# KINGS COUNTY
# Behavioral Health Services Act (BHSA)
# Integrated Plan
# Draft Intermittent Update

KINGS COUNTY
BEHAVIORAL HEALTH

www.kcbh.org

# BEHAVIORAL HEALTH SERVICES ACT INTEGRATED PLAN

## Intermittent Update

September 25, 2026

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# Executive Summary

Kings County Behavioral Health (KCBH) is proposing an Intermittent Update to its Fiscal Year (FY) 2026–29 Behavioral Health Services Act (BHSA) Integrated Plan to respond to current budget constraints while preserving access to mandated and high-need behavioral health services. The update will revise the existing Integrated Plan upon California Department of Health Care Services (DHCS) approval and guide program operations beginning in FY 2026–27.

**Purpose**

KCBH's FY 2026–29 BHSA Integrated Plan was approved by DHCS in July 2026, and program contracts were launched consistent with that plan. Since approval, continued fiscal constraints have required the County to reassess the sustainability of programs across the behavioral health care continuum.

The proposed Intermittent Update is intended to provide a timely, transparent process for revising the Integrated Plan so that available resources are directed toward core, mandated, and high-priority services. The update reflects KCBH's ongoing responsibility to use data-informed community planning to identify community needs, evaluate service capacity, and maintain a balanced behavioral health system.

**Proposed Plan Revisions**

The Intermittent Update proposes the following changes to Behavioral Health Services and Supports, Early Intervention programming:

- **Sunsetting or reducing funding for prevention programs** that cannot be sustained at their current funding levels given present budget conditions and the need to prioritize essential service obligations:
    - **California Health Collaborative,** Young Minds and Outreach and Engagement (Reduction)
    - **Kings Community Action Organization,** Barbara Saville Shelter (Sunsetting)
    - **Kings County Commission on Aging,** Senior Access for Engagement (Sunsetting)
    - **Kings View,** Warmline (Sunsetting)
    - **Kings United Way,** 211 Kings County (Sunsetting)

- **Implementing new early-intervention programs** to address identified community needs and strengthen access to services earlier during behavioral health concerns.
    - **Kings View,** Access Line
    - **Kings View,** Oak Wellness Center

KCBH evaluated programs within the BHSA behavioral health care continuum, which encompasses eight service categories across mental health and substance use disorder service frameworks. The analysis considered each program's role in meeting community needs, fiscal sustainability, service requirements, and the County's ability to preserve essential behavioral health operations.

Based on program need, funding availability, and operational feasibility, programs will be maintained with moderate reductions, recalibrated toward core or mandated services, or restructured and sunset when they can no longer be maintained responsibly. This approach is intended to minimize controllable costs while protecting services for individuals with the greatest level of need.

**Public Process and Approval**

Under BHSA requirements, counties may submit an Intermittent Update at any time during the three-year Integrated Plan period when urgent revisions are needed in allowable plan sections. Once approved by DHCS, the Intermittent Update becomes the revised Integrated Plan and is effective in the fiscal year in which it is approved. The process requires a 30-day public comment period and approval by the Kings County Board of Supervisors.

This draft BHSA Intermittent Update will be available for Public Comment starting on September 25, 2026, at 12:00 p.m. through October 25, 2026, at 12:00 p.m.

A Public Hearing will be held on October 26, 2026, at 12:00 p.m., during the regularly scheduled Behavioral Health Advisory Board meeting held at 1222 W. Lacey Boulevard. A link to the meeting can be requested by emailing BHAdmin@co.kings.ca.us.

Please note: Additions are identified in red font, and deletions are shown with strikethrough formatting throughout this Intermittent Update.

# General Information

1. County, City, Joint Powers, or Joint Submission: **County**
2. Entity Name: **Kings County**
3. Behavioral Health Agency Name: **Kings County Behavioral Health**
4. Behavioral Health Agency Mailing Address: **1400 W. Lacey Boulevard Hanford, CA 93230**
5. Primary Mental Health Contact
    a. Name: **Lisa Rogers**
    b. Email: **lisa.rogers@co.kings.ca.us**
    c. Phone: **559-852-2382**

6. Secondary Mental Health Contact
    a. Name: **Brett Woolman**
    b. Email: **brett.Woolman@co.kings.ca.us**
    c. Phone: **559-852-2290**

7. Primary Substance Use Disorder Contact
    a. Name: **Monique Florez**
    b. Email: **Monique.florez@co.kings.ca.us**
    c. Phone: **559-852-2436**

8. Secondary Substance Use Disorder Contact
    a. Name: **Sandra Ruiz-Rivas**
    **b.** Email: **Sandra.ruizrivas@co.kings.ca.us**
    c. Phone: **559-852-2299**

9. Primary Housing Interventions Contact
    a. Name: **Brenda Tamayo-Pagan**
    b. Email: **Brenda.tamayopagan@co.kings.ca.us**
    c. Phone: **559-852-2386**

10. Compliance Officer for Specialty Mental Health Services (SMHS)
    a. Name: **Pamela Estrada**
    b. Email: **pamela.estrada@co.kings.ca.us**

11. Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
    a. Name: **Pamela Estrada**
    b. Email: **pamela.estrada@co.kings.ca.us**

12. Behavioral Health Services Act (BHSA) Coordinator

| Name | Email Address |
|---|---|
| **Brenda Tamayo-Pagan** | **brenda.tamayopagan@co.kings.ca.us** |
| **Liliana Robles** | **liliana.robles@co.kings.ca.us** |

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

| Name | Email Address |
|---|---|
| **Laura Tafolla** | **bhacctg@co.kings.ca.us** |

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

| Name | Email Address |
|---|---|
| **Lindsay Garfield** | **Lindsay.garfield@co.kings.ca.us** |

15. Medical Director

| Name | Email Address |
|---|---|
| **Abdolreza Saadabadi MD** | **abdolreza.saadabadi@co.kings.ca.us** |
| **Matthew Bryan** | **matthew.bryan@co.kings.ca.us** |

# 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 serviced, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins.

## Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including untreated behavioral health

conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook.

### Children and Youth

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

**Table 5. Number of Children and Youth Served.**

| Criteria | Number of Children and Youth Under Age 21 |
|---|---|
| Received Medi-Cal Specialty Mental Health Services (SMHS) | **1776** |
| Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention | **97** |
| Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Deliver System (DMC-ODS) services | **103** |
| Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan | **44** |
| 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 program | **0** |
| Were chronically homeless or experiencing homelessness or at risk of homelessness | **0** |
| Were in the juvenile justice system | **0** |
| Have reentered the community from a youth correctional facility | **0** |
| Were served by the Mental Health Plan and had an open child welfare case | **66** |
| Were served by the DMC County of DMC-ODS plan and had an open child welfare case | **0** |
| Have received acute psychiatric care | **66** |

### Adults and Older Adults

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

**Table 6. Adults and Older Adults Served.**

| Criteria | Number of Adults and Older Adults |
|---|---|
| Were dual-eligible Medicare and Medicaid members | **262** |
| Received Medi-Cal SMHS | **2421** |
| Received DMC or DMC-ODS services | **363** |
| Received MH and SUD services from the MHP and DMC county or DMC-ODS plan | **157** |
| Were chronically homeless, or experiencing homelessness, or at risk of homelessness | **0** |
| Experienced unsheltered homelessness | **0** |
| Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing) | **0** |
| Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing | **0** |
| Were in the justice system (on parole or probation and not currently incarcerated) | **0** |
| Were incarcerated (including state prison and jail) | **0** |
| Reentered the community from state prison or county jail | **0** |
| Received acute psychiatric services | **371** |

2. Input the number of persons in designated and approved facilities who were:
    a. Admitted or detained for 72-hour evaluation and treatment rate: **0**
    b. Admitted for 14-day and 30-day periods of intensive treatment: **0**
    c. Admitted for 180-day post certification intensive treatment: **0**

3. Please report the total population enrolled in Department of State Hospital (DHS) Lanterman-Petris-Short (LPS) Act Programs:
   **4**

4. Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
   **0**
5. Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
   **No**

6. Please describe the local data used during the planning process
   **All data presented in this section was extracted from the County's SmartCare database. For items where a value of zero is reported, local data was not available at the time of reporting. Tracking systems will be developed to capture this date moving forward.**

7. If desired, provide documentation on the local data used during the planning process
   **N/A**

**Local CARE Act Implementation**

1. 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.

**Kings County Behavioral Health will utilize a multitude of programs from our 3-year Integrated Plan. Our CARE Act team is the same contracted provider team that delivers KCBH's Full-Service Partnership, Assertive community treatment, and forensic assertive community treatment. CARE Act participants are met with the comprehensive and full scope of FSP ACT level of care, including field-based services, to ensure that they have access to high quality, evidence-based mental health treatment. Partnership with local housing supports, such as Kings Community Action Organization (KCAO) who operate Kings County Bridge Housing program, have also been established to ensure that housing units remain accessible to CARE Act participants in need of immediate housing options. Through both this partnership and access to Full-Service Partnership programs, CARE Act participants maintain both priority access and**

**specialized coordination to encourage entry into the behavioral health continuum of care when previously it may not have been accessible.**

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

**CARE Act is a newer and innovative court-linked entry point for individuals to access the county behavioral health continuum of care. Individuals referred and petitioned into CARE Act can access mental health services quickly and in their local community rather than languishing in state hospitals, hospital placements, and local county jails. Kings County Behavioral Health will continue to partner with our local Superior Court system and various judges that identify individuals found incompetent to stand trial in misdemeanor and felony cases that may be a fit for eligibility in CARE Act to ensure that those appropriate are able to access care appropriate to address their mental health and various socioeconomic needs. Additionally, continued integration with our local Public Guardian's office continues to occur in regular meetings to determine appropriate CARE Act referral and petitions for those who are currently LPS conserved but may benefit from CARE Act as a step down back into community-based care.**

3. 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.

**When an individual is identified as potentially eligible for CARE Act, but a referral or petition has not been identified as appropriate, Kings County Behavioral Health has implemented the expectation of outreach and engagement to attempt to connect the individual to services deemed appropriate to support the individual's needs and to build rapport. Individuals identified in this category related to CARE Act are recorded as inquiries for service to ensure documentation of referrals and coordination can be tracked.**

## County Behavioral Health Technical Infrastructure

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

1. Does the county behavioral health system use an Electronic Health Record (EHR)?
   **Yes**
   a) Please select which of the following EHRs the county uses
      ☐Altera Digital Health
      ☐Athena Health

☐Clinicians Gateway
☐CPSI
☐eClinicalWorks
☐Epic Systems
☐GE Centricity
☐Greenway Health
☐MEDHOST
☐MediTech
☐Netsmart
☐NextGen Healthcare
☐Oracle Cerner
☐Practice Fusion
☐Qualifacts credible
☑**SmartCare**
☐TherapyNotes

2. County participates in a Qualified Health Information Organization (QHIO)?
   **No**

### Application Programming Interface Information

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

1. Please provide the link to the county's API endpoint on the county behavioral health plan's website
   **http://www.kcbh.org/access-my-records.html**

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   **Yes**
   a) Please describe these challenges and concerns:
   **Kings County Behavioral Health maintains API information and patient access instructions on its public website in accordance with BHIN 22-068 and federal interoperability requirements. The API endpoint supports third-party applications seeking authorized access to beneficiary health information from SmartCare. CalMHSA, as the EHR vendor and technical authority for participating counties, oversees the technical build, security layers, and API**

**functionality, while KCBH maintains local operational workflows, authorization processes, and oversight of request handling.**

3. Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056, 23-057, and 24-016. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   **Yes**
   a) Please describe these challenges and concerns:
   **KCBH continues to work closely with CalMHSA to ensure ongoing compliance with all federal interoperability requirements. No significant implementation barriers or concerns are reported currently.**

## County Behavioral Health System Service Delivery Landscape

a) Cities submitting their Integrated Plan Independently from their counties do not have to complete this section.

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

1. Will the county participate in SAMHSA's PATH Grant during the Integrated Plan Period?
   **Yes**
   a) Please select all services the county behavioral health system plans to provide under the PATH grant:
   ☐Alcohol or Drug Treatment Services
   **☑Case Management Services**
   **☑Community Mental Health Services**
   ☐Habilitation and Rehabilitation Services
   **☑Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services**
   **☑Outreach services**
   **☑Screening and Diagnostic Treatment Services**
   **☑Staff Training, including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services**
   ☐Supportive and Supervisory Services in Residential Settings

2. 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)

1. 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
   ☐Children's System of Care Set-Aside
   **☑Discretionary/Base Allocation**
   **☑Dual Diagnosis Set-Aside**
   **☑First Episode Psychosis Set-Aside**
   ☐Integrated Services Agency Set-Aside

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

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

1. Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period?
   **Yes**
   a) Please select all set-asides that the county behavioral health system participates in under SUBG:
      **☑Adolescent/Youth Set-Aside**
      **☑Discretionally**
      **☑Perinatal Set-Aside**
      **☑Primary Set-Aside**
      ☐Syringe Services Program Allowance

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

## Opioid Settlement Funds (OSF)

1. 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

☐Select All
☐Address The Needs of Criminal Justice-Involved Persons
☐Address The Needs of Pregnant or Parenting Women and Their Families, Including Babies with Neonatal Abstinence Syndrome
☑**Connect People Who Need Help to The Help They Need (Connections to Care)**
☐First Responders
☑**Leadership, Planning, and Coordination**
☑**Prevent Misuse of Opioids**
☐Prevent Overdose Deaths and Other Harms (Harm Reduction)
☐Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
☐Research
☑**Support People in Treatment and Recovery**
☑**Treat Opioid Use Disorder (OUD)**
☑**Training**

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

## Bronzan-McCorquodale Act

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

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

j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

1. In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:
   ☐Assertive Community Treatment (ACT)
   ☐Clubhouse Services
   ☐Community Health Worker Services (CHW)
   ☐Coordinated Specialty Care for First Episode Psychosis (CSC for FEP)
   ☐Forensic Assertive Community Treatment (FACT)
   ☐Individual Placement and Support (IPS) Model of Supported Employment
   ☑**Other Programs and Services**
   ☐Not Applicable

2. Please describe Other Programs and Services:

   **BMA funds support a continuum of behavioral health services, including crisis intervention and stabilization; acute psychiatric inpatient care in local Psychiatric Health Facilities (PHFs), designated acute care hospitals, and Institutions for Mental Disease (IMDs) for Medi-Cal beneficiaries under age 21 and over age 65; outpatient services to stabilize and treat individuals with serious mental illness (SMI) in the community; case management; medication support services; conservatorship investigations and administration for individuals who are gravely disabled under the Lanterman-Petris-Short (LPS) Act; and court-mandated behavioral health services.**

3. 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

1. Does the county wish to disclose any implantation challenges or concerns with the requirements under this program?
   **Yes**

   a) Please describe these challenges or concerns:

   **Kings County Behavioral Health is currently providing Drug Courts, Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT), Regular and Perinatal Drug Medi-Cal Services, Regular and Perinatal Non-Drug Medi-Cal Services. As of 11/12/2025, Kings County Behavioral Health does not have an approved DMC-ODS Implementation Plan and has been in the active process of revisions with DHCS until approval, therefore the initial go-live date of 07/01/2026 cannot be confirmed.**

### Medi-Cal Specialty Mental Health Services (SMHS)

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

a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services
j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management
m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21

q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21
s. Therapeutic Behavioral Services for individuals under the age of 21
t. Therapeutic Foster Care for individuals under the age of 21
u. All other Medically Necessary SMHS for individuals under the age of 21

1. Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?
   **☑ACT**
   ☐Clubhouse Services
   **☑CSC for FEP**
   **☑Enhanced CHW Services**
   **☑FACT**
   **☑IPS Supported Employment**
   **☑Peer Support Services**

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

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

1. Select which of the following services the county behavioral health system participates in
   **☑DMC Program**
   ☐DMC-ODS Program

### Drug Medi-Cal Program (DMC)

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

a. All other Medically Necessary Services for individuals under the age 21
b. Intensive Outpatient Treatment Services
c. Medications for Addiction Treatment (including medication, counseling services, and behavioral therapy) (MAT)
d. Mobile Crisis Services
e. Narcotic Treatment Program (NTP) Services
f. Outpatient Treatment Services

g. Perinatal Residential Substance Use Disorder (SUD) Treatment for pregnant women and women in the postpartum period

1. Has the county behavioral health system opted to provide the specific services identified in the list below?
   ☐Enhanced CHW Services
   ☐IPS Supported Employment
   ☑**Peer Support Services**
2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
   **No**

### Other Programs and Services

1. Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health SUD programs:
   - **Substance Use Block Grant (SUBG)**
   - **Community Outreach and Engagement**
   - **Primary Prevention**
   - **Perinatal-Residential**
   - **ODF/IOT**

## Care Transitions

1. Hase the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth)?
   **Yes**
2. Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?
   **Yes**

# Statewide Behavioral Health Goals

## Population-Level Behavioral Health Measures

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

information on 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.

## Priority statewide behavioral health goals for improvement

Counties are required to address the six-priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within.

