in disparities by addressing barriers to care and ensuring equitable access to behavioral health services and supports.
- Enhanced caregiver and parent well-being through education, support, and resource navigation that strengthen family stability and caregiving capacity.

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

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	200
FY 2027 - 2028	200
FY 2028 - 2029	200

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

To project the number of individuals served through Early Intervention (EI) programs, El Dorado County relied on historical Mental Health Services Act (MHSA) utilization data, demographic trends, and prevalence estimates for early-onset mental health conditions. Assumptions included population growth patterns, anticipated demand for evidence-based programs.

Youth Connections Program

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

Outreach

Access and Linkage: Screenings

Access and Linkage: Assessments

Access and Linkage: Referrals

Treatment Services and Supports: Other

Please specify “other” type of Treatment Services and Supports

Short-term, non-clinical support focused on reducing isolation, stabilizing individuals after stressful life events, and improving access to behavioral health and social services.

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

No

Please describe intended outcomes of the program or service

- Expanded access and timely linkage to behavioral health services, educational supports, and community resources for children and adolescents at the earliest signs of need.
- Improved emotional, behavioral, and developmental outcomes, including enhanced coping skills, academic performance, and social-emotional well-being.
- Rapid stabilization and recovery support for youth experiencing emerging behavioral health challenges or life stressors, promoting safety, continuity of care, and school engagement.
- Early identification and proactive engagement of youth through screening, outreach, and brief interventions that prevent escalation of behavioral health issues.
- Reduction in behavioral health disparities through inclusive, targeted outreach and service delivery models that reach underserved and at-risk youth populations.
- Strengthened caregiver and family support systems through education, support, and resource navigation that promote resilience and sustained engagement in care.

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

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	600
FY 2027 - 2028	600
FY 2028 - 2029	600

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

To project the number of individuals served through Early Intervention (EI) programs,

El Dorado County relied on historical Mental Health Services Act (MHSA) utilization data, demographic trends, and prevalence estimates for early-onset mental health conditions. Assumptions included population growth patterns, anticipated demand for evidence-based programs.

Child Welfare Involved Families Program

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

Outreach

Access and Linkage: Screenings

Access and Linkage: Assessments

Access and Linkage: Referrals

Treatment Services and Supports: Other

Please specify “other” type of Treatment Services and Supports

Short-term, non-clinical support focused on reducing isolation, stabilizing individuals after stressful life events, and improving access to behavioral health and social services.

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

No

Please describe intended outcomes of the program or service

- Expanded access and coordinated linkage to behavioral health services, educational supports, and community-based resources for youth involved in the child welfare system.
- Improved emotional, behavioral, and developmental outcomes, including increased stability, resilience, and readiness to thrive in school, home, and community settings.
- Timely stabilization and recovery support for youth experiencing behavioral health crises, placement disruptions, or adverse childhood experiences, promoting safety and continuity of care.
- Early identification and proactive engagement of behavioral health needs through screening and outreach in child welfare settings, enabling brief intervention and timely connection to appropriate services.

- Reduction in behavioral health disparities by addressing barriers and ensuring equitable access to care for youth disproportionately impacted by trauma, poverty, and family instability.
- Strengthened caregiver and family support systems through non-clinical services, education, and resource navigation that enhance placement stability and promote healing-centered care.

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

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	100
FY 2027 - 2028	100
FY 2028 - 2029	100

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

To project the number of individuals served through Early Intervention (EI) programs, El Dorado County relied on historical Mental Health Services Act (MHSA) utilization data, demographic trends, and prevalence estimates for early-onset mental health conditions. Assumptions included population growth patterns, anticipated demand for evidence-based programs.

Justice Involved Youth Program

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

Outreach

Access and Linkage: Screenings

Access and Linkage: Assessments

Access and Linkage: Referrals

Treatment Services and Supports: Other

Please specify “other” type of Treatment Services and Supports

Short-term, non-clinical support focused on reducing isolation, stabilizing individuals after stressful life events, and improving access to behavioral health and social services.

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

No

Please describe intended outcomes of the program or service

- Expanded access and coordinated linkage to behavioral health services, reentry supports, and community-based resources for youth involved in the juvenile justice system.
- Improved emotional regulation, behavioral health, and overall well-being, supporting positive development, reduced recidivism, and successful reintegration into school, family, and community life.
- Timely stabilization and recovery support for youth experiencing legal system involvement or that have indications of legal system involvement, promoting safety, healing, and continuity of care.
- Early identification and proactive engagement of behavioral health needs through screening and outreach enabling brief intervention and timely connection to appropriate services.
- Reduction in behavioral health disparities by addressing inequities and ensuring equitable access to care for youth disproportionately impacted by incarceration, trauma, and social determinants of health.
- Strengthened family and caregiver support systems through non-clinical services, education, and resource navigation that promote stability, resilience, and long-term success.

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

No

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	100
FY 2027 - 2028	100
FY 2028 - 2029	100

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

To project the number of individuals served through Early Intervention (EI) programs, El Dorado County relied on historical Mental Health Services Act (MHSA) utilization data, demographic trends, and prevalence estimates for early-onset mental health conditions. Assumptions included population growth patterns, anticipated demand for evidence-based programs.

Veterans' Outreach Program

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

Outreach

Access and Linkage: Screenings

Access and Linkage: Assessments

Access and Linkage: Referrals

Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports

Short-term, non-clinical support focused on reducing isolation, stabilizing individuals after stressful life events, and improving access to behavioral health and social services.

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

No

Please describe intended outcomes of the program or service

- Expanded access and coordinated linkage to behavioral health care, supportive services, and community-based resources for veterans.
- Enhanced behavioral health and overall well-being, including improved daily functioning, resilience, and quality of life for veterans transitioning to civilian life or managing service-related challenges.
- Timely stabilization and recovery support for veterans experiencing behavioral health crises or critical life events, promoting safety, continuity of care, and reintegration into family and community.
- Early identification and proactive engagement of veterans exhibiting signs of behavioral health needs, enabling timely brief intervention and linkage to appropriate care.
- Reduction of behavioral health disparities through culturally responsive, equity-driven outreach targeting underserved and marginalized veteran populations, including those in rural areas or experiencing homelessness.
- Strengthened family and caregiver capacity and well-being through non-clinical supports, education, and resource navigation, improving care quality and sustainability for veterans and their support networks.

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

No

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

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

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

To project the number of individuals served through Early Intervention (EI) programs, El Dorado County relied on historical Mental Health Services Act (MHSA) utilization

data, demographic trends, and prevalence estimates for early-onset mental health conditions. Assumptions included population growth patterns, anticipated demand for evidence-based programs.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to [7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis](#).

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

CSC program name

Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)

CSC program description

The Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP) program in El Dorado County (EDC) delivers timely, evidence-based early intervention services under the Behavioral Health Services Act (BHSA). As an Early Intervention component of BHSA-funded Behavioral Health Services and Supports, EDC is committed to offering CSC for FEP to eligible youth and young adults up to age 25 experiencing first-episode psychosis.

This initiative provides a multidisciplinary care team delivering coordinated services over a typical two- to three-year engagement period. Core services include individual and group psychotherapy, medication management, family education/support, case management, peer support, and assistance with education and employment goals.

CSC for FEP in EDC ensures rapid access to care following onset of psychotic symptoms, empowers shared decision-making with clients and families, and is geared toward reducing hospitalizations and promoting recovery and functional gains. The program adheres to BHSA policy by leveraging shared financing, pairing BHSA allocations with Medi Cal billable Specialty Mental Health Services and maintains fidelity to State-endorsed evidence-based practices with training and oversight from Centers of Excellence. Through CSC for FEP, EDC promotes early detection, delivers structured, holistic care, and aligns with statewide BHSA goals of improving long-term outcomes for young individuals facing early psychosis.

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. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements

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

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	17
Number of Uninsured Individuals	2

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

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	4	4	4
Total Number of Teams	1	1	1

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

Yes

Please list the other funding source(s)
Mental Health Block Grant

Outreach and Engagement (O&E) Programs

For related policy information, refer to [7.A.3 Outreach and Engagement](#).

Continuous Outreach and Engagement

Please describe the program or activity

The Continuous Outreach and Engagement program will provide proactive, person-centered services to individuals who are disconnected from care or at risk of isolation. The program will maintain a structured system for reaching out to individuals who have disengaged, become hospitalized, or are otherwise difficult to engage, ensuring continuity of support and connection to behavioral health resources. Activities will include personalized follow-up contacts, community-based engagement, and assistance in navigating available services. These efforts are designed to reduce barriers, foster trust, and promote recovery by meeting individuals where they are, whether in the community, at home, or in transitional settings. This program will allow flexibility to provide non-clinical engagement services that strengthen relationships and support long-term stability.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 - 2027	200
FY 2027 - 2028	200
FY 2028 - 2029	200

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

Historical patterns of follow-up contacts and re-engagement success informed estimates, with the expectation that proactive, person-centered approaches will maintain or slightly increase participation compared to previous years.

County Workforce, Education, and Training (WET) Program

For related policy information, refer to [7.A.4 Workforce Education and Training](#).

Workforce Development Project

Please select which of the following categories the activity falls under

Workforce Recruitment, Development, Training, and Retention

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

Strategies for addressing disparities in the Behavioral Health workforce include expanding pathways into the behavioral health field through partnerships with educational institutions and community-based organizations. Retention efforts will focus on supportive supervision, mentorship and incentives for specialized skills such as bilingual capacity.

Behavioral Health Staff License and Certification Reimbursement

Please select which of the following categories the activity falls under

Professional Licensing and/or Certification Testing and Fees

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

The investment is designed to support a more stable, diverse and qualified workforce capable of meeting community needs across the behavioral health continuum. By covering expenses BHTSA WET reduces financial barriers that disproportionately impact underrepresented, bilingual, and lived-experience staff. This strategy supports staff retention, promotes career advancement, and strengthens service quality by expanding opportunities for staff who may otherwise lack access to resources needed for professional development.

Behavioral Health Hiring Incentives

Please select which of the following categories the activity falls under

Retention Incentives and Stipends

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

This funding helps address wage competition, burnout, and workforce shortages that disproportionately affect rural communities and culturally diverse staff. By investing in retention initiatives that reduce financial strain and support staff stability, this funding strengthens the County's ability to maintain a skilled, committed workforce.

Community Education Initiative

Please select which of the following categories the activity falls under

Other

Please define the other activity

The Community Education Initiative is developed to expand access to behavioral health education across El Dorado County. The program will focus on training and certifying local instructors to deliver evidence-based courses such as Mental Health First Aid (MHFA) and safeTALK workshops. By equipping local instructors to provide these trainings, the initiative increases access to care by empowering community members to recognize signs of mental health challenges, respond effectively, and connect individuals to appropriate services. Additionally, the program supports workforce development by creating opportunities for residents to gain specialized certifications, enhancing local capacity for prevention and crisis response. These efforts align with Behavioral Health Services Act (BHSA) goals to build a skilled, culturally responsive workforce and improve community engagement in behavioral health care.

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

These courses will be tailored to priority populations identified in the Community Health Improvement Plan and in alignment with Statewide Behavioral Health Goals, including rural residents, youth, older adults, veterans, and tribal communities.

This approach reduces stigma, promotes early intervention, and strengthens pathways to behavioral health resources.

Capital Facilities and Technological Needs (CFTN) Program

Additional information on CFTN policies can be found in [Policy Manual Chapter 7, Section A.5](#).

Electronic Health Record (EHR)

Please select the type of project

Technological needs project

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

Electronic health record system

Monitoring

Personal health record system

Data exchange and interoperability

Please describe the project

The Electronic Health Record (EHR) Project enables the Behavioral Health Division (BHD) to safely and securely access a client's medical record and obtain valuable information to assist in evaluating services. The use of electronic mental health records enhances communication between treating health care professionals, thus promoting coordination of mental and physical health care needs. Funding from this project also may be utilized to provide integration with other mental health service providers and primary health care providers, either through license expansion for Behavioral Health's current electronic health record system, or through the use of add-on software. Add-on software allows for increased communication between entities to facilitate referrals, authorizations, invoicing, and client progress notes, amongst other benefits such as providing a better continuum of care for shared clients. Add-on software may include, but is not limited to Care POV (Mobile Avatar), CareConnect, CareManager, and OrderConnect. Funding from this project also supports equipment purchases, renewal and product support, licenses, and maintenance necessary for County staff to perform their work from out-stationed work locations such as hospitals and medical clinics. This project may also include funds to install devices to aid powering EHR devices when there is a power outage and increase access to telehealth services, for both providers and consumers, such as, but not limited to purchase of handheld devices or kiosks.

Additionally, this funding may be utilized for outcome measure/performance management software, data exchange software and/or other software and hardware in support of Behavioral Health. This project supports funding for 3.0 Full Time Equivalent (FTE) dedicated EHR staff.

Forni Road Housing Services Site

Please select the type of project

Capital facilities project

If capital facilities project, please indicate which of the following categories the project falls under

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

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

No

Please describe the project

This project supports a partial capital development costs to construct a congregate services facility on the same property as temporary tiny homes constructed in part through Housing Interventions Capital Development funding. The close proximity of housing and services will allow for increased engagement in Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) as well as on site housing navigation and supports.

Behavioral Health Facilities Sustainability Program

Please select the type of project

Capital facilities project

If capital facilities project, please indicate which of the following categories the project falls under

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

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

No

Please describe the project

The Behavioral Health Facilities Sustainability Program (BHFS) is designed to preserve and enhance county-owned or operated behavioral health sites through targeted investments in infrastructure. This program prioritizes ongoing maintenance and essential upgrades to ensure facilities remain safe, compliant, and functional for delivering quality behavioral health services. Activities include structural repairs, accessibility improvements, and modernization of building systems such as HVAC, plumbing, and electrical components. By sustaining and improving these physical environments, BHFS supports the long-term viability of behavioral health programs.

Behavioral Health Technologies Sustainability Program (BHTS)

Please select the type of project

Technological needs project

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

Data exchange and interoperability

Data security and privacy

Data warehouse

Individual/family access to computing resources

Imaging/paper conversion

Monitoring

Online information resources for individuals/families

Resources to support web content and mobile app accessibility

System maintenance costs

Telemedicine

Please describe the project

The Behavioral Health Technologies Sustainability Program (BHTS) focuses on maintaining and modernizing technology infrastructure within county-operated behavioral health facilities. This program ensures that essential systems remain secure, reliable, and up to date. By funding technology refresh cycles, system upgrades, and cybersecurity enhancements, BHTS supports efficient service delivery and compliance with state and federal standards. The program's goal is to sustain a robust technological foundation that enables high-quality, accessible behavioral health care across all county-operated sites.

Full Service Partnership Program

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to [7.B.3 Full Service Partnership Program Requirements](#) and [7.B.4 Full Service Partnership Levels of Care](#).

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

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	275
Number of Uninsured Individuals	40
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	107

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

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

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	34

ACT Eligible Population	Estimates
Number of Uninsured Individuals	5

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	17
Number of Uninsured Individuals	3

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	10
Number of Teams Needed to Serve Total Eligible Population	1

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	0	0	0
Total Number of Teams	0	0	0

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

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

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	224
Number of Uninsured Individuals	33

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	15
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 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	15	15	15
Total Number of Teams	3	3	3

High Fidelity Wraparound (HFW) Eligible Population

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	122
Number of Uninsured Individuals	17

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	46
Number of Teams Needed to Serve Total Eligible Population	2

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	12	12	12
Total Number of Teams	2	2	2

Individual Placement and Support (IPS) Eligible Population

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

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	446
Number of Uninsured Individuals	65

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	32
Number of Teams Needed to Serve Total Eligible Population	13

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	0	0	0

Total Number of Teams	0	0	0
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Full Service Partnership (FSP) Program Overview

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

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

Yes

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

Practitioners will be trained and supported to apply multiple Evidence-based Practices (EBP) based on client needs rather than rigid program silos. For example, staff delivering High Fidelity Wraparound (HFW) may integrate Parent Child Interaction Therapy (PCIT) or other EBP strategies for youth and family engagement when appropriate.

Similarly staff providing Intensive Case Management (ICM) may utilize EBPs such as Cognitive Behavioral Therapy (CBT) or Dialectical Behavioral Therapy (DBT) to best meet the client's needs. This flexibility ensures continuity of care and responsiveness to complex needs, including co-occurring mental health and substance use disorders.

El Dorado County’s (EDC) workforce plan emphasizes cross-training in trauma-informed care, cultural competence, and recovery-oriented practices, enabling practitioners to fluidly transition between EBPs as clients progress through levels of care. This approach is supported by BHSA Workforce, Education, and Training (WET) initiatives and aligns with Specialty Mental Health Services (SMHS) requirements for individualized, medically necessary care.

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

El Dorado County (EDC) employs a whole-person, trauma-informed approach through its Specialty Mental Health Services (SMHS) and Full Service Partnership (FSP) programs, in alignment with the California Department of Health Care Services (DHCS) policy manual. This approach recognizes that recovery and wellness are best achieved when care addresses the individual’s physical, emotional, social, and cultural needs while honoring their lived experiences and reducing the risk of re-traumatization.

The county integrates trauma-informed principles across all levels of care. Staff are trained to understand the impact of trauma on behavior and health, create safe environments, and empower individuals through choice and collaboration. Services are culturally responsive and designed to promote dignity, resilience, and self-

determination.

Through FSP, El Dorado EDC provides intensive, “whatever it takes” support for individuals with serious mental health needs. Multidisciplinary teams—including clinicians, psychiatrists, and mental health workers—work together to address not only mental health symptoms but also housing, employment, physical health, and social connection. These teams actively engage families and natural supports in treatment planning and service delivery, recognizing their critical role in recovery. Mental Health Workers and family advocates help strengthen these connections and ensure care plans reflect the individual’s values and community ties.

SMHS further reinforce this whole-person model by offering individualized treatment that incorporates family participation whenever possible. The county ensures alternate language availability, culturally sensitive services, and client rights resources, providing interpretation services and auxiliary aids to remove barriers to care. Programs also align with the Behavioral Health Services Act (BHSA) principles of community collaboration and stakeholder engagement, incorporating feedback from families and individuals into service design.

By combining trauma-informed practices, comprehensive supports, and strong partnerships with families and natural supports, EDC delivers care that fosters recovery, resilience, and long-term wellness—consistent with state policy and best practices for integrated behavioral health.

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

El Dorado County (EDC) has committed to an equitable Full Service Partnership (FSP) system, using data-driven strategies and tailored service models to reduce any disparities evidenced in the data. Here's how the county integrates public data from its Mental Health Plan (MHP) and associated reports into this effort:

Active Engagement and Service Delivery

Non-conserved FSP clients receive active engagement at least three times per week from county behavioral health staff—a practice that promotes early identification of barriers to care, steadily builds trust, and prevents service interruption. This high-touch approach directly addresses potential disparities tied to access and engagement.

Data-Driven Monitoring of Disparities

El Dorado’s interventions have been equally effective across subgroups, helping to close outcome gaps in criminal justice involvement and acute hospitalizations through monitoring of Quality Improvement (QI) data as well as other informative data sources highlighting trends and areas of improved equity.

Culturally Responsive, Trauma-Informed Framework

The Behavioral Health Division's (BHD) Cultural Competency Committee continuously reviews service gaps using Culturally and Linguistically Appropriate Services (CLAS) standards and applies annual updates to address cultural and linguistic disparities. Combined with the high-engagement outreach, this ensures that historically marginalized and under-served groups receive culturally aligned supports designed to reduce any disparities.

By combining frequent, personalized outreach, comprehensive outcome measurement, and a culturally responsive service framework, EDC effectively identifies and reduces disparities among FSP participants. This approach ensures that intensive supports are equitable, tailored to community needs, and backed by measurable results consistent with state law and Department of Health Care Services (DHCS) policy mandates.

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

Justice involvement

Access to care Institutionalization

Removal of children from home Untreated behavioral health conditions Care experience

Engagement in work Overdoses

Quality of life Social connection Suicides

Prevention of co-occurring physical health conditions Engagement in school

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

Intensive Case Management (ICM) in El Dorado County (EDC) serves as a cornerstone of Full Service

Partnership (FSP) programs and broader Specialty Mental Health Services (SMHS). Its primary goal is to provide "whatever-it-takes" support for individuals with serious mental illness or emotional disturbance who face complex challenges such as homelessness, justice involvement, or repeated hospitalizations.

Core Activities and Functions

Personal Service Coordination: ICM teams deliver individualized care planning, linking clients to housing, food, transportation, and other basic needs alongside clinical

services.

24/7 Crisis Response: Crisis Staff maintain round-the-clock availability to stabilize crises and prevent unnecessary inpatient or emergency department utilization inclusive of Mobile Crisis services.

Housing Navigation and Support: Assistance with securing and maintaining stable housing, including landlord mediation.

Integrated Care Coordination: Collaboration with physical health providers, child welfare, probation, and community-based organizations to ensure continuity of care.

Skill-Building and Recovery Support: Coaching for daily living skills, medication adherence, and social integration.

Transition and Reentry Services: Specialized teams (e.g., Community Transition and Support Team) help individuals move from inpatient or custodial settings back into community living.

Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.) El Dorado County (EDC) will comply with the required Full Service Partnership (FSP) levels of care by implementing a tiered approach that aligns with Department of Health Care Services (DHCS) standards while recognizing the county's requested exemption from Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Individual Placement and Support (IPS) Supported Employment requirements for counties with populations under 200,000. This exemption will allow El Dorado to prioritize Intensive Case Management (ICM) and High Fidelity Wraparound (HFW) as core service models, ensuring that individuals receive comprehensive, evidence-based care.

Standing up new FSP ICM teams to serve adults and transitional age youth with significant behavioral health needs. These teams will provide assertive outreach, individualized service planning, and coordination of housing, employment, and wellness supports.

Integrating HFW for children and youth to ensure family-driven, trauma-informed care that leverages natural supports and community resources.

Embedding recovery-oriented practices across all FSP teams, including peer support and culturally responsive engagement, to meet the whole-person needs of participants.

Transitioning clients between levels of care as acuity changes, ensuring smooth movement from intensive FSP ICM to lower-intensity supports without service gaps.

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

Outreach Activities

Primary substance use disorder (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

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

El Dorado County (EDC) will employ a proactive, multi-pronged outreach strategy to enroll individuals with significant behavioral health needs into its Full Service Partnership (FSP) program, consistent with Behavioral Health Services Act (BHSA) and Specialty Mental Health Services (SMHS) requirements. Outreach will be rooted in trauma-informed, culturally responsive principles and will leverage historical successes.

Building on the county's experience with Project Access, which emphasized assertive, field-based engagement and collaboration with community partners, FSP outreach will prioritize meeting individuals where they are—in homes, shelters, hospitals, and community settings.

Key outreach activities will include:

Field-Based Engagement: Mobile teams will visit individuals in natural environments, including encampments, transitional housing, and community spaces, to reduce barriers to care.

Collaboration with Community Partners: The county will coordinate with local hospitals, primary care providers, law enforcement, schools, and social service agencies to identify and refer individuals who meet FSP criteria.

Warm Hand-Offs and Peer Support: Peer specialists and family advocates will accompany clinicians during outreach to foster trust and provide lived-experience support.

Culturally and Linguistically Appropriate Outreach: Materials and engagement strategies will be tailored to diverse populations, ensuring language access and cultural relevance.

Crisis Response Integration: Outreach will be linked to mobile crisis services, allowing immediate stabilization and enrollment for individuals in acute distress.

These strategies reflect EDC's commitment to whole-person care and equity, ensuring that outreach is not a one-time event but an ongoing, relationship-based process. By combining assertive engagement, community partnerships, and culturally responsive practices, the county will successfully connect individuals with significant behavioral health needs to comprehensive FSP services that promote recovery and resilience

Other recovery-oriented services

Yes

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

El Dorado County's (EDC) Full Service Partnership (FSP) program will include a range of recovery-oriented services designed to promote resilience, independence, and community integration, consistent with Behavioral Health Services Act (BHSA) and Specialty Mental Health Services (SMHS) requirements. These services go beyond clinical treatment to address the social, cultural, and wellness needs of individuals living with significant behavioral health challenges.

FSP participants will have access to peer-led groups, life skills training, and socialization activities that foster empowerment and reduce isolation. This approach emphasizes whole-person care, offering opportunities for creative expression, physical wellness activities, and educational workshops that support recovery goals. These services are culturally responsive and trauma-informed, ensuring that participants feel safe, respected, and engaged.

Additional recovery-oriented services will include:

Peer Support and Mentorship: Certified Peer Support Specialists will provide one-on-one and group support, sharing lived experience to inspire hope and model recovery.

Community Integration Activities: Social outings, volunteer opportunities, and skill-building workshops will help participants reconnect with their communities and develop meaningful roles.

Wellness and Self-Management Programs: Classes on stress reduction, nutrition, and mindfulness will promote physical and emotional health.

These recovery-oriented services complement evidence-based practices within FSP by addressing the broader determinants of health and fostering a sense of belonging and purpose. By combining clinical care with holistic supports, EDC ensures that individuals receive comprehensive, person-centered services that align with state policy and the principles of recovery.

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”

Full Service Partnership (FSP) programs will include a comprehensive array of supports delivered at or near transitional housing, permanent supportive housing sites, as well as other allowable residential settings. Services may include intensive case management, employment assistance, linkage to community resources among other allowable FSP services.

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

To address the unique needs of children and youth who are in, or at risk of being in, the juvenile justice system, the Behavioral Health Division (BHD) engaged in a multi-step planning process aligned with Behavioral Health Services Act (BHSA) requirements. The county reviewed local Electronic Health Record (EHR) and claims data to identify service utilization patterns and gaps among justice-involved youth, including those with co-occurring behavioral health needs. Stakeholder engagement and focus groups with juvenile probation, child welfare, education partners, and community-based organizations serving at-risk youth provided perspective on strategies to integrate trauma-informed, culturally responsive practices into Full Service Partnership (FSP) design.

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

In consideration of the unique needs of LGBTQ+ children and youth, consistent with Behavioral Health Services Act (BHSA) policy and equity requirements, the county reviewed local demographic and service utilization data from its Electronic Health Record (EHR) and claims systems to identify gaps in access and engagement among LGBTQ+ youth. Stakeholder engagement with community-based organizations, advocacy groups, and families gathered input on barriers such as stigma, confidentiality concerns, and culturally affirming care considered ensuring alignment with trauma-informed and culturally responsive principles. These activities informed strategies to embed affirming practices, language access, and peer support into Full Service Partnership (FSP) design, creating a safe and inclusive service environment

that promotes recovery and resilience for LGBTQ+ youth.

In the child welfare system

To ensure the Full Service Partnership (FSP) program meets the unique needs of children and youth in the child welfare system, the Behavioral Health Division (BHD) h engaged in a comprehensive planning process. The county reviewed local Electronic Health Record (EHR) and claims data to identify service utilization patterns and gaps among child welfare-involved youth, including those with histories of trauma and complex behavioral health needs. Stakeholder engagement and planning sessions included Child Protective Services, foster care providers, family advocates, and community-based organizations to gather input on barriers and priorities. The county also analyzed state guidance on trauma-informed, family-centered approaches to ensure alignment with evidence-based practices such as High Fidelity Wraparound (HFW) and other EBPs required under BHSA. These efforts informed strategies to embed culturally responsive care, intensive case management, and family engagement into FSP design, creating a system that promotes stability, resilience, and recovery for youth impacted by child welfare involvement.

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

To address the unique needs of older adults in the development of El Dorado County's (EDC) Full Service Partnership (FSP) program, the Behavioral Health Division (BHD) reviewed local demographic and service utilization data from its EHR and claims systems to identify gaps in access and engagement among older adults with serious behavioral health needs. Stakeholder engagement through consultations with senior service providers, aging and adult care programs, and community-based organizations provided increased understanding of barriers such as isolation, mobility challenges, and co-occurring physical health conditions.. These activities informed strategies to integrate intensive case management, culturally responsive supports, and linkages to housing and health services into FSP design, promoting stability, wellness, and independence for older adults.

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

In consideration of the unique needs of LGBTQ+ Adults, consistent with Behavioral Health Services Act (BHSA) policy and equity requirements, the county reviewed local demographic and service utilization data from its Electronic Health Record (EHR) and claims systems to identify gaps in access and engagement among LGBTQ+ youth. Stakeholder engagement with community-based organizations, advocacy groups, and families gathered input on barriers such as stigma, confidentiality concerns, and culturally affirming care considered ensuring alignment with trauma-informed and

culturally responsive principles. These activities informed strategies to embed affirming practices, language access, and peer support into Full Service Partnership (FSP) design, creating a safe and inclusive service environment that promotes recovery and resilience for LGBTQ+ Adults.