### Access to care: Primary Measures

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

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

☐Other

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

1. How does your county status compare to the statewide rate?
    a) For adults/older adults: **Below**
    b) For children/youth: **Below**
2. What disparities did you identify across demographic groups or special populations?
    **☑Age**
    ☐Gender
    **☑Race or Ethnicity**
    **☑Sex**
    ☐Spoken Language
    ☐None identified
    ☐No Disparities Data Available
    **☑Other**
    Please describe other: **Written Language**

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

1. How does your county status compare to the statewide rate?
    a) For adults/older adults: **Below**
    b) For children/youth: **Above**
2. What disparities did you identify across demographic groups or special populations? **No Disparities Data Available**

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

1. How does your county status compare to the statewide rate?
    a) For adults/older adults: **Not Applicable**
    b) For children/youth: **Not Applicable**
2. What disparities did you identify across demographic groups or special populations? **No Disparities Data Available**

### Access to care: Supplemental Measures

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

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

2. What disparities did you identify across demographic groups or special population?
   **No Disparities Data Available**

### Access to care: Disparities Analysis

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

   **Disparity analyses were conducted using 2022 service utilization data from the CalMHSA Access to Care Power BI Dashboards. The analysis examined penetration rates for Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS) for both adult and youth populations. Penetration rates were compared to county averages to identify populations experiencing disparities in access to behavioral health services.**

   **SMHS Penetration Rates-Adults**

   **The overall adult SMHS penetration rate was 4.2%. Groups below this benchmark included:**

   - **Adults aged 65 and older (2.0%)**
   - **Females (4.1%)**
   - **Hispanic residents (3.0%)**
   - **Asian or Pacific Islander residents (3.0%)**

   **SMHS Penetration Rates-Youth**

   **The overall youth SMHS penetration rate was 2.9%. Groups below the county average included:**

   - **Children ages 0-2 (1.4%), 3-5 (1.5%), and 6-11 (2.2%)**
   - **Males (2.8%)**
   - **Hispanic youth (2.5%)**
   - **Youth with unknown race/ethnicity (1.7%)**

   **NSMHS Penetration Rates-Adults**

   **The overall adult NSMHS penetration rate was 12.5%. Groups below the county average included:**

   - **Adults ages 21-32 (11.6%) and 69+ (9.9%)**
   - **Males (8.4%)**

- **Asian or Pacific Islander (7.0%), Hispanic (11.2%), American Indian/Alaska Native (11.3%), and Other/Non-Standard race (10.9%)**
- **Individuals whose preferred written language was Spanish (8.9%) or Russian (7.9%)**

**NSMHS Penetration Rates-Youth**

**The overall youth NSMHS penetration rate was 8.3%. Groups below the county average included:**

- **Children ages 0–2 (4.8%), 3–5 (5.0%), and 6–11 (7.8%)**
- **Females (8.1%)**
- **Black youth (8.0%)**
- **Youth identifying as Other/Non-Standard race (4.8%)**
- **Youth whose preferred written language was English (8.2%)**

**Summary of Findings**

**The data indicated persistent disparities across multiple population groups, particularly younger children, older adults, males, several racial and ethnic minority populations (notably Hispanic, Asian or Pacific Islander, and American Indian/Alaska Native), and individuals whose preferred written language is not English. These findings highlight the continued need for targeted outreach, culturally and linguistically responsive service, and engagement strategies to improve equitable access to behavioral health services across all demographic groups.**

## Access to care: Cross-Measure Questions

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

   **Beginning July 1, 2026, Kings County will strengthen and expand several initiatives to improve access to care, particularly in areas where county performance falls below statewide benchmarks. Key efforts include existing and new programs or partnerships:**

- **Mobile Crisis services**
- **CARE Court services**
- **Justice Involved (JI) services**
- **A 24/7 Access and Crisis Line**
- **Collaboration on Substance Use Disorder (SUD) services with Public Health**
- **Community partnerships related to SB 43 and SB 27**

**These initiatives are informed by local data on service utilization, hospital and law enforcement interactions, and Medi-Cal access, as well as by state requirements under the CARE Act and recent BHSA reforms. Collectively, these efforts are designed to expand timely access, target populations with demonstrated service gaps, and enhance coordinated behavioral health care across the county.**

2. Please identify the category or categories of funding that the county is using to address the access to care goal.
   **☑BHSA Behavioral Health Services and Supports (BHSS)**
   **☑BHSA Full Services Partnerships (FSP)**
   ☐BHSA Housing Interventions
   **☑1991 Realignment**
   **☑2011 Realignment**
   **☑State General Fund**
   **☑Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)**
   **☑Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH)**
   **☑Community Mental Health Block Grant (MHBG)**
   **☑Substance Use Block Grant (SUBG)**

## Homelessness: Primary Measures

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

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

2. What disparities did you identify across demographic groups or special populations?
   **☑Age**
   ☐Gender
   **☑Race or Ethnicity**
   **☑Sex**
   ☐Spoken Language
   ☐None Identified
   ☐No Disparities Data Available
   ☐Other

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

1. How does your county status compare to the statewide rate?
   **Below**
2. What disparities did you identify across demographic groups or special populations?
   **☑Age**
   ☐Gender
   **☑Race or Ethnicity**
   **☑Sex**
   ☐Spoken Language
   ☐None Identified
   ☐No Disparities Data Available
   **☑Other**
   a) Please describe other: **English Learners, Migrant Students, Students with Disabilities**

## Homelessness: Supplemental Measures

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

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

2. What disparities did you identify across demographic groups or special populations?
   **No Disparities Date Available**

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

1. How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
   **Below**
2. What disparities did you identify across demographic groups or special populations?
   **No Disparities Date Available**

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

1. How does your local CoC's rate compare to the average rate across all CoC's?
   **Below**
2. What disparities did you identify across demographic groups or special populations?
   **☑Age**
   ☐Gender
   **☑Race or Ethnicity**
   ☐Sex
   ☐Spoken Language
   ☐None Identified
   ☐No Disparities Data Available
   ☐Other

### Homelessness: Disparities Analysis

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

   **Disparity analyses were conducted using 2024 data from the CalMHSA Homelessness Power BI Dashboards. The review examined three primary measures:**

- **Point-in-Time (PIT) Count of People Experiencing Homelessness**
- **Homeless Student Enrollment by Dwelling Type**
- **Rate of People Experiencing Homelessness Who Access Services from the Continuum of Care (Coc)**

**Population groups performing above or below county averages were identified as experiencing disproportionate rates of homelessness or disparities in service access.**

**People Experiencing Homelessness (PIT Count)**

**The countywide PIT Count rate was 26 per 10,000 residents. Demographic groups performing above this county rate included:**

- **Adults ages 35-44 (51 per 10,000)**
- **Adults aged 45 years and older (34-10,000)**
- **Males (33 per 10,000)**
- **American Indian or Alaska Native residents (103 per 10,000)**
- **Black or African American residents (90 per 10,000)**
- **Native Hawaiian or Other Pacific Islander residents (76 per 10,000)**
- **Individuals identifying as multiple races (47 per 10,000)**
- **White residents (36 per 10,000)**

**These data indicated that middle aged and older adults, males, and several racial and ethnic groups, including American Indian/Alaska Native, Black, and Native Hawaiian or Pacific Islander resides experiencing homelessness at disproportionately higher rates compared to the county overall.**

**Homeless Student Enrollment by Dwelling Type**

**The countywide percentage of homeless students was 3.3%. Demographic groups with rates above the county average included:**

- **Students identifying as non-binary (8.0%)**
- **Pacific Islander students (6.6%)**
- **African American students (6.3%)**
- **Hispanic or Latino students (3.5%)**
- **Students identifying as two or more races (3.5%)**
- **Transitional Kindergarten (4.5%)**
- **Kindergarten (3.5%)**
- **Grade 1 (3.7%)**

- **Grades 9 (3.4%), 10 (3.5%), 11 (4.0%), and 12 (4.2%)**
- **English language learners (5.0%)**
- **Migrant students (9.3%)**
- **Students with disabilities (3.9%)**

**These finding suggest that non-binary youth, students of color, English language learners, migrant youth, and students with disabilities experience disproportionately higher rates of housing instability within the educational system.**

**People Experiencing Homelessness Who Access Services from the Continuum of Care (CoC)**

**The countywide rate of people experiencing homelessness who accessed CoC services was 77 per 10,000 residents. Demographic groups performing below this rate included:**

- **Young adults aged 18-24 (72 per 10,000)**
- **Older adults aged 65 and above (32 per 10,000)**
- **Asian or Asian American residents (18 per 10,000)**

**These findings point to potential barriers in service access for transitional age youth, older adults, and Asian or Asian American residents.**

**Across all measures, disparities are most pronounced among racial and ethnic minority populations, males, middle-aged and older adults, transitional age youth, and specific vulnerable student groups. These patterns underscore the importance of implementing targeted interventions, such as culturally and linguistically inclusive outreach, youth-oriented housing support services, and enhanced coordination between schools, health providers, and homeless service systems to promote equitable access and reduce homelessness among disproportionately affected populations.**

### Homelessness: Cross-Measure Questions

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

any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing.

**Kings County Behavioral Health will enhance its strategies to address housing and homelessness by deepening collaboration with the Kings/Tulare Continuum of Care and improving the accuracy and consistency of data within the Homeless Management Information System (HMIS) entered by our contracted providers. These efforts will strengthen the identification and prioritization of housing opportunities for individuals with serious behavioral health conditions experiencing homelessness. Community feedback highlighted the importance of prioritizing those with the most complex needs through coordinated outreach, accessible resources, and placement in appropriate interim housing. In response, KCBH will invest in targeted outreach and engagement initiatives and develop programming specifically designed to support this population. Housing interventions will build on the successful Behavioral Health Bridge Housing Program model, providing operating subsidies for Housing First housing interventions that ensure low-barrier, access to housing that support tenant stabilization, recovery, and sustained housing retention through voluntary, person-centered supportive services.**

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

**☑BHSA BHSS**
☐BHSA FSP
**☑BHSA Housing Interventions**
☐1991 Realignment
☐2011 Realignment
☐State General Fund
☐Federal Financial Participation (SMHS, DMC/DMC-ODS)
**☑SAMHSA PATH**
☐MHBG
☐SUBG
**☑Other**

a) Please describe other**: Behavioral Health Bridge Housing**

## Institutionalization: Primary Measures

### Inpatient administrative days (DHCS) rate, FY 2023

1. How does your county status compare to the statewide rate/average?
    a) For adults/older adults: **Not Applicable**
    b) Cor children/youth: **Not Applicable**
2. What disparities did you identify across demographic groups or special populations?
    **No Disparities Data Available**

## Institutionalization: Supplemental Measures

### Involuntary Detention Rates, FY 2021-2022

1. How does your county status compare to the statewide rate/average?
    a) 14-day involuntary detention rates per 10,000: **Not Applicable**
    b) 30-day involuntary detention rates per 10,000: **Not Applicable**
    c) 180-day post-certification involuntary detention rates per 10,000: **Not Applicable**
2. What disparities did you identify across demographic groups or special populations?
    **No Disparities Data Available**

## Conservatorships, FY 2021-2022

1. How does your county status compare to the statewide rate/average?
    a) Temporary Conservatorships: **Not Applicable**
    b) Permanent Conservatorships: **Not Applicable**
2. 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 admission to institutional facilities

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

a) Crisis Intervention
    i. For adults/older adults: **Below**
    ii. For children/youth: **Below**
b) Crisis Residential Treatment Services
    i. For adults/older adults: **Not Applicable**

ii. For children/youth: **Not Applicable**

c) Crisis Stabilization
   i. For adults/older adults: **Below**
   ii. For children/youth: **Below**

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

**☑Age**
☐Gender
**☑Race or Ethnicity**
**☑Sex**
☐Spoken Language
☐None Identified
☐No Disparities Data Available
**☑Other**
Please describe other: **Written Language**

### Institutionalization: Disparities Analysis

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

**The County reviewed SMHS crisis utilization data from the CalMHSA Institutionalization Power BI Dashboards and identified populations with higher-than-average use of crisis services, highlighting disparities in how and when residents access care. The analysis focused on FY 2023 DHCS measures for crisis intervention and crisis stabilization, comparing each group's average minutes or hours of service to the County average.**

**Adult Crisis Intervention (SMHS, FY 2023)**

**The County average for adult crisis intervention was 214.7 minutes. Several groups exceeded this average, indicating greater reliance on crisis services:**

- **Age: Adults 33-44 (267.3 minutes), 45-56 (229.5 minutes), and 57-68 (226.6 minutes) used more minutes than the county average, suggesting longer or more intensive service needs**
- **Race/Ethnicity: White adults (219.5 minutes) exceeded the average, indicating more frequent or prolonged crisis episodes**

- **Gender: Females (240.4 minutes) spent more time in crisis interventions overall adult population**
- **Primary Written Language: English (225.9 minutes) and Spanish (220.0 minutes) speakers both exceeded the average, suggesting longer or more intensive crises**

**Children/Youth Crisis Intervention (SMHS, FY 2023)**

**The County average youth crisis intervention was 178.8 minutes, with higher utilization observed among:**

- **Age: Adults 21-32 (23.5 hours) required longer stabilization stays**
- **Race/Ethnicity: Hispanic adults (22.4 hours) had longer episodes**
- **Gender: Males (24.8 hours) spent more time in stabilization**
- **Primary Written Language: English speakers (25.3 hours) had the highest utilization**

**Disparities were observed across age, race/ethnicity, gender, and primary written language. Middle-aged and young adults, adolescents and transition-age youth, White and Hispanic residents, females (for crisis intervention) and males (for crisis stabilization), and English-and Spanish-speaking individuals consistently experienced longer or more intensive crisis service use than the County average. These findings will inform targeted upstream prevention, earlier outpatient access, and post-crisis follow-up to reduce reliance on high acuity crisis services over time.**

## Institutionalization: Cross-Measure Questions

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

   **Kings County does not operate a dedicated Mental Health Rehabilitation Center (MHRC), and utilization of Skilled Nursing Facility-Special Treatment Programs (SNF-STPs) remains low due to a regional emphasis on community-based care under Medi-Cal and BHSA initiatives.**

   **Local data from 2025–2026 indicates stable or declining institutional bed use, with fewer than 5% of BHSA-eligible clients referred to institutional settings**

**county-wide, prioritizing instead outpatient services, crisis stabilization, and supportive housing like the Behavioral Health Bridge Housing program.**

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

   **Beginning July 1, 2026, the County will strengthen crisis residential capacity, expand Full-Service Partnership (FSP) programs utilizing Assertive Community Treatment (ACT) and Forensic ACT (FACT) models, and implement specialized training for ACT, FACT, Intensive Case Management (ICM), First Episode Psychosis (FEP), and Coordinated Specialty Care (CSC) teams. These initiatives are designed to reduce institutionalization, including jail and inpatient psychiatric admissions, by providing earlier, more intensive, and recovery-oriented community-based support to sub-populations identified through local data as being at highest risk of justice involvement and repeated crisis utilization.**

   **The County analyzed arrest rates, three-year recidivism data, and crisis utilization data. Key findings included:**

   - **Arrest and recidivism rates above the statewide median among adults with serious mental illness (SMI).**
   - **Higher-than-average inpatient utilization among individuals with co-occurring SMI and substance use disorders.**
   - **Disproportionate justice involvement among young adults, males, and Black and Hispanic residents.**
   - **Repeated crisis and emergency department utilization among individuals experiencing homelessness.**
   - **Early justice contact among young adults experiencing untreated first episode psychosis.**

**These findings demonstrated that individuals with the most significant behavioral health needs were cycling between crisis services, inpatient settings, homelessness, and jail, often without sustained community-based engagement.**

**In 2025, Good Samaritan Hospital was awarded a grant to construct and operate a Crisis Stabilization Unit (CSU), a Psychiatric Health Facility (PHF), and a Crisis Residential Treatment (CRT) facility in Kings County, with full build-out and opening anticipated within approximately 18 to 24 months. These facilities will serve adults experiencing psychiatric crises and will create a specialized behavioral health response locally. When an adult in crisis requires emergency-level support beyond the capacity of mobile crisis teams, they will be diverted to the CSU for specialized psychiatric assessment and intervention rather than to the local, medically focused emergency department. For individuals who require a longer period of intensive, inpatient crisis support, hospitalization will be available within Kings County through the PHF. In addition, adults in Kings County who are experiencing urgent challenges that may escalate to a psychiatric crisis and who wish to voluntarily receive intensive, short-term, wraparound support to address these challenges and help prevent a crisis will be able to voluntarily enroll in Crisis Residential Treatment.**

**In addition, the County will strengthen FSP programs using ACT and FACT models to serve individuals with the highest levels of need, including those with frequent arrests, homelessness, and repeated hospitalizations.**

**Enhancements include:**

- **Multidisciplinary teams providing intensive, field-based services.**
- **FACT teams working closely with courts, probation, and re-entry programs.**
- **Strong linkage to housing, substance use treatment, and primary care.**

**These services will prioritize sub-populations identified through data as having poorer justice outcomes. The goal is to reduce arrests, days in jail, probation violations, and inpatient readmissions, moving the County closer to statewide averages.**

**The County will provide specialized training to ACT, FACT, and ICM staff to improve engagement, de-escalation, and cross-system collaboration. ICM will focus on stabilizing individuals before they escalate to jail or inpatient care.**

**FEP and CSC teams will receive enhanced training to support youth and young adults experiencing early psychosis, who are an identified group at elevated risk for crisis and justice involvement if untreated. Early, coordinated intervention is expected to reduce long-term institutionalization.**

**The County will use its current arrest, recidivism, and crisis utilization rates as baselines and analyze data to identify:**

- **Reductions in arrests and jail bookings for enrolled participants.**
- **Reduced recidivism for individuals linked from jail to FACT and crisis residential.**
- **Lower inpatient and crisis utilization for FEP/CSC participants.**
- **Reduction in disparities in justice involvement across racial and age groups.**

**Through these coordinated, data-informed efforts, the County will prioritize residents with the highest arrest, recidivism, and crisis-utilization rates and reduce institutionalization by expanding access to intensive, community-based treatment and housing supports.**

3. Please identify the category or categories of funding that the county is using to address the institutionalization goal.
   ☐ BHSA BHSS
   ☑ **BHSA FSP**
   ☑ **BHSA Housing Interventions**
   ☐11991 Realignment
   ☐2011 Realignment
   ☑ **State General Fund**
   ☑ **Federal Financial Participation (SMHS, DMC/DMC-ODS)**
   ☐SAMHSA PATH
   ☑ **MHBG**
   ☐ SUBG
   ☐ Other

## Justice-Involvement: Primary Measures

### Adult and Juvenile Arrest Rates (Department of Justice), Statistical Year 2023

1. How does your county status compare to the statewide rate/average?
    a) For adults/older adults: **Above**
    b) For juveniles: **Above**

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

    ☑ **Age**
    ☐ Gender
    ☑ **Race or Ethnicity**
    ☑ **Sex**
    ☐Spoken Language
    ☐ None Identified
    ☐ No Disparities Data Available
    ☐ Other

## Justice-Involvement: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
    **Above**

2. What disparities did you identify across demographic groups or special populations?
    ☑ **Age**
    ☐ Gender
    ☑ **Race or Ethnicity**
    ☑ **Sex**
    ☐Spoken Language
    ☐ None Identified
    ☐No Disparities Data Available
    ☐Other

3. How does your county status compare to the statewide rate/average?
   **Above**

4. What disparities did you identify across demographic groups or special populations?
   ☐ Age
   ☐ Gender
   ☐ Race or Ethnicity
   ☐ Sex
   ☐Spoken Language
   ☐ None Identified
   ☑ **No Disparities Data Available**
   ☐ Other

### Justice-Involvement: Disparities Analysis

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

   **The County identified significant justice-related disparities through analysis of arrest and recidivism data from the CalMHSA Justice-Involvement Dashboards and the California Department of Corrections and Rehabilitation (CDCR) Convictions Dashboard. The measures reviewed included adult and juvenile arrest rates (per 100,000 population) and three-year adult recidivism conviction rates (percent). Data were reviewed and stratified by age, gender, and race/ethnicity to compare subgroup outcomes to overall County rates.**

   **Arrest Rate Disparities**

   **The County's adult arrest rate was 4,309 per 100,000. Arrest rates were higher than the County average among:**
   - **Adults age 20–29 (4,582 per 100,000)**
   - **Adults age 30–39 (6,394 per 100,000)**
   - **Adult males (5,042 per 100,000)**

**For juveniles, the County arrest rate was 306 per 100,000. Juvenile males had a substantially higher rate of 1,129 per 100,000, demonstrating a significant disparity for boys and young men in early justice involvement.**

**Race/ethnicity-stratified arrest rates were available at the total population level. The overall County population arrest rate (adults and juveniles combined) was 2,979 per 100,000. Arrest rates exceeded this rate among:**

- **Black residents (5,657 per 100,000)**
- **Hispanic residents (3,166 per 100,000)**

**Within these groups:**

- **Black males (6,087 per 100,000)**
- **Black females (4,573 per 100,000)**
- **Hispanic males (4,607 per 100,000)**

**All had arrest rates above the County population rate, indicating pronounced disparities for Black and Hispanic residents, particularly Black and Hispanic men, and Black women.**

**Recidivism Disparities**

**Adult three-year recidivism conviction data from the CDCR dashboard showed an overall County recidivism rate of 44.8 percent.**
**Higher recidivism rates were observed among:**

- **Ages 20–24 (60.5 percent)**
- **Ages 25–29 (46.0 percent)**
- **Ages 30–34 (61.4 percent)**
- **Males (46.2 percent)**

**Black/African American individuals had the highest recidivism conviction rate at 68.8 percent, representing a substantial disparity compared to the County overall rate and all other racial/ethnic groups.**

**The analysis demonstrates that justice-related disparities are concentrated among:**

- **Young adults (ages 20–34)**
- **Males across age groups**

- **Black/African American residents, Hispanic residents, particularly Hispanic males**

**Black/African American individuals experience both elevated arrest rates and the highest recidivism conviction rates, indicating compounded disparity across multiple measures.**

**These findings, supported by CalMHSA justice dashboards and CDCR conviction data, will guide the County's prioritization of diversion programs, reentry supports, crisis services, and intensive community-based behavioral health interventions aimed at reducing justice involvement and addressing disparities among the most impacted populations.**

### Justice-Involvement: Cross-Measure Questions

a) 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)

**Beginning July 1, 2026, the County will strengthen and implement targeted programs, services, partnerships, and initiatives designed to reduce justice involvement among individuals living with significant behavioral health needs. Planned efforts include enhancement of diversion programs, continued collaboration through Collaborative Justice Treatment Courts (CJTC), implementation of CARE Court, and justice-involved initiatives focused on reducing unnecessary hospitalization and incarceration.**

**Additionally, the County will expand Mobile Crisis response services, support ongoing implementation of Assisted Outpatient Treatment (AOT), and strengthen service delivery through the Drug Medi-Cal Organized Delivery System (DMC-ODS) to improve access to treatment and community-based supports for justice-involved individuals.**

b) Please identify the categories of funding that the county is using to address the justice-involvement goal.
☐ BHSA BHSS
☑**BHSA FSP**
☐ BHSA Housing Interventions
☐ 11991 Realignment
☐ 2011 Realignment
☐ State General Fund
☐Federal Financial Participation (SMHS, DMC/DMC-ODS)
☐SAMHSA PATH
☐MHBG
☑**SUBG**
☐ Other

## Removal of Children from the Home: Primary Measures

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

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

2. What disparities did you identify across demographic groups or special populations?
☑ **Age**
☐Gender
☐ Race or Ethnicity
☐Sex
☐Spoken Language
☐None Identified
☐ No Disparities Data Available
☐ Other

## Removal Of Children from Home: Supplemental Measures

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

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

2. What disparities did you identify across demographic groups or special populations?
   **☑ Age**
   ☐Gender
   **☑Race or Ethnicity**
   **☑ Sex**
   ☐Spoken Language
   ☐ None Identified
   ☐No Disparities Data Available
   ☐ Other

### Child Maltreatment Substantiations (CWIP), 2022

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

4. What disparities did you identify across demographic groups or special populations?
   **☑ Age**
   ☐ Gender
   **☑ Race or Ethnicity**
   **☑Sex**
   ☐Spoken Language
   ☐None Identified
   ☐No Disparities Data Available
   ☐ Other

## Removal Of Children from Home: Disparities Analysis

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

   **Analysis of data obtained from the CalMHSA Removal of Children from Home PowerBI Dashboards identified disparities across several child welfare and behavioral health measures in Kings County. Measures reviewed included the Children in Foster Care Point-in-Time (PIT) Count, Open Child Welfare Cases**

**Specialty Mental Health Services (SMHS) Penetration Rate, and Child Maltreatment Substantiations.**

**Review of the Children in Foster Care PIT Count indicates that children aged two years and younger experience foster care placement rates above the overall county average. Children under one year of age (545 per 100,000) and those aged one to two years (665 per 100,000) are placed in foster care at higher rates compared to the countywide rate of 513 per 100,000 children. These findings suggest that infants and toddlers are more likely to be removed from their homes relative to older children.**

**Analysis of the Open Child Welfare Cases SMHS Penetration Rate identified several population groups accessing Specialty Mental Health Services at rates below the county average of 46.0 percent. These groups include females (45.9 percent), children aged 0–2 years (39.4 percent) and 6–11 years (44.3 percent), transition-age youth aged 18–20 years (31.3 percent), Black youth (37.0 percent), and youth identifying as a race other than Black, White, or Hispanic (38.8 percent). These data demonstrate disparities in behavioral health service penetration among younger children, transition-age youth, females, and racially diverse populations.**

**For the Child Maltreatment Substantiations measure, several groups experienced substantiation rates above the county average of 4.9 per 1,000 children. Elevated rates were observed among infants under one year of age (13.9), youth aged 16–17 years (5.2), Black youth (8.6), and female youth (5.6). These findings indicate increased risk of substantiated maltreatment among both the youngest and oldest youth, as well as specific demographic populations.**

**Overall, these disparities highlight a higher vulnerability among very young children, Black youth, and female youth in Kings County regarding foster care placement and maltreatment substantiations, as well as lower rates of mental health service penetration among younger, older, and racially diverse populations. These findings point to opportunities for targeted early intervention, outreach, and culturally responsive engagement strategies to improve equity across child welfare and behavioral health systems.**

## Removal Of Children from Home: Cross-Measure Questions

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

   **Beginning July 1, 2026, the County will strengthen coordination with interagency leadership, regarding the implementation of high-fidelity wraparound services, and enhance the referral process from Child Welfare Services (CWS) to children's mental health services to increase access to care for youth and families.**

   **Local needs assessments and utilization data indicate fragmented referral pathways and inconsistent interagency coordination, resulting in service access gaps for sub-populations, including foster youth with higher unmet behavioral health needs.**

   **To address these gaps, the County will strengthen monthly Interagency Leadership meetings to improve cross-system collaboration among child welfare, mental health, probation, and education partners. These meetings will support coordinated planning, streamline referrals, and improve accountability across systems.**

   **The County will also expand high-fidelity wraparound services as an intensive, individualized care approach for youth with complex needs. This model utilizes child and family teams to coordinate flexible, community-based supports and improve engagement in services. Expansion efforts are informed by data demonstrating poorer outcomes, including repeated out-of-home placements among sub-populations such as transition-age foster youth. These efforts are intended to improve timely access to services by reducing delays in referral processing and supporting seamless enrollment following referral.**

2. Please identify the category or categories of funding that the county is using to address the removal of children from home goals.
   ☐ BHSA BHSS
   ☑ **BHSA FSP**
   ☐BHSA Housing Interventions
   ☐ 11991 Realignment
   ☐ 2011 Realignment
   ☐ State General Fund
   ☐ Federal Financial Participation (SMHS, DMC/DMC-ODS)
   ☐SAMHSA PATH
   ☐MHBG
   ☐ SUBG
   ☐ Other

## Untreated Behavioral Health Conditions: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
   - For the full population measured: **Above**

2. What disparities did you identify across demographic groups or special populations?
   ☐ Age
   ☐ Gender
   ☐ Race or Ethnicity
   ☐ Sex
   ☐ Spoken Language
   ☐None Identified
   ☑ **No Disparities Data Available**
   ☐Other

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

3. How does your county status compare to the statewide rate/average?
   - For the full population measured: **Below**

4. What disparities did you identify across demographic groups or special populations?
   ☐ Age
   ☐ Gender
   ☐ Race or Ethnicity
   ☐ Sex
   ☐Spoken Language
   ☐ None Identified
   ☑ **No Disparities Data Available**
   ☐Other

### Untreated Behavioral Health Conditions: Supplemental Measures

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

1. How does your county status compare to the statewide rate?
   - For the full population measured: **Above**

2. What disparities did you identify across demographic groups or special populations?
   ☑**Age**
   ☐Gender
   ☑**Race or Ethnicity**
   ☑**Sex**
   ☐Spoken Language
   ☐None Identified
   ☐No Disparities Data Available
   ☐Other

### Untreated Behavioral Health Conditions: Disparities Analysis

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

   **Disparity data were extracted from the CalMHSA Untreated Behavioral Health Conditions PowerBI Dashboards. Analysis of the Adults Who Needed Help**

**measure identified disparities among several population groups experiencing higher rates of unmet behavioral health needs compared to the overall County rate of 50.6 percent.**

**Rates of adults reporting a need for help related to emotional or mental health concerns or alcohol and drug use, but who had no mental health or substance use–related visits in the past year, were higher among residents aged 18–24 (55.9 percent), 25–64 (51.0 percent), and 65 years and older (59.7 percent). Elevated rates were also observed among males (63.4 percent), females (51.1 percent), and Latino residents (67.4 percent).**

**Further analysis by race and sex demonstrated particularly high rates among Latino males (84.9 percent), Latino females (60.4 percent), and White males (56.3 percent), all exceeding the County average. These findings indicate disparities in access to or utilization of behavioral health services among adult populations, particularly Latino residents and males, as supported by data from the CalMHSA dashboard analysis.**

### Untreated Behavioral Health Conditions: Cross-Measure Questions

1. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026, that may reduce your county's level of 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).

   **Beginning July 1, 2026, the County will strengthen coordination among Managed Care Plans (MCPs), County Behavioral Health, and hospital partners to reduce the prevalence of untreated behavioral health conditions. Enhanced coordination efforts will focus on streamlining enrollment processes, prior authorizations, and warm handoffs following hospital discharge. These activities are intended to address data-identified gaps in timely follow-up care and improve continuity of treatment, thereby reducing untreated behavioral health needs.**

   **County will strengthen collaboration with hospital-based substance use navigators to support screening of emergency department patients, provide**

**immediate assessments, and facilitate referrals to Substance Use Disorder (SUD) treatment services, including the Drug Medi-Cal Organized Delivery System (DMC-ODS). This approach was informed by data identifying high rates of untreated substance use disorders among frequent emergency department utilizers.**

**In addition, a focus on strengthening Mobile Crisis teams, public health partnerships, and of the Crisis Intervention Team (CIT), will support 24/7 crisis de-escalation and linkage to appropriate behavioral health services, reducing untreated acute behavioral health episodes. The County will also optimize Lanterman-Petris-Short (LPS) hold processes through more timely conservatorship evaluations and improved acute care coordination to promote continuity of treatment following crisis stabilization, particularly for high-risk populations.**

2. 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: Opioid Settlement**

## Additional statewide behavioral health goals for Improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals. In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

### Care Experience: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
    a. For adult/older adults: **Below**
    b. For Children/youth: **Above**

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

2. How does your county status compare to the statewide rate/average?
    a. For adults/older adults: **Not applicable**
    b. For children/youth: **Not applicable**

### Engagement In School: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
   **Below**

### Engagement In School: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
   **Below**

Student Chronic Absenteeism Rate (Data Quest), 2022

2. 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

1. How does your county status compare to the statewide rate/average?
   **Above**

### Engagement In Work: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
   **Above**

### Overdoses: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
   a) For the full population measured: **Below**
   b) For adults/older adults: **Above**
   c) For children/youth: **Below**

### Overdoses: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
   a) For the full population measured: **Above**
   b) For adults/older adults: **Above**
   c) For children/youth: **Above**

### Prevention And Treatment of Co-Occurring Physical Health Conditions: Primary Measures

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

1. How does your county status compare to the statewide rate/average?
   a) For adults (specific to Adults' Access to Preventive/Ambulatory Health Service): **Above**
   b) For children/youth (specific to Child and Adolescent Well-Care Visits): **Below**

## Prevention And Treatment of Co-Occurring Physical Health Conditions: Supplemental Measures

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

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

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

1. How does your county status compare to the statewide rate/average?
    a) For the full population measured: **Above**
    b) For adults/older adults: **Above**
    c) For children/youth: **Below**

## Quality Of Life: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
    a) For the full population measured: **Same**

## Social Connection: Primary Measures

### Perception of Social Connectedness Domain Score (CPS), 2024

1. How does your county status compare to the statewide rate/average?
    a) For the full population measured: **Below**
    b) For adults/older adults: **Below**
    c) For children/youth: **Above**

### Social Connection: Supplemental Measures

#### Caring Adult Relationships at School (CHKS), 2023

1. How does your county status compare to the statewide rate/average? **Below**

### Suicides: Primary Measures

#### Suicide Deaths, 2022

1. How does your county status compare to the statewide rate/average?
    a) For the full population measured: **Below**

### Suicides: Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
    a) For the full population measured: **Above**
    b) For adults/older adults: **Above**
    c) For children/youth: **Above**

## County-selected statewide population behavioral health goals

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

### Goal: Suicides

1. Please describe why this goal was selected

    **Kings County selected this goal in direct response to what recent suicide data reveals about both need and opportunity for improvement. Across 2024 and 2025, the county recorded 24 suicide deaths, with an increase from 9 deaths in 2024 to 15 deaths in 2025. This rise underscores that suicide remains a significant and growing concern locally rather than a rare or isolated event.**

    **The 2022 data provide critical additional context for this decision, highlighting a disparity between suicide mortality and serious suicidal behavior. In 2022, Kings County's suicide death rate was 9.9 per 100,000, slightly lower than the statewide rate of 11 per 100,000; however, the county had a much higher rate of non-fatal emergency department visits due to self-harm at 138 per 100,000 compared to**

**85.8 statewide. This pattern suggests a large population of residents experiencing severe distress and requiring acute medical intervention, presenting both a substantial unmet behavioral health need and a key opportunity for upstream prevention.**

**Emergency departments emerge as vital touchpoints for identifying and linking at-risk individuals to care, helping bridge the gap between high self-harm morbidity and the later observed increase in suicide deaths. Patterns by sex, age, and method across 2024–2025 further shaped the county's decision. Men and adults ages 25–64 account for most deaths, while women, youth, and older adults are also represented, indicating the need to prioritize high-burden groups while maintaining tailored strategies for younger and older residents.**

**At the same time, data highlight substantial gaps in system contact. Only a minority of decedents were enrolled in Kings View services or had documented substance use treatment involvement at the time of death, indicating that many individuals who die by suicide are not engaged in specialty behavioral health services. This finding demonstrates the need for suicide prevention efforts to extend beyond the behavioral health system into primary care, emergency departments, schools, justice settings, and community-based organizations.**

**Kings County therefore selected this goal to strengthen a coordinated, cross-system suicide prevention framework and to target interventions toward the populations most reflected in its recent suicide deaths.**

2. 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

**Kings County identified several disparities across demographic groups and priority populations through analysis of 2022–2025 suicide data. Disparities were observed in suicide deaths and related behavioral health outcomes by sex, age, behavioral health system engagement, and crisis service utilization. These findings are supported by local surveillance data documenting 24 total suicide deaths across 2024–2025 (9 deaths in 2024 and 15 deaths in 2025), a 2022 suicide death rate of 9.9 per 100,000 compared to the statewide rate of 11 per 100,000, and a substantially higher non-fatal self-harm emergency department (ED) visit rate of 138 per 100,000 compared to 85.8 statewide.**

**Adults ages 25–64 experienced the greatest burden, accounting for 12 of the 24 suicide deaths (50%). Older adults ages 65 and older accounted for three deaths, while youth under age 17 and transition-age youth (TAY), ages 18–24, each accounted for three deaths. These findings demonstrate suicide risk across the lifespan, with disproportionate impact among working-age adults and older residents.**

**A significant disparity was identified in behavioral health service engagement prior to death. Only 5 of the 24 individuals who died by suicide had documented enrollment in Kings View services or involvement in substance use disorder (SUD) treatment, while the majority (19 individuals) had no documented or unknown system involvement. This indicates that many individuals experiencing suicide risk were not connected to specialty behavioral health services prior to death.**

**The elevated 2022 self-harm ED visit rate highlights a morbidity disparity within the county. Although suicide mortality rates were slightly below the statewide average, the substantially higher rate of non-fatal self-harm suggests that many residents are reaching crisis-level distress requiring emergency care but are not successfully linking to ongoing behavioral health treatment.**

**Overall, Kings County data indicate disparities affecting working-age adults, older adults, youth populations, and individuals not engaged in behavioral health or substance use treatment services. The findings underscore the need to strengthen early identification, improve linkage to care following crisis events, and expand coordinated suicide prevention efforts across healthcare and community systems.**

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

**Beginning July 1, 2026, Kings County Behavioral Health plans to strengthen and implement several targeted programs, services, partnerships, and initiatives aimed at reducing suicide deaths and improving suicide prevention outcomes. These efforts are directly informed by local data from 2022–2025 demonstrating elevated non-fatal self-harm emergency department (ED) visits, increasing suicide deaths, and identified demographic and behavioral health system engagement gaps.**

**First, the county will strengthen postvention and survivor support services through a contracted provider to implement LOSS (Local Outreach to Suicide Survivors) programming and expand Survivors of Suicide support groups. This decision is informed by the increase in suicide deaths from 9 in 2024 to 15 in 2025, totaling 24 deaths over two years. Expanded postvention services will provide immediate outreach, peer support, and linkage to behavioral health care for families and communities affected by suicide, with the goal of reducing trauma impacts and preventing additional suicide risk among survivors.**

**Second, Kings County will expand crisis-response capacity through enhanced mobile crisis services. Local data indicate that only a minority of individuals who died by suicide were enrolled in Kings View services or had documented substance use disorder (SUD) treatment involvement at the time of death, demonstrating that many individuals experiencing crisis are not engaged in specialty behavioral health services. Mobile crisis teams will provide community-based response in homes, schools, and public settings to support individuals experiencing acute distress through de-escalation, on-site assessment, safety planning, and warm handoffs to ongoing care.**

**Third, the county plans to strengthen child and youth-focused suicide prevention interventions, including collaboration with child welfare partners and expansion of Mobile Crisis Services Teams (MCST) serving youth. Suicide deaths among youth and transition-age youth identified in 2024–2025 data highlight the need for earlier intervention within youth-serving systems. Embedding crisis and prevention supports within child welfare, schools, and juvenile justice settings will improve early identification of risk, enhance care coordination, and address factors such as trauma exposure, placement instability, and family stress.**

**Fourth, Kings County will expand community outreach and prevention efforts targeting older adults. Local suicide data include deaths among residents age 65 and older, a population that may experience social isolation, medical comorbidities, and reduced engagement with traditional behavioral health services. Planned outreach will include education on suicide warning signs, stigma reduction, and strengthened referral pathways from primary care providers, aging services, and community-based organizations into behavioral health supports.**

**Collectively, these planned programs and partnerships respond directly to county data demonstrating elevated self-harm morbidity (2022), increasing suicide deaths between 2024 and 2025, concentration of deaths among adults**

**ages 25–64, suicide risk across the lifespan, low engagement with specialty behavioral health services prior to death, and identified system coordination gaps. These initiatives aim to strengthen an integrated, community-based suicide prevention framework and improve timely access to behavioral health care across Kings County.**

4. Please identify the category or categories of funding that the county is using to address this goal.
   ☑ **BHSA BHSS**
   ☐BHSA FSP
   ☐BHSA Housing Interventions
   ☐ 11991 Realignment
   ☐ 2011 Realignment
   ☐ State General Fund
   ☐ Federal Financial Participation (SMHS, DMC/DMC-ODS)
   ☐SAMHSA PATH
   ☐MHBG
   ☐ SUBG
   ☐ Other

# Community Planning Process

## Stakeholder Engagement

1. Please indicate the type of engagement used to obtain input on the planning process.
   ☑**County outreach through social media**
   ☐County outreach through town hall meetings
   ☐County outreach through traditional media (e.g., television, radio, newspaper)
   ☑**Focus group discussion**
   ☑**Key informant interviews with subject matter experts**
   ☑**Meeting(s) with county**
   ☑**Provided data to county**
   ☐Public e-mail inbox submission
   ☑**Survey participation**
   ☐Training, education, and outreach related to community planning
   ☐Workgroups and committee meetings
   ☐Other