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

To address the unique needs of adults who are in, or at risk of being in, the justice system, the Behavioral Health Division (BHD) reviewed local Electronic Health Record (EHR) and claims data to identify service utilization patterns and gaps among justice-involved adults, including those with co-occurring behavioral health conditions. Stakeholder engagement included probation, courts, law enforcement, and reentry service providers to gather input on barriers such as housing instability, criminogenic risk factors, and access to treatment. These activities informed strategies to integrate intensive case management, cross-system coordination, and culturally responsive supports into Full Service Partnership (FSP) design, promoting recovery, reducing recidivism, and supporting successful community reintegration.

Assertive Field-Based Substance Use Disorder (SUD) Questions

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

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

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs

N/A

Program descriptions

N/A

Current funding source

N/A

BHSA changes to existing programs to meet BHSA requirements

N/A

Expected timeline of operation

N/A

Mobile-field based programs

Existing programs

N/A

Program descriptions

N/A

Current funding source

N/A

BHSA changes to existing programs to meet BHSA requirements

N/A

Expected timeline of operation

N/A

Open-access clinics

Existing programs

Marshall CARES (Clinically Assisted Recovery and Education Services)

Program descriptions

Marshall CARES runs and open access clinic in Placerville. County entered a Memorandum of Understanding (MOU) to credential Marshall staff to be part of Substance Use Disorder (SUD) network. MOU allows for bilateral referrals and placements/same day access.

Current funding source

Clinic: Non-Behavioral Health Funded, County access: Opioid Settlement Fund (OSF)

BHSA changes to existing programs to meet BHSA requirements

No changes to Marshall CARES are identified under BHSA.

Expected timeline of operation

The expansion of Open-Access Clinics is projected to occur over the course of this Three Year Plan.

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs

Substance Use Disorder (SUD) Outreach

Program descriptions

To implement data-informed, targeted outreach that directly connects Behavioral Health Services Act (BHSA)-eligible individuals with Substance Use Disorder (SUD) to mobile field-based programs, enabling same-day or next-day initiation of U.S. Food and Drug Administration (FDA)-approved Medications for Addiction Treatment. BHD will partner with community organizations to use data to drive outreach to individuals to identify hotspots, engage individuals, and offer same-day Medication for Addiction Treatment (MAT) initiation.

Planned funding

Opioid Settlement Funds (OSF)

Planned operations

County is leveraging Opioid Settlement Fund (OSF) dollars to fund targeted outreach with two providers. Marshall Medical Center will be helping justice involved individuals exiting the judicial system and unhoused individuals by going out into the community and engaging in field-based services in multiple locations where partnerships exist for unhoused individuals; ie. food pantries, soup kitchens. El Dorado Community Health Center is utilizing OSF funds for mobile MAT services throughout the county especially focusing on rural areas and hard-to-reach locations where transportation is an identified barrier. Both Marshall Medical and El Dorado Community Health Center have been approved for a 3-year grant utilizing Opioid Settlement Fund dollars through El Dorado County that will run from 7/1/26 through 6/30/29.

Expected timeline of implementation

The development of targeted outreach projected to occur over the course of this Three Year Plan with initial implementation on 7/1/26.

Mobile-field based programs

New programs

Mobile Medications for Addiction Treatment (MAT) Clinic

Program descriptions

The Behavioral Health Division (BHD) will partner with El Dorado Community Health Center through the use of Opioid Settlement Funds (OSF) to provide Mobile MAT services.

Planned funding

Opioid Settlement Funds (OSF)

Planned operations

El Dorado Community Health Center will receive Opioid Settlement Funds (OSF) and will address access disparities with the deployment of their Mobile Medical Unit (MMU), which delivers low-threshold MAT services directly to underserved communities. By bringing care directly to locations throughout the community, El Dorado Community Health Centers eliminates geographic and transportation barriers that disproportionately affect individuals experiencing homelessness or living in remote areas. This strategy ensures that high-quality care is not confined to a physical clinic but is distributed equitably to where the need is greatest." Grant funds will be distributed 7/1/26-6/30/29.

Expected timeline of implementation

The development of Mobile Medications for Addiction Treatment (MAT) is projected to occur over the course of this Three Year Plan with initial implementation on 7/1/26.

Open-access clinics

New programs

Same-day Access Walk-in Clinics

Program descriptions

Under Behavioral Health Services Act (BHSA) the Behavioral Health Division (BHD) will work with Opioid Treatment Providers (OTP) to implement and expand same day access walk in clinics availability.

Planned funding

Drug Medi-Cal - Organized Delivery System (DMS-ODS) funding

Planned operations

Aegis, a DMC-ODS contracted provider, provides open-access 6 days per week Monday- Friday 5am-1:30pm and Saturdays 6am-9am. Marshall Cares provides open-access 5 days per week patients can receive same-day MAT services Monday-Friday 8am-5pm. Marshall Cares will be funded through Opioid Settlement Fund (OSF) dollars and will be funded through a 3 year grant beginning 7/1/26 through 6/30/29.

Expected timeline of implementation

The development of the Same-day Access Walk-in Clinics is projected to occur over the course of this Three-Year Plan with initial implementation on 7/1/26.

Medications for Addiction Treatment (MAT) Details

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

El Dorado County uses a structured, data-driven approach to assess gaps between current Medications for Addiction Treatment (MAT) resources and estimated community needs:

Data & Needs Analysis: Collects opioid use and overdose data from state and national sources to estimate treatment demand.

Community & Stakeholder Input: Engages residents and providers through surveys and forums to prioritize substance use disorder as a key health issue.

Resource Inventory: Maps existing MAT programs and providers.

Formal Gap Analysis: Compares current capacity to estimated needs identifying service shortages and underserved populations.

Gap-Filling Strategy: Aligns with Behavioral Health Services Act (BHSA) and Department of Health Care Services (DHCS) requirements to expand MAT infrastructure, provider training, and outreach through targeted funding.

Ongoing Monitoring: A multi-agency taskforce tracks progress, adjusts strategies, and sets measurable goals for MAT access and equity.

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

Contract directly with MAT providers in the County

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

Contract with MAT providers in other counties

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

Placer and Sacramento Counties

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

Buprenorphine

Methadone

Naltrexone

Housing Interventions

For related policy information, refer to [7.C.3 Program priorities](#) and [7.C.4 Eligible and priority populations](#)

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local [Continuum of Care \(CoC\) Housing Inventory Count \(HIC\)](#) to inform responses to this question.

Supportive housing

Large gap

Apartments, including master-lease apartments

Large gap

Single and multi-family homes

Medium gap

Housing in mobile home communities

No gap

(Permanent) Single room occupancy units

Large gap

(Interim) Single room occupancy units

Large gap

Accessory dwelling units, including junior accessory dwelling units

Large gap

(Permanent) Tiny homes

Large gap

Shared housing

Large gap

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

Medium gap

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

Medium gap

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

Small gap

License-exempt room and board

Medium gap

Hotel and Motel stays

Small gap

Non-congregate interim housing models

Large gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)

Large gap

Recuperative Care

Medium gap

Short-Term Post-Hospitalization housing

Medium gap

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

Large gap

Peer Respite

Not applicable

Permanent rental subsidies

Large gap

Housing supportive services

Small gap

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

The Behavioral Health Division (BHD) currently operates multiple housing programs that utilize both state and federal funding to house persons experiencing or at-risk-of experiencing homelessness. Behavioral Health Services Act (BHSA) eligible individuals would have access through referral and linkage to programs such as Behavioral Health Bridge Housing (BHBH), Homeless Disability Advocacy Program (HDAP), APS Homesafe, CalWORKs HSP (for individuals with children) and Public Housing Authority (PHA) Housing Choice Voucher program which are also operated within the integrated El Dorado County (EDC) Health and Human Services Agency (HHS). Other homelessness grants, such as state funded Homeless Housing, Assistance and Prevention (HHAP) and Permanent Local Housing Allocation (PLHA) are funding programs such as emergency shelters and transitional housing, which offer case management, housing navigation and other supportive services to assist individuals with obtaining and retaining permanent housing.

Housing Navigators also refer Medi-Cal Member clients to Managed Care Plan (MCP) Community Supports and Enhanced Care Management (ECM), which increases access to housing and retention of housing. BHD's Transitional Rent implementation in 2026 will be available for BHSA eligible individuals, providing rental subsidies and/or interim housing to eligible participants. The Emergency Solutions Grant (ESG) Rapid Rehousing funding that BHD receives is being used to provide rental subsidies for participants exiting the Navigation Center into permanent housing. Implementation of the Flex Pool will streamline access to the housing programs available to eligible clients, and with focus on Landlord engagement can increase the supply of housing available to BHSA eligible clients.

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?

Behavioral Health Services Act (BHSA) Housing Interventions (HI) will complement existing housing resources by filling critical gaps and creating a seamless continuum of care. Funds will be braided with programs like Behavioral Health Bridge Housing (BHBH), and other voucher and grant funded programs, and coordinated through the

Flex Pool. Integration with the Coordinated Entry System ensures prioritization of BHSA-eligible individuals, while Housing Navigators provide tenancy support and linkages to behavioral health services. Capital development projects, will shorten the distance and remove barriers between housing and services, strengthening engagement and retention.

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

The Behavioral Health Division (BHD) Housing and Homelessness staff includes Social Workers and Mental Health workers trained as Housing Navigators (HN), to assist all eligible participants with becoming housing ready. This involves getting necessary documents, proof of income, and developing a housing plan that is client focused, identifies housing barriers, and allows for client preference and choice. HN will perform outreach with landlords and property managers to identify available units, mitigate potential losses, and outreach for rental opportunities to Behavioral Health Services Act (BHSA) eligible clients. Additionally, HN will assist participants in completing applications, sourcing funds for application fees and security deposits, reviewing lease details, and transportation.

Additional funds can be sourced to assist with home habitability goods, easing the transition into housing. HN provide ongoing supports to clients to connect them to other services and community supports to aid in housing retention, such as Supplemental Nutrition Assistance Program (SNAP) benefits and food distribution sites.

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)?

El Dorado County (EDC) County has entered into an agreement with Mercy Housing for their No Place Like Home housing development, to provide Behavioral Health (BH) supportive services to the PSH units in that community (currently under development; planned for opening 2026). The Behavioral Health Division (BHD) currently supports clients in several PSH units throughout the region, providing rental subsidies and BH supportive services.

Clients are referred to The Front Door, the Coordinated Entry System (CES) for El Dorado County to receive intake into the homeless system of care. Clients are assessed using the VI-SPDAT and are referred to programs based on their

vulnerability scores. The most vulnerable clients are referred to PSH programs. For the No Place Like Home housing program, clients will be referred through Coordinated Entry, with Behavioral Health staff further evaluating for eligibility for NPLH. Similarly, when other PSH programs have availability, clients are referred through CES and then further evaluated for program specific eligibility requirements.

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

The Behavioral Health Division (BHD) housing programs include staffing of Social Workers and Mental Health Workers, working collaboratively to ensure access to clinical services and other necessary supports to maintain housing. Clients will also have access to the Mobile Crisis Unit, which provides direct clinical assistance in the event of a behavioral health crisis for clients in the BHD housing programs. Social Workers and Mental Health Workers remain engaged with clients after placement into housing, to ensure a safe transition and encourage ongoing health care and stability.

Eligible Populations

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

El Dorado County (EDC) identifies and refers eligible individuals through its coordinated entry system, behavioral health clinics, crisis services, and outreach teams. Staff screen for Behavioral Health Services Act (BHSA) criteria using standardized assessments. Eligible individuals are prioritized in the housing queue and referred to BHSA-funded housing with tenancy support. A flexible housing subsidy pool is used to cover rental gaps and operating costs, ensuring rapid placement and housing stability in coordination with the Continuum of Care and behavioral health providers.

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

El Dorado County reviewed local data, engaged juvenile justice and youth-serving stakeholders, and analyzed best-practice research to address the unique housing

needs of children and youth in or at risk of juvenile justice involvement to evaluate population specific housing referral pathways.

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

El Dorado County (EDC) reviewed local data and engaged stakeholders, including LGBTQ+ advocacy groups and youth-serving providers, to better understand housing barriers faced by LGBTQ+ youth and to evaluate population specific housing referral pathways.

In the child welfare system

El Dorado County (EDC) reviewed child welfare data, engaged stakeholders including Child Protective Services, foster care providers, and youth advocates. The planning process incorporated input from interagency teams such as the Child Welfare Services and Behavioral Health collaborative to ensure BHSA Housing Interventions include trauma-informed, developmentally appropriate strategies and referral pathways.

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

El Dorado County (EDC) reviewed demographic and service utilization data to understand housing and behavioral health needs of older adults eligible for Behavioral Health Services Act (BHSA) Services including but not limited to FSP. The county engaged stakeholders including senior service providers, and aging and adult care programs to evaluate population specific housing referral pathways.

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

El Dorado County (EDC) reviewed local justice-involved population data, engaged stakeholders including probation, courts, and reentry service providers, and analyzed research on housing and behavioral health needs for individuals with criminal justice involvement to evaluate strategies addressing criminogenic risk factors and behavioral health needs unique to this population.

In underserved communities

El Dorado County (EDC) analyzed demographic trends, housing stability indicators, and behavioral health service utilization data to identify gaps impacting adults in underserved communities. The county engaged stakeholders to evaluate referral pathways and ensure interventions were responsive to population-specific needs.

Local Housing System Engagement

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

The Behavioral Health Division (BHD) leadership maintains board membership on the Continuum of Care (CoC) Board, and engages in all CoC meetings. Additionally, BHD Housing and Homelessness unit acts as the Administrative Entity for the CoC, which includes administering the Coordinated Entry System (CES). CES will be utilized to provide referrals to participating programs. For non-CES participating programs, a referral pathway will be clearly identified.

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

Local CoC

The Behavioral Health Division (BHD) is actively engaged with the Continuum of Care (CoC) and collaborates from a leadership perspective with membership on the CoC Board. The BHD Housing and Homelessness unit acts as administrative entity, which includes administering the Homeless Management Information System (HMIS) and Coordinated Entry System (CES) and contracts, acting as HMIS lead agency, and administering all contracts and agreements for services entered into by the CoC. BHD Housing and Homelessness sits on various committees to collaborate on financial and strategic initiatives for the CoC. BHD Housing and Homelessness unit also acts in a lead role for the annual Point in Time (PIT) count and Housing Inventory Count (HIC) counts for U.S. Department of Housing and Urban Development (HUD).

When new housing interventions are defined, BHD staff collaborates with the CoC to add programs to HMIS, develop CES referral processes, and non-CES referral pathways.

Public Housing Agency

The El Dorado County (EDC) Public Housing Authority (PHA) is housed within the Housing and Homelessness unit and administers the U.S. Department of Housing and Urban Development (HUD) Housing Choice Voucher program. EDC PHA administers Project Based Vouchers that are awarded to affordable housing providers in the region to expand the availability of subsidized units.

MCPs

The Behavioral Health Division (BHD) is actively collaborating with the Managed Care Plan's (MCP) in the region, both through the relationship on the Continuum of Care (CoC) Board and directly with monthly meetings to determine how MCP's can address

any gaps in service and inform on new or expanding programming. BHD is entering into agreements with the MCP's to provide Transitional Rent beginning in 2026, with additional Medi-Cal Community Supports to be determined.

ECM and Community Supports Providers

Behavioral Health Division (BHD) staff are actively engaging clients with local Community Supports (CS) and Enhanced Care Management (ECM) providers as part of their Housing Navigation services. Often, housing programs will provide rental subsidies but will not cover housing deposits or utility payments, so clients can access services through Community Supports providers to bridge together the supports they need for successful placement into permanent housing. Behavioral Health clients exiting homelessness may also be facing comorbid physical health concerns, so Housing Navigation will also connect them with ECM to address those ongoing or chronic health concerns. As new programs are added to the system of care, determination on what the programs cover and what gaps exist will direct staff on how to continue to engage CS and ECM for these new programs.

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

CalWORKS Housing Support Program (HSP) and child welfare Bringing Families Home are programs that are administered within HHSA, participate in HMIS and are available for referrals from the Coordinated Entry System (CES). Program staff work together to identify available housing for clients with families and provides case management to include Behavioral Health Division (BHD) staff engagement for Behavioral Health services. Clients can be referred to BHD for assessment for services from any program or service providers. When eligibility is established, case managers will include BH services and treatments in the plan for their clients.

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?

El Dorado County's (EDC) Coordinated Entry System (CES) provides referrals to Homekey and supportive housing sites that are participating in CES and Homeless Management Information System (HMIS). Clients experiencing or at risk of homelessness are encouraged to contact CES for an intake and an assessment which provides them access to the referrals available to eligible housing programs. They Behavioral Health Division (BHD) provides rental subsidies and supportive services to several Permanent Supportive Housing (PSH) units in the region. The ECD Public Housing Authority (PHA) administers Project Based Vouchers (PBV) to new low-income housing developers to aid in their funding and providing long-term subsidized units to eligible clients.

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

Yes

How will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community?

The Behavioral Health Division (BHD) Housing and Homelessness unit budgets and administers the Homeless Housing, Assistance and Prevention (HHAP) funding for both the El Dorado County (EDC) allocation and the Continuum of Care (CoC) allocation. EDC funds are budgeted for use for various programs, including the 60-bed low barrier Navigation Center which provides year-round emergency shelter to homeless individuals and operation of a contract Transitional Housing program for youth. The CoC has a Finance Committee that manages the budget for the CoC allocations, and all spending decisions are authorized by the CoC Board. As Administrative Entity, EDC administers contracts and pays invoices on behalf of the CoC through County contracts and processes. The CoC provides guidance on how to fund programs based on need in the community and interest by service providers. The CoC focuses on supporting interim housing and emergency shelter, rapid rehousing programs, and programs for youth shelter. Behavioral Health Services Act (BHSA) clients may be eligible for the programs that are funded by HHAP, with referrals coming from the Coordinated Entry System (CES).

BHSA Housing Interventions Implementation

For more information, please see [7.C.9 Allowable expenditures and related requirements](#)

Rental Subsidies [\(Chapter 7. Section C.9.1\).](#)

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

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

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

40

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

30

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

10

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?

In order to determine projections, historical data in HMIS is used to evaluate annual enrollments and durations for programs providing rental subsidies, such as Emergency/Interim Shelter and Rapid Rehousing programs. Many programs require rents to fall within Fair Market Rents (FMR) for the region. The El Dorado Public Housing Authority maintains regional FMR tables and Utility allowances that can be referenced by all housing programs. When program budgets are determined, the total numbers served is based on utilizing these FMR's and determining any limitations on duration of the subsidies. For example, some programs have a limited funding duration, therefore the rental subsidies must fall within the term of the funding. The County must also provide detailed financial and programmatic reporting back to the funding sources on a quarterly or annual basis. These reports are used to forecast both expenditures and enrollments based on past actual costs and persons served.

For which setting types will the county provide rental subsidies?

Non-Time-Limited Permanent Settings: Supportive housing

Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments

Non-Time-Limited Permanent Settings: Single and multi-family homes

Non-Time-Limited Permanent Settings: Housing in mobile home communities

Non-Time-Limited Permanent Settings: Single room occupancy units

Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units

Non-Time-Limited Permanent Settings: Tiny Homes

Non-Time-Limited Permanent Settings: Shared housing

Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)

Non-Time-Limited Permanent Settings: License-exempt room and board

Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing

Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit

Time Limited Interim Settings: Hotel and motel stays

Time Limited Interim Settings: Non-congregate interim housing models

Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)

Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units

Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

Will this Housing Intervention accommodate family housing?

Yes

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

El Dorado County (EDC) utilizes BHSA Housing Interventions to fill critical gaps across the homelessness-to-housing continuum:

Acquisition & development of units tailored to behavioral health needs. Rental and operating subsidies, enhanced by Medi-Cal Community Supports.

Outreach programs offering prevention, street-level engagement, and resource access.

Together, these funded interventions align with state requirements and local homelessness needs, ensuring BHSA dollars deliver effective housing solutions for residents with behavioral health challenges.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?

Project-based

Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in

Through integration of El Dorado County's (EDC) Housing and Homelessness services within the Behavioral Health Division (BHD), EDC has operationalized a responsive and dynamic housing portfolio capable of placing BHSA-eligible individuals across a spectrum of safe, supported housing options, by combining owned units, leased facilities, and master-leasing flex pools and by working in concert with a wide network of community, nonprofit, and health partners.

Total number of units funded with BHSA Housing Interventions per year

46

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

15

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

El Dorado County (EDC) will use Behavioral Health Services Act (BHSA) Housing Interventions (HI) braided with allowable grant funded supports to provide operating subsidies for supportive housing and transitional housing units serving individuals homeless or at risk and who currently have or are in recovery of a serious behavioral health condition including those transitioning from institutional settings. Operating costs will be utilized as a foundation to obtain and sustain a portfolio of housing units at various levels of support through property management implementation.

For which setting types will the county provide operating subsidies?

Non-Time-Limited Permanent Settings: Supportive housing

Non-Time-Limited Permanent Settings: Apartments, including master-lease

apartments

Non-Time-Limited Permanent Settings: Shared housing

Time Limited Interim Settings: Hotel and motel stays

Time Limited Interim Settings: Non-congregate interim housing models

Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)

Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units

Will this be a scattered site initiative?

Yes

Will this Housing Intervention accommodate family housing?

Yes

Total number of units funded with BHSA Housing Interventions per year

5

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

20

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

El Dorado County (EDC) will use Behavioral Health Services Act (BHSA) Housing Interventions (HI) funding to implement a landlord engagement strategy that expands housing options for BHSA-eligible individuals. Funds will support outreach to property owners, education on program benefits, and mitigation measures such as covering damages beyond security deposits, unpaid rent, and vacancy loss. These efforts will be coordinated through EDC's Flex Pool and Housing Navigation team, leveraging

existing partnerships with the Continuum of Care (CoC) and Medi-Cal Managed Care Plan (MCP) Community Supports (CS). The goal is to reduce landlord risk, increase unit availability, and promote long-term housing stability for individuals with serious behavioral health needs.

Total number of units funded with BHSA Housing Interventions per year

20

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

20

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

El Dorado County (EDC) will use Behavioral Health Services Act (BHSA) Housing Interventions funding for Participant Assistance Funds to remove financial barriers that prevent individuals from securing and maintaining housing. These funds will cover essential costs such as application fees, security deposits, utility setup, and habitability items (e.g., bedding, cookware) that are not otherwise funded through Medi-Cal Community Supports (CS) or other programs. Assistance will be administered through Housing Navigators within the Behavioral Health Division (BHD), ensuring timely support for BHSA-eligible individuals transitioning from homelessness, shelters, or institutional settings into permanent housing.

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

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

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year

20

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

El Dorado County (EDC) will use Behavioral Health Services Act (BHSA) Housing Interventions (HI) funding to provide Housing Transition Navigation and Tenancy Sustaining Services for individuals not eligible for Medi-Cal Community Supports (CS). These services include assistance with housing searches, completing applications, securing documentation, and coordinating move-in logistics. Post-placement, Housing Navigators will deliver ongoing tenancy support such as landlord mediation, budgeting guidance, and linkage to behavioral health and social services to prevent eviction and promote housing stability. This intervention complements existing programs to ensuring BHSA-eligible individuals receive comprehensive, client-centered support throughout the housing continuum.

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

30

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

El Dorado County (EDC) will use Behavioral Health Services Act (BHSA) Housing Interventions (HI) funding to provide proactive outreach and engagement services for individuals experiencing homelessness or at risk, who have serious behavioral health needs. Activities will include street-based engagement, relationship-building, and linkage to housing programs and behavioral health services. These efforts will be coordinated with the EDC's Housing Navigation team, Flex Pool, and Continuum of Care (CoC) partners to ensure timely access to housing resources and supportive services. The goal is to reduce barriers, foster trust, and connect BHSA-eligible individuals to permanent housing and care.

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?

One

Forni Road Housing Services Site

What setting types will the capital development project include?

Time Limited Interim Settings: Non-congregate interim housing models

Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units

Capacity (Anticipated number of individuals housed at a given time)

30

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

10

Total number of units funded with Housing Interventions funds only

5

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)

6/30/2028

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than \$450,000)

\$50,000

Have you utilized the “by right” provisions of state law in your project?

No

If you have not incorporated use of the “by right” provisions into your project, please explain why

The project is at the initial stage of development and has not yet been determined if it meets all necessary “by right” requirements.

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)

As funding is available, Behavioral Health Services Act (BHSA) Housing Interventions (HI) will be utilized to support ongoing housing services and supports within applicable laws and policies.

Several current housing programs are set expire in the near future, including Behavioral Health Bridge Housing (BHBH) and Emergency Housing Vouchers (EHV). EDC plans to use several programs, including Transitional Rent and BHSA HI to continue to house persons eligible under those programs.

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see [7.C.7 Relationship to Medi-Cal Funded Housing Services](#)

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?

Transitional Rent

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

Yes

When does the county behavioral health system plan to become an MCP-contracted provider?

1/1/2026

How will the county behavioral health system identify, confirm eligibility, and [refer Medi-Cal members to housing-related Community Supports covered by MCPs](#) (including Transitional Rent)?

El Dorado County Behavioral Health will identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports—including Transitional Rent—through a coordinated process leveraging the Flex Pool strategy and the Continuum of Care’s Coordinated Entry System (CES).

The CES serves as the primary intake and prioritization mechanism, ensuring that individuals experiencing homelessness or housing instability are assessed using standardized tools and screened for BHSA and Medi-Cal eligibility. Once eligibility is confirmed, Housing Navigators will initiate referrals to Community Supports offered by Managed Care Plans (MCPs), such as Housing Transition Navigation Services, Tenancy Sustaining Services, and Transitional Rent.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county

The Behavioral Health Division (BHD) ensures its contracted provider network for Housing Interventions (HI) is known and shared with Medi-Cal Managed Care Plans (MCPs) through structured coordination and ongoing communication processes.

The Behavioral Health Division maintains an integrated Housing and Homelessness

unit that serves as the Administrative Entity for the Continuum of Care (CoC) and Contracts with a local provider do administer the Coordinated Entry System (CES). This centralized role allows the county to maintain a current roster of BHSA-funded housing providers and interventions within the CES and Homeless Management Information System (HMIS).

To keep MCPs informed, the county conducts monthly cross-system meetings with MCP representatives (Anthem, Kaiser, and Health Plan of San Joaquin) to review housing resources, eligibility pathways, and referral processes. These meetings include updates on new BHSA-funded housing interventions, Flex Pool operations, and provider capacity. Additionally, the county shares provider network details through secure data exchanges and closed-loop referral systems, ensuring MCPs have real-time visibility into available housing supports.

The Flex Pool strategy further strengthens coordination by serving as a fiscal and operational hub for braiding BHSA Housing Interventions with MCP Community Supports (CS). Through this model, MCPs receive regular reports on housing inventory, utilization, and provider engagement, enabling streamlined referrals and continuity of care for 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)?

No

What processes does the county behavioral health system have in place to ensure

Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available? The Behavioral Health Division (BHD) has established multiple safeguards to prevent gaps in housing services for Medi-Cal members with significant behavioral health conditions once Medi-Cal Managed Care Plans (MCP)-funded Community Supports are exhausted.

The county leverages its Flex Pool strategy and Coordinated Entry System (CES) to ensure continuity of care. When MCP housing benefits such as Transitional Rent or Tenancy Sustaining Services end, Housing Navigators immediately assess ongoing needs and transition members to BHSA-funded Housing Interventions, including rental subsidies, operating subsidies, and landlord mitigation supports.

Through the Flex Pool, the county braids Behavioral Health Services Act (BHSA) dollars with other local, state, and federal resources, enabling rapid deployment of funds to maintain housing stability. Closed-loop referral processes between Behavioral Health, MCPs, and housing providers ensure real-time communication and prevent service interruptions. Additionally, Housing Navigators provide tenancy

support, landlord engagement, and linkage to behavioral health services throughout the transition, prioritizing members at risk of homelessness or institutionalization.