2. Include date(s) of stakeholder engagement for each type of engagement. Stakeholder engagement:
    - **Focus group discussions dates: 08/26/2025, 08/26/2025, 08/26/2025, 08/27/2025, 08/27/2025, 08/28/2025, 09/15/2025, 09/16/2025, 09/23/2025, 09/25/2025**
    - **County outreach through townhall meetings: 08/27/2025, 09/15/2025**
    - **Workgroups and committee meetings: 01/30/2026**
    - **Key informant interview with subject matter experts: 08/21/2025, 09/25/2025, 09/30/2025, 09/30/2025, 09/30/2025, 10/01/2025, 10/02/2025**
    - **Survey Participation: 09/22/2025, 09/22/2025**

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

    **Stakeholder organizations engaged in the planning process included Oak Wellness Center; Behavioral Health Bridge Housing providers; Veterans Support Group; Samuel's House; LGBTQ+ Support Group; Kings Commission on Aging; The Family Support Group; California Health Collaborative; Kings Community Action Organization; First 5 Kings County; Kings County Department of Public Health; Adventist Health; Anthem; and Sister Speak Support Group.**

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

    **Not Applicable**

4. Were you able to engage all required stakeholders/groups in the planning process? **No**

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

    ☐Area agencies on aging
    ☐BHSA eligible adults and older adults (individuals with lived experience)
    ☐Community-based organizations serving culturally and linguistically diverse constituents
    ☐Continuums of care, including representatives from the homeless service provider community

☐County social services and child welfare agencies
☑**Disability insurers**
☐Early childhood organizations
☐Emergency medical services
☐Families of BHSA eligible children and youth, eligible older adults (with lived experience)
☐Higher education partners
☐Health care organizations, including hospitals
☐Health care service plans, including Medi-Cal managed care plans
☐Independent living centers
☐Individuals with behavioral health experience, including peers and families
☑**Labor representative organizations**
☐Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+) communities
☐Local education agencies
☐Local public health jurisdictions
☐Organizations specializing in working with underserved racially and ethnically diverse communities
☐People with lived experience of homelessness
☐Providers of mental health services
☐Providers of substance use disorder treatment services
☐Public safety partners, including county juvenile justice agencies
☐Regional centers
☐The five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities.)
☑**Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes**
☐Veterans and representatives from veterans' organizations
☐Victims of domestic violence and sexual abuse
☐Youth from historically marginalized communities
☐Youths (individuals with lived experience), youth mental health organizations, or youth substance use disorder organizations

Disability insurers: **Attempted but did not receive a response**
Labor representative organizations: **Stakeholder declined to participate**
Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes: **Stakeholder declined to participate**

5. 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

**Kings County Behavioral Health incorporated diverse stakeholder viewpoints into the development of its Three-Year Integrated Plan (FY 2026–27–2028/29) through a comprehensive Community Planning Program Process (CPPP) conducted between late August and early October 2025.**

**The process utilized multiple inclusive strategies to ensure broad and meaningful participation, consistent with BHSA requirements for stakeholder engagement.**

**A total of 13 focus groups (116 participants) were conducted in person and virtually, in both English and Spanish. These sessions were hosted at community-based locations including Oak Wellness Center; Kings Community Action Organization (KCAO); Veterans Support Group; Samuel's House; Corcoran Family Resource Center; Hanna's House; LGBTQ+ Support Group; Family Engagement Center (Avenal); Kings County Commission on Aging; Family Support Group; and California Health Collaborative.**

**In addition, eight key stakeholder interviews were conducted with representatives from Kings Community Action Organization; First 5 Kings County (two representatives); Kings County Department of Public Health; Adventist Health (Emergency Department); Anthem (two representatives); and Sister Speak (African American Women's Support Group).**

**Two surveys were also administered: a general community survey (66–83 respondents across demographic groups) capturing input from individuals with lived behavioral health experience, family members, providers, and individuals with private insurance, Medi-Cal, or uninsured status; and a survey specifically for domestic violence survivors.**

**Feedback from all engagement activities was thematically analyzed and organized according to the 14 BHSA Statewide Goals (e.g., Access to Care, Homelessness, Suicide and Overdose Prevention). Themes were quantified by frequency of mention (e.g., geographic barriers referenced in nine focus groups) to identify areas of greatest concern**

**The County successfully engaged 27 of the 30 required stakeholder groups identified in BHSA guidelines (Appendix 2). Engaged groups included area agencies on aging; BHSA-eligible adults and older adults; community-based organizations serving culturally and linguistically diverse populations; continuums of care; county social services and child welfare; early childhood organizations; families of eligible individuals; healthcare organizations and hospitals; health plans (e.g., Anthem); independent living centers; individuals with lived behavioral health experience (including peers and family members); LGBTQ+ communities; local education agencies; local public health; and organizations representing underserved racial and ethnic communities.**

**Three stakeholder groups, disability insurers, labor representative organizations, and Tribal/Indian health, were not formally consulted due to non-response or declination. However, considerations from these groups were considered and at least incorporated in the integrated plan.**

**For disability insurers, although a formal interview was not able to be conducted, several other stakeholders engaged reflected perspectives closely connected to those of disability insurers. For example, two focus groups were conducted with individuals in a residential treatment setting, indicating that they had potentially or likely disabling mental illnesses and/or substance use disorders. Additionally, feedback from Regional Center leadership addressed concerns of individuals with co-occurring developmental disabilities and behavioral health conditions. Finally, significant representation from family members of individuals with behavioral health conditions, who are often de facto caretakers of individuals with partially or fully disabling behavioral health conditions, were included through the community survey (n=32, 48% of respondents) and a focus group (12 individuals participated) with a local Family Support Group (for family members of individuals with serious mental illness or substance use disorder).**

**For labor representative organizations, although a formal interview was declined, many of the focus group participants and survey respondents were local members of the behavioral health workforce (or behavioral health-adjacent workforce) and therefore can be presumed to have converging interests with that of the relevant labor representative organizations. For example, nearly half (n=29, 44%) of the community survey respondents identified themselves as 'staff provider, or volunteer mainly working with people with mental health or**

**substance use conditions.' Additionally, at least 2 of the focus groups (i.e., in Avenal, and with CA Health Collaborative providers/staff) consisted of predominately or entirely members of the behavioral health workforce.**

**For tribal/Indian health, although a formal interview for the community planning process was declined, an individual from Central Valley Indian Health regularly meets with program managers and other staff from Kings County Behavioral Health to discuss coordination of services and emerging needs or program changes. Because of these regular meetings that occur, including during the time the CPP was occurring, there was consideration of Tribal/Indian Health in the program planning.**

**Community-identified strengths emphasized the County's responsiveness and strong partnerships. Stakeholders highlighted listening sessions as valuable opportunities for outreach and education. Community sites such as Oak Wellness Center and Samuel's House were recognized for fostering peer support, connection, and life skills development. Participants described the impact of peer support in promoting recovery and strengthening family involvement.**

**Identified needs and barriers reflected systemic gaps compounded by Kings County's rural geography. Transportation and distance were the most frequently cited challenges (mentioned in nine focus groups), particularly for residents of Avenal and Corcoran who must travel 45 minutes or more to access services in Hanford. These barriers were further intensified by extreme heat, limited public transportation, and financial constraints. Participants also reported frustration with system navigation (four groups), including provider turnover, referral delays, and fragmented care. Stigma and fear of consequences (three to five groups) deterred help-seeking, particularly among farm workers and parents concerned about child welfare involvement. Justice-related concerns were significant; inadequate mental health crisis training among law enforcement (noted in eleven groups) was reported to contribute to crisis escalation and mistrust. Stakeholders also identified high reliance on emergency departments for self-harm, increasing homelessness linked to relationship instability and limited affordable housing, and data gaps affecting rural and unhoused populations. Participants emphasized the need for culturally responsive services for Latino, African American, and LGBTQ+ communities.**

**Community priorities focused on expanding accessible, trauma-informed, and culturally responsive services. Frequently recommended strategies included mobile clinics and outreach in schools, markets, and agricultural fields (eleven groups); peer mentorship programs (four groups); integrated "one-stop" service models (four groups); mandatory mental health and de-escalation training for law enforcement (twelve groups); and increased family involvement in discharge planning (three groups). For priority populations, stakeholders emphasized low-barrier and non-religious supports for individuals experiencing homelessness and LGBTQ+ individuals; extended evening and weekend hours for farmworkers; expanded naloxone distribution and harm reduction services; and strengthened school-based prevention services, along with expansion of the housing continuum, life skills training, and cross-system coordination across behavioral health, child welfare, and law enforcement systems.**

## Local Health Jurisdiction (LHJ)

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

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

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

   **Kings County Behavioral Health (KCBH) has established monthly meetings with the Kings County Department of Public Health and Medi-Cal Managed Care Plans (MCPs) to discuss Community Health Assessment (CHAs) data and the Community Health Improvement Plan (CHIP), focusing on coordinated upstream interventions for population health. KCBH has also identified and exchanged relevant county and statewide data to build holistic community profiles.**

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

### Collaboration

1. 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**
   ☐Other

### Data-Sharing

#### Data-Sharing to Support the CHA/CHIP

1. Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP
   **☑Access to Care**
   **☑Care Experience**
   **☑Engagement in School**
   **☑Engagement in Work**
   **☑Homelessness**
   **☑Institutionalization**
   **☑Justice Involvement**
   **☑Overdoses**
   **☑Prevention and Co-Occurring Physical Health Conditions**
   **☑Quality of Life**
   **☑Removal of Children from Home**
   **☑Social Connection**
   **☑Suicides**
   **☑Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)**
   ☐Other
2. Was data shared?
   **Yes**

### Data-Sharing from MCPS and LHJs to Support IP development

1. Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development
   **☑Access to Care**
   **☑Care Experience**
   **☑Engagement in School**
   **☑Engagement in Work**
   **☑Homelessness**
   **☑Institutionalization**
   **☑Justice Involvement**
   **☑Overdoses**
   **☑Prevention and Co-Occurring Physical Health Conditions**
   **☑Quality of Life**
   **☑Removal of Children from Home**
   **☑Social Connection**
   **☑Suicides**
   **☑Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)**
   ☐Other

2. Was data shared?
   **Yes**

### Stakeholder Activities

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

   ☐Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process
   ☐Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP

☐Co-hosted community sessions, listening tours, and/or other community events that can be used to strengthen stakeholder engagement for both the IP and CHA/CHIP
☐Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement
**☑Other**

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

**The County is currently conducting bi-monthly meetings with the Local Health Jurisdiction (LHJ) to coordinate required stakeholder activities. These meetings focus on establishing a comprehensive community planning process, enhancing data collection and analysis, and developing a joint Request for Proposal (RFP) process to support the upcoming Integrated Plan (IP) and Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) initiatives.**

**Kings County Behavioral Health staff attended the LHJ CHIP Kick-off meeting and will be participating in CHIP subgroup meetings to establish priorities and strategies for each group.**

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

1. Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP?
   **Yes**
   i. Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP.

   **Kings County Behavioral Health (KCBH) reviewed the Kings County Department of Public Health's (KCDPH) Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and Strategic Plan during the development of its Integrated Plan (IP). This review ensured alignment between the IP's BHSA Statewide Goals and KCDPH's identified community health priorities, strategies, and areas of focus.**

## Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

   **Kings County Behavioral Health (KCBH) collaborated with the following Managed Care Plans (MCPs) to inform their respective community reinvestment planning and decision-making processes: CalViva Health, Anthem Blue Cross, and Kaiser Permanente.**

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

   **The County has established monthly coordinated meetings with Public Health and the Medi-Cal Managed Care Plans (MCPs) to enhance collaboration and promote a shared understanding of community behavioral health needs. These meetings are designed to facilitate joint planning and the development of appropriate, sustainable interventions, including activities implemented through the MCP Community Reinvestment Plan.**

# Comment Period and Public Hearing

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

☑ Confirm that the data is up to date and reflects the correct information for a Intermittent Update

1. Date the Intermittent Update was released for stakeholder comment (optional)

**9/25/2026**

2. Date the stakeholder comment period closed (optional)

**10/25/2026**

3. Date of behavioral health board public hearing on draft IP (optional)

**10/26/2026**

3a. Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality (optional)

**☑Link**

☐PDF, image, or other document

Please provide the link to the public posting (optional)

**http://www.kcbh.org/public-notices.html**

4. If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page (optional)

**http://www.kcbh.org/public-notices.html**

5. Please select the process by which the draft plan was circulated to stakeholders (optional)

**☑Public Posting**

☐Email

☐Other

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

**TBD**

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

**TBD**

# County Behavioral Health Services Care Continuum

## County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

**☑Mark section as complete**

# County Provider Monitoring and Oversight

## Medi-Cal Quality Improvement Plans

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

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

2. Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under and integrated SMHS/DMC-ODS contract)?
   **No**

## Contracted BHSA Provider Locations

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

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

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

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

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

| Services Provided | Number of Contracted BHSA Provider Locations |
|---|---|
| SMHS only | **2** |
| DMC/DMC-ODS only | **0** |
| Both SMHS and DMC/DMC-ODS systems | **0** |

## All BHSA Provider Locations

1. Among the county's BHSA funder 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?
   **14%**

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

   **To increase MCP contracting rates, the County will strategically transition eligible services to Medi-Cal/MCP reimbursement where allowable, with the goal of completing this shift within two years beginning July 1, 2027.**

   1. **County to identify BHSA funded SMHS sites whose services overlap with the NSMHS benefit (e.g., Outpatient therapy, medication management, low moderate acuity levels of care).**
   2. **For services that fall clearly within NSMHS scope, build expectations into BHSA contracts (starting in FY 2029-2030 renewals) that providers will pursue and maintain MCP NSMHS contracts whenever feasible.**
   3. **Where appropriate, finalize and roll-out county standard templates, documentation and billing guidance (e.g., intake treatment plans, progress notes) that meet MCP NSMHS requirements to reduce administrative burden and reduce duplication of items.**
   4. **Re-evaluate BHSA funding allocations for NSMHS type services to ensure that, as MCP reimbursement grows, BHSA resources are redirecting toward specialty, high acuity, and non-covered services.**

**Through these strategies, the county intends to increase the proportion of BHSA funded SMHS provider locations that hold at least one Medi-Cal MCP NSMHS contract, while maintaining appropriate specialty mental health capacity, thereby ensuring that services which can and should be reimbursed by MCPs are billed accordingly and that BHSA funds are reserved for higher acuity, specialty, and non-covered services.**

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

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

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

b) 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)

### General

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

☐Childre's System of Care (non-Full Service Partnership (FSP))
**☑Adult and Older Adult System of Care (non-FSP)**
**☑Early Intervention Programs (EIP) – 51%**
**☑Outreach and Engagement (O&E)**
☐Workforce, Education and Training (WET)
**☑Capital Facilities and Technological Needs (CFTN)**

#### Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #1

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to **7.A.2 Children's, Adult, and Older Adult Systems of Care**

1. Please select the service types provided under Program

**☑Mental health services**
**☑Supportive services**
☐Substance Use Disorder (SUD) treatment services

2. Please describe the specific services provided

~~**The intended outcomes of the Senior Access for Engagement (SAFE) Early Intervention Program are to address early signs and risk factors associated with mental health challenges among older adults in Kings County and prevent the escalation of behavioral health needs. Through services provided at the Kings County Commission on Aging Office, the program aims to reduce the negative impacts of untreated mental health symptoms and enhance overall well-being among participating older adults.**~~

~~The program is intended to support BHSA-eligible older adults age 60 and older, as well as their caregivers, by addressing stress, burnout, grief, and other early emotional or behavioral health concerns. Expected outcomes include improved emotional well-being, increased access to supportive services, strengthened coping skills, and early identification and intervention to prevent progression to more serious behavioral health conditions for both older adults and caregivers.~~

**The Oak Wellness Center fosters recovery and wellness by providing safe, supportive environment for members to connect with peers and staff. It offers a variety of educational, recreations and wellness activities designed to promote overall well-being.**

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

**Table 12. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year.**

| Plan Period by FY | Projected Number of Individuals Served |
|---|---|
| FY 2026 – 2027 | ~~767~~ 258 |
| FY 2027 – 2028 | ~~786~~ 266 |
| FY 2028 – 2029 | ~~802~~ 273 |

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

~~Projections for Fiscal Year (FY) 2026–27 were based on actual historical service utilization data reported for the SAFE Program under Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI). Projections for FY 2027–28 and FY 2028–29 were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections.~~

**Projections for Fiscal Year (FY) 2026–27 were based on actual historical service utilization data reported for the Oak Wellness Center Annual Report. Projections for FY 2027–28 and FY 2028–29 were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections**.

**Early Intervention (EI) Programs #1**

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

1. Program or service name
   **Sister Speak**
1. Please select which of the three EI components are included as part of the program or service
   ☐Outreach
   ☐Access and Linkage: Screening
   ☐Access and Linkage: Assessments
   ☑**Access and Linkage: Referrals**
   ☐Access and Linkage: Other
   ☐Treatment Services and Supports: Services to address first episode psychosis (FEP)
   ☑**Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
   ☐Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   ☐Treatment Services and Supports: Other

2. 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**
3. Please describe intended outcomes of the program or service.

   **The group seeks to reduce the onset and negative impacts of mental health challenges by strengthening individual and community resilience through shared cultural identity, social connection, and mutual support.**

   **The primary target population is adult women of color residing in Kings County, including but not limited to Black/African American, Latinx, Indigenous, Asian, Pacific Islander, Middle Eastern/North African, and multiracial individuals who may experience cultural, social, economic, and systemic stressors contributing**

**to behavioral health disparities. The group is open to individuals seeking support, cultural affirmation, and community connection within a safe and inclusive environment and may also include caregivers and family members, when appropriate.**

4. 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**
5. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

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

| Plan Period by FY | **Projected Number of Individuals Served** |
|---|---|
| FY 2026-2027 | **24** |
| FY 2027-2028 | **24** |
| FY 2028-2029 | **24** |

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

   **Projections for FY 2026–27 were based on actual historical service utilization reported under MHSA Prevention and Early Intervention (PEI) programs. Projections for FY 2027–28 and FY 2028–29 were estimated using Kings County population growth trends, including a 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections. Due to the small baseline number of individuals served, projected population growth did not result in substantial increases in projected service numbers.**

### Early Intervention (EI) Programs #2

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3., but counties may develop multiple programs/interventions to meet all county EI requirements. For related policy information, refer to 7.A.7 Early Intervention Programs

1. Program or service name
   **The Family Support Group**

2. Please select which of the three EI components are included as part of the program or service
   ☐Outreach
   ☐Access and Linkage: Screening
   ☐ Access and Linkage: Assessments
   **☑Access and Linkage: Referrals**
   ☐Access and Linkage: Other
   ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)
   **☑Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
   ☐ Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   ☐ Treatment Services and Supports: Other
3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
   **No**
4. Please describe intended outcomes of the program or service

   **The intended outcomes of the group are to provide support, referral, and linkage to families and individuals coping with mental health challenges. Through a peer-driven model facilitated by a mental health professional, the group aims to increase access to supportive resources and strengthen participants' ability to navigate behavioral health services.**

   **The program is intended to support BHSA-eligible individuals, as well as parents, caregivers, and family members experiencing early signs of a mental health or substance use disorder or who have known risk factors, including trauma or involvement with child welfare or justice systems. Expected outcomes include improved connection to appropriate services, increased support for families, and early intervention to help prevent the progression of behavioral health conditions.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
   **No**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

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

| Plan Period by FY | Projected Number of Individuals Served |
|---|---|
| FY 2026-2027 | **56** |
| FY 2027-2028 | **57** |
| FY 2028-2029 | **56** |

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

   **Projections for Fiscal Year (FY) 2026–27 were based on actual historical service utilization data reported under Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs. Projections for FY 2027–28 and FY 2028–29 were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections. The actual figures were too small to result in a meaningful projected increase.**

## Early Intervention (EI) Programs #3

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

1. Program or service name
   **Veterans Support Group**
2. Please select which of the three EI components are included as part of the program or service
   **☑Outreach**
   ☐Access and Linkage: Screening
   ☐Access and Linkage: Assessments
   **☑Access and Linkage: Referrals**
   ☐ Access and Linkage: Other
   ☐Treatment Services and Supports: Services to address first episode psychosis (FEP)
   **☑Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
   ☐Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   ☐Treatment Services and Supports: Other

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

   **No**

4. Please describe intended outcomes of the program or service

   **The intended outcomes of the support group are to provide culturally responsive and trauma-informed services that promote early identification of behavioral health needs among veterans and their families and improve linkage to appropriate care. Through a peer-driven model facilitated by a mental health professional, the program aims to increase awareness of behavioral health resources, strengthen social support, and encourage early help-seeking behaviors.**

   **The group is intended to support adult and older adult veterans experiencing emerging or existing behavioral health needs, including substance use disorders, as well as their families or support persons when appropriate. Expected outcomes include improved connection to behavioral health services, increased engagement in care, and early intervention consistent with Behavioral Health Services Act (BHSA) Early Intervention goals.**

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

   **No**

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

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

| Plan Period by FY | **Projected Number of Individual Served** |
|---|---|
| FY 2026-2027 | **15** |
| FY 2027-2028 | **15** |
| FY 2028-2029 | **15** |

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

**Projections for Fiscal Year (FY) 2026–27 were based on actual historical service utilization data reported under Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs. Projections for FY 2027–28 and FY 2028–29 were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections. The actual figures were too small to result in a meaningful projected increase.**

### Early Intervention (EI) Programs #4

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

1. Program or service name
   **The Source-LGBTQ+ Support Group**
2. Please select which of the three EI components are included as part of the program or service
   **☑Outreach**
   ☐Access and Linkage: Screening
   ☐Access and Linkage: Assessments
   **☑Access and Linkage: Referrals**
   ☐Access and Linkage: Other
   ☐Treatment Services and Supports: Services to address first episode psychosis (FEP)
   **☑Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
   ☐Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   ☐Treatment Services and Supports: Other

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
   **No**
4. Please describe intended outcomes of the program or service

   **The intended outcomes of the LGBTQ+ and Transgender Peer Support Groups are to reduce the onset and negative impacts of mental health challenges among**

**LGBTQ+ community members in Kings County by providing culturally responsive, peer-driven Early Intervention services in safe and affirming environments. Through peer support and community education, the program aims to foster social connection, affirmation, early help-seeking behaviors, and timely linkage to behavioral health services.**

**The program is expected to improve overall wellness, resilience, and sense of belonging among LGBTQ+ individuals, including transgender, nonbinary, and gender diverse participants who experience elevated behavioral health risks related to stigma, discrimination, and social isolation. Additional intended outcomes include increased community awareness, strengthened peer support networks, and enhanced provider and community capacity to better serve LGBTQ+ populations, consistent with Behavioral Health Services Act (BHSA) Early Intervention goals.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
   **No**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

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

| Plan Period by FY | **Projected Number of Individual Served** |
|---|---|
| FY 2026-2027 | **53** |
| FY 2027-2028 | **54** |
| FY 2028-2029 | **55** |

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

   **Projections for Fiscal Year (FY) 2026–27 were based on actual historical service utilization data reported under Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs. Projections for FY 2027–28 and FY 2028–29 were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections.**

### Early Intervention (EI) Programs #5

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

1. Program or service name
   **Local Outreach to Survivors of Suicide Support Group (LOSS)**
2. Please select which of the three EI components are included as part of the program or service
   **☑Outreach**
   ☐Access and Linkage: Screening
   ☐Access and Linkage: Assessments
   **☑Access and Linkage: Referrals**
   ☐Access and Linkage: Other
   ☐Treatment Services and Supports: Services to address first episode psychosis (FEP)
   **☑ Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
   ☐Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
   ☐Treatment Services and Supports: Other
3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
   **No**
4. Please describe intended outcomes of the program or service

   **The intended outcomes of the LOSS (Local Outreach to Suicide Survivors) Program are to provide timely information, support, and linkage to services for Kings County residents affected by suicide loss. Through immediate outreach and grief and bereavement counseling, the program aims to support healing and reduce the emotional and psychological impacts experienced by survivors of suicide.**

   **By offering six to eight one-hour counseling sessions and connection to community resources, the program is intended to increase access to supportive services, promote coping and recovery, and reduce the risk of prolonged grief or behavioral health challenges among individuals and families impacted by suicide.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
   **No**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

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

| Plan Period by FY | **Projected Number of Individual Served** |
|---|---|
| FY 2026-2027 | **13** |
| FY 2027-2028 | **13** |
| FY 2028-2029 | **13** |

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

   **Projections for Fiscal Year (FY) 2026–27 were based on actual historical service utilization data reported under Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs. Projections for FY 2027–28 and FY 2028–29 were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections. The actual figures were too small to result in a meaningful projected increase.**

### Early Intervention (EI) Programs #6

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

1. Program or activity name
   **Kings United Way**
2. Please select which of the three EI components are included as part of the program or service
   ☐Outreach
   ☐Access and Linkage: Screenings

☑**Access and Linkage: Assessments**
☑**Access and Linkage: Referrals**
☐Access and Linkage: Other
☐Treatment Services and Supports: Services to address first episode psychosis (FEP)
☐Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
☐Treatment Services and Supports to address co-occurring mental health and substance use issues
☐Treatment Services and Supports: Other

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
   **No**
4. Please describe intended outcomes of the program or service

~~**Kings United Way provides direct client services to individuals in the community who are seeking resources, including support related to mental health and substance use. Through direct engagement, staff assess individual needs, provide resource navigation, and connect individuals to appropriate services. In addition to initial referrals, Kings United Way conducts follow-ups with clients to confirm successful linkage to services and to address any barriers to access. The intended outcomes of these direct services include increased access to behavioral health and supportive services, improved service linkage and engagement, and reduced gaps in care for individuals seeking assistance.**~~

**Kings United Way provides direct client services to individuals in the community who are seeking resources, including support related to housing and homelessness through the Homeless Management Information System (HMIS). Through direct engagement, staff assess individual needs, provide resource navigation, and connect individuals to appropriate housing services. The intended outcome of these direct services include increased access and linkage to housing resources for individuals engaged in behavioral health services.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
   **No**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

**Table 13. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year.**

| Plan Period by FY | Projected Number of Individuals Served |
|---|---|
| FY 2026 – 2027 | ~~**2153**~~ **75** |
| FY 2027 – 2028 | ~~**2206**~~ **77** |
| FY 2028 – 2029 | ~~**2261**~~ **79** |

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

   ~~**Projections for Fiscal Year (FY) 2026–27 were based on actual historical service utilization data reported by Kings United Way under Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs. Projections for FY 2027–28 and FY 2028–29 were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections.**~~

   **Projections for Fiscal Year (FY) 2026-27 were based on actual historical service utilization data reported for individuals that received housing supports and housing interventions. Projections for FY 2027-28 and FY 2028-29 were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections.**

~~**Early Intervention (EI) Programs #7**~~

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

~~1. Program or service name~~
   ~~**Senior Access for Engagement (SAFE)**~~

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

**☑Outreach**

☐Access and Linkage: Screening

☐Access and Linkage: Assessments

**☑Access and Linkage: Referrals**

☐Access and Linkage: Other

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

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

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

☐Treatment Services and Supports: Other

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

**No**

4. Please describe intended outcomes of the program or service

**The intended outcomes of the Senior Access for Engagement (SAFE) Early Intervention Program are to address early signs and risk factors associated with mental health challenges among older adults in Kings County and prevent the escalation of behavioral health needs. Through services provided at the Kings County Commission on Aging Office, the program aims to reduce the negative impacts of untreated mental health symptoms and enhance overall well-being among participating older adults.**

**The program is intended to support BHSA-eligible older adults age 60 and older, as well as their caregivers, by addressing stress, burnout, grief, and other early emotional or behavioral health concerns. Expected outcomes include improved emotional well-being, increased access to supportive services, strengthened coping skills, and early identification and intervention to prevent progression to more serious behavioral health conditions for both older adults and caregivers.**

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

**No**

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

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

| Plan Period by FY | Projected Number of Individual Served |
|---|---|
| FY 2026-2027 | **767** |
| FY 2027-2028 | **786** |
| FY 2028-2029 | **802** |

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

**Projections for Fiscal Year (FY) 2026–27 were based on actual historical service utilization data reported for the SAFE Program under Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI). Projections for FY 2027–28 and FY 2028–29 were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections.**

## Early Intervention (EI) Programs #7

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

1. Program or activity name
   **Depression Reduction Achieving Wellness (DRAW)**
2. Please select which of the three EI components are included as part of the program or service
   ☐Outreach
   ☑**Access and Linkage: Screenings**
   ☑**Access and Linkage: Assessments**
   ☑**Access and Linkage: Referrals**
   ☐Access and Linkage: Other
   ☐Treatment Services and Supports: Services to address first episode psychosis (FEP)

☑**Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
☐Treatment Services and Supports to address co-occurring mental health and substance use issues
☐Treatment Services and Supports: Other

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
   **No**
4. Please describe intended outcomes of the program or service

   **The DRAW program is a screening and brief intervention program for college and transitional-aged students in Kings County. The program is offered at no cost to 12th grade students at local high schools in Kings County and students at Lemoore College, and College of the Sequoias – Hanford Campus. The purpose of the program is to screen students for mental illness, provide brief intervention, and refer participants to further services as needed to reduce risk of depression, suicide, and related behavioral health concerns.**

   **The Depression Reduction Achieving Wellness Program will serve 75 unduplicated students per year across 12th-grade students in Kings County high schools and students at Lemoore College and College of the Sequoias – Hanford Campus.**

   **Screen at least 75 students per year for depression and related behavioral health concerns, with documentation of screening tools used.**

   **Provide brief intervention services to at least 60 of the 75 students (80%) who screen with mild to moderate symptoms or identified risk factors.**

   **Provide at least one referral to ongoing behavioral health or supportive services based on screening and clinical judgment.**

   **Conduct pre/post surveys to measure changes in knowledge, coping skills, and help-seeking intentions.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
   **No**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

**Table 14. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year.**

| Plan Period by FY | Projected Number of Individuals Served |
|---|---|
| FY 2026 – 2027 | **75** |
| FY 2027 – 2028 | **80** |
| FY 2028 – 2029 | **80** |

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

   **The county used historical program data and increased the number to include high school students transitioning to a college setting.**

~~**Early Intervention (EI) Programs #8**~~

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

~~1. Program or service name~~
   ~~**Barbara Saville Shelter**~~
~~2. Please select which of the three EI components are included as part of the program or service~~
   ~~☐Outreach~~
   ~~☐Access and Linkage: Screenings~~
   ~~☑**Access and Linkage: Assessments**~~
   ~~☑**Access and Linkage: Referrals**~~
   ~~☐Access and Linkage: Other~~
   ~~☐Treatment Services and Supports: Services to address first episode psychosis (FEP)~~
   ~~☑**Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**~~
   ~~☐Treatment Services and Supports to address co-occurring mental health and substance use issues~~

☐Treatment Services and Supports: Other

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

**No**

4. Please describe intended outcomes of the program or service

**The intended outcome of this program is to provide services that prevent the onset or escalation of mental health problems among adults and children residing at the Barbara Saville Shelter (BSS) who are experiencing, or are at risk of, serious mental illness (SMI) or serious emotional disturbance (SED) due to domestic violence and homelessness. The program focuses on timely, short term, developmentally appropriate interventions designed to reduce risk factors (e.g., trauma exposure, housing instability) and build protective factors (e.g., coping skills, safety, social supports) before conditions progress into more severe and disabling mental health conditions.**

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

**No**

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

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

| Plan Period by FY | Projected Number of Individual Served |
|---|---|
| FY 2026-2027 | **120** |
| FY 2027-2028 | **123** |
| FY 2028-2029 | **126** |

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

**Projections for Fiscal Year (FY) 2026-27 were based on actual historical service utilization data reported under Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs. Projections for FY 2027-28 and FY 2028-29**

~~were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections.~~

### Early Intervention (EI) Programs #8

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

1. Program or activity name
   **California Health Collaborative Young Minds**
2. Please select which of the three EI components are included as part of the program or service
   **☑Outreach**
   ☐Access and Linkage: Screenings
   ☐Access and Linkage: Assessments
   **☑Access and Linkage: Referrals**
   ☐Access and Linkage: Other
   ☐Treatment Services and Supports: Services to address first episode psychosis (FEP)
   **☑Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
   ☐Treatment Services and Supports to address co-occurring mental health and substance use issues
   ☐Treatment Services and Supports: Other

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
   **No**
4. Please describe intended outcomes of the program or service

   **The intended outcomes of this program are to prevent the onset or escalation of mental health problems among children, youth, and young adults who are exhibiting early signs of emotional or behavioral distress. The program aims to strengthen emotional regulation, coping, and resiliency skills; reduce stress**

**and anxiety; and support improved school performance and interpersonal relationships.**

**Through the provision of timely, short-term, and developmentally appropriate services, the program is intended to reduce risk factors and increase protective factors before behavioral health conditions progress into serious emotional disturbance or serious mental illness. The program also seeks to promote early intervention and support positive emotional and behavioral functioning consistent with Behavioral Health Services Act (BHSA) Early Intervention requirements.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
   **No**

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

**Table 14. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year.**

| Plan Period by FY | Projected Number of Individuals Served |
|---|---|
| FY 2026 – 2027 | ~~1970~~ 985 |
| FY 2027 – 2028 | ~~2019~~ 1009 |
| FY 2028 – 2029 | ~~2069~~ 1034 |

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

   **Projections for Fiscal Year (FY) 2026-27 were based on actual historical service utilization data previously reported under Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs. Projections for FY 2027-28 and FY 2028-29 were estimated using Kings County population growth trends. Specifically, projected service numbers were adjusted using an estimated population growth rate of 2.5 percent observed between 2023 and 2025, based on U.S. Census Bureau estimates and related demographic projections. Estimates for the Intermittent Update were revised to reflect the reduction in school-based services.**

**Early Intervention (EI) Programs #9**

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

1. Program or activity name
   **Oak Wellness Center**
2. Please select which of the three EI components are included as part of the program or service
   **☑Outreach**
   **☑Access and Linkage: Screenings**
   **☑Access and Linkage: Assessments**
   **☑Access and Linkage: Referrals**
   ☐Access and Linkage: Other
   ☐Treatment Services and Supports: Services to address first episode psychosis (FEP)
   **☑Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
   **☑Treatment Services and Supports to address co-occurring mental health and substance use issues**
   ☐Treatment Services and Supports: Other

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
   **No**
4. Please describe intended outcomes of the program or service
   **The Oak Wellness Center is intended to foster recovery, wellness, and meaningful community connection by providing a safe, supportive environment where members can engage with peers and staff. Through educational, recreational, and wellness-focused activities, the program seeks to improve participants' overall well-being, reduce social isolation, strengthen healthy coping skills, support progress toward individual recovery goals, and encourage ongoing involvement in recovery-oriented services. Performance will be evaluated across four key areas: the effectiveness of services, including how participation contributes to recovery, wellness, stability, peer connection, and goal attainment; the efficiency of services, including how available staffing, funding, facilities, and other resources are used to achieve meaningful results;**

**service access, including how easily individuals can learn about, access, and participate in available supports and activities; and satisfaction of persons served, including feedback from members, staff, and community partners regarding the quality, usefulness, accessibility, and overall value of the services provided.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
   **No**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

**Table 14. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year.**

| Plan Period by FY | Projected Number of Individuals Served |
|---|---|
| FY 2026 – 2027 | **258** |
| FY 2027 – 2028 | **266** |
| FY 2028 – 2029 | **273** |

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

   **Projections for Fiscal Year (FY) 2026-27 were based on actual historical program data through Mental Health Block Grant reporting for the Oak Wellness Center. Projections for FY 2027-28 and FY 2028-29 were estimated using Kings County population growth trends. Specifically, projected service numbers were adjusted using an estimated population growth rate of 2.5 percent observed between 2023 and 2025, based on U.S. Census Bureau estimates and related demographic projections.**

**Early Intervention (EI) Programs #10**

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

1. Program or activity name
   **Access Line**
2. Please select which of the three EI components are included as part of the program or service

☑Outreach
**☑Access and Linkage: Screenings**
**☑Access and Linkage: Assessments**
**☑Access and Linkage: Referrals**
☐Access and Linkage: Other
☐Treatment Services and Supports: Services to address first episode psychosis (FEP)
☐Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
☐Treatment Services and Supports to address co-occurring mental health and substance use issues
☐Treatment Services and Supports: Other

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
   **No**
4. Please describe intended outcomes of the program or service
   **The intended outcome is to improve timely and equitable access to behavioral health services for Kings County residents by providing a centralized, 24/7 point of contact for individuals and families seeking mental health and substance use disorder services. The Access Line will support appropriate screening, triage, referrals, and connection to the level that best meets each individual's needs, including crisis and community-based supports. The program is intended to reduce barriers to accessing care, improve connections to services, and promote timely intervention and continuity of behavioral health support throughout Kings County.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
   **No**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

**Table 14. Estimated Number of Individuals Served in Early Intervention Programs by Plan Year.**

| Plan Period by FY | Projected Number of Individuals Served |
|---|---|
| FY 2026 – 2027 | **2693** |
| FY 2027 – 2028 | **2760** |

| | |
|---|---|
| FY 2028 – 2029 | **2829** |

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

   **Projections for Fiscal Year (FY) 2026-27 were based on actual historical program data for Access Line reporting. Projections for FY 2027-28 and FY 2028-29 were estimated using Kings County population growth trends. Specifically, projected service numbers were adjusted using an estimated population growth rate of 2.5 percent observed between 2023 and 2025, based on U.S. Census Bureau estimates and related demographic projections.**

## Coordinated Specialty Care for First Episode Psychosis (CSC) program

1. Please provide the following information on the County's Coordinated Specialty Care for First Episode Psychosis (CSC) program
   a) CSC Program Name: **New - Providers TBD**
   b) CSC Program Description**: Coordinated Specialty Care (CSC) is an evidence-based, community-based outpatient program that provides integrated early intervention services for youth and young adults ages 12–30 who are experiencing a First Episode of Psychosis (FEP) or exhibiting symptoms consistent with a clinical high-risk syndrome. The program is designed to reduce the negative impacts associated with untreated psychosis, including psychiatric hospitalization, justice system involvement, homelessness, substance use, and functional decline, by ensuring timely access to comprehensive, recovery-oriented services. CSC services are delivered through a multidisciplinary team that includes a psychiatric prescriber, peer support specialist, and licensed and credentialed behavioral health practitioners. The team provides individualized clinical, psychological, and family-centered interventions consistent with Department of Health Care Services (DHCS) CSC/FEP eligibility criteria. The CSC model emphasizes early identification, family and caregiver engagement, and culturally responsive, strength-based approaches that promote recovery, prevent relapses, and support participants in achieving stability, independence, and long-term wellness within their communities.**

2. Please review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence

Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county in the table below.