This integrated approach—combining CES prioritization, Flex Pool funding, and proactive case management—ensures that Medi-Cal members do not experience gaps in housing or supportive services to the extent resources are available.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools (“Flex Pools”) are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: [Flexible Housing Subsidy Pools - Technical Assistance Resource](#). Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to [7.C.8 Flexible Housing Subsidy Pools](#).

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS’ Flex Pools TA Resource Guide)?

Yes

Is the county behavioral health system participating in or planning to participate in the Flex Pool?

Yes

What role does the county behavioral health system have or plan to have in the Flex Pool?

Lead Entity

Operator

What organization is serving as the Operator?

El Dorado County Behavioral Health Division.

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?

Yes

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?

Rental Subsidies

Operating Subsidies

Landlord Outreach and Mitigation Funds Participant Assistance Funds

Housing Transition Navigation Services and Tenancy and Sustaining Services

Outreach and Engagement (up to 7 percent)

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above

The Behavioral Health Division (BHD) will play an active role in launching and scaling the Flex Pool by leveraging participation in the DHCS Flex Pool Academy and utilizing dedicated planning funds to build capacity. The county will coordinate closely with its Fiscal team to design and streamline payment processes, ensuring efficient financial workflows for housing interventions. Specialized staff will be deployed to manage landlord engagement, unit acquisition, and payment requests and authorizations, strengthening relationships with property owners and expanding housing inventory. Additionally, the county plans to contract out real estate and property management functions to enhance operational efficiency and maintain a dynamic portfolio of units. These efforts, combined with integration of housing programs within Behavioral Health and alignment with the Coordinated Entry System, will create a robust infrastructure for braiding funding streams, supporting housing navigation, and sustaining long-term housing solutions for BHSA-eligible individuals.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

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

For more information on this section, please see [6.C.2 Securing Medi-Cal Payment](#).

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)?

43%

For county behavioral health (including county-operated providers), please select the [five positions](#) with the greatest vacancy rates

Psychiatric Technician (PT)

Mental Health Rehabilitation Specialist

Licensed Clinical Social Worker

Licensed Marriage and Family Therapist

Licensed Professional Clinical Counselor

Please describe any other key workforce gaps in the county

In addition to high vacancies for licensed clinicians, El Dorado County faces several key workforce gaps that impact service delivery. These include local availability of bilingual and culturally responsive providers, particularly in rural and underserved areas such as South Lake Tahoe. Recruitment and retention challenges are compounded by limited local training pipelines for specialized roles, as well as competition with neighboring counties for qualified staff.

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, El Dorado County expects workforce needs to shift significantly due to new requirements under Behavioral Health Transformation (BHT) and BH-CONNECT. The county anticipates increased demand for county or contracted staff trained in evidence-based practices such as High Fidelity Wraparound, Coordinated Specialty Care for First Episode Psychosis, and integrated care models that address co-occurring conditions. This would indicate the need to expand clinical capacity, particularly licensed clinicians (LCSWs, LMFTs, LPCCs), psychiatrists, and substance use disorder counselors, as well as building a pipeline for Medi-Cal Certified Peer Support Specialists to meet engagement and recovery goals.

Recruitment and retention challenges are expected to intensify as competition for qualified staff grows statewide, making hiring incentives, loan repayment programs, and flexible work arrangements critical.

Technology adoption will also require training for field-based staff to support care coordination and timely documentation. Overall, workforce planning will focus on cross-training, supervision capacity, and leveraging state initiatives to sustain a qualified, culturally responsive workforce.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?

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

No additional workforce initiatives underway at this time.

Budget and Prudent Reserve

For more information on this section, please see [6.B.3 Local Prudent Reserve](#).

Please upload the completed [budget template](#)

[El Dorado County Integrated Plan Budget Template \(Version 3 04.06.206\)](#)

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template

Behavioral Health Services and Supports (BHSS)

N/A Prudent Reserve not over Maximum

Full Service Partnership (FSP)

N/A Prudent Reserve not over Maximum

Housing Interventions

N/A Prudent Reserve not over Maximum

Enter date of last [prudent reserve assessment](#)

5/30/2026

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan

BHSS

N/A Prudent Reserve not over Maximum

FSP

N/A Prudent Reserve not over Maximum

Housing Interventions

N/A Prudent Reserve not over Maximum

Plan Approval and Compliance

For more information on this section, please see [3.A.1 Reporting Period](#).

Behavioral Health Director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Certification will be added upon approval of the Integrated Plan

County Administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Certification will be added upon approval of the Integrated Plan

Board of Supervisor certification

For final submission, download and complete the board of supervisor certification template using the button below before starting this section

Certification will be added upon approval of the Integrated Plan

Requests

For related policy information, refer to [7.C.6 Transfers and Exemptions](#).

Assertive Community Treatment (ACT) – EXEMPTION APPROVED

Please select which FSP exemptions criteria the county meets

Limited workforce (e.g. qualified providers)

Limited need (e.g., estimated population with a clinical need for ACT)

Other hardships

Please provide justification for this FSP exemption request

As a rural county with a relatively small and dispersed population, sustaining a full ACT team, requiring multiple specialized staff and intensive service delivery, is not feasible. Instead, the county has invested in a strong continuum of care that includes crisis intervention, outpatient treatment, and Intensive Case Management (ICM), services. These programs effectively address the needs of individuals with severe mental illness without the resource intensity of ACT.

BHSA guidelines allow flexibility for counties with populations under 200,000. For El Dorado, redirecting resources toward housing supports, mobile crisis response, and other high-need areas ensures better outcomes for residents. The county's existing infrastructure already provides several of the functions associated with ACT, such as intensive engagement and coordination for individuals with complex needs. Requiring El Dorado County to implement ACT would divert limited funds from programs that are already working and better suited to its rural context. Exemption from this requirement allows the county to continue focusing on cost-effective, locally responsive services while maintaining high-quality behavioral health care for its most vulnerable populations.

Please upload supporting data

[BHD Update 12-2025 Data.pdf](#)

Please select the data source

County demographic data

County workforce data

Forensic Assertive Community Treatment (FACT) - EXEMPTION APPROVED

Please select which FSP exemptions criteria the county meets

Limited workforce (e.g. qualified providers)

Limited need (e.g., estimated population with a clinical need for ACT)

Other hardships

Please provide justification for this FSP exemption request

As a rural county with a small, widely dispersed population, the county lacks the infrastructure and client volume necessary to support a full, multidisciplinary FACT team. Operating FACT would require a dedicated team of clinical, forensic, and peer-support staff providing 24/7 wraparound care, a model that is impractical and likely inefficient in El Dorado's context.

Instead, the Behavioral Health Division has established effective alternatives that deliver many of the same benefits. Its existing mobile crisis teams, outpatient services, case management, and justice & diversion services including CARE Act coordination, provide intensive, targeted support to individuals at risk of justice involvement. These programs, while less resource-intensive, effectively mitigate risk and improve outcomes for individuals with serious behavioral health needs.

For El Dorado, prioritizing housing supports, mobile crisis response, and outpatient interventions proves more effective given its rural demographics and existing strong service continuum.

Requiring FACT would divert scarce resources from these proven, cost-effective models, potentially reducing access to critical supports. An exemption allows El Dorado County to continue leveraging its existing crisis and forensic linkage infrastructure to support high need populations, while aligning with Behavioral Health Services Act (BHSA) goals of tailored, outcome-driven behavioral health resource allocation.

Please upload supporting data

[BHD Update 12-2025 Data.pdf](#)

Please select the data source

County demographic data

County workforce data

Individual Placement and Support (IPS) Supported Employment – EXEMPTION APPROVED

Please select which FSP exemptions criteria the county meets

Limited workforce (e.g. qualified providers)

Limited need (e.g., estimated population with a clinical need for ACT)

Other hardships

Please provide justification for this FSP exemption request

El Dorado County seeks an exemption from implementing Individual Placement and Support (IPS) Supported Employment under the Behavioral Health Services Act (BHSA). IPS is an evidence-based model designed to help individuals with serious mental illness obtain and maintain competitive employment through intensive, individualized support. While this approach is highly effective in urban areas with large populations and diverse job markets, it is not practical for El Dorado County's rural setting.

The county's small and geographically dispersed population limits the ability to sustain a dedicated IPS team and to provide the volume of employer partnerships needed for successful implementation.

Additionally, transportation barriers and limited local employment opportunities further reduce the feasibility of IPS in this context. Instead, El Dorado County has invested in alternative strategies that align with BHSA goals, such as vocational rehabilitation partnerships, supported education, and case management services that incorporate employment readiness. These programs provide meaningful pathways to work and recovery without the resource intensity of IPS.

Requiring IPS would divert limited funds from programs that are already effective and better suited to the county's rural context. Granting an exemption allows El Dorado County to continue focusing on cost-effective, locally responsive services while maintaining high-quality behavioral health care and recovery supports for its most vulnerable populations.

Please upload supporting data

[BHD Update 12-2025 Data.pdf](#)

Please select the data source

County demographic data

Other

Please describe
limited local employment opportunities

Appendix

**Behavioral Health Services Act (BHSA)
Community Planning Process (CPP)
SPANISH Presentation**



BHSA CPP

Proceso de planificación comunitaria de la
Ley de Servicios de Salud Conductual

Presentación de Capacitación Comunitaria

HEALTH AND HUMAN
SERVICES AGENCY
EL DORADO COUNTY
Transforming Lives and Improving Futures

¿Qué es BHSA?

- ▶ Transformación de la salud conductual: la Proposición 1 fue aprobada por los votantes en 2024 y es una revisión completa del Servicio de Salud Conductual
- ▶ BHSA incluye el Bono de Infraestructura de Salud Conductual y reemplaza la Ley de Servicios de Salud Mental (MHSA).
- ▶ BHSA también prioriza la atención para los californianos que experimentan o corren el riesgo de quedarse sin hogar, con responsabilidad para garantizar el impacto local.
- ▶ BHSA financia el desarrollo de instalaciones de tratamiento, viviendas y servicios para personas con enfermedades mentales graves o trastornos por uso de sustancias.

Plan Integrado

- ▶ BHSa requiere que los condados presenten un Plan Integrado de tres años para Servicios y Resultados de Salud Conductual
 - ▶ Plan de gastos globales que incluye TODAS las fuentes de financiación disponibles
 - ▶ Las fuentes de financiamiento incluyen BHSa, realineación de 1991 y 2011, programas de subvenciones federales, participación financiera federal de Medi-Cal, fondos de liquidación de opioides, fondos locales y cualquier otro financiamiento
- ▶ El primer IP cubrirá los años fiscales 2026-2029

Plan Integrado

	Plan Integrado (IP)	Actualizaciones Anuales (AU)
Los condados deben completar y someter	Sí	Sí
Plazo de Sumisión	Cada 3 años	Segundo y tercer año del ciclo de PI
Proceso de planificación comunitaria requerido	Sí	No, pero se anima
Período requerido de comentarios públicos de 30 días	Sí	Sí
Audiencia requerida de la Junta de Salud Conductual	Sí	Solo si el condado involucra a las partes interesadas
Aprobación y presentación de la Junta de Supervisores	IP final antes del 30 de junio	AU final antes del 30 de junio

Población de enfoque

▶ Poblaciones de prioridad

- ▶ Personas sin hogar crónicas, sin hogar o en riesgo de quedarse sin hogar
- ▶ Están en el sistema de justicia o en riesgo de estarlo.
- ▶ Reingreso a la comunidad desde una prisión estatal, una cárcel del condado o un centro correccional juvenil
- ▶ Están en el sistema de bienestar infantil
- ▶ En riesgo de institucionalización o tutela

Requisitos de CPP:

- ▶ Los condados DEBEN involucrar a las partes interesadas para cada plan de tres años
- ▶ Las partes interesadas incluirán personas que representen diversos puntos de vista
- ▶ Los condados deben demostrar asociación con los electores y las partes interesadas a través del proceso de planificación comunitaria
- ▶ Comprometerse con las jurisdicciones de salud locales, así como con los planes de atención administrada de Medi-Cal en la preparación del Plan Integrado (la colaboración será monitoreada por DHCS)
- ▶ Período de comentarios de las partes interesadas de 30 días
- ▶ Audiencia pública de la Junta (Comisión) de BH después de un período de comentarios de 30 días
- ▶ Informe anual presentado a la Junta de Supervisores que incluye recomendaciones sustantivas
- ▶ Se ha actualizado el proyecto de P.I. para incluir recomendaciones sustantivas, un resumen y un análisis de las revisiones

Indicadores claves de rendimiento

14 objetivos estatales de salud conductual

Metas de mejora

- ▶ Experiencia asistencial
- ▶ Acceso a la atención
- ▶ Prevención y tratamiento de afecciones de salud física concurrentes
- ▶ Calidad de vida
- ▶ Conexión social
- ▶ Participación en la escuela
- ▶ Dedicación en el trabajo



Metas de reducción

- ▶ Suicidios
- ▶ Sobredosis
- ▶ Condiciones de salud conductual no tratadas
- ▶ Institucionalización
- ▶ Indigencia
- ▶ Involucramiento en el sistema de justicia
- ▶ Retirar a los niños del hogar



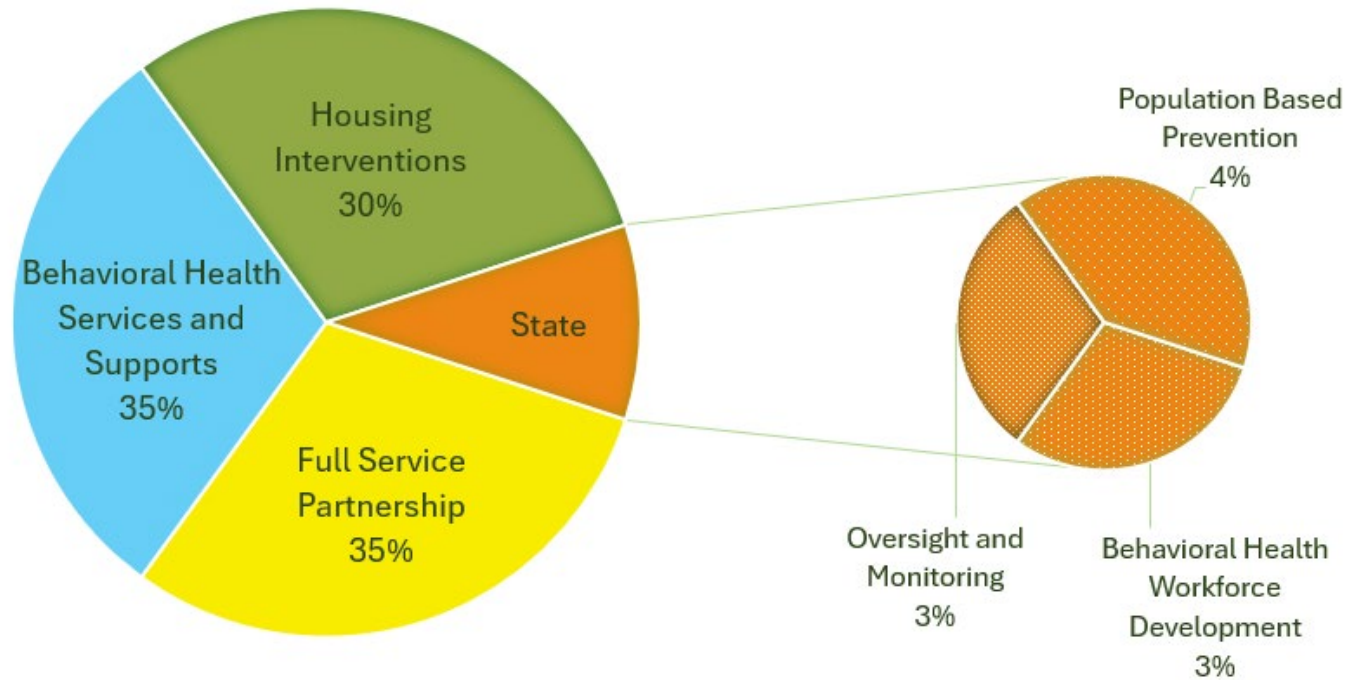
Fuentes de financiación

- ▶ County Behavioral Health está financiado por muchas fuentes federales, estatales y de otro tipo, incluidos los ingresos de BHSA
- ▶ La política de BHSA requiere que los condados informen sobre TODAS las fuentes de financiamiento para servicios y resultados de salud conductual
- ▶ Los condados DEBEN utilizar otras fuentes de financiamiento disponibles antes de gastar dólares de BHSA
- ▶ Componentes de financiación de BHSA
 - ▶ Servicios y apoyos de salud conductual
 - ▶ Asociación de servicio completo
 - ▶ Intervenciones de vivienda

Uso de fondos

- ▶ Los condados deben asegurarse de que los proveedores hagan esfuerzos de buena fe para solicitar el reembolso de cualquier servicio financiado por BHSA que también esté cubierto por el Sistema de Prestación de Salud Conductual de Medi-Cal (BHDS), los Planes de Atención Administrada de Medi-Cal y/o el Seguro de Salud Comercial.
 - ▶ Participe en el BHDS de Medi-Cal del condado
 - ▶ Verificar y apoyar la inscripción en Medi-Cal
 - ▶ Verifique el estado del seguro
 - ▶ Facturar constantemente a Medi-Cal BHDS o seguro comercial
 - ▶ Pago seguro del seguro médico comercial
 - ▶ Reportar quejas sobre la conducta del Plan de Salud Comercial
 - ▶ Apropiémonos de otros fondos que no sean BHSA
- ▶ Los condados y proveedores pueden atender a personas que cumplen con los criterios para un servicio en particular, incluidas las personas sin seguro.

Asignaciones de fondos





Collaboracion de servicio completo 35%

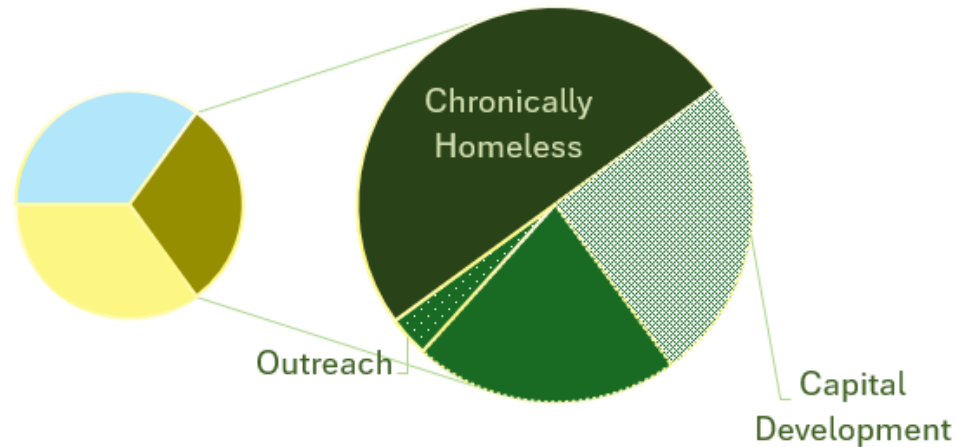
- ▶ Brinda atención individualizada y en equipo a personas que viven con necesidades significativas de salud conductual
- ▶ Enfoque de "lo que sea necesario"
- ▶ Enfoque basado en la comunidad, persona integral
- ▶ Informado sobre el trauma, centrado en la recuperación, apropiado para la edad
- ▶ Entregado en asociación con familias y sistemas de apoyo

Colaboracion de Servicio Completo

- ▶ Debe cumplir con los criterios de elegibilidad Sección 5892 del Código WIC, subdivisión (d)
- ▶ Debe incluir servicios de tratamiento por uso de sustancias cuando corresponda
- ▶ Proporcionado de acuerdo con la necesidad clínica demostrada
 - ▶ Tratamiento comunitario asertivo (ACT)
 - ▶ Acto forense (FACT)
 - ▶ Gestión intensiva de casos (ICM) de FSP
 - ▶ Envoltura de alta fidelidad (HFW)
- ▶ Debe proporcionar servicios de participación continua
- ▶ Debe incluir servicios de salud conductual clínicos o de campo
- ▶ Coordinar con el proveedor de atención primaria de los participantes según corresponda

Intervenciones de vivienda 30%

- ▶ 50% de personas crónicamente sin hogar
 - ▶ debe usarse para apoyar las necesidades de vivienda de las personas sin hogar crónicas (enfoque en los campamentos)
- ▶ Hasta el 25% puede utilizarse para el desarrollo de capital
- ▶ Hasta el 7% se puede utilizar para el alcance y la participación en la vivienda



Intervenciones de vivienda

- ▶ Reducir la falta de vivienda para las personas con necesidades de salud conductual
- ▶ La estabilidad de la vivienda es fundamental para la recuperación y la mejora de los resultados de salud conductual.
- ▶ Reducción de daños y enfoques de vivienda primero
- ▶ Proporcionar vivienda de apoyo permanente con servicios flexibles voluntarios
- ▶ Garantizar el acceso a los servicios de salud conductual para quienes están en programas de vivienda
- ▶ Alinearse con otros esfuerzos estatales locales, tribales y de Medi-Cal para abordar la falta de vivienda

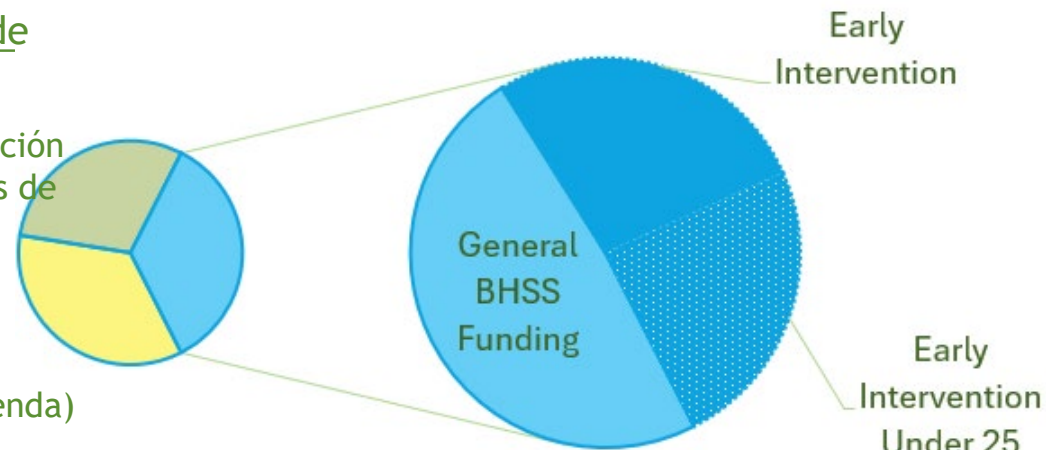
Servicios y apoyos de salud conductual (BHSS) 35%

▶ 51% de la intervención temprana de BHSS

- ▶ El 51% de los servicios de intervención temprana deben ser para personas de 25 años o menos

▶ Financiación restante de BHSS

- ▶ Sistemas de atención para niños y adultos mayores (no FSP y no vivienda)
- ▶ Alcance y participación (no vivienda)
- ▶ Educación y capacitación de la fuerza laboral
- ▶ Instalaciones de capital y necesidades tecnológicas
- ▶ Pilotos y proyectos innovadores de salud conductual



Servicios y apoyos de salud conductual

- ▶ Sistemas de atención para niños, adultos y adultos mayores (no FSP y no vivienda)
- ▶ Componentes del programa de intervención temprana
 - ▶ Alcance Comunitario
 - ▶ Acceso y vinculación a la atención
 - ▶ Servicio y apoyos de tratamiento temprano de salud mental y trastornos por uso de sustancias
- ▶ Educación y capacitación de la fuerza laboral
- ▶ Instalaciones de capital y necesidades tecnológicas
- ▶ Pilotos y proyectos innovadores de salud conductual
 - ▶ Se utiliza para crear una base de evidencia para la efectividad de las estrategias estatales

Servicios y apoyos de salud conductual

Intervención temprana

- ▶ Los proyectos de intervención temprana deben enfatizar los servicios que reducen los resultados adversos de:
 - ▶ Suicidio y autolesiones
 - ▶ Encarcelamientos
 - ▶ Suspensión escolar, expulsión, derivación a una escuela alternativa o comunitaria, o falta de finalización (incluida la primera infancia de cero a cinco años de edad, Kindergarten de Transición (TK)-12 y educación superior)
 - ▶ Desempleo
 - ▶ Sufrimiento prolongado
 - ▶ Vivienda
 - ▶ Traslado de los niños de sus hogares
 - ▶ Sobredosis
 - ▶ Enfermedad mental en niños y jóvenes a través de servicios y apoyos sociales, emocionales, de desarrollo y conductuales en la primera infancia
- ▶ Programas requeridos
 - ▶ Sistemas coordinados de atención especializada para el primer episodio de psicosis (CSC para FEP) a partir de julio de 2026

Servicios administrativos

- ▶ Administración general del sistema
 - ▶ Fiscal, Gestión de Sistemas de TI, Instalaciones, Personal
- ▶ Planificación de BHSA y desarrollo del Plan Integrado
- ▶ Administración indirecta de servicios
- ▶ Gestión de la calidad
 - ▶ Mejora de la calidad
 - ▶ Garantía de calidad
 - ▶ Revisión de utilización
- ▶ Informes
 - ▶ Requisitos del plan de salud mental y del sistema de entrega organizada de Medi-Cal de medicamentos
 - ▶ Informe de resultados, responsabilidad y transparencia de salud conductual de BHSA
 - ▶ Informes requeridos de subvenciones y otras fuentes de financiación

Financiación y servicios que no son de BHSA

- ▶ La siguiente información no se incluirá en el Plan Integrado de BHSA, pero puede considerarse en la determinación de los proyectos de BHSA:
 - ▶ Financiamiento recibido por socios comunitarios
 - ▶ Servicios de tutores públicos más allá de la atención de salud conductual del cliente

BHOATR

Informe de resultados, responsabilidad y transparencia de salud conductual

- ▶ Informe completo de todas las fuentes y servicios de financiación de salud conductual
- ▶ DEBE informar sobre todos los gastos de BH, la utilización de servicios y el logro de metas y resultados
- ▶ Los condados deben presentar al Departamento de Servicios de Atención Médica (DHCS) anualmente
- ▶ El primer BHOATR cubrirá el año fiscal 2026-27
 - ▶ Borrador VENCIDO 30 de enero de 2028
 - ▶ VENCIMIENTO final 30 de enero de 2029
- ▶ La plantilla BHOATR reflejará la plantilla IP

Conclusiones claves

- ▶ Los condados DEBEN maximizar los fondos de Medi-Cal primero e informar sobre todos los gastos en el Plan Integrado
- ▶ Incluye un fuerte enfoque en las poblaciones sin hogar, las enfermedades mentales graves y brinda la capacidad de financiar servicios para trastornos por uso de sustancias
- ▶ Requiere que el condado recopile información de una variedad de grupos comunitarios, siga los indicadores clave de desempeño exigidos por el estado e informe públicamente los resultados anualmente.
- ▶ Siga todos los requisitos fijos (como asignaciones de fondos, requisitos de informes y participación de la comunidad)

▶ **Email:**

BHAdmin@edcgov.us

▶ **US Mail:**

BHSA Team
El Dorado County Behavioral Health
768 Pleasant Valley Road, Suite 201
Diamond Springs, CA 95619

▶ **Online BHSA Survey:**

<https://forms.office.com/g/cPtkLKpxf4>

▶ **For BHSA updates and resources visit our webpage**

<https://www.eldoradocounty.ca.gov/Health-Well-Being/Behavioral-Health>

**BHSA Community Planning
Process (CPP) Survey - Fiscal Year
2026/27**



**Behavioral Health Services Act (BHSA)
Community Planning Process (CPP)
ENGLISH Presentation**



BHSA CPP

Behavioral Health Services Act
Community Planning Process

Community Training Presentation

HEALTH AND HUMAN
SERVICES AGENCY
EL DORADO COUNTY
Transforming Lives and Improving Futures

What is BHSA?

- ▶ BHSA is legislation, policy, and funding requirements intended to completely transform statewide Behavioral Health Services
- ▶ Proposition 1 was passed by voters in March 2024 including AB 531 Behavioral Health Infrastructure Bond Act (BHIBA) and SB 326 the Behavioral Health Services Act (BHSA)
- ▶ BHIBA funds the development of treatment facilities, housing and services for people with serious mental illness or substance use disorders
- ▶ BHSA also prioritizes care for Californians experiencing or at risk of homelessness, with accountability to ensure local impact

Integrated Plan

- ▶ Three-year Integrated Plan for ALL Behavioral Health funding, services and outcomes
 - ▶ County Demographics and BH needs
 - ▶ County Behavioral Health Care Continuum Capacity
 - ▶ Plan Goals and Objectives
 - ▶ Community Planning Process including Comment Period and Public Hearing
 - ▶ ALL County Behavioral Health services and funding
 - ▶ Services by Total Funding Source
 - ▶ Workforce Strategy
 - ▶ Budget and Prudent Reserve
- ▶ The first IP will cover Fiscal Years 2026-2029

Integrated Plan

Development Process Steps	Integrated Plan (IP)	Annual Updates (AU)
Counties are Required to Complete and Submit	Yes	Yes
Submission Timeframe	Every 3 years	Second and third years of IP cycle
Community Planning Process Required	Yes	No, but encouraged
30-day Public Comment Period Required	Yes	Yes
Behavioral Health Board Hearing Required	Yes	Only if county engages stakeholders
Board of Supervisors Approval and Submission	Final IP by June 30	Final AU by June 30

Populations of Focus

- ▶ Medi-Cal members meeting medical criteria for a Serious Mental Illness (adult) or Serious Emotional Disturbance (youth)
- ▶ Priority Populations (W&I Code § 5892, subdivision (d))
 - ▶ Chronically homeless, experiencing homelessness or at risk of homelessness
 - ▶ Are in, or at risk of being in the justice system or juvenile justice system
 - ▶ Reentering the community from a state prison, county jail, or youth correctional facility
 - ▶ Are in the child welfare system
 - ▶ At risk of institutionalization or conservatorship
- ▶ BHSA may fund services open to all county residents with moderate to severe mental health needs in coordination with Managed Care Plans and private insurance.

CPP Requirements:

- ▶ Counties **MUST** engage stakeholders for each Three-year Plan
- ▶ Stakeholders shall include individuals representing diverse viewpoints
- ▶ Counties must demonstrate partnership with constituents and stakeholders through the community planning process
- ▶ Engage with Local Health Jurisdictions as well as the Medi-Cal Managed Care Plans in preparing the Integrated Plan (collaboration will be monitored by DHCS)
- ▶ 30-day stakeholder comment period
- ▶ BH Board (Commission) public hearing following 30-day comment period
- ▶ Annual Report provided to Board of Supervisors including substantive recommendations
- ▶ IP Draft updated to include substantive recommendations, summary and analysis of revisions

Key Performance Indicators

14 Statewide Behavioral Health Goals

Goals for Improvement

- ▶ Care experience
- ▶ Access to care
- ▶ Prevention and treatment of co-occurring physical health conditions
- ▶ Quality of life
- ▶ Social Connection
- ▶ Engagement in school
- ▶ Engagement in work



Goals for Reduction

- ▶ Suicides
- ▶ Overdoses
- ▶ Untreated behavioral health conditions
- ▶ Institutionalization
- ▶ Homelessness
- ▶ Justice-Involvement
- ▶ Removal of children from home



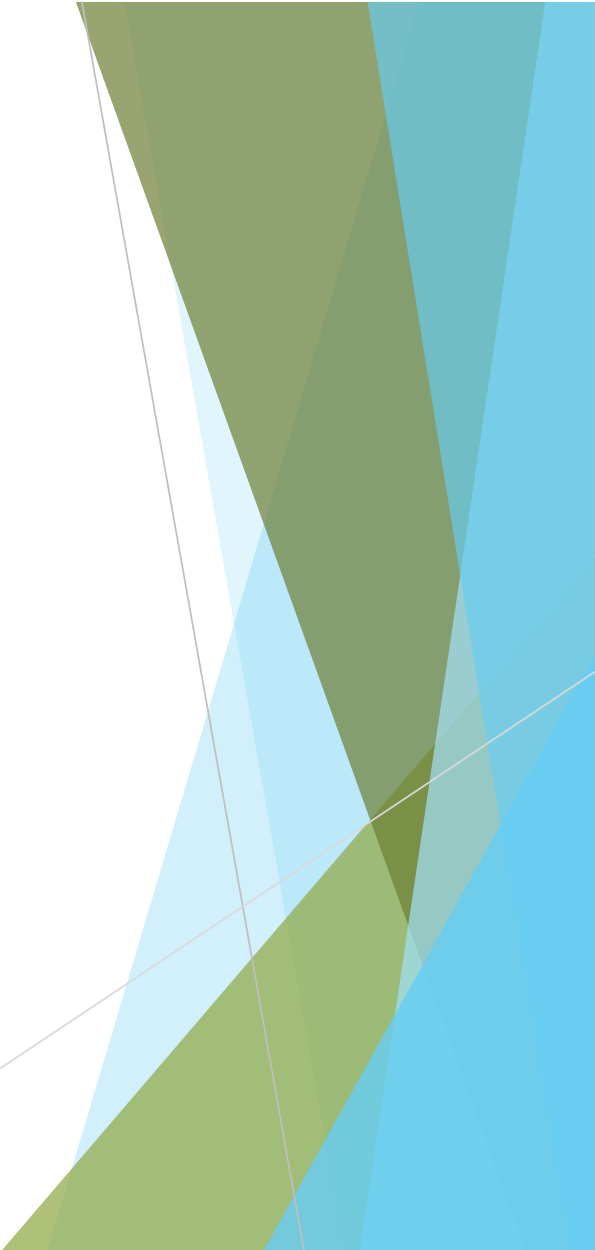
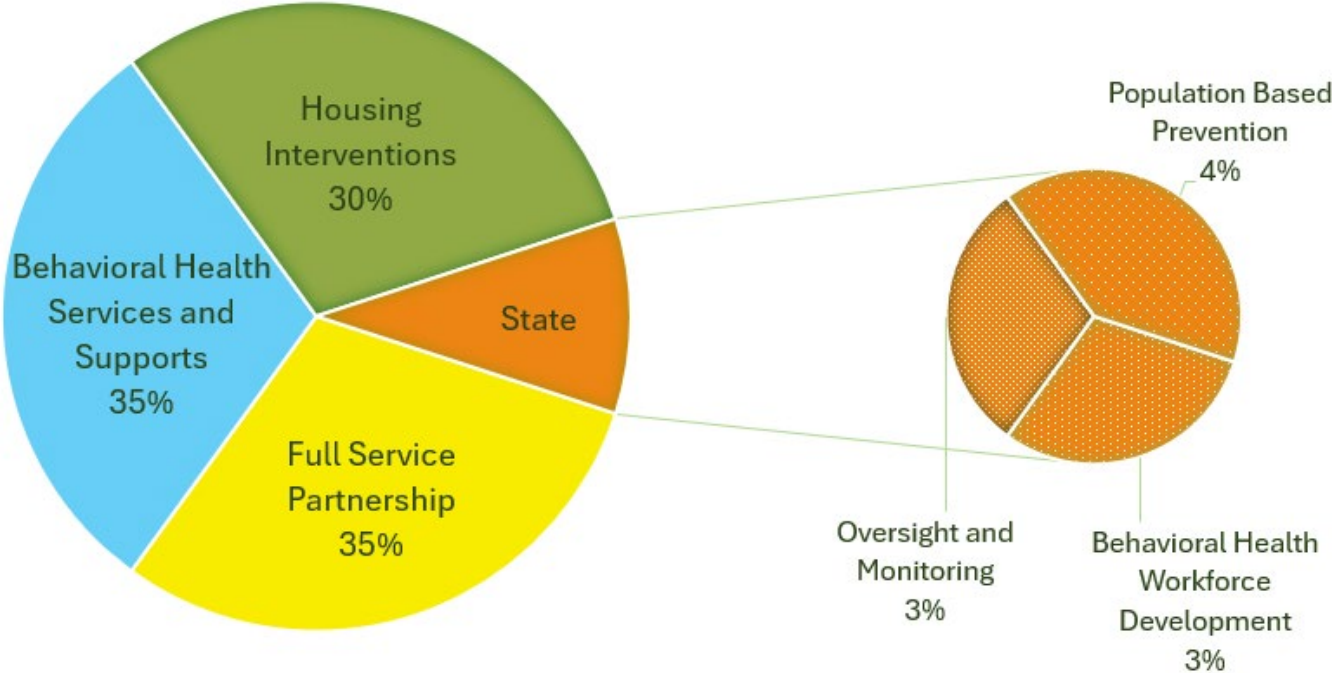
Funding Sources


- ▶ County Behavioral Health is funded by many different Federal, State and other sources including BHSA revenue
- ▶ BHSA policy requires counties to report on ALL funding sources for behavioral health services and outcomes
- ▶ Counties MUST utilize other available funding sources prior to expending BHSA dollars
- ▶ BHSA funding components
 - ▶ Behavioral Health Services and Supports
 - ▶ Full Service Partnership
 - ▶ Housing Interventions

Use of BHSA Funds

- ▶ BHSA policy emphasizes maximizing revenues wherever possible.
- ▶ Counties are required to ensure providers seek reimbursement from other sources before any BHSA is utilized.
- ▶ Counties and providers are expected to:
 - ▶ Check individual's insurance status
 - ▶ Check for Medi-Cal eligibility and support individuals with enrollment
 - ▶ Consistently bill Medi-Cal, Managed Care Plan or Commercial Insurance
 - ▶ Secure payment from Commercial Health Insurance
 - ▶ Report complaints about Commercial Health Plan conduct
 - ▶ Assure appropriate use of other Non-BHSA Funds
- ▶ Counties and Providers may serve individuals who meet criteria for a particular service including uninsured individuals.

BHSA Funding Allocations





Full Service Partnerships 35%

- ▶ Provides individualized, team-based care to individuals living with significant behavioral health needs
- ▶ “Whatever it takes” approach
- ▶ Community-based, whole person approach
- ▶ Trauma informed, recovery focused, age appropriate
- ▶ Delivered in partnership with families and support systems

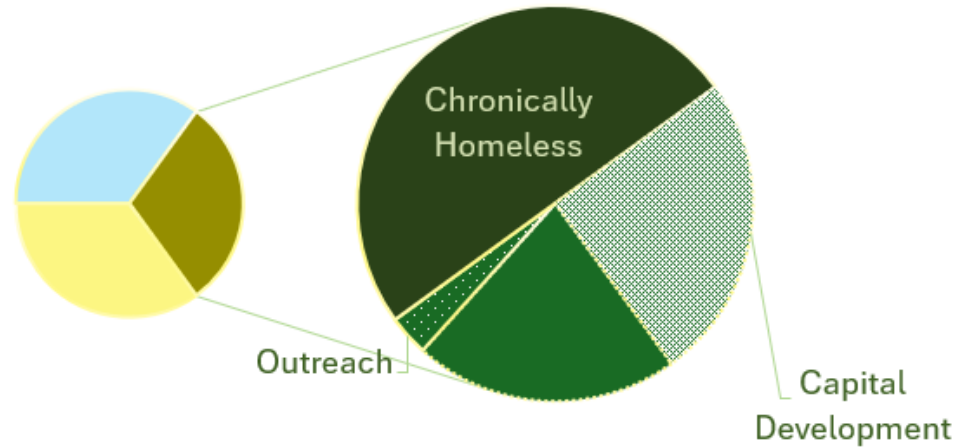


Full Service Partnership

- ▶ Clients must meet medical necessity (defined by WIC 14184.402)
- ▶ Must include Substance Use Treatment services where appropriate
- ▶ Must use evidence-based practices depending on clinical need
 - ▶ Assertive Community Treatment (ACT)
 - ▶ Forensic Act (FACT)
 - ▶ FSP Intensive Case Management (ICM)
 - ▶ High Fidelity Wraparound (HFW)
- ▶ Must provide ongoing engagement services
- ▶ Must include clinical or field based behavioral health services
- ▶ Coordinate with participants primary care provider as appropriate

Housing Interventions 30%

- ▶ 50% Chronically Homeless
 - ▶ must be used to support housing needs of chronically homeless (focus on those in encampments)
- ▶ Up to 25% may be used for capital development
- ▶ Up to 7% may be used for Housing Outreach and Engagement



Housing Interventions

- ▶ Reduce homelessness for people with behavioral health needs
- ▶ Housing stability is foundational for recovery and improved behavioral health outcomes.
- ▶ Harm reduction, and housing first approaches
- ▶ Provide permanent supportive housing with voluntary flexible services
- ▶ Ensure access to behavioral health services for those in housing programs
- ▶ Align with other local state, tribal, and Medi-Cal efforts to address homelessness

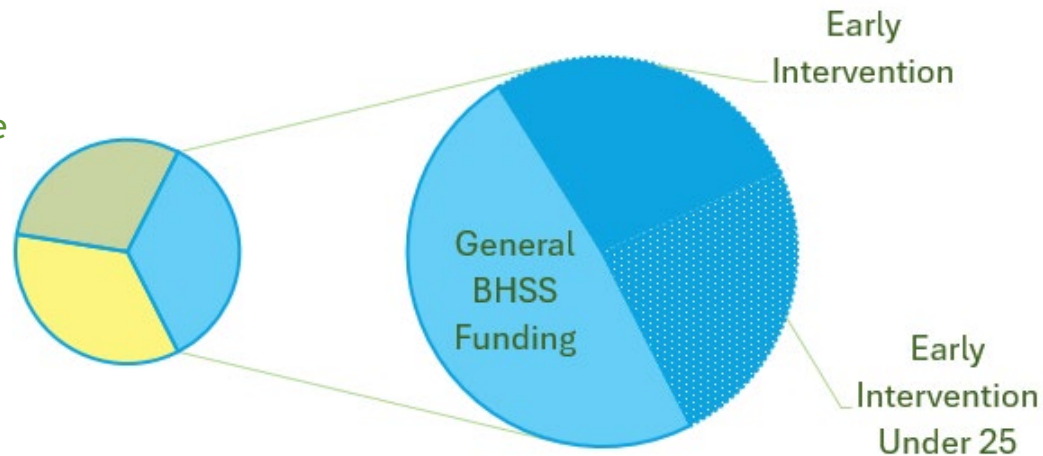
Behavioral Health Services and Supports (BHSS) 35%

▶ 51% of BHSS Early Intervention

- ▶ 51% of early intervention services must be for people 25 years of age and younger

▶ Remaining BHSS funding

- ▶ Children's Adults and Older Adults Systems of Care (non-FSP & non-housing)
- ▶ Outreach and Engagement (non-housing)
- ▶ Workforce Education and Training
- ▶ Capital Facilities and Technology Needs
- ▶ Innovative Behavioral Health Pilots and Projects



Behavioral Health Services & Supports

- ▶ Children's, Adult, and Older Adults Systems of Care (non-FSP & non-housing)
- ▶ Early Intervention Program Components
 - ▶ Outreach
 - ▶ Access and linkage to care
 - ▶ Mental health and substance use disorder early treatment service and supports
- ▶ Workforce Education and Training
- ▶ Capital Facilities and Technology Needs
- ▶ Innovative Behavioral Health Pilots and Projects
 - ▶ Used to build evidence base for the effectiveness of statewide strategies

Behavioral Health Services & Supports

Early Intervention

- ▶ Early Intervention Projects must emphasize services that reduce the adverse outcomes of:
 - ▶ Suicide and self-harm
 - ▶ Incarcerations
 - ▶ School suspension, expulsion, referral to an alternative or community school, or failure to complete (inclusive of early childhood zero to five years of age, Transitional Kindergarten (TK)-12, and higher education)
 - ▶ Unemployment
 - ▶ Prolonged suffering
 - ▶ Homelessness
 - ▶ Removal of children from their homes
 - ▶ Overdose
 - ▶ Mental illness in children and youth through social, emotional, developmental, and behavioral services and supports in early childhood
- ▶ Required Programs
 - ▶ Coordinated Specialty Systems of Care for First Episode Psychosis (CSC for FEP) beginning July 2026

Administrative Services

- ▶ General system administration
 - ▶ Fiscal, IT Systems Management, Facilities, Personnel
- ▶ BHSA planning and Integrated Plan development
- ▶ Indirect service administration
- ▶ Quality Management
 - ▶ Quality Improvement
 - ▶ Quality Assurance
 - ▶ Utilization Review
- ▶ Reporting
 - ▶ Mental Health Plan and Drug Medi-Cal Organized Delivery System requirements
 - ▶ BHSA Behavioral Health Outcomes, Accountability, and Transparency Report
 - ▶ Grant and other funding source required reporting

Non-BHSA Funding and Services

- ▶ The following information will not be included in the BHSA Integrated Plan but may be considered in the determination of BHSA projects:
 - ▶ Funding received by community partners
 - ▶ Public Guardian Services beyond client's Behavioral Health Care

BHOATR

Behavioral Health Outcomes, Accountability, and Transparency Report

- ▶ Comprehensive report of all Behavioral Health funding sources and services
- ▶ MUST report on all BH spending, service utilization, and achievement of goals and outcomes
- ▶ Counties must submit to Department of Health Care Services (DHCS) yearly
- ▶ First BHOATR will cover FY 2026-27
 - ▶ Draft DUE January 30, 2028
 - ▶ Final DUE January 30, 2029
- ▶ BHOATR Template will mirror IP template

Key Takeaways

- ▶ Counties MUST maximize Medi-Cal funding first, and report on all spending in the Integrated Plan
- ▶ Includes strong focus on unhoused populations, severe mental illness, and gives the ability to fund substance use disorder services
- ▶ Requires County to gather input from a variety of community groups, follow state-mandated key performance indicators, and publicly report outcomes annually.
- ▶ Follow all fixed requirements (such as funding allocations, reporting requirements, and community engagement)

▶ **Email:**

BHAdmin@edcgov.us

▶ **US Mail:**

BHSA Team
El Dorado County Behavioral Health
768 Pleasant Valley Road, Suite 201
Diamond Springs, CA 95619

▶ **Online BHSA Survey:**

<https://forms.office.com/g/cPtkLKpxf4>

▶ **For BHSA updates and resources visit our webpage**

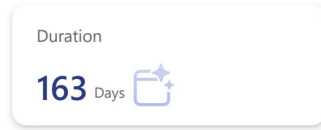
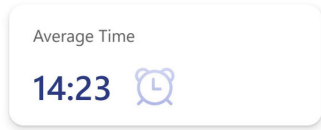
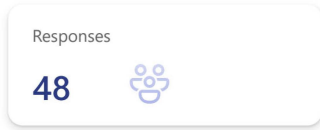
<https://www.eldoradocounty.ca.gov/Health-Well-Being/Behavioral-Health>

**BHSA Community Planning
Process (CPP) Survey - Fiscal Year
2026/27**



**Behavioral Health Services Act (BHSA)
Community Planning Process (CPP) Survey
Fiscal Year 2026/27**

Responses Overview Closed



1. What area(s) do you represent relative to behavioral health needs? (Check all that apply)



2. Are you affiliated with a provider currently contracted to do business with El Dorado County?



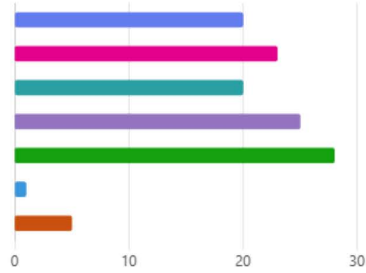
3. What El Dorado County contracted provider are you affiliated with and how (current or past employee or board member, donor or sponsor)?

28
Responses

Latest Responses
"Tahoe Youth and Family Services- current employee"
...

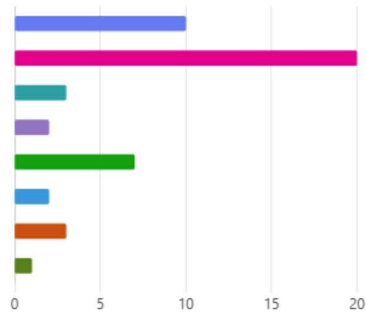
4. W&I Code § 5963.03, subdivision (a)(2)(A)(ii) requires Counties to engage "individuals representing diverse viewpoints". Which of these State required areas do you represent (Check all that apply)

- Youth from historically marginalized communities 20
- Organizations specializing in working with underserved racially and ethnically diverse... 23
- Representatives from LGBTQ+ communities 20
- Victims of domestic violence and sexual abuse 25
- People with lived experience of homelessness 28
- Decline to Answer 1
- None 5



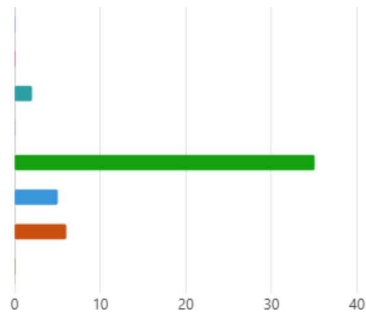
5. Where do you live? (choose only one)

- West County (Cameron Park, El Dorado Hills, Rescue, Shingle Springs) 10
- Placerville Area (Diamond Springs, El Dorado, Placerville, Pleasant Valley) 20
- North County (Coloma, Cool, Lotus, Garden Valley, Georgetown, Greenwood, Kelsey, Lotus,...) 3
- South County (Fair Play, Grizzly Flats, Mt. Aukum, Somerset) 2
- Mid County (Camino, Cedar Grove, Echo Lake, Pollock Pines, Kyburz, Pacific House, Riverton) 7
- Tahoe Basin (Meyers, South Lake Tahoe, Tahoma) 2
- Out of County, but I work in El Dorado County 3
- Declined to state 1



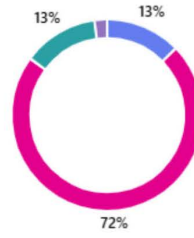
6. What is your race? (choose only one)

- American Indian or Alaskan Native 0
- Asian 0
- Black or African American 2
- Native Hawaiian or other Pacific Islander 0
- White 35
- Multiracial 5
- Declined to state 6
- Other 0



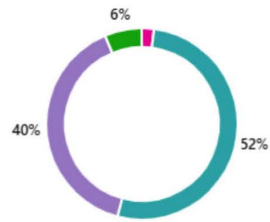
7. What is your ethnicity? (choose only one)

● Hispanic or Latino	6
● Non-Hispanic or Non-Latino	34
● Declined to state	6
● Other	1



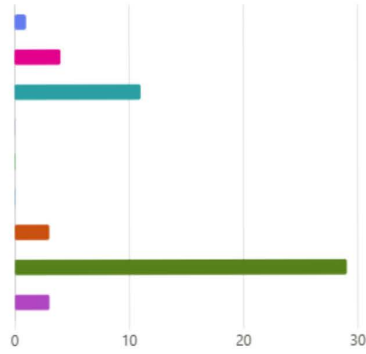
8. What is your age? (choose only one)

● 0-15 Years	0
● 16-24 Years	1
● 25-59 Years	25
● 60+ Years	19
● Declined to state	3



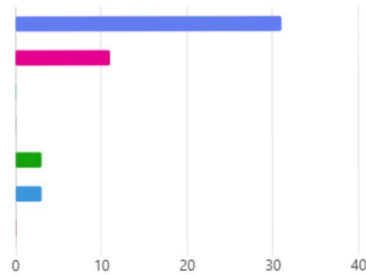
9. What is your military affiliation? (choose all that apply)

● Service Member	1
● Parent of Service Member	4
● Child of Service Member	11
● Spouse of Service Member	0
● Active Duty	0
● Reservist	0
● Veteran	3
● Does not apply	29
● Decline to State	3



10. What is your gender identity?

● Female	31
● Male	11
● Trans male/trans man	0
● Trans female/trans woman	0
● Genderqueer/gender non-conforming	3
● Declined to state	3
● Other	0

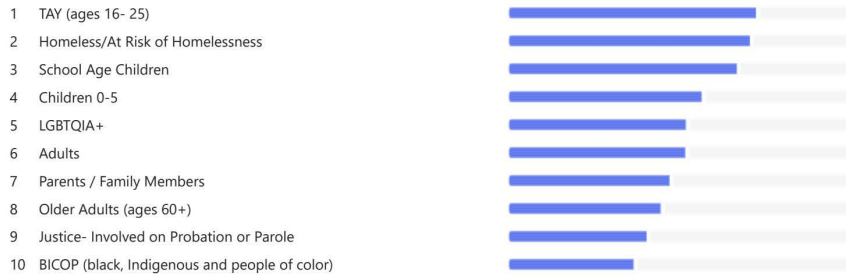


11. The Department of Health Care Services (DHCS) defines seven (7) negative outcomes of untreated mental illness.

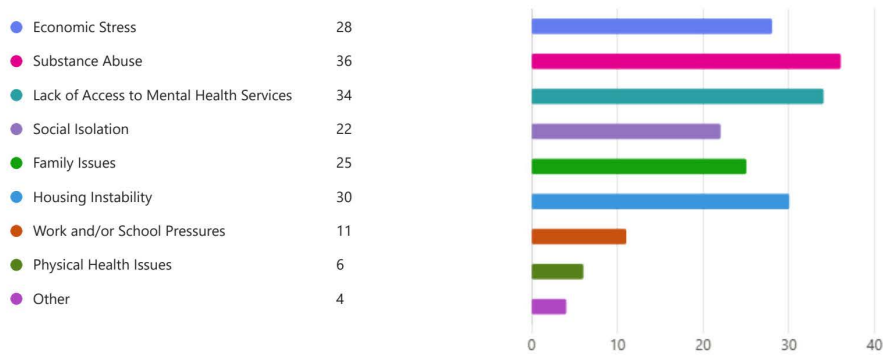
In your opinion, what are the most negative outcomes in El Dorado County?



12. In your opinion, what groups of people are in the greatest need of additional Behavioral Health Services and Supports in El Dorado County? (1=greatest need)

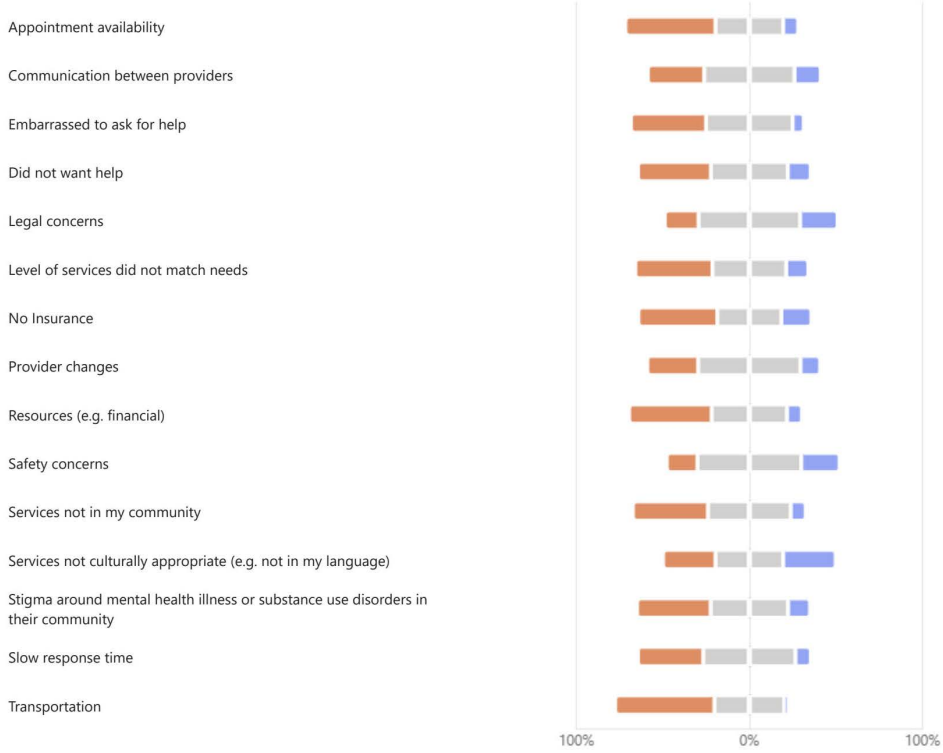


13. What do you feel are the greatest contributing factors to Behavioral Health issues in El Dorado County?



14. To what extent do the following barriers create challenges for individuals and family member(s) with behavioral health needs to access services?

Very Challenging Somewhat Challenging No added challenge



Public Comment Flyer Fiscal Year 2026/27

Public Comment is Now Open

for the

El Dorado County

Behavioral Health Services Act (BHSA)

FY 2026/27-2028/29

Draft Integrated Plan (IP)



Comments are due by:
March 29, 2026
5:00 p.m.