**Table 14. Estimated Number of Individuals Eligible for CSC and Estimated Number of Teams Needed to Serve Total Eligible Populations.**

| CSC Eligible Population | Estimates |
|---|---|
| Number of Medi-Cal Enrolled Individuals | **27** |
| Number of Uninsured Individuals | **3** |

| CSC Practitioners and Teams Needed | Estimates |
|---|---|
| Number of Practitioners Needed to Serve Total Eligible Population | **4.25** |
| Number of Teams Needed to Serve Total Eligible Population | **1** |

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

**Table 15. Total Number of CSC Practitioners and Teams.**

| 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** |

4. Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?
   **No**

## Outreach and Engagement (O&E) Program #1

For each program or activity that is part of the county's standalone O&E programs provide the following information. For related policy information, refer to 7.A.3 Outreach and Engagement.

1. Program or activity name:
   **California Health Collaborative (NEW)**

2. Please Describe the program or activity

   **The purpose of this program is to provide comprehensive, culturally and linguistically appropriate community outreach, engagement, education, and training services to increase awareness of, and reduce stigma and barriers related to, mental health and substance use disorders (SUD) in Kings County. The California Health Collaborative's O&E services include community presentations, youth and family engagement activities, school-based outreach, resource navigation, and trainings for community partners, caregivers, and service providers to improve understanding of behavioral health needs and connect individuals to appropriate care. These services are trauma-informed, culturally responsive, and designed to reach BHSA priority populations, especially children, youth, and young adults ages 25 and under, as well as individuals experiencing or at risk of mental health or substance use challenges, homelessness, justice involvement, foster care involvement, trauma exposure, health inequities, or school disengagement. The overall goal is to strengthen Kings County Behavioral Health's Behavioral Health Transformation by increasing behavioral health literacy, promoting access to County services, reducing stigma and disparities, and supporting early identification and linkage to services. For example, the contractor may conduct outreach at schools, community centers, libraries, faith-based organizations, youth events, and housing sites; provide educational workshops on mental health, substance use, coping skills, suicide prevention, and how to access services; distribute translated and culturally appropriate materials; and offer training that helps families, educators, and community partners recognize warning signs and make timely referrals. At least 51% of BHSA Outreach and Training services must be directed to children, youth, and young adults ages 25 and under.**

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

**Table 16. Estimated Number of Individuals Served in O&E Programs by Plan Year.**

| Plan Period by FY | Projected Number of Individuals Served |
|---|---|
| FY 2026 – 2027 | ~~**1000**~~ **500** |
| FY 2027 – 2028 | ~~**1025**~~ **512** |
| FY 2028 – 2029 | ~~**1050**~~ **525** |

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

**Projections for Fiscal Year (FY) 2026–27 were based on actual internal historical data for outreach and engagement services. Projections for FY 2027–28 and FY 2028–29 were developed using Kings County population growth trends, including an estimated 2.5 percent population increase between 2023 and 2025 based on U.S. Census Bureau estimates and related demographic projections. Estimates for the Intermittent Update were revised to reflect the reduction in school-based services.**

## Capital Facilities and Technology Needs (CFTN) Program #1

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

1. Project name
   **SmartCare**

2. Please select the type of project
   ☐ Capital facilities project
   ☑ **Technological needs project**

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

   **Electronic Health Record System**

3. Please describe the project
   **The program will build the evidence base by using SmartCare to systematically track participant demographics, service utilization, and key outcomes. SmartCare data will allow the County to establish baselines, measure progress, and evaluate effectiveness over time.**

   **SmartCare data will allow the County to track baseline measures, monitor participant progress over time, and evaluate whether the program is achieving meaningful improvements in stability, recovery, and quality of life. These outcomes will support ongoing evaluation and continuous quality improvement efforts.**

   **This project is a continuing MHSA-encumbered INN project.**

## 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.

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

**Table 17. Estimated Number of Individuals Eligible for Full-Service Partnership Services.**

| Total Adult FSP Eligible Population | Estimates |
|---|---|
| Number of Medi-Cal Enrolled Individuals | **550** |
| Number of Uninsured Individuals | **69** |
| Number of Total FSP Eligible Individuals with Some Justice-System Involvement | **266** |

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

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

**Table 18. Estimated Number of Individuals Eligible for ACT.**

| ACT Eligibility Population | Estimates |
|---|---|
| Number of Medi-Cal Enrolled Individuals | **90** |
| Number of Uninsured Individuals | **12** |

**Table 19. Estimated Number of Individuals Eligible for FACT.**

| FACT Eligible Population (ACT with Justice-System Involvement) | Estimates |
|---|---|
| Number of Medi-Cal Enrolled Individuals | **45** |
| Number of Uninsured Individuals | **6** |

**Table 20. Esteemed Number of Teams Needed to Serve Total Eligible Population.**

| ACT/FACT Practitioners and Teams Needed | Estimates |
|---|---|
| Number of Practitioners Needed to Serve Total Eligible Population | **20** |
| Number of Teams Needed to Serve Total Eligible Population | **2** |

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

**Table 21. Total Number of ACT and FACT Practitioners and Teams.**

| County Actuals | FY 26-27 | FY 27-28 | FY 28-29 |
|---|---|---|---|
| Total Number of Practitioners | **20** | **20** | **20** |
| Total Number of Teams | **1** | **1** | **1** |

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

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

**Table 22. Estimated Number of Individuals Eligible for FSP ICM and Estimated Number of Teams to Serve Total Eligible Population.**

| FSP ICM Eligible Population | Estimates |
|---|---|
| Number of Medi-Cal Enrolled Individuals | **414** |
| Number of Uninsured Individuals | **52** |

| FSP ICM Practitioners and Teams Needed | Estimates |
|---|---|

| | |
|---|---|
| Number of Practitioners Needed to Serve Total Eligible Population | **20** |
| Number of Teams Needed to Serve Total Eligible Population | **4** |

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and 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.

**Table 23. Total Number of FSP ICM Practitioners and Teams.**

| County Actuals | FY 26-27 | FY 27-28 | FY 28-29 |
|---|---|---|---|
| Total Number of Practitioners | **20** | **20** | **20** |
| Total Number of Teams | **1** | **1** | **1** |

## High Fidelity Wraparound (HFW) Eligible Population

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

**Table 24. Estimated Numbers of Individuals Eligible for HFW and Estimated Number of Teams Needed to Serve Total Eligible Population.**

| HFW Eligible Population | Estimates |
|---|---|
| Number of Medi-Cal Enrolled Individuals | **248** |
| Number of Uninsured Individuals | **37** |

| HFW Practitioners and Teams Needed | Estimates |
|---|---|
| Number of Practitioners Needed to Serve Total Eligible Population | **93** |
| Number of Teams Needed to Serve Total Eligible Population | **4** |

2. Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and 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.

**Table 25. Total Number of HFW Practitioners and Teams.**

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

## Individual Placement and Support (IPS) Eligible Population

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

**Table 26. Estimated Number of Individuals Eligible for IPS and Estimated Number of Teams Needed to Serve Total Eligible Population.**

| IPS Eligible Population | Estimates |
|---|---|
| Number of Medi-Cal Enrolled Individuals | **788** |
| Number of Uninsured Individuals | **102** |

| IPS Practitioners and Teams Needed | Estimates |
|---|---|
| Number of Practitioners Needed to Serve Total Eligible Population | **57.5** |
| Number of Teams Needed to Serve Total Eligible Population | **23** |

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

**Table 27. Total Number of IPS Practitioners and Teams.**

| County Actuals | FY 26-27 | FY 27-28 | FY 28-29 |
|---|---|---|---|
| Total Number of Practitioners | **2** | **2** | **2** |
| Total Number of Teams | **1** | **1** | **1** |

## Full-Service Partnership (FSP) Program Overview

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

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

**Yes**

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

**The Children's Full-Service Partnership (FSP) provider will assume responsibility for delivering multiple Evidence-Based Practices (EBPs), including Intensive Care Management (ICM), High Fidelity Wraparound (HFW), and Multisystemic Therapy (MST). This approach is supported by the provider's existing experience serving diverse populations enrolled in the FSP program and demonstrated organizational capacity to implement and sustain multiple structured, evidence-based service models. The designated Children's Provider has substantial expertise in Wraparound services and currently serves the largest proportion of the target population, including youth involved in child welfare and juvenile justice systems and those at elevated behavioral health risk.**

**The Functional Family Therapy (FFT) evidence-based practice (EBP) will be delivered by a separate provider, in consultation with the Centers of Excellence, as Multisystemic Therapy (MST) and FFT cannot be implemented by the same provider.**

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

**Kings County employs a whole person, trauma-informed approach by aligning provider scopes of work with Full-Service Partnership (FSP) standards under the Behavioral Health Services Act, with a strong emphasis on high-fidelity wraparound principles. These updates include enhanced staff training, improved reporting procedures, and revised team staffing requirements to better support comprehensive, individualized care. The county has also strengthened its minor consent policy to promote active family engagement and increased the focus on peer and parent support, ensuring individuals are offered meaningful opportunities to connect with family members and natural supports within their community.**

**In addition, Kings County Behavioral Health utilizes several committees and practice guidelines to ensure services remain culturally responsive and trauma informed. Committees such as the Cultural Humility Task Force, Quality Improvement Committee, Documentation Committee, and Utilization Review Committee meet regularly to monitor best practices and continuous**

**improvement. Contracted providers are guided by county policies and procedures that emphasize ongoing collaboration with families and natural supports. Full-Service Partnership programs within both the Children's and Adult systems of care, as well as the Assertive Community Treatment program, include performance measures that highlight the importance of family and natural supports in promoting wellness and recovery. These outcome measures are routinely monitored through ongoing provider contract meetings.**

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

   **Kings County has prioritized multiple strategies to reduce disparities, including targeted training on the needs of LGBTQ+, those experiencing substance use challenges, youth in foster care, and commercially sexually exploited children (CSEC). Memorandums of Understanding (MOU) are being developed and implemented with Child Welfare Services, local school districts, and justice system entities to strengthen interagency collaboration and address service gaps. The selection of the Full-Service Partnership Provider reflects a commitment to equity by engaging an organization with extensive experience and specialized training in Wraparound service delivery. Additionally, the County is examining options to limit out-of-county placements, such as therapeutic foster care, and exploring integrated service approaches when local placement is not feasible, all to better meet the needs of program participants.**

4. Select which goals the county is hoping to support based on the county's allocation of FSP funding
   **☑Access to care**
   **☑Homelessness**
   **☑Institutionalization**
   **☑Justice involvement**
   ☐Removal of children from home
   **☑Untreated behavioral health conditions**
   ☐Care experience
   **☑Engagement in school**
   **☑Engagement in work**
   **☑Overdoses**
   **☑Prevention of co-occurring physical health conditions**
   **☑Quality of life**
   **☑Social connection**

☑**Suicides**

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

   **According to the current scope of work for our FSP provider, their primary approach is founded on the "whatever it takes" philosophy. The provider's main efforts emphasize comprehensive community outreach, the development of individualized care plans tailored to each client's unique needs, and the provision of a diverse array of services that address behavioral health, housing, transportation, and educational needs for our children, youth, and their families. Crisis services are accessible 24/7, with specialized support lines such as the Family Urgent Response System (FURS) for both current and former foster youth, and crisis intervention available in school settings through the Mobile Crisis Support Team (MCST). Collaborating closely with another provider offering Recovery-Oriented Services (ROS) and entry into the Medi-Cal Behavioral Health system, our FSP provider receives and reviews referrals for clients appropriate for FSP enrollment, maintaining regular communication regarding clients experiencing crisis or exhibiting at-risk behaviors while engaged in behavioral health services.**

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

   **High Fidelity Wraparound (HFW) Aftercare Services may be offered to youth and children who are assigned lower levels of care such as recovery-oriented services. Engagement efforts will focus on identifying clinically appropriate clients within the community whether actively engaged or new to behavioral health services. Ongoing outreach will be supported through targeted events and various grant-funded initiatives. Our FSP provider already conducts regular outreach activities, particularly related to crisis services. Current data reporting reflects these ongoing efforts to deliver services and disseminate information within the community. A Memorandum of Understanding (MOU) is currently pending approval with the Kings County Office of Education (KCOE). This agreement will facilitate increased access to school campuses, thereby enhancing the provider's capability to conduct outreach and perform assessments. These efforts will support the**

**identification of potential FSP clients and enable the integration of early intervention strategies. Along with community partnerships, engagement will be attempted for the targeted populations in the Behavioral Health Services Act.**

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

   **Kings County Behavioral Health will comply with the required Full-Service Partnership levels of care which include both FSP Intensive Case Management (ICM) and Assertive Community Treatment (ACT). The county will strengthen its existing FSP Team and expand staffing to ensure that the multidisciplinary staff have completed training to satisfaction of state fidelity standards for ICM integration. During this fiscal year, required trainings set forth by state guidance and ACT COE will be completed by ACT team staff while the composition of the team transforms from a small ACT team to a Full ACT team. Training regarding ACT level of care needs will occur to ensure that those meeting ACT criteria are appropriately placed into this highly acute and field-based program.**

   **Kings County will continue to assess workforce capacity increases based upon caseload sizes and identified clinical need for individuals highlighted with high acuity needs. Program expansions or restructuring for both FSP ICM and ACT programs will be guided by data on service utilization, outcomes, and equity considerations to ensure access to the required level of care in Kings County. While the County remains committed to expanding services and ensuring appropriate caseloads to fidelity models, funding limitations, and challenges related to hiring and retaining qualified staff continues to affect the ability to implement to full fidelity of some EBPs.**

7. Please indicate whether the county FSP program will include any of the following optional and allowable services
   **N/A**

   a) Primary substance use disorder (SUD) FSPs
      **No**
   b) 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**

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

**The County will engage with community stakeholders and behavioral health providers to identify and establish referral pathways for individuals living with significant behavioral health needs into Full-Service Partnership (FSP) programs. Through twice-weekly meetings with mental health providers, individuals with complex behavioral health needs are identified and referred to ensure timely engagement in higher levels of care consistent with FSP services.**

**In addition, the Mental Health Plan (MHP) conducts weekly coordination meetings with the local county jail to identify and refer individuals with significant behavioral health needs directly to FSP services upon release from incarceration.**

c) Other recovery-oriented services
**No**

8. If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams. If no additional FSP services, use "N/A"
**N/A**
9. What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's FSP program who are:

a) In, or at-risk of being in, the juvenile justice system:
**The county reviewed cross-system data on children and youth under age 21 who are in, or at risk of being in, the juvenile justice system, including rates of juvenile hall bookings, probation involvement, youth correctional facility reentry, behavioral health service utilization, and demographic disparities.**

**The county held focus groups and stakeholder interviews and with probation, school administrators, and child welfare to identify referral pathways, service gaps, and opportunities to use FSP as an alternative to or step-down from detention and the child welfare system and to**

**incorporate their recommendations for trauma-informed, family-centered, and culturally responsive FSP supports.**

b) Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+):
**The County is actively engaging with partners to ensure comprehensive training is provided to our service providers in working with sensitive and diverse communities. Additionally, the County conducted a Focus Group with members of a LGBTQ+ Support Group as well as with an organization that serves LGBTQ+ youth, as part of the Community Planning Process. Concurrently, efforts are underway to enhance data collection practices to accurately capture and reflect the impact of services delivered within these communities.**

c) In the child welfare system:
**The county reviewed cross-system data on children and youth under age 21 who are in, or at risk of entering, the child welfare system, including rates of child welfare involvement, placement types, behavioral health service utilization, and demographic disparities.**

**Through Community Program Planning and targeted outreach, the county engaged youth and young adults with lived experience, parents and caregivers (including resource and kin caregivers), and community-based organizations that support families involved with child welfare, using focus groups, listening sessions, and surveys to understand barriers to care and desired supports.**

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

a) Older adults:
**As part of the Community Planning Process, the County conducted focus groups with several target populations of eligible adults, including participants from Oak Wellness Center, Veterans Support Group, Samuel's House (Substance Use Disorder services), and Hannah's House (Substance Use Disorder services), as well as organizations serving eligible adult populations. In addition, two community surveys were conducted between mid-September and early October 2025 to gather**

**input regarding behavioral health needs, service gaps, and priorities impacting older adults and other eligible populations.**

b) Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+):
**The County conducted a focus group with members of an LGBTQ+ Support Group and an organization serving LGBTQ+ adults as part of the Community Planning Process.**

c) In, or are at risk of being in, the justice system:
**The County reviewed data from the CalMHSA Justice-Involvement PowerBI Dashboards related to Statewide Behavioral Health Goals to better understand justice involvement among eligible adults. Data analysis indicated that Kings County's adult arrest rate exceeds the statewide average, with higher rates observed among adults ages 20–29 (4,582 per 100,000), ages 30–39 (6,394 per 100,000), and adult males (5,042 per 100,000), compared to the county rate of 4,309 per 100,000.**

**Population-level data further showed disproportionately higher arrest rates among Black residents (5,657 per 100,000) and Hispanic residents (3,166 per 100,000), including Black females (4,573), Black males (6,087), and Hispanic males (4,607). Review of adult recidivism conviction data also identified disparities, with individuals ages 20–24 (60.5%), ages 25–29 (46.0%), ages 30–34 (61.4%), males (46.2%), and Black/African American individuals (68.8%) experiencing higher three-year recidivism conviction rates compared to the county average of 44.8%.**

## Assertive Field-Based Substance Use Disorder (SUD) Questions

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

### Existing Programs for Assertive Field-Based SUD Treatment Services

Existing programs:

**Currently, Kings County does not have an existing Assertive Field-Based SUD treatment program. The County's current SUD service array is delivered through outpatient, intensive outpatient, and residential providers and does not yet include field-based outreach or assertive engagement models.**

**Kings County is in the process of transitioning to the Drug Medi-Cal Organized Delivery System (DMC-ODS) and is awaiting approval of its Implementation Plan. As part of this transition, the County anticipates expanding its continuum of care to include field-based outreach, enhance SUD engagement strategies, and improved care coordination for high-need individuals once DMC-ODS services become operational.**

**The County will continue planning for these service enhancements while aligning system designed, staffing, and funding with forthcoming DMC-ODS requirements**.