**HEALTH AND HUMAN
SERVICES AGENCY**
EL DORADO COUNTY
Transforming Lives and Improving Futures

Comments may be provided during the public comment period using the Substantive Comment form via:

Website: <https://www.eldoradocounty.ca.gov/Health-Well-Being/Behavioral-Health/Behavioral-Health-Services-Act-BHSA>

Email: BHAdmin@edcgov.us

Postal Mail: Health and Human Services Agency
Behavioral Health Division, BHSA Team
768 Pleasant Valley Road, Suite 201
Diamond Springs, CA 95619

The Health and Human Services Agency will document and consider all substantive feedback received during the public comment period.

Substantive Comment Form

SUBSTANTIVE COMMENT FORM

El Dorado County Behavioral Health Services Act (BHSA) FY 2026-2029 Integrated Plan (IP)

The following regulation and policy provide more information on the County's requirements for 30-day Public Comment process

- [WELFARE AND INSTITUTIONS CODE 5963.03 \(a\)\(2\)\(B\)](#)
- [California Code of Regulations 3315](#)
- [BHSA Policy Manual](#)

COMMENT REQUIREMENTS:

- All published comments must be within the scope of the BHSA Integrated Plan (IP) funding and not an alternative county funding source.
- Alternative research supporting comments will not be included in the published response due to the inability to vet all sources in a timely manner.
- Reported financial figures that can be reasonably vetted by County Staff may be included in published responses. Inaccurate or incomplete figures will be excluded.

Behavioral Health staff will respond to all submitted comments confirming receipt. Comments not meeting the above requirements may include a staff response with a suggested altered comment for confirmation. Per the DHCS required application portal, comments are limited to 10,000 characters. For clarification purposes, Staff may suggest revisions that would not impact the intent of the comment. All comments, including those outside of the requirements listed above are read and when possible provided to the applicable staff/unit to best receive and/or act on the feedback.

Please voluntarily provide your name and affiliation. These will not be included in the IP list of public comments.

Per California Code, WIC 5963.03 and BHSA Policy, county is required to engage a non-exhaustive list of stakeholders. The applicable stakeholder group(s) must be listed in the County's BHSA IP in association with comments provided. Comments received without a selected stakeholder group will not be included in the published BHSA IP.

If you would like to comment on more than one Project or program area we request that you submit separate responses if applicable.

SUBSTANTIVE COMMENT FORM

Name (optional)

Organization/Affiliation (optional)

Stakeholder group (Required) - Please select all that apply to the submitter(s) of this comment.

- Eligible adults and older adults (individuals with lived experience)
- Families of eligible children and youth, eligible adults, and eligible older adults (families with lived experience)
- Youths (individuals with lived experience) or youth mental health or substance use disorder organizations
- Providers of mental health services and substance use disorder treatment services
- Public safety partners, including county juvenile justice agencies
- Local education agencies
- Higher education partners
- Early childhood organizations
- Local public health jurisdictions
- County social services and child welfare agencies
- Labor representative organizations
- Veterans
- Representatives from veterans' organizations
- Health care organizations, including hospitals
- Health care service plans, including Medi-Cal Managed Care Plans (MCPs)
- Disability insurers (a commercial disability insurer that covers hospital, medical or surgical benefits as defined in Insurance Code section 106, subdivision (b))
- Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- Area agencies on aging
- Independent living centers
- Continuums of care, including representatives from the homeless service provider community
- Regional centers
- Emergency medical services
- Community-based organizations serving culturally and linguistically diverse constituents
- Representatives from youth from historically marginalized communities
- Representatives from organizations specializing in working with underserved racially and ethnically diverse communities
- Representatives from LGBTQ+ communities
- Victims of domestic violence and sexual abuse
- People with lived experience of homelessness
- Other: _____

**Fiscal Year 2025/26
El Dorado County
Mental Health (MH) Quality Improvement (QI)
Work Plan FINAL**

El Dorado County Health & Human Services Agency, Behavioral Health Division
Annual Quality Improvement (QI) Work Plan
Fiscal Year 2025-26

Measurable Goals in Red

Changes from previous year’s QI Work Plan are reflected in blue, underlined text.

The content and structure of this QI Work Plan is taken from the MHP’s contract with the State Department of Health Care Services (DHCS).

Contents

1. Quality Improvement	2
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3. Service Delivery and Capacity	3
4. Accessibility of Services	4
5. Program Integrity	5
6. Cultural and Linguistic Competency	5
7. Beneficiary Satisfaction	6
8. Service Delivery System and Clinical Issues Affecting <u>Members</u>	7
9. Interface with Physical Health Care	8
10. Utilization Management	9
11. Provider Relations	10

1. Quality Improvement

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP will evaluate effectiveness of QI program annually	Complete QI Year-End Report for FY 24-25	<ul style="list-style-type: none"> • QI Program Managers • QI Committee Members 	<ul style="list-style-type: none"> • QI Committee Minutes • Avatar Reports 	Nov. 2026
b. Members and family members shall have substantial involvement in QI activities and MHSa planning	Ensure that the QI Committee includes at least one member and one family member.	<ul style="list-style-type: none"> • QI Program Managers • QI Committee Members • MHSa Coordinator 	<ul style="list-style-type: none"> • QI Committee Sign-In Sheets and Minutes • MHSa Sign-In Sheets, Comment Forms, and Minutes 	Ongoing through June 2026
c. QI Activities shall include collaboration & exchange of information with MHSa stakeholders and BH Commission	Ensure QI representation at MHSa stakeholders' and BH Commission meetings; report progress to QI Committee	<ul style="list-style-type: none"> • BH Director • Assistant Director of Adult Services • Deputy Director of Behavioral Health • QI Program Manager • MHSa Coordinator 	<ul style="list-style-type: none"> • QI Committee Minutes • Avatar Reports • BH Dashboard 	Ongoing through June 2026

2. Performance Improvement Projects (PIPs)

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
<p>a. Two QI activities shall meet the criteria for Performance Improvement Projects (PIP), one clinical and one non-clinical</p>	<p>PIP #1 GOAL (non-clinical): Increase the percentage of members who receive at least one peer support service</p> <p>PIP #2 Goal (clinical): Increase the percentage of medication compliance of members with schizophrenia and schizoaffective disorder</p>	<ul style="list-style-type: none"> • QI Program Managers • Access Supervisor • Access Clinicians • Outpatient Clinicians 	<ul style="list-style-type: none"> • API Model for Improvement 	<p>PIP #1</p> <p>Remeasurement Year 1: July 2027 & Remeasurement Year 2: July 2028</p> <p>PIP #2</p> <p>Remeasurement Year 1: July 2027 & Remeasurement Year 2: July 2028</p>

3. Service Delivery and Capacity

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP will describe and monitor data to ensure capacity	BHD will use AVATAR reports to monitor crisis and access trends. Management Team to review data regularly to ensure adequate resource allocations.	<ul style="list-style-type: none"> •QI Program Managers •Access Supervisor •Sr. IT Analyst •MHP Leadership Team 	<ul style="list-style-type: none"> •AVATAR Reports •Leadership Team meeting minutes 	Ongoing through June 2026
b. Ensure capacity and timeliness for <u>members</u> with urgent conditions	<u>Members</u> presenting in person or on the telephone with urgent BH conditions will be served within 24 business hours of request (excludes Psychiatric Emergency Services) .	<ul style="list-style-type: none"> •Front Desk Staff •Worker of the Day Staff •Access Clinicians •Access Coordinator •QI Program Managers 	<ul style="list-style-type: none"> •AVATAR “Request for Service” report 	Ongoing through June 2026
c. Ensure capacity and timeliness	Individuals requesting service will be provided an appointment within 10 business days of request	<ul style="list-style-type: none"> •Front Desk Staff •Worker of the Day Staff •Access Clinicians •Access Coordinator •QI Program Managers 	<ul style="list-style-type: none"> •AVATAR “Request for Service” reports 	Ongoing through June 2026
d. Ensure capacity and timeliness	<u>Members</u> requesting a psychiatric evaluation appointment will be seen by a psychiatrist within 10 business days of request	<ul style="list-style-type: none"> •BH Medical Director & Staff Psychiatrists •Management Team •Front Desk Staff •Worker of the Day Staff •Access Clinicians •Access Coordinator •QI Program Managers 	<ul style="list-style-type: none"> •AVATAR reports 	Ongoing through June 2026

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<p>e. Ensure capacity and timeliness</p>	<p>Beneficiaries will have access to after-hours care via telephone, clinic and/or at the hospital emergency department 100% of the time (after hours defined as outside 8:00 am to 5:00 pm, Monday through Friday)</p>	<ul style="list-style-type: none"> ● PES Managers ● PES Clinicians ● ICM Teams ● UR Clinicians ● UR Coordinator ● QI Program Manager ● On Call Managers ● On Call Mental Health Crisis Line vendor ● Mobile Crisis Team 	<ul style="list-style-type: none"> ● AVATAR report ● Contractor reports 	<p>Ongoing through June 2026</p>
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QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
f. Clinical staff productivity	Track and trend provider productivity. Staff will bill at 65% billable productivity rate.	<ul style="list-style-type: none"> •MH Program Coordinators •MH Managers •QI Program Manager •BH Analyst 	•AVATAR Report	Ongoing through June 2026

4. Accessibility of Services

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. Ensure access lines answered by front-desk staff are providing linguistically appropriate services to callers	Outcome of Test Calls will demonstrate 80% success in accessing a bilingual staff or “Language People” for non-English speaking callers	<ul style="list-style-type: none"> •UR Coordinator •QI/UR Staff 	•Test Calls with outcomes logged	Ongoing through June 2026
b. Ensure the accessibility to medically necessary after-hours care	Beneficiaries will have access to after-hours care via telephone and/or at the hospital emergency department 80% of the time (after hours defined as outside 8:00 am to 5:00 pm, Monday through Friday)	<ul style="list-style-type: none"> •PES Managers •PES Clinicians •Contract Providers 	<ul style="list-style-type: none"> •AVATAR report •Contractor reports 	Ongoing through June 2026
c. Ensure time and distance standards are met	<ul style="list-style-type: none"> • For psychiatry, travel time and distance shall not exceed 45 miles or 75 minutes • For other outpatient Specialty Mental Health Services, travel time and distance shall not exceed 45 miles or 75 minutes 	<ul style="list-style-type: none"> •UR Coordinator •QI/UR Staff 	<ul style="list-style-type: none"> •AVATAR report •Geographic mapping program (e.g., ArcGIS) 	Ongoing through June 2026

5. Program Integrity

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP shall have a process to verify services reimbursed by Medi-Cal were actually furnished to beneficiaries	The service verification tool was implemented July 2013. 80% of services verified were confirmed by member. Corrective action will be taken with staff 100% of the time if indicated.	<ul style="list-style-type: none"> •UR Coordinator •Admin Support Staff •QI Program Manager •Management Team 	<ul style="list-style-type: none"> •Service Verification Log 	Ongoing through June 2026
b. MHP shall monitor the no-show rate for psychiatry and outpatient services, including services provided by its contracted providers.	For psychiatry, the no-show rate goal is 10%. For clinicians, the no-show rate goal is 15%.	<ul style="list-style-type: none"> •UR Coordinator •QI/UR Staff •Clinic/Admin Support Staff •QI Manager 	<ul style="list-style-type: none"> •AVATAR Report 	Ongoing through June 2026

6. Cultural and Linguistic Competency

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP shall ensure services are provided in culturally and linguistically competent manner	BHD will require staff complete at least four hours of training annually to build cultural and linguistic competency. BHD will hold a monthly Diversity, Equity, and Inclusion Committee to engage stakeholders in ensuring the MHP is providing service in a culturally competent manner.	<ul style="list-style-type: none"> •Management Team •Cultural Competency Manager 	<ul style="list-style-type: none"> •Training Attendance Log & Outlines/Handouts •Diversity, Equity, Inclusion Committee 	Ongoing through June 2026
b. MHP shall ensure services are provided in culturally and linguistically competent manner	HHSA will certify bilingual and cultural competence of all staff receiving bilingual compensation	<ul style="list-style-type: none"> •EDC Personnel Unit 	<ul style="list-style-type: none"> •HR report 	Ongoing through June 2026

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
c. MHP shall update the Cultural Competence Plan (CCP) and submit these updates to DHCS for review and approval annually	CCP shall be updated in compliance with State issued requirements.	<ul style="list-style-type: none"> •MHSA Coordinator •QI/QA Manager 	<ul style="list-style-type: none"> •CCP •DHCS Notices 	Annually, as requested by DHCS

7. Beneficiary Satisfaction

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP shall monitor and Evaluate Beneficiary Satisfaction	BHD shall administer the Consumer Perception Surveys at least once annually or at other intervals specified by the State. BHD will evaluate outcomes data to drive impactful changes in service delivery with support from the QIC.	<ul style="list-style-type: none"> •Admin Support Staff •Front Desk Staff •Members / Family of Members (for children) •Organizational Providers •UR Coordinator 	<ul style="list-style-type: none"> •Consumer Perception Survey issued by DHCS, supported by CIBHS or other contracted vendor •Data Analysis of CPS •QIC meeting minutes 	May 2026, or per the timeline set by the State.
b. MHP shall inform service providers of the results of beneficiary/family satisfaction activities	BHD will report results of Consumer Perception Surveys to BHD staff and contracted organizational providers	<ul style="list-style-type: none"> •Admin Support Staff •UR Coordinator •QI Program Manager 	<ul style="list-style-type: none"> •All-Staff meeting minutes •CBO meeting minutes •Emails •QIC meeting minutes 	Generally, twice per year, after the data from the previous Consumer Perception Survey becomes available and is analyzed

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QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
c. MHP shall evaluate beneficiary Grievances, Appeals, Expedited Appeals, State Hearings, Expedited State Hearings, and change of provider requests	BHD will track and trend programmatic or staffing issues identified in Grievances, Appeals, Expedited Appeals, State Hearings, Expedited State Hearings, and Requests for Change of Provider, identifying and correcting any indications of poor quality of care.	<ul style="list-style-type: none"> •UR Coordinator •Patients’ Rights Advocate •MHSA Coordinator •Management Team 	<ul style="list-style-type: none"> •Tracking logs •QIC Minutes •Management Team Minutes •Behavioral Health Commission minutes 	Ongoing through June 2026
d. MHP shall evaluate MHSA disputes (Issue Resolution)	MHP will track and trend MHSA Issue Resolutions, identifying and correcting any indications of program changes.	<ul style="list-style-type: none"> •MHSA Coordinator •BH Analyst •MHSA Manager 	<ul style="list-style-type: none"> •Tracking logs •QIC Minutes 	Ongoing through June 2026

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8. Service Delivery System and Clinical Issues Affecting Members

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QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
<p>a. MHP shall implement mechanisms to monitor safety and effectiveness of medication practices</p>	<p>BHD will conduct a quarterly Med Monitoring Committee which provides oversight of the safety and effectiveness of outpatient medication practices through a 5% audit of charts for <u>members</u> receiving medication from EDCBH. When findings are made, 100% of findings will be corrected by the responsible practitioner.</p>	<ul style="list-style-type: none"> •BH Medical Director •Assistant Director of Health Services •Community Public Health Nursing Division Manager •QI Program Manager •UR Coordinator 	<ul style="list-style-type: none"> •Med Monitoring Committee minutes •QIC meeting minutes 	<p>Ongoing (quarterly meetings) through June 2026</p>
<p>b. MHP shall conduct performance outcome monitoring activities.</p>	<p>BHD has selected the CANS and the PSC-35 instruments to measure treatment outcomes for Children’s Services. BHD will aggregate data to evaluate outcomes and drive systemic changes, if needed. BHD is evaluating a streamlined tool for measuring treatment outcomes for adults.</p>	<ul style="list-style-type: none"> •UR Coordinator •Avatar System Specialist •QI Program Manager •MHP Leadership Team 	<ul style="list-style-type: none"> •AVATAR report comparing baseline data to data collected at regular intervals 	<p>Ongoing through June 2026</p>

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
c. MHP shall ensure that progress notes are timely.	BHD’s standard for note completion: by end of business, 3 business days following delivery of the service. Reason for late note will be explained in the progress note for notes entered 5 days past date of service. GOAL: standard will be met 80% of the time.	<ul style="list-style-type: none"> •UR Coordinator •Avatar System Specialist •QI Program Manager •MHP Leadership Team 	<ul style="list-style-type: none"> •AVATAR timeliness report 	Ongoing through June 2026
d. MHP shall monitor clinical issues affecting <u>members</u>	Continue to develop AB 109 program, targeting BH <u>members</u> involved in the criminal justice system. GOAL: Improvement in BH recovery and decrease in criminal justice system recidivism.	<ul style="list-style-type: none"> •AB 109 Manager, Program Coordinator and Clinical Staff 	<ul style="list-style-type: none"> •QIC meeting minutes 	Ongoing through June 2026
e. MHP shall monitor <u>member</u> services for over- and under-utilization of services.	<p>15% of all children’s charts shall be monitored once per year. Outcomes shall be reported back to the contracted provider.</p> <p>15% of all adult charts shall be monitored once per year. Outcomes shall be reported back to each practitioner’s Supervisor and Manager.</p>	<ul style="list-style-type: none"> •QI Program Manager •UR Coordinator •Access Team Clinicians •Fiscal Team 	<ul style="list-style-type: none"> •Avatar Utilization Report 	Ongoing through June 2026

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9. Interface with Physical Health Care

Fiscal Year 2025-26

QI Directive	Goal	Responsible Parties	Auditing Tool	Goal Assessment Date
a. MHP shall make clinical consultation and training available to beneficiaries' primary care providers (PCP)	BHD will provide training to PCPs at the FQHC on an as requested basis. BHD will also develop a protocol for standardizing and tracking psychiatric/PCP consultation.	<ul style="list-style-type: none"> •BH Medical Director •Assistant Director of Health Services •FQHC Medical Director •QI Program Manager •UR Coordinator 	•Training sign-in sheet and outline/handouts	Ongoing through June 2026

10.Utilization Management

QI Directive	Goal	Responsible Parties	Auditing Tool	Goal Assessment Date
<p>a. MHP shall evaluate inpatient medical necessity appropriateness and efficiency of services provided to beneficiaries prospectively and retrospectively</p>	<p>80% of all out-of-county Hospital Treatment Authorization Requests (TAR) shall be completed within 14 days of receipt of request.</p>	<ul style="list-style-type: none"> •UR Coordinator •Admin Support Staff •QI Program Manager •Crisis Clinicians •Contracted provider “Kepro” to complete TARs 	<ul style="list-style-type: none"> •TAR Log •Crisis Assessment Report •Invoice from “Kepro” 	<p>Ongoing through June 2026</p>
<p>b. MHP shall evaluate medical necessity appropriateness and efficiency of outpatient services provided to beneficiaries prospectively and retrospectively.</p>	<p>At the time of initial assessment, each individual SMHS service, and re-assessment, the assigned clinician will ensure that medical necessity is established 100% of the time. The MHP will evaluate medical necessity and efficiency of outpatient services during routine quarterly audits. Subcontractors of the MHP will evaluate medical necessity and efficiency of outpatient services during routine quarterly audits. Findings will be submitted for further corrective action (i.e. training, moving member to higher/lower level of care)</p>	<ul style="list-style-type: none"> •UR Clinical Staff •QI Program Manager •BH Program Coordinators •UR Coordinator •Avatar System Specialist 	<ul style="list-style-type: none"> •Avatar reports; assessment reviews; service authorization requests 	<p>Ongoing through June 2026</p>

QI Directive	Goal	Responsible Parties	Auditing Tool	Goal Assessment Date
c. MHP shall comply with timeliness when processing of submitting authorization requests for children in foster care or Kin-Gap living outside county of origin	80% of authorizations for Out-of-County children shall be completed within 3 calendar days from the receipt of the original Service Authorization Request (SAR). If complete additional information is requested and not received within 14 days from the date of receipt of the original SAR, the BHD shall complete the SAR within 3 business days from the date the complete additional requested information is received.	<ul style="list-style-type: none"> •UR Clinical Staff •QI Program Manager •UR Coordinator 	<ul style="list-style-type: none"> •Managed Care Authorization Binder 	Ongoing through June 2026

11.Provider Relations

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
a. MHP has ongoing monitoring system in place that ensures contracted providers sites are certified and recertified as per Title 9 regulations	BHD will certify and re-certify all contracted provider sites meeting 80% compliance in the following manner: <ul style="list-style-type: none"> •Within state required time frames of a new contracted provider or if current contracted provider changes/adds locations, certifications will be performed as needed to maintain compliance with current state requirements. •Re-certify every 3 years thereafter. 	<ul style="list-style-type: none"> •QI/UR Staff 	<ul style="list-style-type: none"> •Certification Protocol from DHCS 	Ongoing through June 2026

QI Directive	Goal	Responsible parties	Auditing Tool	Goal Assessment Date
b. Monitor Provider Satisfaction	BHD will conduct as-needed meetings of BHD senior management and Contract Provider Management.	<ul style="list-style-type: none"> • BH Director • Assistant Director of Health Services • QI Program Manager • UR Coordinator 	<ul style="list-style-type: none"> • CBO meeting minutes 	Ongoing through June 2026
c. Monitor FSP Reporting	80% reported timely.	<ul style="list-style-type: none"> • FSP Report Monitors • UR Coordinator 	<ul style="list-style-type: none"> • State website • Tracking document 	Ongoing through June 2026
d. Monitor Provider Appeals	BHD will track and trend issues identified in Provider Appeals.	<ul style="list-style-type: none"> • UR Coordinator • MHSA Coordinator • Management Team 	<ul style="list-style-type: none"> • Tracking Logs • QIC Minutes • Meeting Minutes 	Ongoing through June 2026

As appropriate, the MHP will track and trend outcomes over time to determine any ongoing needs and provide those trends to the QIC. The QIC will review actions taken for previously identified issues, targeted areas of improvement, or changes in service delivery.

**Fiscal Year 2025/26
El Dorado County
Drug Medi-Cal Organized Delivery System
(DMC-ODS)
Quality Improvement (QI)
Work Plan FINAL**



EL DORADO COUNTY BEHAVIORAL HEALTH
SUBSTANCE USE DISORDER SERVICES
QUALITY IMPROVEMENT PLAN

County of El Dorado
SUDS Quality Assurance
July 2025

Quality Management

It is the goal of El Dorado County Drug Medi-Cal Organized Delivery System (EDC DMC-ODS) to build a structure that ensures the overall quality of services. This goal is accomplished by realistic and effective quality improvement activities and data-driven decision-making; collaboration amongst staff, including consumer/family member staff; and utilization of technology for data analysis. Through data collection and analysis, significant trends are identified, and policy and system-level changes are implemented, when appropriate. Executive management and program leadership is crucial to ensure that findings are used to establish and maintain the overall quality of the service delivery system and organizational operations.

Quality Management (QM) monitors member and system outcomes, provider credentialing and monitoring and resolution of beneficiary grievances and appeals. Quality Management activities ensure linguistically and culturally accessible, quality-focused, evidence-based and appropriate treatment services. Their purpose is to assess performance against best practice guidelines to ensure that services follow generally accepted standards of clinical practice and to continuously improve service delivery. The EDC DMC-ODS Quality Management Program encompasses the following activities:

- Monitoring the accessibility, delivery and capacity of services and attainment of service quality benchmarks and ensuring services are provided in a linguistically and culturally competent manner.
- Ensuring provider network adequacy and retention and compliance with program requirements.
- Submitting quality performance measurement data to the state in compliance with reporting requirements.
- Assessing the quality and appropriateness of care provided to members with special health care needs.
- Assessing member satisfaction and resolution of grievances.
- Facilitating the External Quality Review Organization (EQRO) evaluation processes; and

- Conducting at least two ongoing quality improvement projects as part of the process of continuous quality improvement (CQI).

Quality Management Work Plan

A guiding document for EDC DMC-ODS quality management activities is the Quality Management Work Plan. Its purpose is to provide actionable information to the [Quality Improvement Committee](#) (QIC) on the quality of EDC DMC-ODS services to:

- Identify targeted areas for improvement.
- Monitor activities for sustaining improvement for previously identified issues, including tracking issues over time.
- Track progress and outcomes of at least two quality improvement projects selected from targeted areas for improvement each contract cycle, with one having a clinical focus and one administrative.

The Quality Management Plan is reviewed and updated at least once each calendar year by the County SUDS Quality Assurance (QA) staff. Quality is audited continuously at defined intervals by EDC DMC-ODS program management using defined [Quality Management Benchmarks and Processes](#).

Each quarter, EDC DMC-ODS quality management compiles data from this ongoing monitoring into quality performance reports that are provided to the QIC for review at its monthly meeting. Data includes:

- Number of days to the first DMC-ODS service encounter at appropriate level of care after referral.
- Existence of a 24/7 telephone access line with prevalent non-English languages.
- Timely access to DMC-ODS services with translation services in prevalent non-English languages.
- Number and percentage of denied authorization requests; and
- Time period of authorization requests approved or denied.

Quality Improvement Committee

El Dorado County operates an integrated Quality Improvement Committee (QIC) to oversee quality management of the EDC DMC-ODS. Reporting to the EDC DMC-ODS Quality Program manager, the QIC supports quality management and continuous quality improvement of the variety of program/services under the El Dorado County Behavioral Health Department including mental health and substance abuse treatment.

The Quality Improvement Committee is composed of the Behavioral Health Director; Mental Health and Substance Use Medical Director(s); Mental Health Plan Quality Improvement Coordinator & Manager of Mental Health Programs; Alcohol and Drug (AOD) Administrator/designee; Patient's Rights Advocate; Cultural Competency Chairperson; Behavioral Health Commission designee, a Certified Addiction Treatment Counselor, a Licensed Mental Health Professional, two contract provider representatives, and eight plan member or family representatives. Other members and stakeholders may be added as necessary and may include additional contract providers or liaisons for programs provided through the Plans, family and plan members, administration and other program service staff.

QIC Subcommittees

The QIC contains two subcommittees to address issues that raise immediate quality of care concerns: one assigned to the Mental Health Plan (MHP) and one assigned to EDC DMC-ODS. These subcommittees convene on an ad hoc basis at the request of EDC DMC-ODS program management and report their activities to the core QIC for review at the QIC's monthly meetings.

Key responsibilities of the QIC are to:

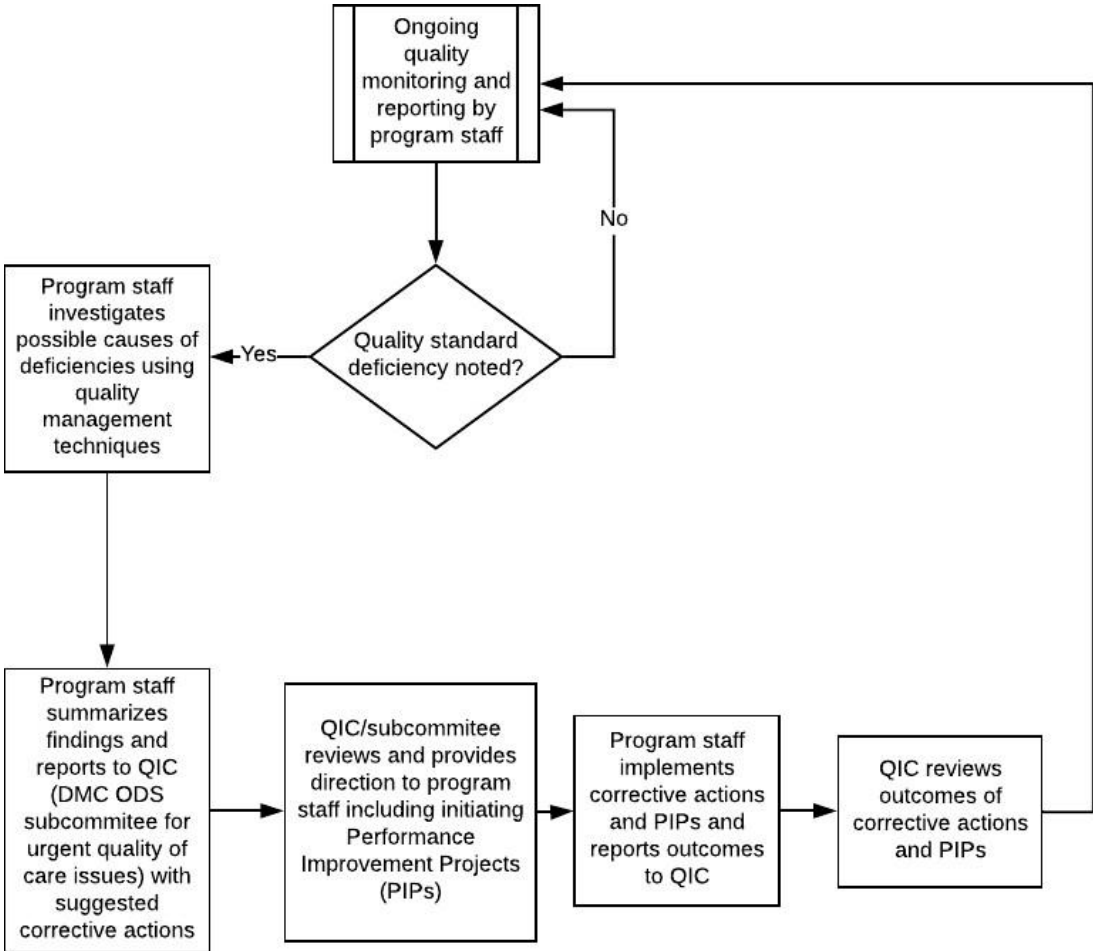
- Annually evaluate the overall effectiveness of the Quality Management Plans utilizing data to demonstrate that quality management activities have contributed to meaningful improvement in clinical care and member service.
- Develop quality improvement objectives and activities for the coming year.