Program description**: 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:

**Mobile Crisis Response**

Program descriptions:

**Kings County currently contracts with Kings View to provide Mobile Crisis Response services.**

**The mobile crisis team is trained on the DHCS-required mobile crisis services training. Any team member who has received this training can conduct a crisis assessment and can deliver initial face-to-face crisis assessment following DHCS standardized crisis assessment tool template.**

**The mobile crisis encounter is comprised of six service components including:**

- **Initial face-to-face assessment**
- **Mobile crisis response**

- **Crisis planning- including documentation of progress notes and/or rationale for not engaging individuals in crisis planning**
- **Facilitation of a warm handoff (if needed)**
- **Referrals to ongoing services (if needed)**
- **Follow-up check-ins**

**Mobile crisis teams providing the initial mobile crisis response shall include access to an LPHA. Mobile crisis team for SUD services are composed of LPHA, AOD Counselor, and a Certified Peer Support Specialist.**

**Telehealth services are available to connect individuals with practitioners, specialists, translators, interpreters, and other providers who may offer additional services. A telehealth option in accordance with BHIN 23-018 (or superseding guidance).**

Current funding source:

- **Children's unit funding source: CHFFA, Medical dollars and MHSA**
- **Adult's unit funding source: CCMU, Medical dollars and realignment**

BHSA changes to existing programs to meet BHSA requirements:

**To meet BHSA programmatic requirements by July 1, 2029, Kings County Behavioral Health (KCBH) will leverage and expand existing county infrastructure and contracted provider capacity to deliver targeted outreach and field-based initiation of treatment. KCBH will partner with a new contracted provider and collaborate with an existing contracted provider to implement a Mobile Narcotic Treatment Program (NTP) as an extension of the established "brick and mortar" infrastructure. This mobile capability will support rapid access to medication for addiction treatment, including methadone, and enable initiation of SUD treatment in community-based settings. Due to site certification timeframes and constraints, KCBH will also explore partnerships with CA Bridge to further expand rapid access to MAT and other SUD services for beneficiaries.**

Expected timeline of operation:

**As of May 2026, Kings County Behavioral Health (KCBH) is actively working toward releasing a Request for Proposals (RFP) to contract with a new provider for Mobile NTP/MAT services. KCBH, the Mobile NTP/MAT provider, and the existing Mobile Crisis Response provider will develop workflows to ensure beneficiaries who contact the Access Line for SUD services are connected to harm-reduction services through Kings County Public Health locations and have**

**access to lower-barrier MAT and other SUD services. KCBH anticipates awarding and contracting with a provider by January 2027 to support implementation of BHSA requirements.**

**The Mobile NTP/MAT provider will serve as a coordinated partner for referral and follow-up services, including motivational interviewing, trust building, harm-reduction education, and facilitating rapid access to MAT and other SUD services.**

## Open-access clinics

Existing programs:

- **Champions Recovery Alternative Programs: Early Intervention Services (ASAM Level 0.5), Outpatient Drug Free (ASAM Level 1.0), Intensive Outpatient Treatment (ASAM Level 2.1)**
- **West Care: Adolescent Early Intervention, Adolescent Outpatient Drug Free, Adolescent Intensive Outpatient Treatment**

Program descriptions:

**Champions Recovery Alternative Programs:**

**Early Intervention Services (ASAM Level 0.5): Support individuals 18-21 who may be at risk for developing substance use problems. Services include screening and early intervention, regardless of if the individual met diagnosis criteria. Services are provided under the outpatient treatment modality and may be provided via in person, telehealth, or telephone. If an individual under the age of 21 meets criteria for SUD, then a full ASAM assessment shall be performed and the individual referred to appropriate level of care.**

**Outpatient Drug Free (ASAM Level 1.0):**

**Organized services that provide addiction treatment to support ongoing recovery through regularly scheduled sessions that include fewer than nine hours of service a week for adults. Services include:**
**1.Assessment**
**2.Group counseling**
**3. Individual counseling**
**4. Medication services**

**5. Patient Education**
**6. MAT Referral**
**Intensive Outpatient Treatment Services (ASAM Level 2.1): Provide intensive counseling and psychoeducation to individuals related to addiction and mental health needs. Treatment addresses multi-dimensional factors. Services include:**

- **Assessment**
- **Counseling**
- **Patient Education**
- **MAT Referral**

**West Care:**

**Adolescent Early Intervention and Treatment Services: priority participants shall be youth ages 12-17. Services are provided on site at the Hanford Kings County facility as well as school-based services in the communities of Avenal, Corcoran, Hanford, and Lemoore.**

Current funding source:

**Champions Recovery Alternative Programs: DMC, SUBG**

**West Care: DMC, SUBG**

BHSA changes to existing programs to meet BHSA requirements:

**Current open-access clinics in the county involve Champions Recovery Inc for adults and West Care for adolescents. These existing providers will connect clients with CA Bridge for lower barrier rapid access to MAT services and the anticipated Mobile NTP/MAT provider once operational. Open-access clinics will also be able to connect individuals to harm reduction services with Kings County Department of Public Health and other SUD related services.**

Expected timeline of operation:

**As of May 2026, Kings County Behavioral Health (KCBH) is in the process of obtaining County Administration and Purchasing approval for the RFP for the Mobile NTP/MAT service provider. The RFP is anticipated to be released for bids in July or August 2026, with an expected provider award in October 2026. To ensure compliance with BHSA requirements, KCBH will actively explore a partnership with CA Bridge to support rapid MAT access and strengthen connections to other SUD services within the county.**

## New Programs for Assertive Field-Based SUD Treatment Services

### Targeted outreach

New programs:

**For the anticipated Mobile NTP/MAT provider, within the RFP it is written that the provider must provide or collaborate with local service providers or organizations, as outlined in BHSA 7.B.7.2.2. The new Mobile NTP/MAT provider will incorporate data-informed targeted outreach to prioritize individuals and locations with the highest need, including persons experiencing housing instability, individuals recently released from jail, justice-involved populations, and people encountering repeated emergency department, overdose, and crisis contacts. Outreach teams will use field –based engagement to conduct on-the-ground, immediate support, and directly connect individuals to same-day options. Additionally, the provider will be required to collaborate with Emergency Medical Services (EMS), law enforcement, managed care plans (MCPs), health systems and hospitals, FQHC/RHS', individuals with living or lived experience, and other partners to obtain data on regions and populations with high rates of overdose, overdose reversals, drug-related arrests, and other relevant statistics on a regular basis for their Outreach plan to determine areas of need.**

### Program description:

**To align with the regulatory requirements outlines in Policy Manual Chapter 7.B.7.2 and 7.B.7.2.2, Kings County Behavioral Health (KCBH) will implement a data-informed, targeted outreach program designed to connect BHSA-eligible individuals to SUD services, including MAT.**

**The new Mobile NTP/MAT provider and the existing Mobile Crisis Response team will incorporate data-informed, targeted outreach to prioritize individuals and locations with the highest need, including people experiencing housing instability, individuals recently released from jail, justice-involved populations, and people encountering repeated emergency department, overdose, and crisis contacts. Outreach teams will use field-based engagement to conduct on-the-ground, immediate support and directly connect individuals to same-day options. This proactive model ensures that every community contact serves as an opportunity to provide trust-building, motivational interviewing, and rapid**

**access to MAT and other SUD services, consistent with BHSA policy requirements.**

Planned funding:

**Funding to support the Community Outreach and Training Provider will be drawn from Behavioral Health Services Act (BHSA) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) to support outreach for ASFBSS and overall, all Kings County Behavioral Health service providers.**

Planned operations:

**The RFP specifies that the selected Mobile NTP/MAT provider will be responsible for conducting ongoing and targeted outreach to connect individuals to SUD services, including MAT. Effective outreach strategies are expected to include meeting individuals where they are, providing harm reduction services, utilizing community-driven approaches, and offering overdose prevention tools and education. KCBH will monitor and review outreach activities during monthly provider meetings, including the number of individuals engaged, referrals made to open-access clinics, and linkages to other county providers. In collaboration and current efforts with the Mobile Crisis Response provider, KCBH will identify priority outreach needs by strengthening and integrating connections with EMS, law enforcement, MCPs, and FQHCs through the existing Collaboration Network established to assist in outreach strategies for the Mobile NTP/MAT Provider.**

Expected timeline of implementation:

**As of February 2026, Kings County Behavioral Health is in the process of contract development, with the goal of finalizing an agreement to present to the Kings County Board of Supervisors for approval. The contract is expected to be executed by July 1, 2026. The agreement with the Community Outreach and Training Services provider will extend through June 30, 2029. Champions will be able to add AFBSS within their existing outreach once services are executed.**

## Mobile-field based programs

New programs:

**Kings County Behavioral Health is exploring the development of mobile, field-based programs to deliver Narcotic Treatment Program (NTP) and Medication-Assisted Treatment (MAT) services throughout the county. Currently, there are no fixed-site NTP or MAT facilities within Kings County, leaving a significant gap in**

**access. By establishing mobile treatment units, the county aims to meet people where they are to improve TADT, remove barriers related to transportation and improve access to essential recovery services.**

Program description:

**Mobile NTP and MAT services expand access to life-saving medications and services for individuals with OUD in underserved and high-need areas. These mobile units will offer treatment directly to communities and other locations where healthcare access is limited or unavailable. By offering on-site medication distribution, private counseling, and recovery support, the program reduces barriers to care and ensures that individuals can receive consistent, confidential, and evidence-based treatment close to where they live or reside. This approach not only enhances the reach of opioid treatment services but also strengthens community health by fostering recovery, reducing overdose risk, and improving long-term outcomes for those impacted by addiction.**

Planned funding:

**The planning and development of Mobile NTP and MAT services will be supported through Opioid Settlement funds (OSF). These funds will be utilized to establish a contracted provider through the program aimed at expanding treatment access across Kings County.**

Planned operations:

**Kings County Behavioral Health is seeking to release a Request for Proposal (RFP) to contract services to uplift a mobile NTP and MAT services to Kings County residents.**

Expected timeline of implementation:

**Kings County Behavioral Health has established a projected timeline for the release of the Mobile NTP and MAT Request for Proposals (RFP) in April 2026. Following the proposal review and award process, contract development is anticipated to begin in August or September 2026. The finalized agreement will then be presented to the Kings County Board of Supervisors for approval, with the goal of executing the contract and launching program implementation by January 2027.**

## Open-access clinics

New programs:

**As noted in the Mobile Field-Based Programs section, Kings County Behavioral Health is considering releasing an RFP for mobile Narcotic Treatment Program (NTP) and Medication-Assisted Treatment (MAT) services to support both mobile and open access clinics. Kings County Behavioral Health is additionally exploring in establishing an MOU with FQHCs to develop referral processes.**

Program descriptions:

**As of May 2026, Kings County Behavioral Health (KCBH) is in the process of obtaining County Administration and Purchasing approval for the RFP for the Mobile NTP/MAT service provider to address low threshold and low barrier rapid access to meet. To ensure compliance with BHSA requirements, KCBH will actively explore a partnership with CA Bridge to support rapid MAT access and strengthen connections to other SUD services within the county. Beyond mobile capabilities, KCBH is establishing a formal partnership with a local FQHC to provide low-threshold, low-barrier rapid access to MAT in a "brick-and-mortar" clinic setting. This clinical anchor will standardize intake procedures by eliminating unnecessary administrative delays and prioritizing same-day initiation for individuals seeking care.**

Planned funding:

**The planning and development of Mobile NTP and MAT services will be supported through Opioid Settlement funds (OSF). These funds will be utilized to establish a contracted provider through the program aimed at expanding treatment access across Kings County.**

Planned operations:

**Kings County Behavioral Health is seeking to release a Request for Proposal (RFP) to contract services to uplift a mobile NTP and MAT services to Kings County residents.**

Expected timeline of implementation:

**Kings County Behavioral Health has established a projected timeline for the release of the Mobile NTP and MAT Request for Proposals (RFP) in April 2026. Following the proposal review and award process, contract development is anticipated to begin in August or September 2026. The finalized agreement will then be presented to the Kings County Board of Supervisors for approval, with the goal of executing the contract and launching program implementation by**

**January 2027. For the implementation of an MOU with local FQHCs, Kings County will be actively initiating conversations in March 2026.**

## Medications for Addiction Treatment (MAT) Details

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

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

   **Kings County will use multiple data sources to assess the gap between current MAT capacity and the estimated need for same-day access. This includes evaluating providers' staffing, prescribing availability, clinic hours, geographical coverage, and expected patient capacity once operational.**

   **The County will analyze Access line call data, ER/hospital referrals, probation referrals, and demographic trends to identify the demand for MAT and highlight underserved areas such as Avenal, Corcoran, and Kettleman City. Workforce capacity, including the number of prescribing clinicians and availability of telehealth, will also be reviewed to assess whether current resources can meet population needs.**

   **As part of this gap assessment, Kings County is evaluation the feasibility of releasing an RFP to track a Narcotic Treatment Program (NTP) to expand access to methadone services. An NTP would strengthen the county's continuum of MAT options and help meet projected needs by 2029. The RFP exploration will be guided by data on opioid use trends, withdrawal management needs, community readiness, and geographical access consideration.**

   **The results of these assessments will inform decisions about necessary expansions in staffing, clinic hours, field-based options, and partnerships to ensure the County can meet BHSA MAT expectations.**

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

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

a) Please provide the names of the neighboring counties the county will partner with.
**Kings County Behavioral Health will explore connections with Tulare and Fresno County to share additional MAT resources to Kings County beneficiaries.**

3. What forms of MAT will the county provide utilizing the strategies selected above?
**☑Buprenorphine**
**☑Methadone**
☐Naltrexone
☐Other

## Housing Interventions

### Planning

#### System Gaps

1. Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap-resources and connectivity available; Small gap- some resources available but limited connectivity; Medium gap- minimal resources and limited connectivity available' Large gap- limited or no resources and connectivity available; Not applicable- county does no have setting and does not consider there to be a gap.
    a) Supportive housing: **Large gap**
    b) Apartments, including master-lease apartments: **Medium gap**
    c) Single and multi-family homes: **Large gap**
    d) Housing in mobile home communities: **Large gap**

e) (Permanent) Single room occupancy units: **Large gap**
f) (Interim) Single room occupancy units: **Large gap**
g) Accessory dwelling units, including junior accessory dwelling units: **Large gap**
h) (Permanent) Tiny homes: **Large gap**
i) Shared housing: **Large gap**
j) (Permanent) Recovery/sober living housing, including recovery-oriented housing: **Large gap**
k) (Interim)Recovery/sober living housing, including recovery-oriented housing: **Large gap**
l) Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care): **Large gap**
m) Licensed-exempt room and board: **Large gap**
n) Hotel and Motel stays: **Large gap**
o) Non-congregate interim housing models: **Large gap**
p) 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**
q) Recuperative Care: **Large gap**
r) Short-Term Psot-Hospitalization housing: **Large gap**
s) (Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units: **Large gaps**
t) Peer Respite: **Large gap**
u) Permanent rental subsidies: **Large gap**
v) Housing supportive services: **Medium gap**

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

   **Kings County Behavioral Health expands housing supply and access for BHSA-eligible individuals through braided non-BHSA resources and funding. Key partnerships include the Kings Tulare Housing Alliance for regional affordable housing coordination, the Continuum of Care for streamlined homelessness responses, and collaborations with CBO Partners and Non-Profit Developers to deliver supportive housing. Managed Care Plans enable Medi-Cal Community Supports like Transitional Rent, prioritized before BHSA funds.**

**Data sharing leverages the Homeless Management Information System (HMIS) for client tracking, while federal resources provide Housing and Urban Development (HUD) vouchers such as Section 8 Housing Choice Vouchers and Department of Veterans Affairs (VA) programs like HUD-VASH for veterans.**

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

   **Kings County Behavioral Health integrates BHSA Housing Interventions with non-BHSA resources to form a braided continuum of housing support for eligible individuals at risk of or experiencing homelessness. By prioritizing Medi-Cal Managed Care Plans' Transitional Rent as the first-line support, BHSA funds fill critical gaps such as pet deposits, utilities, move-in costs, landlord incentives, and extensions up to 12 months.**

   **Through partnerships, including the Kings Tulare Housing Alliance, BHSA-backed projects like Behavioral Health Bridge Housing blend with HUD vouchers, Continuum of Care programs, and VA initiatives like HUD-VASH to transition clients from interim crisis housing to permanent supportive units. Behavioral Health Bridge Housing serves as a bridge, facilitating smooth moves to PSH while harm reduction principles sustain tenancies through ongoing support.**

   **Retention strategies include landlord outreach, mitigation funds, and integrated services via community partners and Continuum of Care, monitoring progress to prevent returns to homelessness.**

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

   **Kings County Behavioral Health employs a Housing First, low-barrier strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions, emphasizing rapid transitions from interim supports to stable, long-term units paired with behavioral health services.**

   **Housing Support Plans (HSPs) guide each client, identifying permanent housing solutions like rental subsidies or supportive units, addressing barriers, and incorporating client preferences to ensure individualized paths to stability.**

**These plans coordinate with Managed Care Plans post-Transitional Rent (up to 6 months), using BHSA funds for extensions in interim settings (up to 12 months total) before mandating permanent placements.**

**BHSA resources such as rental/operating subsidies, landlord incentives, and participant assistance, braid with HUD vouchers, VA programs, and local partners like Kings Tulare Housing Alliance to prioritize Permanent Supportive Housing (PSH), with HMIS data tracking retention and outcomes.**

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

   **KCBH is using BHSA Housing Interventions to make existing PSH more accessible and sustainable for BHSA-eligible individuals.**

   **BHSA Housing Interventions are used to help cover tenant rent shares in PSH or other permanent housing when federal or state subsidies (e.g., vouchers) do not fully cover ongoing housing costs, preventing returns to homelessness.**

   **For PSH operated with partners such as KCAO, Champions Recovery, and the Housing Authority, BHSA funds can support project operations (e.g., staffing, on-site services, property-related operating gaps) so that units remain dedicated to people with serious behavioral health needs. KCBH will also provide BHSA funds for housing through contracted mental health providers.**

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

   **Kings County Behavioral Health ensures all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services through integrated on-site staffing, formalized partnerships, and mandatory service linkages in every project contract.**

### Eligible Populations

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

   **Through contracted providers this is part of the intake process, BHSA individuals are entered into HMIS system for housing supports. Additionally eligible individuals will be referred to the Transitional Rent provider to determine housing eligibility prior to using BHSA funds. Projects like ANCHORS permanent supportive housing and Behavioral Health Bridge Housing (e.g., Holiday Lodge) feature dedicated Full-Service Partnership (FSP) teams on-site, delivering clinical services (psychiatry, therapy, medication management), case management, life skills training, and crisis intervention directly to residents alongside housing navigation.**

   **County contracts with CBOs such as Kings View Behavioral Health and Champions Recovery require provision of Enhanced Care Management (ECM), peer support, substance use disorder treatment, and tenancy skills coaching in all BHSA-funded settings, including transitional rent units and operating subsidy projects, with 24/7 access lines like the Kings County Mobile Crisis and Access Line for immediate behavioral health response.**

   **Every Housing Support Plan mandate documented linkage to behavioral health services via HMIS tracking and Coordinated Entry System referrals, while braided Medi-Cal benefits ensure no resident lacks clinical care.**

2. Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only?
   **No**

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

   ☐Insufficient need (i.e., individuals living with an SUD only have sufficient access to housing, there is a limited number of individuals with an SUD only who are unhoused)

   ☐Insufficient resources

   **☑Other**

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

**These housing interventions will be covered by SUD funding.**

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

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

    **Kings County Behavioral Health engaged stakeholders through its Fall 2025 Community Program Planning Process (CPPP) to address unique needs of children and youth in or at-risk of juvenile justice involvement for BHSA Housing Interventions. This included 13 focus groups (116 participants, including Family Engagement Center in Avenal, California Health Collaborative youth/providers, and Integrated Leadership Meeting with probation reps), 8 key interviews (e.g., First 5, Public Health), and surveys, covering required BHSA groups like child welfare, probation, and continuums of care. We also analyzed local metrics on justice involvement (e.g., recidivism, MH crises misread as criminal acts noted in n=11 groups), alongside survey data showing low agreement on service continuity for justice-involved youth with MH/SUD (e.g., <40% for MH conditions).**

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

    **KCBH hosted a dedicated in-person focus group with the LGBTQ+ Support Group (3 participants) as one of 13 total focus groups, fulfilling BHSA requirements for this mandated category. Each focus group had questions to integrate broader discussions on homelessness and housing, alongside other groups like Family Engagement Centers and youth providers. KCBH also reviewed survey data and qualitative feedback revealing housing instability risks for LGBTQ+ youth, including stigma, religious trauma barring access to faith-based shelters, and lack of non-judgmental, trauma-informed transitional options. Feedback emphasized peer support, low-barrier non-religious housing (e.g., safe gated communities or bridge housing), and mobile outreach to build trust and prevent homelessness among LGBTQ+ youth, informing Kings County's BHSA planning with partners like KCAO's Behavioral Health Bridge Housing.**

c) In the child welfare system:

**KCBH engaged child welfare representatives and groups (e.g., Family Engagement Center-Avenal, Hanna's House, Corcoran Family Resource Center with English/Spanish sessions), Integrated Leadership Meeting, and key interviews (e.g., First 5 Commission with BH director involvement), fulfilling BHSA mandates for child welfare agencies. KCBH also analyzed local data on child removals (e.g., contributing factors like isolated families, substance misuse, homelessness; survey metrics on family maintenance gaps), cross-referencing with child welfare metrics on foster placements and prevention services. Barriers identified were rushed system processes disrupting youth stability, fear of removal deterring help-seeking (n=4 groups), and coordination gaps between child welfare/prevention (n=4 groups); prioritized housing strategies like family support classes, mobile services, and referrals to bridge housing to reduce out-of-home removals.**

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

a) Older adults:

**The county used local data, community input, and state guidance to design Housing Interventions responsive to adults' needs. It analyzed homelessness data, conducted BHSA community planning and a key stakeholder interview with the Kings County Commission on Aging, and met with people with lived experience, families, providers, CoC partners, and Medi-Cal plans to identify gaps, target populations, and coordination needs. It also aligned services with BHSA/DHCS housing priorities (e.g., encampments, chronic homelessness, Housing First and harm reduction) and intentionally braided BHSA Housing Interventions with CoC, Behavioral Health Bridge Housing, Community Supports, and local housing resources so people can move smoothly from outreach or bridge housing into permanent supportive housing**.