- Monitor previously identified issues, including tracking issues over time through data analysis; and
- Oversee activities for sustaining quality improvement.

Key functions of the QIC:

- Reviews and evaluates quality improvement activities.
- Implements quality assurance (QA) projects and actions.
- Follows up on quality improvement processes.
- Documents QIC minutes.
- Suggests policy considerations.
- Reviews the Quality Management Plans and its effectiveness annually during the External Quality Review Organization (EQRO) review.
- Submits the Quality Management Plan and effectiveness reports to California Department of Health Care Services annually.
- Reviews attainment of EDC DMC-ODS quality benchmarks quarterly using reports provided by the SUDS QA Supervisor or designee.
- Assures that quality activities are completed and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities, including [Performance Improvement Projects](#). This feedback loop helps to monitor previously identified issues and provides an opportunity to track issues over time.
- Continuously conducts planning and initiates new activities for sustaining improvement. The following figure provides an overview of EDC DMC-ODS quality process:

Overview of the Continuous Quality Improvement Process



Performance Improvement Projects

Performance improvement projects (PIPs) are systemic interventions to achieve improvements having the widest impact on program quality. They are designed to achieve significant improvement in clinical and non-clinical care areas expected to have a favorable, sustainable effect on health outcomes and plan member satisfaction.

Performance improvement projects focus on at least one clinical area and one non-clinical area, evaluate the effectiveness of interventions and the plan, and initiate activities for increasing or sustaining improvement. In consultation with EDC DMC-ODS management, the QIC reviews reported deficiencies and proposed remediation actions based on the [Quality Management Benchmarks and Processes](#).

The QIC designates and oversees at least two performance improvement projects on an ongoing basis and evaluates their effectiveness. The purpose of the evaluation is to determine what quality interventions worked, which didn't and the reasons. This in turn will help refine ongoing performance improvement projects and define new projects using learnings from previous projects. Each PIP is to be completed in a reasonable time period to generally allow information on the success of PIPs taken together to produce new information on quality of care annually.

Quality Management Work Plan Benchmarks and Processes

Quality Standard	Quality Benchmark	Quality monitoring tools and measurement processes	Benchmark Assessment Timeframe
Accessibility of Services			
Timeliness of first initial contact to face-to-face appointment or synchronous video or audio-only interaction, consistent with BHIN 23-018 or any subsequent Departmental guidance.	Within 10 business days following initial request for services.	<ul style="list-style-type: none"> Review of Timeliness Reports and Level of Care Reports 	Quarterly
Timeliness of first initial contact to face-to-face appointment for members with ASAM LOC 2.1 or lower.	Within 10 business days following initial request for outpatient services.	Utilization review of member clinical records.	Quarterly
Timeliness for scheduling of routine appointments for members with ASAM LOC 2.1 or lower.	Within 10 business days of member request.	Utilization review of member clinical records.	Quarterly

<p>Time and distance standards for member access to services.</p>	<ul style="list-style-type: none"> • For outpatient services other than opioid treatment programs (OTPs), travel time and distance shall not exceed 90 minutes or 60 miles from member's place of residence. • For opioid treatment programs (OTPs), travel time and distance shall not exceed 75 minutes or 45 miles from member's place of residence. 	<p>Review of applications for services and member residence addresses relative to services provided.</p>	<p>Quarterly</p>
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Timeliness of services for urgent conditions for members with ASAM LOC 3.1, 3.5, or 3.2-WM.	Within 72 hours of request.	Utilization review of member clinical records.	Quarterly
Access to after-hours care.	<ul style="list-style-type: none"> • Access to 24/7 access line. • Availability of on-call staff. 	<ul style="list-style-type: none"> • Test calls by DMC ODS management staff. • Review of complaints by public and plan applicants and members. • Contract provider site reviews. 	Random, at least Quarterly
Responsiveness of the access line.	24 hours a day, 7 days a week.	<ul style="list-style-type: none"> • Test calls by DMC ODS management staff. • Review of complaints by public and plan applicants and members. 	Random, at least Quarterly
Waitlist time for residential treatment.	10 Business Days	Utilization review of member's clinical records.	Quarterly
Timeliness of response to prior authorization requests.	Within 24 hours of request being submitted by provider.	Utilization review of member clinical records.	Quarterly
Number and percentages of prior authorization approved/denied.	Accurate recordkeeping of these occurrences.	Utilization review of AVATAR records.	Annually
Telephone access line services in the prevalent non-English languages.	Access line service in Spanish.	<ul style="list-style-type: none"> • Test calls by Spanish speaking certified DMC-ODS management staff. • Review of complaints by public and plan applicants and members. 	Random, at least Quarterly
Services are culturally and linguistically accessible.	<p>Access line service in Spanish as well as English.</p> <p>Zero substantiated complaints from applicants</p>	<ul style="list-style-type: none"> • Test calls by Spanish speaking certified DMC ODS management staff. 	Ongoing, at least Quarterly

	<p>and members of cultural and/or linguistic barriers to accessing services.</p> <p>Updated cultural competency plan.³</p>	<ul style="list-style-type: none"> • Review of complaints by public and plan applicants and members. • Contract provider site reviews. 	
<p>Ensuring provider directory updated and accurate particularly re cultural competency and disabled access.</p>	<p>Paper directory updated at least monthly.</p> <p>Electronic provider directory updated no later than 30 calendar days after EDC DMC ODS receives updated provider information.⁴</p>	<ul style="list-style-type: none"> • Review of paper and electronic provider directories and information updates from providers. • Review of provider directory inaccuracy complaints by public and plan applicants and members. • Review of complaints by public and plan applicants and members regarding cultural competency and disabled access. • Contract provider site reviews. 	<p>Monthly</p>
<p>Members with physical or mental disabilities afforded physical access, reasonable accommodations and accessible equipment.</p>	<p>Zero substantiated member complaints of disability access issues.</p>	<ul style="list-style-type: none"> • Review of complaints by public and plan applicants and members. • Contract provider site reviews. 	<p>Annually</p>

Selection and retention of providers.	In accordance with Selection and Retention of Network Providers process.	Review of provider selection and retention processes to check if procedures followed.	Prior to provider contract awards and renewals.
Member handbook provided to members within reasonable time following enrollment.	Within 5 business days.	Review of member records; records shall note how and when Member Handbook provided.	Annually

Quality Standard	Quality Benchmark	Quality monitoring tools and measurement processes	Benchmark Assessment Timeframe
Quality of Services and Member Satisfaction			
Criteria governing admissions, continued care and discharge planning utilized to assure that maximum benefit is obtained by members at each ASAM LOC and that transitions between LOC occur in a timely and coordinated manner.	Adherence to contract specified criteria.	<ul style="list-style-type: none"> • Utilization review of member clinical records. • Contract provider site reviews. 	Annually
Initial screening of member needs.	Within 90 calendar days of date of enrollment including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.	<ul style="list-style-type: none"> • Utilization review of member clinical records. 	Annually
Timeliness of services of the first dose of Narcotic Treatment Program (NTP) services.	Within three business days	<ul style="list-style-type: none"> • Utilization review of member clinical records. 	Quarterly
Safety and effectiveness of medication practices.	Adherence to Monitoring safety and effectiveness of medication practices.	<ul style="list-style-type: none"> • Utilization review of member clinical records. • Contract provider site reviews. 	Annually
Coordination of services by providers with physical and mental health services and training of care	Appropriate treatment for a co-occurring client with behavioral health and SUDS	Review of SUD and MHP clinical records, problem lists, and progress notes to ensure case management	Ongoing, at least Annually

<p>coordinator on coordination procedures.</p>	<p>and case management utilized to facilitate coordination along with Multi-Discipline Team Meetings, peer supports, and the utilization of natural supports.</p>	<p>utilized to facilitate coordination along with Multi-Discipline Team Meetings, peer supports, and the utilization of natural supports.</p>	
<p>Problem identification/treatment planning for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring.</p>	<ul style="list-style-type: none"> • Developed with member participation, and in consultation with any providers. • Developed by a clinician trained in person-centered planning using a person-centered process and plan; • Approved by DMC ODS management in a timely manner, if this approval is required by the Contractor; • In accordance with any applicable DHCS quality assurance and utilization review standards; and • Reviewed and revised upon reassessment of 	<ul style="list-style-type: none"> • Utilization review of member clinical records. 	<p>Ongoing, at least Annually</p>

	<p>functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member. ¹⁰</p> <ul style="list-style-type: none"> • Provisions to allow member to directly access a specialist as appropriate for the member's condition and identified needs. 		
Frequency of follow-up appointments in accordance with individualized needs.	Reflected in member's problem list.	<ul style="list-style-type: none"> • Utilization review of member clinical records. 	Ongoing, at least Annually.
Strategies to reduce avoidable hospitalizations.	Reflected in member's problem list.	<ul style="list-style-type: none"> • Utilization review of member clinical records. 	Ongoing, at least Annually
Monitoring and appropriate, timely intervention for occurrences that raise quality of care concerns.	Appropriate intervention is initiated when such an occurrence is identified.	<ul style="list-style-type: none"> • Utilization review of member clinical records. • Contract provider site reviews. • Review of member complaints and grievances. • Review of timeliness and effectiveness of intervention in 	<ul style="list-style-type: none"> • Ongoing monitoring • Effectiveness of interventions reviewed quarterly

		addressing quality of care issue identified.	<ul style="list-style-type: none"> Effectiveness of interventions evaluated at least annually.¹²
Complaints, grievances, and appeals.	Adherence to N-SUDS-003 Grievances, Appeals & Fair Hearing.	Management review of complaints, grievances and appeals to ensure procedures followed.	Monthly.
Assessing member satisfaction.	Member/ Family satisfaction will be assessed annually	<ul style="list-style-type: none"> satisfaction survey of the county's services Evaluating beneficiary grievances, appeals, and requests for state fair hearings Evaluating requests to change persons providing services Informing providers of the results of beneficiary / family satisfaction activities. 	Annually
Provider staff training before services are delivered to members.	2 ASAM E Modules	Provider attestation and compliance monitoring of provider employee records	Upon hire and annual monitoring
Utilization Review - Services are medically necessary, rendered at the appropriate ASAM Level of Care, and interventions are appropriate for the diagnosis and Level of Care	Services are provided in the appropriate setting or manner required for the beneficiary's medical condition-the right care at	<ul style="list-style-type: none"> Utilization review of member clinical records in accordance with Utilization Review Process 	Ongoing, at least Annually

	the right time in the right setting;		
Use of evidence based clinical practices used by providers.	<p>At least two of the following evidence-based practices utilized:</p> <ul style="list-style-type: none"> • Motivational Interviewing • Cognitive Behavioral Therapy • Relapse Prevention • Trauma-Informed Treatment • Psychoeducation 	<ul style="list-style-type: none"> • Utilization review of member clinical records. 	Annually
Notice to current members of change to their services.	At least 30 days before effective date of change. ¹³	<ul style="list-style-type: none"> • Utilization review of member clinical records. 	Annually

Quality Management Work Plan Quality Improvement Activities

Goal	Activity	Steps to Achieve Goal	Benchmark Assessment Timeframe
<p>Improve client access to culturally competent and linguistically appropriate SUD services by targeting underserved communities within El Dorado County and increasing Latinx and other minority enrollment by 5% in FY 25-26</p>	<p>Conduct outreach activities with community coalitions to increase Latinx participation in committee meetings to inform processes that increase enrollment in services.</p>	<ul style="list-style-type: none"> • Leverage community partnerships to engage minority populations to address access to care issues by 06/30/2026 • Invite minority beneficiaries and community members to Cultural Committee meetings by 06/30/2026 • Utilize recommendations to update Cultural Competence Plan by 06/30/2026 • Implement changes based on recommendations by 06/30/2026 	<p>Annually</p>
<p>Reduce follow-up time after Emergency Department visit by increasing the number of individuals that receive follow-up care within 7 & 30 days by 10 percent.</p>	<p>Credential Marshall Medical staff to provide assessments and meet with LPHA's to establish medical necessity reducing time it takes to receive services after ED visit.</p>	<ul style="list-style-type: none"> • Monthly collaborative with MM staff to respond to challenges and reduce barriers to care. • Quarterly data review to identify bottlenecks and points of failure 	<p>Quarterly</p>
<p>Increase by 10% the MOUD Maintained 180+ Days without an 8+ day gap.</p>	<p>Utilize the provider's Notice of Adverse Benefit Determination's as a triggering event to contact client to re-engage with services.</p>	<ul style="list-style-type: none"> • Assign County Health Education Coordinator to receive NOABD and call the client to attempt reengagement. 	<p>Quarterly</p>

		<ul style="list-style-type: none"> Weekly meeting with Aegis and County to maintain correct contact information and processes. 	
Increase the percentage of members who receive at least one Peer Support Service.	Increase provider's use of Peer Support Specialists to engage with El Dorado County beneficiaries.	<ul style="list-style-type: none"> Connect with providers that utilize Peer Support Specialists to design a plan where PSS are utilized for EDC clients. Utilize county analysts to verify data through DHCS claims. 	Quarterly
Improve satisfaction with coordination of care between MH and PCP by 10%.		<ul style="list-style-type: none"> Provide educational material to beneficiaries describing care coordination practices by July 1, 2026 Provide additional training for care coordinators improving quality of services by 01/31/2026 	Annually
Work with the DHCS supported Quality Health and Equity Workplan to improve processes to increase the initiation and engagement in treatment, focusing specifically on initiation.	County QA staff will update the Access and care coordination efforts to increase client's initiation in treatment. This includes receiving 1 qualifying service within 14 days after diagnosis.	<ul style="list-style-type: none"> Implement an updated access and care coordination process Collaborate with outpatient providers on the updated County involvement in assuring client's initiation into treatment. County staff tracking necessary data to ensure initiation into treatment. 	Monthly

Quality Standard Deficiency Investigation and Remediation Steps

Step	Action	When performed	Responsible parties
1	<p>Investigate possible causes of deficiencies using quality management techniques as appropriate including but not limited to:</p> <ul style="list-style-type: none"> • Review of processes involved in area of deficiency including flow of service delivery and information to identify potential quality gaps and root causes. • Interviews of program staff, contract management and plan members. • Review of applicant and member complaints and grievances. 	<ul style="list-style-type: none"> • Quarterly upon direction by QI Committee • Within two business days upon learning of issues that raise immediate quality of care concerns 	Program management
2	Summarize findings of investigation and develop suggested corrective action steps for QI Committee approval.	<ul style="list-style-type: none"> • Quarterly • For deficiencies that raise immediate quality of care concerns, NLT than two business days following completion of Step 1 investigation. 	Program management
3	Selection and approval of recommended corrective action steps.	<ul style="list-style-type: none"> • Quarterly • For deficiencies that raise immediate quality of care concerns, NLT than two business days 	<ul style="list-style-type: none"> • QI Committee • EDC DMC ODS QI Subcommittee

		following referral by program management.	
4	Implement corrective action(s) and prepare report to QIC on outcomes.	<ul style="list-style-type: none"> Quarterly upon QI Committee direction. For deficiencies that raise immediate quality of care concerns, NLT than two business days following direction by QI Subcommittee. 	Program management
5	Review outcomes and effectiveness of corrective actions, adjusting as needed.	Quarterly	QI Committee
6	Selection of identified deficiencies for potential inclusion in at least two quality improvement projects, one in program administration and one in clinical services delivery.	Quarterly	<ul style="list-style-type: none"> QI Committee Program management
7	Development, implementation, and monitoring of quality improvement projects. RR Spreadsheet Item # 77 EL Dorado County DMC-ODS QM Work Plan Updated.docx	Quarterly following QI Committee direction. Projects shall be completed, and outcomes reported within one calendar year after assignment by QI Committee.	Program management
8	Review of quality improvement project outcomes.	Quarterly and annually.	QI Committee

Substance Use Disorder Services DMC-ODS Utilization Review Frequency and Sampling Process

As stated in El Dorado County Behavioral Health Policies, plan will conduct UR audits of clinical documentation utilizing an agreed upon sampling method and frequency to ensure services and related documentation are medically necessary and comply with CalAIM documentation reform standards as well as all applicable laws and regulations. The following process provides a more detailed description of the frequency of reviews and sampling method utilized.

UTILIZATION REVIEW FOR RESIDENTIAL TREATMENT

Residential treatment is for the purpose of stabilization prior to a transition to a lower level of care. The Intergovernmental Agreement requires authorization to access DMC-ODS residential treatment services.

A beneficiary's length of stay for residential treatment services shall be determined by a Licensed Practitioner of the Healing Arts (LPHA) and based on medical necessity and individualized clinical need. The statewide goal for the average length of stay for residential treatment services is 30 days. The goal for a statewide average length of stay for residential services of 30 days is not a quantitative treatment limitation or hard "cap" on individual stays. In furtherance of that goal, counties shall adhere to the length of stay monitoring requirements set forth by DHCS.

Initial residential lengths of stay will be for thirty (30) days and residential clients will be assessed and have a discharge plan developed to ensure a seamless transition to another level of care before completion of the initial episode.

If the provider believes, in their clinical judgment, that the initial authorization period is insufficient and that the beneficiary is not yet stabilized or ready for transition to a lower level of care, the following process will be followed:

Extension Request Authorization Request Process

1. Seven (7) business days prior to expiration of the previous authorization, the provider will submit the Extension Request Packet, which includes the following:

- Treatment Extension Request form
- Verification of EDC Medi-Cal benefits
- Current Problem List
- Documentation of current moderate or severe level substance use disorder
- Continuing care ASAM assessment and LOC recommendation with LPHA signature
- Document describing what medically necessary services the beneficiary requires that cannot be provided at an outpatient or intensive outpatient level
- Document describing goals that have not yet been met and a timeline for expected implementation and completion of the goals that have not yet been met.

2. Extension Request – Late Request Form required if request is not submitted before seven (7) business days prior to expiration of previous authorization.

3. The QA/UR Clinician will review the extension authorization request and make a re-authorization determination within three (3) business days.

Quarterly Record Review Process

In addition to QA reviews of residential TARs, SUDS QA will review a sample of five percent (5%) of all DMC-ODS residential charts/electronic health records per quarter to assess that beneficiaries have appropriate access to SUD services, that services are medically necessary, that the ASAM Criteria were used to determine placement into the appropriate level of care, that the interventions are appropriate for the diagnosis and level of care and detect possible underutilization or overutilization of services.

Sampling of Records for Quarterly Reviews

Within 30 calendar days of each quarter's conclusion, the sampling of records will be completed by the QA Supervisor or designee. QA Supervisor or designee will begin by

accessing Dimensions database and creating a spreadsheet report of all services provided in the previous quarter. The report will then be stratified by level of care. Once stratified, the records will be randomized utilizing the excel randomization function to identify the sample of five percent (5%) of services provided within the quarter being sampled. Quarterly UR's cycle will conclude within 45 calendar days of sample identification.

UTILIZATION REVIEW FOR OUTPATIENT AND OTHER TREATMENT SERVICES

SUDS QA and/or contracted providers will regularly assess the utilization of outpatient, intensive outpatient, OTP, case management and recovery services and transition clients to lower or higher levels of care as medically necessary or indicated.

Every client will be transitioned from one level of care to another in a collaborative way and per the County Policy N-SUDS-002 Continuity and Care Coordination.

SUDS QA will review at minimum five percent (5%) of all DMC-ODS client charts/electronic health records per quarter to assess possible underutilization or overutilization of services, per the Department's BH-184 Policy.

SUDS QA reserves the right to determine underutilization or overutilization of services and to transition any client to another level of care as indicated by medical necessity and ASAM criteria.

Sampling of records will follow same procedure as residential, but with the focus on outpatient levels of care.

BIANNUAL CLINICAL RECORDS REVIEW

DMC-ODS services County and contracted service providers will be subject to periodic internal sampling reviews on a quarterly basis. Decisions on sampling may be modified for the DMC-ODS depending on system needs but will use criteria such as the selection of claims will be based on the following criteria: high cost paid claims (of 200 dollars or more), claims that show higher than usual times claimed and paid claims which appear to be duplicates.

The SUDS QA Team will select at least ten (10) paid claims to ensure appropriate billing and to ensure the documentation meets County, State and Federal documentation standards. SUDS QA team will provide feedback to the supervisor and manager of the county unit and/or contracted clinic reviewed and follow-up will be conducted to ensure that any non-compliant services have been appropriately repaid, as necessary.

All County and contracted provider billed services will be subject to sampling reviews at least biannually, and if the error rate is greater than 5% the next review will be conducted within three (3) months. Sampling will follow the same process described above. The report on the findings will go to the SUDS QA coordinator and supervisor providing oversight to that contractor. SUDS QA will facilitate technical assistance with provider staff and/or corrective action plan if indicated.

El Dorado County Integrated Plan Budget Template (Version 3 04.06.206)

Instructions

Counties shall report their planned expenditures for all behavioral health funding sources, not limited to only BHSA, along the Behavioral Health Care Continuum in Tab One. For Annual Updates, counties should review and make updates only to the next fiscal year. For Intermittent Updates, counties should review and make updates to the current fiscal year.

Column C: counties shall indicate whether they provide each category of services using the check box.

Columns D through I: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs by each Behavioral Health Care Continuum category. Counties should consider children/youth as 21 and under for Columns G - I.

Columns J and K: counties shall input their estimated total count of all individuals served through the county behavioral health system across all funding sources/programs. These counts may be duplicated. Counties should consider eligible children/youth as 21 and under for Column K.

Row 38: the total projected expenditures in columns D through I and total projected individuals served annually in columns J and K will be auto-populated from rows 20 through 36.

Note: For a list of all funding streams that should be included in the projected expenditures calculation for each BH Care Continuum Category, please see the Behavioral Health Services Act (BHSA) County Policy Manual Chapter 3, Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table One: Behavioral Health Care Continuum Projected Expenditures

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (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	<input checked="" type="checkbox"/>	\$ -	\$ -	\$ -	\$ 265,000.00	\$ 265,000.00	\$ 265,000.00	0	1000
Early Intervention Services	<input type="checkbox"/>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0	0
Outpatient Services	<input checked="" type="checkbox"/>	\$ 3,570,000.00	\$ 3,570,000.00	\$ 3,570,000.00	\$ 100,000.00	\$ 100,000.00	\$ 100,000.00	325	8
Intensive Outpatient Services	<input checked="" type="checkbox"/>	\$ 70,000.00	\$ 70,000.00	\$ 70,000.00	\$ -	\$ -	\$ -	35	0
Crisis and Field-Based Services	<input checked="" type="checkbox"/>	\$ 3,800,000.00	\$ 3,800,000.00	\$ 3,800,000.00	\$ 300,000.00	\$ 300,000.00	\$ 300,000.00	60	5
Residential Treatment Services	<input checked="" type="checkbox"/>	\$ 1,630,000.00	\$ 1,630,000.00	\$ 1,630,000.00	\$ 65,000.00	\$ 65,000.00	\$ 65,000.00	115	3
Inpatient Services	<input checked="" type="checkbox"/>	\$ 500,000.00	\$ 500,000.00	\$ 500,000.00	\$ 500,000.00	\$ 500,000.00	\$ 500,000.00	10	10
Mental Health (MH) Services									
Primary Prevention Services	<input type="checkbox"/>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0	0
Early Intervention Services	<input checked="" type="checkbox"/>	\$ 1,180,777.50	\$ 1,180,777.50	\$ 1,180,777.50	\$ 1,228,972.50	\$ 1,228,972.50	\$ 1,228,972.50	1000	1000
Outpatient and Intensive Outpatient Services	<input checked="" type="checkbox"/>	\$ 11,846,413.00	\$ 11,846,413.00	\$ 11,846,413.00	\$ 8,500,000.00	\$ 8,500,000.00	\$ 8,500,000.00	3000	800
Crisis Services	<input checked="" type="checkbox"/>	\$ 3,500,000.00	\$ 3,500,000.00	\$ 3,500,000.00	\$ 1,500,000.00	\$ 1,500,000.00	\$ 1,500,000.00	2200	800
Residential Treatment Services	<input checked="" type="checkbox"/>	\$ 3,000,000.00	\$ 3,000,000.00	\$ 3,000,000.00	\$ 1,250,000.00	\$ 1,250,000.00	\$ 1,250,000.00	121	30
Hospital and Acute Services	<input checked="" type="checkbox"/>	\$ 8,000,000.00	\$ 8,000,000.00	\$ 8,000,000.00	\$ 3,000,000.00	\$ 3,000,000.00	\$ 3,000,000.00	389	100
Subacute and Long-Term Care Services	<input checked="" type="checkbox"/>	\$ 4,000,000.00	\$ 4,000,000.00	\$ 4,000,000.00	\$ -	\$ -	\$ -	30	0
Housing Services (MH + SUD)									
Housing Services	<input checked="" type="checkbox"/>	\$ 4,300,000.00	\$ 4,000,000.00	\$ 4,000,000.00	\$ 390,000.00	\$ 350,000.00	\$ 350,000.00	169	15
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		\$ 45,397,190.50	\$ 45,097,190.50	\$ 45,097,190.50	\$ 17,098,972.50	\$ 17,058,972.50	\$ 17,058,972.50	7454	3771

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activities, other than those that are part of the Behavioral Health Care Continuum in Tab Two.

Rows 17 through 20: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Tab One, "BH CoC Expenditures."

Row 22: total projected expenditures will be auto-populated from rows 17 through 20. For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Two: Other County Expenditures			
Other Expenditures	Total Projected Expenditures (Year One)	Total Projected Expenditures (Year Two)	Total Projected Expenditures (Year Three)
Capital Infrastructure Activities	\$ 2,130,000.00	\$ 2,500,000.00	\$ 1,500,000.00
Workforce Investment Activities	\$ 200,000.00	\$ 200,000.00	\$ 200,000.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	\$ 2,200,000.00	\$ 2,200,000.00	\$ 2,200,000.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	\$ 2,000,000.00	\$ 2,000,000.00	\$ 2,000,000.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	\$ 6,530,000.00	\$ 6,900,000.00	\$ 5,900,000.00

Instructions

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Tab Three.

Rows 18 through 33: counties shall report projected expenditures for each funding source/program.

Row 21: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 26: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 35: total expenditures will be auto-populated from rows 18 through 33.

Row 36: will be auto-validated by DHCS against rows 35, 37, and 38. Validation: total projected expenditure variance should total out to \$0.

Rows 37 and 38: will be auto-validated by DHCS against total projected expenditures in Tabs One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSAs County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSAs County Policy Manual, including requiring BHSAs-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSAs funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Three: Projected Annual Expenditures by County BH Funding Source

	Total Annual Projected Expenditures (Year One)	Total Annual Projected Expenditures (Year Two)	Total Annual Projected Expenditures (Year Three)
BHSA	\$ 16,939,750.00	\$ 17,309,750.00	\$ 16,309,750.00
1991 Realignment (Bronzan-McCorquodale Act)	\$ 6,776,358.00	\$ 6,776,358.00	\$ 6,776,358.00
2011 Realignment (Public Safety Realignment)	\$ 3,736,516.00	\$ 3,736,516.00	\$ 3,736,516.00
State General Fund	\$ 2,600,000.00	\$ 2,840,000.00	\$ 2,840,000.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	\$ 22,380,000.00	\$ 23,000,000.00	\$ 23,000,000.00
Projects for Assistance in Transition from Homelessness (PATH)	\$ 36,594.00	\$ 36,594.00	\$ 36,594.00
Community Mental Health Block Grant (MHBG)	\$ 437,347.00	\$ 437,347.00	\$ 437,347.00
Substance Use Block Grant (SUBG)	\$ 1,047,088.00	\$ 1,047,088.00	\$ 1,047,088.00
Commercial Insurance	\$ 122,000.00	\$ 122,000.00	\$ 122,000.00
County General Fund	\$ 16,510.00	\$ 16,510.00	\$ 16,510.00
Opioid Settlement Funds	\$ 9,734,000.00	\$ 9,734,000.00	\$ 9,734,000.00
Other Funding Sources	Total Annual Projected Expenditures (Year One)	Total Annual Projected Expenditures (Year Two)	Total Annual Projected Expenditures (Year Three)
Other federal grants	\$ -	\$ -	\$ -
Other state funding (including DSH funding)	\$ 2,200,000.00	\$ 1,000,000.00	\$ 1,000,000.00
Other county mental health or SUD funding	\$ 3,000,000.00	\$ 3,000,000.00	\$ 3,000,000.00
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)	\$ 69,026,163.00	\$ 69,056,163.00	\$ 68,056,163.00
Total Projected Expenditure Variance	\$ -	\$ -	\$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	\$ 62,496,163.00	\$ 62,156,163.00	\$ 62,156,163.00
Auto-validation: Table 2: Other County Expenditures	\$ 6,530,000.00	\$ 6,900,000.00	\$ 5,900,000.00

Instructions

Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet.**

Rows 38-40: input your county's base BHSA funding allocation by component and year.

Rows 43-54: this section will be auto-populated from the sections below it.

Rows 43, 49, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers

Rows 44, 50, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Row 45: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.

Row 46: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.

Rows 58, 80, and 102: the base funding amount for Housing Interventions will auto-populate from Column C, rows 38-40

Rows 59, 81, and 103: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value. It will automatically display as a negative value in the cell.

Rows 60, 82, and 104: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions. Enter this percentage as a positive value

Rows 63, 85, 107: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 38-40

Rows 68, 90, 112: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 38-40

Rows 64, 69, 86, 91, 108, and 113: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.

Rows 65, 70, 87, 92, 109, and 114: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.

Rows 74, 96, 118: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."

Rows 75, 97, 119: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."

Rows 76, 98, 120: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."

Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 75) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions

Rows 77, 99, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."

Rows 124-130: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN funds should also be included

Please see Policy Manual Chapter 6, Section 7 for additional information.

Row 130: the total dollar amount of MHSA Transfers to BHSA is auto-populated.

Row 133: enter the dollar amount of prior year prudent reserve ending balance

Row 134: enter the prudent reserve maximum for your county.

Row 135: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. **Negative values indicate no transfer is necessary.**

Rows 136-138: enter the amount of excess prudent reserve funds allocated to each component

Row 139: the total transferred excess prudent reserve is auto-populated.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Four: BHSA Transfers

	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)	\$	4,050,000.00	\$	4,725,000.00	\$	4,725,000.00	\$	13,500,000.00
Year Two Component Allocation (dollars)	\$	4,050,000.00	\$	4,725,000.00	\$	4,725,000.00	\$	13,500,000.00
Year Three Component Allocation (dollars)	\$	4,050,000.00	\$	4,725,000.00	\$	4,725,000.00	\$	13,500,000.00

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)	\$ 4,050,000.00	\$ 4,725,000.00	\$ 4,725,000.00	\$ 13,500,000.00
Unspent Mental Health Services Act (MHSA) to BHSA	\$ -	\$ 9,124,702.00	\$ 3,208,069.00	\$ 12,332,771.00
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)	\$ 4,050,000.00	\$ 4,725,000.00	\$ 4,725,000.00	\$ 13,500,000.00

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)	\$ 4,050,000.00	\$ 4,725,000.00	\$ 4,725,000.00	\$ 13,500,000.00

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%	\$ 4,050,000.00
Percentage Reduced	0%	\$ -
Percentage Added	0%	\$ -
New Housing Interventions Base Percentage (auto-populated)	30%	\$ 4,050,000.00
Transferred To/From	Full Service Partnership Percentage (Year One)	Full Service Partnership Funds (Year One)
Base Percentage and Funding	35%	\$ 4,725,000.00
Percentage Reduced	0%	\$ -
Percentage Added	0%	\$ -
New FSP Base Percentage (auto-populated)	35%	\$ 4,725,000.00
Transferred To/From	Behavioral Health Services and Support Percentage (Year One)	Behavioral Health Services and Support Funding (Year One)
Base Percentage and Funding	35%	\$ 4,725,000.00
Percentage Reduced	0%	\$ -
Percentage Added	0%	\$ -
New BHSS Base Percentage (auto-populated)	35%	\$ 4,725,000.00

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%	\$	4,050,000.00	
Percentage Reduced	0%	\$	-	
Percentage Added	0%	\$	-	
New Housing Interventions Base Percentage (auto-populated)	30%	\$	4,050,000.00	
Transferred To/From	Full Service Partnership Percentage (Year Two)	Full Service Partnership Funds (Year Two)		
Base Percentage and Funding	35%	\$	4,725,000.00	
Percentage Reduced	0%	\$	-	
Percentage Added	0%	\$	-	
New FSP Base Percentage (auto-populated)	35%	\$	4,725,000.00	
Transferred To/From	Behavioral Health Services and Support Percentage (Year Two)	Behavioral Health Services and Support Funding (Year Two)		
Base Percentage and Funding	35%	\$	4,725,000.00	
Percentage Reduced	0%	\$	-	
Percentage Added	0%	\$	-	
New BHSS Base Percentage (auto-populated)	35%	\$	4,725,000.00	
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%	\$	4,050,000.00
Percentage Reduced	0%	\$	-
Percentage Added	0%	\$	-
New Housing Interventions Base Percentage (auto-populated)	30%	\$	4,050,000.00
Transferred To/From	Full Service Partnership Percentage (Year Three)	Full Service Partnership Funds (Year Three)	
Base Percentage and Funding	35%	\$	4,725,000.00
Percentage Reduced	0%	\$	-
Percentage Added	0%	\$	-
New FSP Base Percentage (auto-populated)	35%	\$	4,725,000.00
Transferred To/From	Behavioral Health Services and Support Percentage (Year Three)	Behavioral Health Services and Support Funding (Year Three)	
Base Percentage and Funding	35%	\$	4,725,000.00
Percentage Reduced	0%	\$	-
Percentage Added	0%	\$	-
New BHSS Base Percentage (auto-populated)	35%	\$	4,725,000.00

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 BHSF				
MHSA Component	Available Unspent BHSF Funds	Transferred to Housing Intervention	Transferred to Full-Service Partnership	Transferred to Behavioral Health Services and Support
CSS	\$ 4,905,755.00	\$ -	\$ 4,905,755.00	\$ -
PEI	\$ -	\$ -	\$ -	\$ -
Encumbered INN	\$ -	\$ -	\$ -	\$ -
Unencumbered INN	\$ 4,218,947.00	\$ -	\$ 4,218,947.00	\$ -
WET	\$ -			\$ -
CFTN	\$ 3,208,069.00			\$ 3,208,069.00
Total (auto-populated)	\$ 12,332,771.00	\$ -	\$ 9,124,702.00	\$ 3,208,069.00

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	\$ 1,655,402.00
Local Prudent Reserve Maximum (2)	\$ 3,085,053.81
Excess Prudent Reserve Funding that must be transferred	\$ (1,429,651.81)
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.

Instructions

Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Tab Five.

Rows 39-42: input the estimated total Housing Intervention component allocation received for each year. Row 39 will auto-populate from Tab Four in the BHSA Transfers tab. Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-populate -the sum of rows 40-42 to account for total funding.

Row 40: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 136 that you will be transferring excess PR funds to Housing Interventions please report them here.

Rows 47-64: input the projected expenditures for each Housing Intervention component service category or program for each year.

Row 46: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent through their Medi-Cal MCP.

Row 51: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns F, G, and H.

Row 63: input expenditures for BHSA-funded innovation pilots or projects.

Row 64: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub -allocations above.

Row 65: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 69 enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 70: the overall total of Housing Intervention expenditures will be auto-populated -from rows 65, 67, and 69.

Row 72: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. This amount should equal 50% of Housing Interventions component allocation.

Row 73: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 72.

Row 75: the proportion of funds dedicated to capital development will be auto-populated .

Row 76: the proportion of funds dedicated to the chronically homeless population will be auto-populated .

Row 77: the proportion of funds dedicated to Outreach and Engagement will be auto-populated.

Rows 79-80: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

Row 82: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table 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)	\$ 4,050,000.00	\$ 4,050,000.00	\$ 4,050,000.00
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)	\$ 4,050,000.00	\$ 4,050,000.00	\$ 4,050,000.00

Housing Interventions Category						
Type of Service	Projected Expenditures - Unspent MHSAs and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSAs and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSAs and BHSA Funding Only (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)
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	\$ 540,000.00	\$ 540,000.00	\$ 540,000.00	\$ 635,000.00	\$ 635,000.00	\$ 635,000.00
Operating Subsidies	\$ 200,000.00	\$ 200,000.00	\$ 200,000.00	\$ -	\$ -	\$ -
Bundled Rental and Operating Subsidies	\$ 600,000.00	\$ 600,000.00	\$ 600,000.00	\$ -	\$ -	\$ -
% of Rental and Operating Subsidies Administered through Flex Pools	100%	100%	100%	100%	100%	100%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	\$ 720,000.00	\$ 720,000.00	\$ 720,000.00	\$ 618,000.00	\$ 330,000.00	\$ 330,000.00
Operating Subsidies	\$ 100,000.00	\$ 100,000.00	\$ 100,000.00	\$ -	\$ -	\$ -
Bundled Rental and Operating Subsidies	\$ 520,000.00	\$ 520,000.00	\$ 520,000.00	\$ 147,600.00	\$ 147,600.00	\$ 147,600.00
% of Rental and Operating Subsidies Administered through Flex Pools	100%	100%	100%	100%	100%	100%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	\$ 50,000.00	\$ 50,000.00	\$ 50,000.00	\$ 100,000.00	\$ 100,000.00	\$ 100,000.00
Other Housing Supports: Participant Assistant Funds (2)	\$ 140,000.00	\$ 140,000.00	\$ 140,000.00	\$ 215,000.00	\$ 215,000.00	\$ 215,000.00
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	\$ 400,000.00	\$ 400,000.00	\$ 400,000.00	\$ 450,000.00	\$ 450,000.00	\$ 450,000.00
Other Housing Supports: Outreach and Engagement (2)	\$ 80,000.00	\$ 80,000.00	\$ 80,000.00	\$ 220,000.00	\$ 220,000.00	\$ 220,000.00
Capital Development Projects	\$ 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)	\$ 3,850,000.00	\$ 3,850,000.00	\$ 3,350,000.00	\$ 2,385,600.00	\$ 2,097,600.00	\$ 2,097,600.00

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	\$ 200,000.00	\$ 200,000.00	\$ 200,000.00
Total Housing Interventions Expenditures (auto-populated)	\$ 4,050,000.00	\$ 4,050,000.00	\$ 3,550,000.00
Housing Interventions Populations to be Served	Year One	Year Two	Year Three
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	\$ 2,025,000.00	\$ 2,025,000.00	\$ 2,025,000.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	\$ 30,000.00	\$ 30,000.00	\$ 30,000.00
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)	12.3%	12.3%	0.0%
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)	2.0%	2.0%	2.0%
Projected Individuals to be Served (Unduplicated)	Year One	Year Two	Year Three
Eligible Children/TAY (25 years and younger)	50	50	50
Eligible Adults/Older Adults	150	150	150
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.

Instructions

Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six.

Rows 24-27: input the total estimated FSP component allocation received for each year. Row 24 will auto-populate from Tab Four in the BHSA Transfers tab. Input unspent MHSA dollars carried over to this component into row 26. Row 27 will auto-populate the sum of rows 24-26 to account for total funding.

Row 26: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable. If you reported on Tab 4, row 137 that you will be transferring excess PR funds to FSP please report them here.

Rows 31-40: input the projected expenditures for each FSP service category or program for each year.

Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 31-36. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 37-38, accordingly.

Row 39: input expenditures for BHSA-funded innovation pilots or projects.

Row 40: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub -allocations above.

Row 41: the subtotal of FSP programs/services will be auto-populated from rows 31-40.

Row 43: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.

Row 45: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 46: total projected expenditures for FSP for each year will be auto-populated from rows 41, 43, and 45.

Rows 48 and 49: input the estimated unduplicated count of individuals that will be served across all FSP programs.

Row 51: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA FSP component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table 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)	\$ 4,725,000.00	\$ 4,725,000.00	\$ 4,725,000.00
Transfers into Full Service Partnership component from Local Prudent Reserve	\$ -	\$ -	\$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	\$ 6,500,000.00	\$ 2,624,702.00	
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	\$ 11,225,000.00	\$ 7,349,702.00	\$ 4,725,000.00

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)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
FSP Intensive Case Management	\$ 2,000,000.00	\$ 2,000,000.00	\$ 2,000,000.00	\$ 4,000,000.00	\$ 4,000,000.00	\$ 4,000,000.00	\$ 1,000,000.00	\$ 1,000,000.00	\$ 1,000,000.00
High Fidelity Wraparound	\$ 1,000,000.00	\$ 1,000,000.00	\$ 1,000,000.00	\$ 3,000,000.00	\$ 3,000,000.00	\$ 3,000,000.00	\$ 1,000,000.00	\$ 1,000,000.00	\$ 1,000,000.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Assertive Field-Based Initiation for SUD Treatment Services	\$ 600,000.00	\$ 600,000.00	\$ 600,000.00	\$ 3,200,000.00	\$ 3,200,000.00	\$ 3,200,000.00	\$ 375,000.00	\$ 375,000.00	\$ 375,000.00
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	\$ 2,000,000.00	\$ 2,000,000.00	\$ 2,000,000.00	\$ 5,000,000.00	\$ 5,000,000.00	\$ 5,000,000.00	\$ 1,000,000.00	\$ 1,000,000.00	\$ 1,000,000.00
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)	\$ 5,600,000.00	\$ 5,600,000.00	\$ 5,600,000.00	\$ 15,200,000.00	\$ 15,200,000.00	\$ 15,200,000.00	\$ 3,375,000.00	\$ 3,375,000.00	\$ 3,375,000.00
FSP Transfer Information									
Transfers out of FSP component into Local Prudent Reserve	\$ -	\$ -	\$ -						
FSP Administrative Information									
FSP Component Admin Expenses	\$ 400,000.00	\$ 400,000.00	\$ 400,000.00						
Total Full Service Partnership Expenditures (auto-populated)	\$ 6,000,000.00	\$ 6,000,000.00	\$ 6,000,000.00						
Projected Individuals to be Served (Unduplicated)									
Eligible Children/TAY (25 years and younger)	650	650	650						
Eligible Adults/Older Adults	2800	2800	2800						
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)									
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.									

Instructions

Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Seven.

Row 26-29: input the total estimated BHSS component allocation received for each year. Row 26 will auto-populate from Tab Four in the BHSA Transfers tab.

Row 27: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 138 that you will be transferring excess PR funds to BHSS please report them here. Input unspent MHSA dollars carried over to this component into row 28. Row 29 will auto-populate the sum of rows 26-28.

Rows 33-46: input the projected expenditures for each BHSS service category or program for each year. Rows 35, 39, and 42 auto-populate from their sub rows.

Row 45: input expenditures for BHSA-funded innovation pilots or projects.

Row 46: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 47: the subtotal for projected expenditures will be auto-populated from rows 33 - 35, 38, 39, 42, 45, and 46.

Row 49: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.

Row 51: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 52: the total for projected BHSS expenditures will be auto-populated from rows 47, 49, and 51.

Row 54: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.

Row 56: the proportion of EI funds will auto-populate from rows 29 and 35. Note: MHSA WET, INN, and CF/TN funds in Rows 65-67 will be deducted from the revenue (excluded from the denominator).

Row 57: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 35 and 54.

Rows 59-60: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.

Rows 62-63: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.

Rows 65-67: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Seven: BHSA

	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)	\$ 4,725,000.00	\$ 4,725,000.00	\$ 4,725,000.00
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)	\$ 1,630,000.00	\$ 1,578,069.00	\$ -
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	\$ 6,355,000.00	\$ 6,303,069.00	\$ 4,725,000.00

Behavioral Health Services and Supports Category (1)									
Type of Service	Projected Expenditures - Unspent MHA and BHA Funding Only (Year One)	Projected Expenditures - Unspent MHA and BHA Funding Only (Year Two)	Projected Expenditures - Unspent MHA and BHA 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)	\$ 500,000.00	\$ 500,000.00	\$ 500,000.00	\$ 2,000,000.00	\$ 2,000,000.00	\$ 2,000,000.00	\$ 1,500,000.00	\$ 1,500,000.00	\$ 1,500,000.00
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	\$ 750,000.00	\$ 750,000.00	\$ 750,000.00	\$ 3,000,000.00	\$ 3,000,000.00	\$ 3,000,000.00	\$ 2,250,000.00	\$ 2,250,000.00	\$ 2,250,000.00
Early Intervention Expenditures	\$ 2,409,750.00	\$ 2,409,750.00	\$ 2,409,750.00	\$ 50,000.00	\$ 50,000.00	\$ 50,000.00	\$ 220,901.00	\$ 220,901.00	\$ 220,901.00
Coordinated Specialty Care for First Episode Psychosis	\$ 50,000.00	\$ 50,000.00	\$ 50,000.00	\$ 50,000.00	\$ 50,000.00	\$ 50,000.00	\$ 220,901.00	\$ 220,901.00	\$ 220,901.00
All Other EI Expenditures	\$ 2,359,750.00	\$ 2,359,750.00	\$ 2,359,750.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Outreach and Engagement	\$ 175,000.00	\$ 175,000.00	\$ 175,000.00	\$ -	\$ -	\$ -	\$ 25,000.00	\$ 25,000.00	\$ 25,000.00
Workforce Education and Training (WET)	\$ 75,000.00	\$ 75,000.00	\$ 75,000.00	\$ -	\$ -	\$ -	\$ 125,000.00	\$ 125,000.00	\$ 125,000.00
Dedicated BHA WET funds	\$ 75,000.00	\$ 75,000.00	\$ 75,000.00	\$ -	\$ -	\$ -	\$ 125,000.00	\$ 125,000.00	\$ 125,000.00
Dedicated MHA WET funds	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Capital Facilities and Technological Needs (CFTN)	\$ 1,630,000.00	\$ 2,000,000.00	\$ 1,500,000.00	\$ -	\$ -	\$ -	\$ 870,000.00	\$ 500,000.00	\$ 500,000.00
Dedicated BHA CF/TN funds	\$ -	\$ 421,931.00	\$ 1,500,000.00	\$ -	\$ -	\$ -	\$ 870,000.00	\$ 500,000.00	\$ 500,000.00
Dedicated MHA CF/TN funds	\$ 1,630,000.00	\$ 1,578,069.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
BHA Innovative BHSS Pilots and Projects	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MHA INN Projects	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Subtotal (auto-populated)	\$ 5,539,750.00	\$ 5,909,750.00	\$ 5,409,750.00	\$ 5,050,000.00	\$ 5,050,000.00	\$ 5,050,000.00	\$ 4,990,901.00	\$ 4,620,901.00	\$ 4,620,901.00
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	\$ 125,000.00	\$ 125,000.00	\$ 125,000.00						
Total Behavioral Health Services and Supports Expenditures (auto-populated)	\$ 5,664,750.00	\$ 6,034,750.00	\$ 5,534,750.00						
Youth-Focused Early Intervention Expenditures	Year One	Year Two	Year Three						
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	\$ 1,228,972.50	\$ 1,228,972.50	\$ 1,228,972.50						

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)	76.6%	51.0%	51.0%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	51.0%	51.0%	51.0%
Projected Individuals to be Served (Unduplicated)	Year One	Year Two	Year Three
Eligible Children/TAY (25 years and younger)	2000	2000	2000
Eligible Adults/Older Adults	3500	3500	3500
Projected BHSS Funds transferred to WET or CF/TN	Year One	Year Two	Year Three
BHSS transfer to WET	\$ 125,000.00	\$ 125,000.00	\$ 125,000.00
BHSS transfer to CF/TN	\$ -	\$ 921,931.00	\$ 2,000,000.00
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	\$ -	\$ -	\$ -
Estimated MHSA CF/TN Funds	\$ 3,208,069.00	\$ 1,578,069.00	\$ -
MHSA "Encumbered" INN	\$ -	\$ -	\$ -

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. BHS Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHS 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. BHS Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHS funding should be in proportion to the extent the BHS program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Instructions

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in Tab Eight.

Row 27: the total dollar-amount of BHSA component allocations dedicated to improvement and monitoring activities, including plan operations, quality and outcomes, data reporting pursuant to W&I Code § 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants by year. Under W&I Code § 5892 (e)(2)(B), the total amount shall equal 2% or less of total projected annual revenues of the local behavioral health services fund for counties with a population over 200,000 or 4% of the total projected annual revenues of the local behavioral health services fund for counties with a population of less than 200,000. Any costs that exceed that amount will be included in the governor’s budget. Administrative costs for improving and monitoring will only be reported on this tab, not the BHSA component tabs.

Row 28: input amounts of BHSA component allocations dedicated to county Integrated Plan annual planning costs, including stakeholder engagement in planning and local Behavioral Health Board activities by year. Under W&I Code § 5892 (e)(1)(B), this amount shall be 5% or less of total projected annual revenues of the local behavioral health services fund. Any costs that exceed that amount will be included in the governor’s budget. Planning costs will only be reported on this tab, not the BHSA component tabs.

Row 29: input total dollar amount of new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71

Row 30: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately.

Row 32: total projected annual revenues of the Local Behavioral Health Services Fund.

Row 33: the proportion of funding used for improvement and monitoring will be auto-populated from rows 32 and 27.

Row 34: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 32.

Row 36-38: based upon the county population size selected in row 31, this calculator will auto-populate any Improvement and Monitoring expenditures that exceed (2%/4%) of the total projected annual revenues of the Local Behavioral Health Services Fund and any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund.

Table Eight: BHSA Plan			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	Year One	Year Two	Year Three
Total Projected Improvement and Monitoring Expenditures	\$ 860,000.00	\$ 700,000.00	\$ 540,000.00
Total Projected County Integrated Plan Annual Planning Expenditures	\$ 100,000.00	\$ 100,000.00	\$ 100,000.00
New and Ongoing Administrative Costs	\$ 840,000.00	\$ 840,000.00	\$ 840,000.00
Select County Population Size:	Less than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	\$ 21,630,000.00	\$ 17,702,771.00	\$ 13,500,000.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	4.0%	4.0%	4.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	0.5%	0.6%	0.7%
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.

Instructions

Counties shall report their estimated local prudent reserve maximums for each allocation component in Tab Nine.

Rows 18-19: dollar amounts will be auto-populated from Tab 4 rows 133-134.

Row 20: total excess prudent reserve dollars will be auto-populated from rows 18-19.

Rows 21-23: total dollar amounts will be auto-populated from Tab 4, rows 136-138.

Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21-23.

Row 25: auto-validates from rows 20 and 24 to check if the county has "No Excess" or if county must "Reduce Excess" prudent reserve.

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations across all plan years will be auto-populated from Tab 5 row 67, Tab 6 row 43, and Tab 7 row 49.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations across all plan years will be auto-populated from Tab 5 row 40, Tab 6 row 25, and Tab 7 row 27.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	\$ 1,655,402.00
Local Prudent Reserve Maximum (1)	\$ 3,085,053.81
Excess Prudent Reserve Funds (auto-populated)	\$ (1,429,651.81)
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).	

Instructions

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 43, 49, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26.

Rows 36, 44, and 52: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Rows 38, 46, and 54: estimated total available funding will be auto-populated from rows 35-37, 43-45 and 51-53.

Rows 39, 47, and 55: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 67; Tab 6, row 43; and Tab 7, row 49.

Rows 40, 48, and 56: estimated expenditures for each component will be auto-populated from Tab 5, row 70; Tab 6, row 46; and Tab 7, row 52.

Rows 45 and 53: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.

Rows 59-61: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Ten: BHSA Funding Summary (auto-populated)

	Housing Interventions	Full-Service Partnerships	Behavioral Health Services and Supports	Total
Year One				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	\$ 4,050,000.00	\$ 4,725,000.00	\$ 4,725,000.00	\$ 13,500,000.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	\$ 4,050,000.00	\$ 4,725,000.00	\$ 4,725,000.00	\$ 13,500,000.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	\$ 4,050,000.00	\$ 4,725,000.00	\$ 4,725,000.00	\$ 13,500,000.00

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 <i>(BHSA Funding Only)</i>	\$ 4,050,000.00	\$ 4,725,000.00	\$ 4,725,000.00	\$ 13,500,000.00
Transfers From PR Into Component	\$ -	\$ -	\$ -	\$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) <i>(Unspent Carryover MHSA Funds)</i>	\$ -	\$ 6,500,000.00	\$ 1,630,000.00	\$ 8,130,000.00
Estimated Total Available Funding for Year One	\$ 4,050,000.00	\$ 11,225,000.00	\$ 6,355,000.00	\$ 21,630,000.00
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -
Estimated Total Year One Expenditures	\$ 4,050,000.00	\$ 6,000,000.00	\$ 5,664,750.00	\$ 15,714,750.00
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 <i>(BHSA Funding Only)</i>	\$ 4,050,000.00	\$ 4,725,000.00	\$ 4,725,000.00	\$ 13,500,000.00
Transfers From PR Into Component	\$ -	\$ -	\$ -	\$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	\$ -	\$ 7,849,702.00	\$ 2,268,319.00	\$ 10,118,021.00
Estimated Total Available Funding for Year Two	\$ 4,050,000.00	\$ 12,574,702.00	\$ 6,993,319.00	\$ 23,618,021.00
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -
Estimated Total Year Two Expenditures	\$ 4,050,000.00	\$ 6,000,000.00	\$ 6,034,750.00	\$ 16,084,750.00

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 <i>(BHSA Funding Only)</i>	\$ 4,050,000.00	\$ 4,725,000.00	\$ 4,725,000.00	\$ 13,500,000.00
Transfers From PR Into Component	\$ -	\$ -	\$ -	\$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	\$ -	\$ 6,574,702.00	\$ 958,569.00	\$ 7,533,271.00
Estimated Total Available Funding for Year Three	\$ 4,050,000.00	\$ 11,299,702.00	\$ 5,683,569.00	\$ 21,033,271.00
Transfers from Component Into PR	\$ -	\$ -	\$ -	\$ -
Estimated Total Year Three Expenditures	\$ 3,550,000.00	\$ 6,000,000.00	\$ 5,534,750.00	\$ 15,084,750.00
BHSA Plan Admin Expenses				
Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	\$ 860,000.00	\$ 700,000.00	\$ 540,000.00	\$ 2,100,000.00
Total Projected County Integrated Plan Annual Planning Expenditures	\$ 100,000.00	\$ 100,000.00	\$ 100,000.00	\$ 300,000.00
Total Projected New and Ongoing Administrative Expenditures	\$ 840,000.00	\$ 840,000.00	\$ 840,000.00	\$ 2,520,000.00

Behavioral Health Division (BHD) Update December 2025 Data

Presented to the El Dorado County Behavioral Health Commission at their regular meeting on January 21, 2026.

**Behavioral Health Division Update
Behavioral Health Commission
January, 2026 Data
February 18, 2026, Meeting**

EL DORADO COUNTY BEHAVIORAL HEALTH DIVISION STAFFING

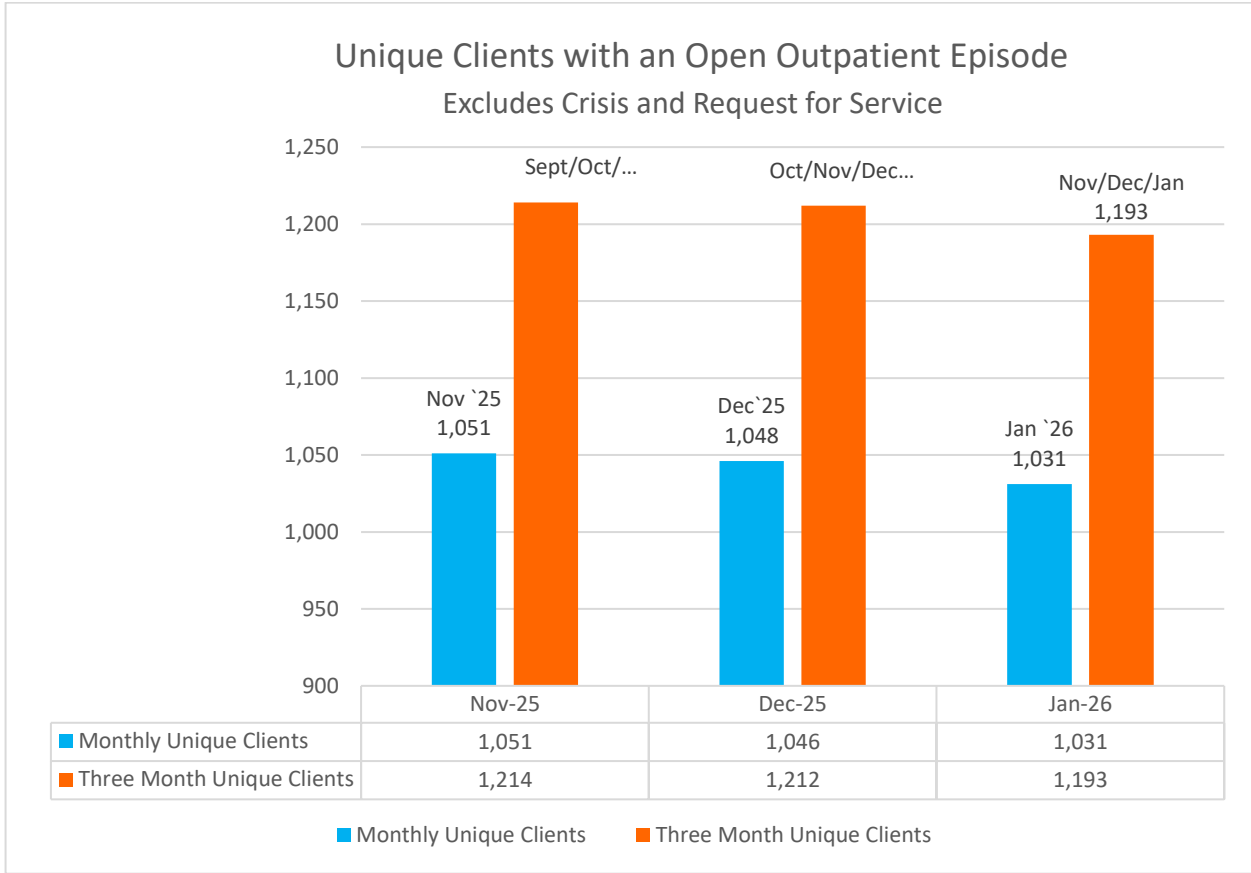
- **New Hires:**
 - Elizabeth “Liz” Drabant, SLT MH Clinician
- **Promotions:**
 - None
- **Recruitments:**
 - Ongoing
 - Manager of Mental Health Programs, Crisis Services
 - WS MH Clinician - Substance Use Disorder Services Division- Quality Assurance
 - WS MH Clinician – Substance Use Disorder Services Division- Access
 - WS MH Clinicians 2 FSP, 4 Wellness/Access
 - WS Mental Health Workers
 - WS Office Assistant – Substance Use Disorder Services Division
 - WS Advanced Level Substance Use Disorder Services Counselor
 - WS Prevention Coordinator
 - SLT Advanced Level Substance Use Disorder Services Counselor
 - SLT Mental Health Clinicians
 - SLT Mental Health Worker
 - SLT Psych Tech
- **Separations:**
 - None
- **Position Changes:**
 - None

Filled and Vacant Clinician and Clinical Support Positions (as of 2/9/2025)

Position Category	Allocated	Filled	Filled by Amergis Contracted Staff	Vacant	Vacancy by Position	Division-Wide Vacancy %
Manager of MH	4	3	0	1	25%	40% (45% not including Amergis Contracted Staff)
MH Coordinator	8	4.8	0	3.2	40%	
MH Clinician	34.5	13.8	5	15.7	46%	
MH Worker	27	10.2	n/a	16.8	38%	
Sup. MH Worker	1	1	n/a	0	0%	
Sr. Office Assistant	5	3	n/a	2	40%	
Medical Office Assistant	1	1	n/a	0	0%	
MH Aide	6.25	0.75	n/a	5.5	88%	
Psych Tech	3	2	0	1	33%	
SUDS Health Educator	11	8	n/a	3	27%	
Sup. Health Education Coordinator	2	2	n/a	0	0%	

“Clinical Support” includes all Health Education Coordinators (even if assigned to Prevention activities), Program Assistants, Mental Health Workers, Mental Health Aides, and Psychiatric Technicians.

THIS MONTH'S SERVICES BY THE NUMBERS...



ADULT OUTPATIENT SERVICES

- West Slope: 439
- South Lake Tahoe: 104

CHILDREN'S SERVICES

- Sierra Child & Family Services: 185
- Summitview Child & Family Services: 85
- Stanford Youth Solutions: 89
- New Morning Youth Services: 36

Access – Request for Service

Mental Health

Requests for Service - Received

MONTH	TOTAL #	ROUTINE	EXPEDITED	URGENT
02/2025	130	122	8	0
03/2025	172	164	8	0
04/2025	120	112	7	1
05/2025	124	113	11	0
6/2025	98	95	4	0
7/2025	104	94	10	0
8/2025	139	125	14	0
9/2025	128	116	12	0
10/2025	164	147	14	1
11/2025	119	113	6	0
12/2025	164	151	11	0
1/2026	111	105	6	0
Total	1,573	1,473	111	2

Disposition of Request of Service

MONTH	OPENED TO EDC BH	REFERRED TO MCP	REFERRED TO COMMUNITY	CANCELLED CONTACT, NO SHOW
2/2025	63	17	8	40
3/2025	93	29	13	37
4/2025	58	23	10	29
5/2025	58	16	7	43
6/2025	54	23	2	18
7/2025	40	31	12	21
8/2025	75	29	3	32
9/2025	72	29	3	24
10/2025	98	43	2	19
11/2025	68	33	1	17
12/2025	93	25	5	39
1/2026	61	25	6	20
Total	773	323	71	339

Substance Use Disorder Services

Requests for Service – Received

MONTH	TOTAL #	ROUTINE	EXPEDITED	URGENT
2/2025	40	40	0	0
3/2025	31	28	0	3
4/2025	45	42	0	3
5/2025	44	40	0	4
6/2025	34	33	0	1
7/2025	44	42	0	2
8/2025	36	36	0	0
9/2025	48	46	2	2
10/2025	30	30	0	0
11/2025	26	24	0	2
12/2025	29	28	0	1
1/2026	38	38	0	0
Total	445	427	0	18

Disposition of Request of Service

MONTH	ACCESS EPISODE OPENED – LoC PENDING	OPENED TO EDC SUDS	Does Not Meet Medical Necessity	REFERRED TO COMMUNITY	CANCELLED CONTACT, NO SHOW	MOVED OUT OF COUNTY
2/2025	23	8	1	1	7	0
3/2025	14	7	1	3	7	0
4/2025	25	11	1	2	6	0
5/2025	20	13	3	4	5	0
6/2025	18	10	1	0	5	0
7/2025	34	14	0	2	4	0
8/2025	17	7	2	3	5	0
9/2025	28	14	2	1	1	1
10/2025	20	6	1	1	2	0
11/2025	17	5	0	0	4	0
12/2025	17	7	0	3	2	0
1/2026	26	10	0	2	0	0
Total	285	120	15	22	48	1

Notice of Adverse Benefit Determination (NOABD) Issued

Mental Health

Month	Delivery System – No Med Criteria	Delivery System – Admin Close	Delivery System - Timely Access	Modification Of Service	Term of Service	Pymt Denial
2/2025	1	23	0	0	10	0
3/2025	1	25	0	1	14	0
4/2025	0	29	0	3	29	0
5/2025	0	25	0	1	14	0
6/2025	0	25	0	1	14	0
7/2025	0	13	0	1	19	0
8/2025	0	33	0	0	11	0
9/2025	0	16	0	2	8	0
10/2025	0	22	0	0	12	0
11/2025	0	10	0	1	30	0
12/2025	0	13	2	1	24	0
1/2026	2	13	0	0	17	0
Total	4	247	2	11	212	0

Substance Use Disorder Services

EDC SUDS NOABD type						
Month	Timely Access Notice	Termination Notice	Modification Notice	Denial Notice	Delivery System Notice	Payment Denial Notice
2/2025	11	24	0	0	2	0
3/2025	10	26	0	0	0	0
4/2025	11	14	0	0	2	0
5/2025	21	33	0	0	3	0
6/2025	21	32	0	0	1	0
7/2025	14	31	0	1	2	0
8/2025	21	38	0	0	2	0
9/2025	12	33	0	0	1	0
10/2025	18	27	0	0	0	0
11/2025	9	30	0	0	2	0
12/2025	12	37	0	0	2	0
1/2026	9	28	0	0	0	0
Total	169	353	0	1	13	0

Inpatient and Residential Treatment

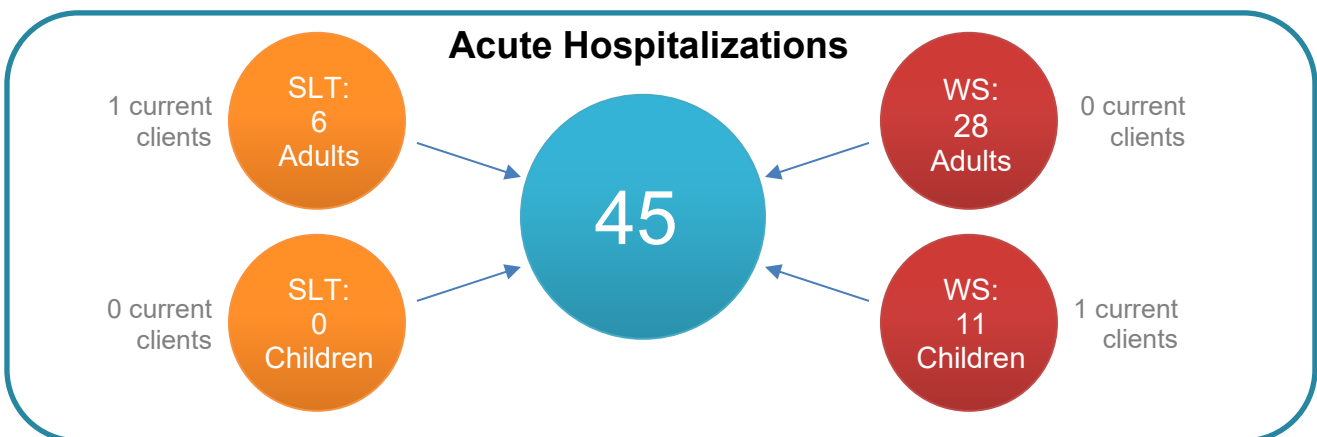
Mental Health

Month	Telecare PHF	Average Length of Stay – PHF	Crisis Res Tx - Adult	Out of County – Adult	Out of County – Youth	Average Length of Stay - OUCH	Residential	Long-Term Care/Skilled Nursing
2/2025	22	15.37		5	5	5.7	31	18
3/2025	29	10.77		10	4	10.57	31	9
4/2025	21	10.00	2	5	4	6.00	30	18
5/2025	25	10.77	4	12	4	7.06	30	18
6/2025	11	10.73	6	9	5	7.29		
7/2025	13	33.76	6	21	4	13.96		
8/2025	23	13.13	6	12	13	6.76	29	15
9/2025	24	19.04	8	11	7	6.44	31	15
10/2025	18	16.43	11	28	12	6.05	29	13
11/2025	20	18.15	5	15	6	10.19	32	14
12/2025	17	14.41	9	23	5	5.71	28	13
1/2026	13	37.38	6	20	9	12.24	26	13
Total	232	17.5	63	191	87	8.16		

Substance Use Disorder Services

Month	Clients in Residential Treatment
2/2025	17
3/2025	18
4/2025	20
5/2025	23
6/2025	21
7/2025	24
8/2025	34
9/2025	36
10/2025	28
11/2025	22
12/2025	20
1/2026	14
Total	277

Psychiatric Emergency Services (PES) (Crisis Services)



34 Adults were placed in Acute Hospital

- **10 placed at EDC Telecare PHF**
- 7 El Dorado County Medi-cal beneficiaries placed at an Out of County Hospital by EDCBH
- 6 Medicare as primary coverage
- 14 with Private Insurance or Medi-Cal from another California county, placement approved by County of responsibility.

The MHP is contracted with the State to provide Psychiatric Emergency Services to any individual within the boundaries of the County, regardless of insurance or residency status.

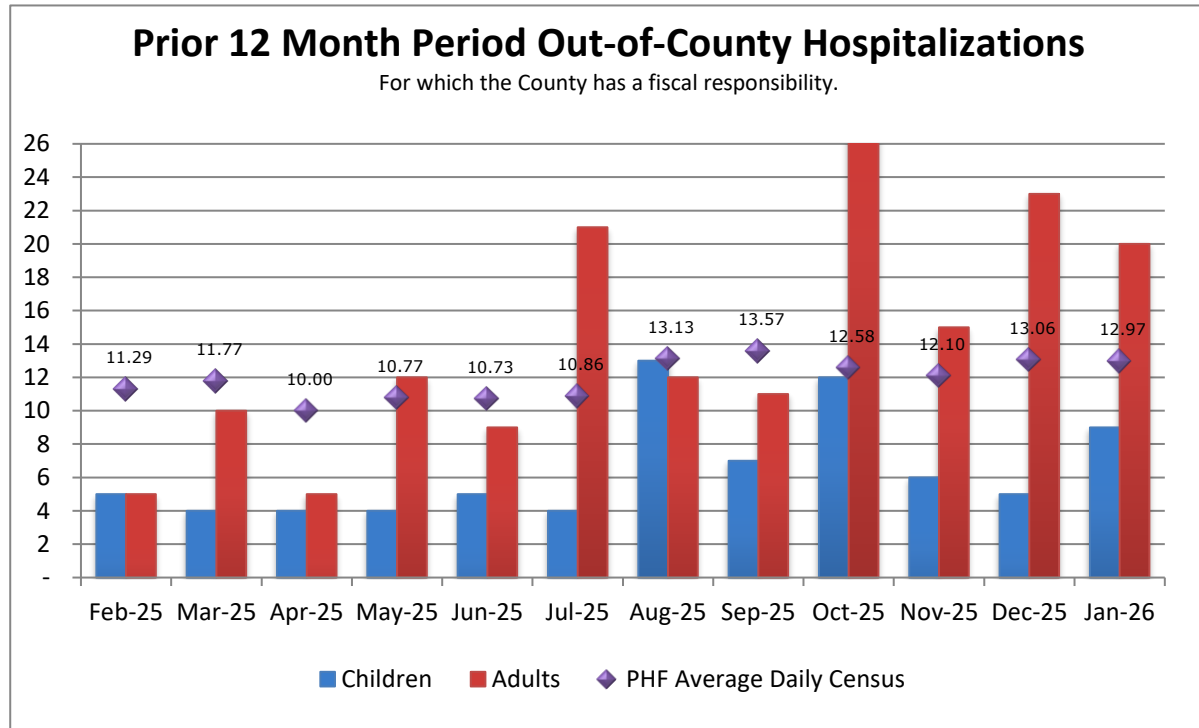
MOBILE CRISIS SERVICES MONTHLY ENCOUNTERS

MCT NUMBERS	
Calls to Crisis Line	325
Dispatched to MCT	75
MCT Transport to ED	9
5150 by MCT	21

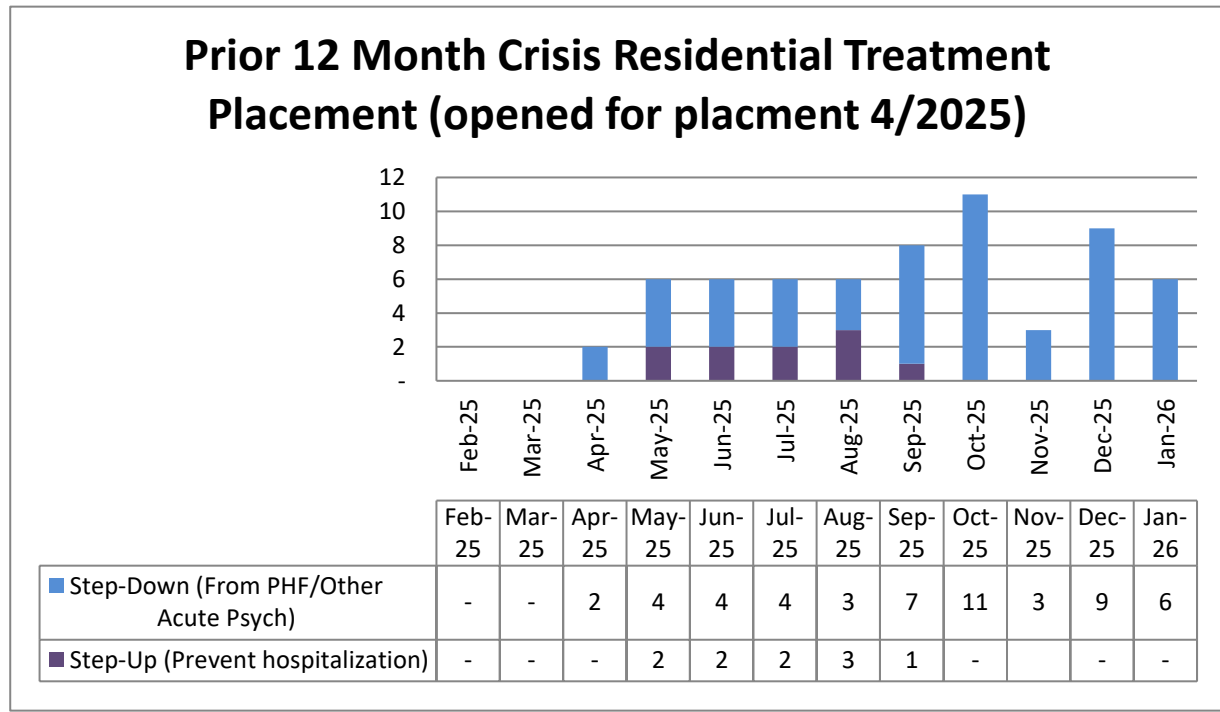
Psychiatric Health Facility (Moriah Weldy)

- There were **13** Admissions; **11** Admissions were El Dorado County residents and **2** were Out of County residents.
- There were **9** El Dorado County residents discharged; **3** to Home with Support, **0** to Home without support, **2** MHRC/IMD, **0** Board and Care, **0** to ICM T-House, **3** to CRT, **1** to Shelter, **0** to Other/Homeless, and **0** to Emergency Department.
- Upon discharge, **8** El Dorado County residents were insured and **1** El Dorado County residents were pending insurance.
- There were **4** Seclusion Episodes, **1** Physical Restraint Episodes for **5** minutes, **3** Patient to Patient Assaults, **4** Patient to Staff Assault, **3** Patient to Staff Assault, **0** Elopements, **0** Medication Errors (**0** medication errors with no patient involvement), Client Surveys **13**
- There was **0** denial of El Dorado County referrals: N/A.
- Average daily census was **37.38** (range 10-15) with **14.41** average length of stay of days.
- Concurrent Reviews resulting in no medical necessity found. **0**

Out-of-County Acute Psychiatric Hospitalizations (Medi-Cal Beneficiaries Only) (Moriah Weldy)



Oak Lane Crisis Residential Treatment (CRT) Center Placement (Moriah Weldy/Christy Sonnenburg)



WELLNESS CENTER ACTIVITIES

South Lake Tahoe:

Wellness is open five days a week providing groups and activities to enhance Clients' lives (games, snacks, outings, art, independent living skills, symptom management, skills educational groups, and more).

SLT Wellness Center Groups

- Peer Support
- Anger Management
- DBT Distress Tolerance
- Expressive Arts
- Forensic
- Friends & Fitness
- Games & Socialization
- Seasonal Cooking
- Independent Living Skills
- Trauma & Resiliency Training
- Gardening
- Sports
- Nature Hiking
- Field trips

West Slope:

The WSOP Wellness Center is open four days per week: Monday, Tuesday, Thursday, Friday from 1pm – 4pm. Wellness Center is closed Wednesdays, holidays and weekends. The Wellness Center is a safe, welcoming space to partake in a meal, socialize, participate in a variety of groups, activities, and outings that emphasize independence, self-sufficiency, healthy living, healthy relationships, self-improvement and to share, learn, and to secure support, resources, education, and information in efforts to enhance and transform lives and improve futures.

WSOP Wellness Center Groups:

- Art
- Co-Occurring / Process Groups
- Conflict Resolution
- Cooking daily
- Current Events
- DBT
- Forensic Check-In (Closed Group)
- Games & Socialization daily
- Gardening
- Healthy Habits
- Menu Planning
- Mindfulness
- Movement
- Movie Mondays
- Music
- Music Improv & Intro to the Dried Mangoes Band
- Outside sports
- Outings
- T-House T-Skills
- Walking
- Writing Circle

There have been several Wellness Center participants who have begun to volunteer regularly and consistently in the Wellness Center in various roles such as thoughtfully engaging participants in activities to encourage socialization, decorating for the seasons and kitchen and overall clean-up activities, stating that they want to “give back” because they have benefitted from attending and have received so much from their participation at the Wellness Center.

INITIALS & DEFINITIONS

Initials	Definition
AB	Assembly Bill
ACEs	Adverse Childhood Experiences
ADL	Activities of Daily Living
ADP	Alcohol and Drug Programs
AMFT	Associate Marriage and Family Therapist
AOT	Assisted Outpatient Treatment
APCC	Associate Professional Clinical Counselor
APS	Adult Protective Services
ARF	Adult Residential Facility
ARPA	American Rescue Plan Act of 2021
B&C	Board and Care
BHBH	Behavioral Health Bridge Housing
BHC	Behavioral Health Court
BHD	Behavioral Health Division (formerly the Mental Health Division)
BOMUSD	Black Oak Mine Unified School District
BSCC	Board of State and Community Corrections
CalAIM	California Advancing and Innovating Medi-Cal
CalMHSA	California Mental Health Services Authority
CalQIC	California Quality Improvement Coordinators
CANS	Child and Adolescent Needs and Strengths
CARE Act	Community Assistance, Recovery and Empowerment Act
CBHDA	County Behavioral Health Directors Association of California
CBO	Community Based Organization
CBT	Cognitive Behavior Therapy
CCC	Community Corrections Center or California Conservation Corps
CCMU	Crisis Care Mobile Unit
CCP	Community Corrections Partnership
CCR	Continuum of Care Reform
CDCR	California Department of Corrections and Rehabilitation
CDSS	California Department of Social Services
CEU	Continuing Education Unit
CFMG	California Forensic Medical Group
CFR	Code of Federal Regulations
CFT	Children and Family Teams
CFTN	Capital Facilities and Technology Needs
CHP	California Highway Patrol
CIT	Crisis Intervention Team
CIT	Crisis Intervention Training
CMS	Centers for Medicare & Medicaid Services
CPP	Community Planning Process

CPS	Child Protection Services
CPT	California Psychiatric Transitions
CRRSAA	Coronavirus Response and Relief Supplemental Appropriations Act, 2021
CSS	Community Services and Supports
CWS	Child Welfare Services
DBT	Dialectical Behavior Therapy
DHCS	Department of Health Care Services (California)
DMC-ODS	Drug Medi-Cal Organized Delivery System
DUI	Driving Under the Influence
Dx	Diagnosis
ED	Emergency Department
EDC	El Dorado County
EDCMH	El Dorado County Mental Health
EDCOE	El Dorado County Office of Education
EDCSO	El Dorado County Sheriff's Office
EDSO	El Dorado Sheriff's Office
EDCVC	El Dorado Community Vision Coalition
EH	Extra Help
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQRO	External Quality Review Organization
ER	Emergency Room
FAQs	Frequently Asked Questions
FEP	First Episode Psychosis
FFPSA	Families First Prevention Services Act
FSP	Full Service Partnership
FTE	Full-Time Equivalent
FURS	Foster Youth Urgent Response System
FY	Fiscal Year
HHSA	Health and Human Services Agency
HOT	Homeless Outreach Team
Hubs	Reference to the Innovation Program "Community-Based Engagement and Support Services", also called "Community Hubs"
IA	Intergovernmental Agreement
ICC	Intensive Care Coordination
ICM	Intensive Case Management
IHBS	Intensive Home-Based Services
IMD	Institution for Mental Disease (facility)
ITWS	Information Technology Web Services
Katie A.	<i>Katie A. vs. Bonta</i> Lawsuit and/or resulting programs/services
LCSW	Licensed Clinical Social Worker
LL	Laura's Law
LoC	Level of Care
LOCUS	Level of Care Utilization System
LPCC	Licensed Professional Clinical Counselor

LPS	Lanterman Petris Short
LT	Limited Term
LTCC	Lake Tahoe Community College
MAR	Medication Administration Record
MCT	Mobile Crisis Team
MDT	Multi-Disciplinary Team
M-F	Monday through Friday
MH	Mental Health
MHBG	Mental Health Block Grant
MHD	Mental Health Division
MHRC	Mental Health Rehabilitation Center (facility)
MHSA	Mental Health Services Act
MHSOAC	Mental Health Oversight and Accountability Commission
MHSUDS	Mental Health and Substance Use Disorder Services, a division of the State's Department of Health Care Services (DHCS)
MHW	Mental Health Worker
MIOCR	Mentally Ill Offender Crime Reduction
MOA	Medical Office Assistant
MOU	Memorandum of Understanding
MRT	Moral Reconciliation Therapy
NACT	Network Adequacy Certification Tool
NM	New Morning Youth & Family
NMD	Non-Minor Dependent
NOABD	Notice of Adverse Benefit Determination
NTE	Not-to-Exceed
NTP	Narcotic Treatment Program
OAC	Mental Health Services Oversight and Accountability Commission, also MHSOAC
OP	Outpatient
PA	Physician Assistant
PATH	Projects for Assistance in Transition from Homelessness
PCP	Primary Care Physician
PD	Police Department
PEI	Prevention and Early Intervention
PERT	Psychiatric Emergency Response Team
PES	Psychiatric Emergency Services
PG	Public Guardian
PHF	Psychiatric Health Facility
PIP	Primary Intervention Program or Program Improvement Plan
PL	Public Law
POC	Plan of Correction
PPD	Placerville Police Department
PPE	Personal Protective Equipment
PSC-35	Pediatric Symptom Checklist
QA/UR	Quality Assurance/Utilization Review
QI	Quality Improvement or Qualified Individual

QI/UR	Quality Improvement/Utilization Review
QIC	Quality Improvement Committee
RIF	Reduction in Force
RFI	Request for Information
RFP	Request for Proposal
RFQ	Request for Qualifications
ROI	Authorization for Release of Information
ROC	Restoration of Competence
RV	Remi Vista
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SCF	Sierra Child & Family
SLT	South Lake Tahoe
SLTPD	South Lake Tahoe Police Department
SMHS	Specialty Mental Health Services
SO	Sheriff's Office
STACS	South Tahoe Alternative Collaborative Services
STHS	South Tahoe High School
STRTP	Short-Term Residential Therapeutic Program
SUD	Substance Use Disorders
SUDS	Substance Use Disorder Services
SV	Summitview Child & Family
SYS	Stanford Youth Solutions
T-House	Transitional Housing
TAY	Transitional Age Youth
TBD	To Be Determined
TCH	Tahoe Coalition for the Homeless
TFC	Therapeutic Foster Care
TYFS	Tahoe Youth and Family Services
Tx	Treatment
TY	Tahoe Youth and Family Services
UR	Utilization Review
VA	United States Department of Veterans Affairs
WET	Workforce Education and Training
WIA	Workforce Investment Act
WOIA	Workforce Innovations and Opportunities Act
WS	West Slope