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

**Identified how BHSA Housing Interventions (e.g., permanent supportive housing, rental and operating subsidies) will complement Continuum of Care resources, Behavioral Health Bridge Housing, Medi-Cal Community Supports**

**(including transitional rent), and local re-entry and rental assistance programs to create a clear path from custody or supervision into stable permanent housing for justice-involved adults.**

**Through the BHSA community planning process and targeted stakeholder engagement, the county gathered input from people with lived experience of justice involvement, their families, re-entry and homeless service providers, probation and jail partners, Continuum of Care partners, and Medi-Cal managed care plans to identify gaps.**

c) In underserved communities:

**Through the BHSA community planning process, the county partnered with community-based and culturally specific organizations, rural stakeholders (Avenal and Corcoran), and people with lived experience from underserved communities to gather input on barriers to housing and needed support. The county drew on BHSA policy guidance and equity-focused best practices to design Housing Interventions that are culturally responsive, low-barrier, and aligned with Housing First principles, and then targeted BHSA housing resources—alongside Medi-Cal Community Supports, Behavioral Health Bridge Housing, and local/state housing programs—to underserved communities most impacted by homelessness and behavioral health inequities.**

### Local Housing System Engagement

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

**County Behavioral Health will coordinate with the local Continuum of Care, coordinated entry, shelters, and housing partners to identify BHSA-eligible individuals experiencing or at risk of homelessness, receive referrals, and connect them to Housing Interventions through housing navigation, service coordination, and alignment with Medi-Cal housing supports.**

**County Behavioral Health will coordinate with the local HMIS Lead Agency to support shared referrals, ensure required housing data is entered accurately, and align housing services with the county's homelessness response system.**

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

    a) Local CoC

    **The county will participate in CoC governance and planning, including regular workgroups, to align target populations, eligibility criteria, and prioritization between BHSA Housing Interventions and CoC housing resources.**

    **Use the Coordinated Entry System (CES) and standardized referral tools so that referrals can flow both from the CoC to BHSA Housing Interventions and from behavioral health programs into CoC housing when appropriate.**

    **Establish written policies and procedures describing referral pathways, documentation requirements, warm hand-offs, and feedback loops so referrers know the status and outcome of referrals.**

    **Ongoing engagement and data sharing to sustain coordination, the county behavioral health system will:**

    **Attend the monthly Coordination Meetings, Continuum of Care monthly stakeholder meetings and trainings, to stay aligned on system changes, best practices, and shared clients.**

    **Exchange data, within privacy and data-sharing rules, to track referrals, placements, and outcomes and use this information for joint problem-solving and system improvement.**

    **Participate in the annual Point in Time Count to help identify and understand the needs of people experiencing homelessness who may be eligible for BHSA Housing Interventions, and to refine targeting and outreach strategies accordingly.**

    b) Public Housing Agency

    **The county behavioral health system will collaborate with the local Public Housing Agency to prioritize BHSA-eligible clients for vouchers. Currently, the Director of Behavioral Health and the Housing Authority are both committee members for the Kings County Homelessness Collaborative.**

**Broader coordination with housing partners including the CoC, rental assistance programs, and landlords will occur through cross-sector planning tables, braided funding strategies, and capacity-building trainings to ensure seamless implementation and long-term housing stability.**

c) MCPs

**County Behavioral Health staff meet monthly with MCP providers to discuss housing needs, review implementation progress for transitional rent and other tenancy-sustaining services and align client referrals and braided funding opportunities. These meetings facilitate real-time problem-solving for shared clients experiencing or at risk of homelessness.**

**Contracted behavioral health providers refer to BHSA clients to MCPs for Community Supports like transitional rent payments, housing navigation, and tenancy skills training, while MCPs refer back clients needing intensive BHSA Housing Interventions such as permanent supportive housing or operating subsidies.**

d) ECM and Community Supports Providers

**County Behavioral Health staff have started meeting with ECM and Community Support Providers monthly. Representatives from these organizations also participate in the Kings County Homelessness Collaborative.**

e) Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
- **KCAO/BHBH, Shelter, Barbara Saville Shelter**

5. 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?

**Kings County Behavioral Health contracts with Kings County Action Organization (KCAO) on the Behavioral Health Bridge Housing (BHBH) project to integrate services for BHSA-eligible individuals. Homekey+ bonds cover capital costs while KCBH allocates operational BHSA dollars for sustainability. Streamlined referrals will originate from CPP-identified partners (e.g., probation, child welfare, homeless collaboratives) through interagency meetings, mobile crisis**

**teams, and 2-1-1, prioritizing BHSA eligibles like justice-involved youth or those with untreated conditions for rapid housing navigation.**

6. Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
   **No**

## BHSA Housing Interventions Implementation

### Rental Subsidies

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.

1. Is the county providing this intervention?
   **Yes**
2. Is the county providing this intervention to chronically homeless individuals?
   **Yes**
3. How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
   **35**
   a) How many of these individuals will receive rental subsidies for permanent housing on and annual basis?
      **20**
   b) How many of these individuals will receive rental subsidies for interim housing on an annual basis?
      **15**
4. What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?

   **The County's estimates are informed by prior-year rental subsidy utilization, current Fair Market Rent and rent reasonableness standards, and projected housing placements based on historical caseload and program capacity. These data sources are used to determine the expected subsidy amount and the number of individuals to be served in interim and permanent settings each year.**

5. For which types of setting will the county provide rental subsidies?
   **☑Non-Time-Limited Permanent Settings: Supportive housing**

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

6. Will this Housing Intervention accommodate family housing?
   **No**

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

**Kings County Behavioral Health uses BHSA Housing Interventions to address housing instability among eligible individuals experiencing or at risk of homelessness, particularly those with serious mental health or substance use disorders. This includes funding for tenant-based rental subsidies paid directly to landlords on behalf of individual tenants, as well as support for interim housing such as the Behavioral Health Bridge Housing program.**

**BHSA rental subsidy funds will be used exclusively for allowable rental costs in accordance with P.M. 7.C.9.1 and will not be used to fund operating subsidies, move-in costs, utilities, landlord incentives, or Transitional Rent. These non-allowable services may be supported through other funding sources, including Medi-Cal Managed Care Plan (MCP) services such as Transitional Rent, to ensure appropriate coordination of care and housing support.**

8. 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**

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

   **The County Behavioral Health Department will build and maintain a diverse portfolio of housing units by partnering with a broad range of county and community entities, including county housing authorities, Continuums of Care (CoCs), other county departments, state and federal housing programs, community-based organizations (CBOs), and tribal entities, as applicable. The County will work collaboratively to identify and sustain a mix of scattered-site units, project-based housing, and master leasing/Flex Pool resources that can serve BHSA-eligible individuals.**

   **To identify available units, the County will:**

**• Partner with the local Housing Authority and other public housing agencies to access project-based and scattered-site Section 8 units, public housing, and other supported housing resources.**

**• Coordinate with the local Continuum of Care and homeless response system partners (shelters, outreach teams, coordinated entry, and housing providers) to locate available units, identify people experiencing homelessness with behavioral health needs, and align referrals.**

**• Engage with community-based organizations that operate supportive housing, transitional housing, and permanent supportive housing programs to expand available unit inventories.**

**• Sustain master leasing agreements and Flex Pool strategies, including working with a leasing company and regional housing partners, to maintain a pool of temporarily held units for BHSA-eligible individuals, including FSP and ACT clients.**

**• Hold regular (monthly) coordination meetings with the Kings-Tulare Homeless Alliance and related partners to review available units, discuss barriers to placement, and plan for new unit acquisition or master-lease expansion.**

**Through these collaborative efforts, the County will maintain a diversified portfolio that includes scattered-site units, project-based housing, and master-leased/Flex Pool units, ensuring that BHSA-eligible individuals can be placed in appropriate, stable housing settings.**

10. Total number of units funded with BHSA Housing Interventions per year
    **40 (FSP/BHBH)**

11. Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units.

    **The County is funding BHSA Housing Interventions that allows it to pay rent on behalf of individual tenants rather than allocating all funding to a pre-set number of dedicated units. Through its FSP contracted provider, the county issues payments directly to landlords or property owners for eligible participants, consistent with BHSA Housing Interventions guidelines.**

**Operating Subsidies**

1. Is the county providing this intervention?
   **Yes**
2. Is the county providing this intervention to chronically homeless individuals?
   **Yes**
3. Anticipated number of individuals served per year
   **40**
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding

   **BHSA Housing Interventions funding will be used to provide operating subsidies that support the day-to-day physical operation of interim and permanent housing units serving BHSA eligible individuals experiencing or at risk of homelessness. Operating subsidies will be used to cover allowable housing operating costs, such as utilities, maintenance and repairs, property management, security or site monitors, insurance, taxes, and basic furnishings and appliances needed to keep units habitable and available.**

5. 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: Single and multi-family homes
   ☐ Non-Time-Limited Permanent Settings: Housing in mobile home communities
   ☐ Non-Time-Limited Permanent Settings: Single room occupancy units
   ☐ Non-Time-Limited Permanent Settings: Accessory dwelling units, including Junior Accessory Dwelling Units
   ☐ Non-Time-Limited Permanent Settings: Tiny Homes
   ☐ Non-Time-Limited Permanent Settings: Shared housing
   **☑Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing**
   ☐ Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
   **☑ Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit**
   **☑ Time Limited Interim Settings: Hotel and motel stays**
   **☑ Time Limited Interim Settings: Non-congregate interim housing models**

☐ Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134](does not include behavioral health residential treatment settings)
☐ Time Limited Interim Settings: Recuperative Care
☐ Time Limited Interim Settings: Short-Term-Post-Hospitalization housing
☐ Time Limited Interim Settings: Tiny homes, emergency sleeping cabins, emergency stabilization units
☐ Time Limited Interim Settings: Peer Respite
**☑ Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit**

6. Will this be a scattered site initiative?
   **Yes**

7. Will this Housing Intervention accommodate family housing?
   **No**

8. Total number of units funded with BHSA Housing Interventions per year.
   **40**

9. Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units.

   **N/A**

### Landlord Outreach and Mitigation Funds

1. Is the county providing this intervention?
   **Yes**

2. Is the county providing this intervention to chronically homeless individuals?
   **Yes**

3. Anticipated number of individuals served per year
   **40**

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

**BHSA Landlord Outreach and Mitigation funds will be used to recruit and support landlords who rent to BHSA eligible tenants by providing outreach, education, and mitigation payments for unit damages, turnover, and limited vacancy or unit hold costs. These funds are intended to reduce landlord risk and expand available units and will not pay for client case management or rent.**

5. Total number of units funded with BHSA Housing Interventions per year
   **45**

6. Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units.

   **N/A**

### Participant Assistance Funds

1. Is the county providing this intervention?
   **Yes**

2. Is the county providing this intervention to chronically homeless individuals?
   **Yes**

3. Anticipated number of individuals served per year
   **40**

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

   **Individuals enrolled in the FSP program may require limited financial assistance to achieve treatment goals and prevent a crisis that could result in homelessness, hospitalization, or other adverse outcomes. To address these needs, the provider has reserved Participant Assistance funds in its budget to support housing stability and immediate basic needs consistent with BHSA Housing Interventions.**

   **These funds will be used to provide individuals with short-term assistance necessary to obtain or maintain housing, including items such as food, temporary shelter, household start-up expenses (e.g., essential furnishings and**

**supplies), personal hygiene items, transportation directly related to securing or maintaining housing, and fees associated with obtaining vital documents (e.g., birth certificates or identification) required for housing access.**

**All Participant Assistance expenditures will be reasonable, necessary, and directly linked to supporting the individual's housing stability and treatment goals and will comply with all applicable BHSA requirements.**

### Housing Transition Navigation Services and Tenancy Sustaining Services

1. Is the county providing this intervention?
   **No**

2. Please explain why the county is not providing this intervention?

   **These services are provided by community partners such as Champions or Kings View Enhanced Care Management services and some resources are available through Kings Community Action Organization (emergency food, childcare, etc.).**

### Housing Interventions Outreach and Engagement

1. Is the county providing this intervention?
   **Yes**

2. Is the county providing this intervention to chronically homeless individuals?
   **Yes**

3. Anticipated number of individuals served per year
   **165**

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

   **BHSA Housing Intervention outreach and engagement activities will be delivered through other existing service providers (e.g., PATH, Champions Recovery Alternative Programs). These providers will conduct outreach designed to locate, identify, and build relationships with BHSA-eligible individuals experiencing or at risk of homelessness, including those living in encampments or other unsheltered locations.**

**Through these partnerships, outreach and engagement staff will provide immediate, housing-related support such as one-on-one engagement in high-need areas, distribution of basic survival and hygiene items (e.g., food, water, blankets, clothing, hygiene supplies) to build trust, and onsite navigation to housing resources and referrals to homeless assistance and housing programs. Individuals identified as BHSA-eligible will be referred to Kings County Behavioral Health for assessment and linkage to appropriate behavioral health services.**

**All outreach and engagement activities conducted by outreach and engagement providers will be tracked in HMIS to monitor contacts, housing placements, and housing retention outcomes. BHSA Housing Interventions funds will not be used to pay for these services; such services will be provided separately, as appropriate, through other funding sources and programs.**

### Capital Development Projects

1. Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
   **No**

2. Please explain why the county is not providing this intervention.

   **Kings County is not currently providing capital development funding through BHSA Housing Interventions.**

   **The county has prioritized immediate housing needs, like tenant-based rental subsidies and operating subsidies for existing projects (e.g., Behavioral Health Bridge Housing), over capital development due to limited local opportunities for new construction, and a strategic focus on rapid rehousing rather than long-lead-time projects in the current BHSA planning cycle.**

### Other Housing Interventions

1. If the county is providing another type of Housing Interventions not listed above, please describe the intervention.
   **N/A**

a) Is the county providing this intervention to chronically homeless individuals? **No**
b) Anticipated number of individuals served per year? **0**

### Continuation of Existing Housing Programs

1. Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending.

   **Continuation of existing Behavioral Health Bridge Housing units for chronically homeless individuals.**

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

1. Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
   ☐Housing Transition Navigation Services
   ☐Housing Deposits
   ☐Housing Tenancy and Sustaining Services
   ☐Short-Term Post-Hospitalization Housing
   ☐Recuperative Care
   ☐Day Habilitation
   ☐Transitional Rent
   ☑**None of the Above**

2. For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?
   a) Housing Transition: **No**
   b) Housing Deposits: **No**
   c) Housing Tenancy and sustaining Services: **No**
   d) Short-Term Post-Hospitalization Housing: **No**
   e) Recuperative Care: **No**
   f) Day Habilitation: **No**
   g) Transitional Rent: **No**

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

**Kings County Behavioral Health (KCBH) identifies, confirms eligibility, and refers Medi-Cal members to MCP-covered housing Community Supports like Transitional Rent through coordinated processes with community partners such as Champions, KCAO, or Kings View Enhanced Care Management services. KCBH has an established referral process to refer clients to Champions for the Transitional Rent benefit.**

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

   **Kings County Behavioral Health will maintain and regularly update a Housing Interventions provider roster (including services offered, target populations, and referral pathways) and share it with all Medi-Cal Managed Care Plans at least quarterly and whenever network changes occur. The County will embed this network information and referral processes into MOUs and standing bimonthly coordination meetings with MCPs and will use these meetings and existing care coordination forums to jointly review shared members with housing needs, avoid duplication with MCP Community Supports, and ensure MCP care managers know how to connect members to BHSA Housing Interventions providers.**

**5.** Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?
   **No**

6. What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extend resources are available?

   **Kings County Behavioral Health (KCBH) will implement specific procedures, in coordination with Medi-Cal Managed Care Plans (MCPs), to ensure that Medi-Cal members with significant behavioral health conditions do not experience gaps in housing support when MCP housing services (such as Transitional Rent) are exhausted, to the extent resources are available. These procedures are grounded in DHCS guidance on braiding and sequencing MCP Community Supports with BHSA Housing Interventions.**

**First, KCBH will work with MCPs to identify members receiving Transitional Rent and other housing Community Supports at the time those services are authorized. MCPs will share, through existing data sharing agreements and care coordination channels, a roster of members receiving Transitional Rent that includes start and end dates, housing setting, and assigned MCP care manager or ECM provider, consistent with DHCS expectations for bidirectional data sharing.**

**Second, beginning no later than 90 days before the expected end of Transitional Rent, MCP care managers and KCBH housing coordination staff will jointly review each member's housing status and long-term housing plan. During this review, KCBH will assess BHSA eligibility and determine whether the member may be prioritized for BHSA Housing Interventions (e.g., rental subsidies, operating subsidies, or interim housing funded by BHSA) if no other long-term subsidy (such as a HUD voucher or permanent supportive housing slot) is available at the end of Transitional Rent.**

**Third, for members determined to be BHSA eligible and prioritized based on need, KCBH will initiate BHSA Housing Interventions prior to the end of the Transitional Rent period, to the extent resources allow. This may include issuing a BHSA rental subsidy or securing a BHSA funded interim or permanent unit so that the member can transition directly from MCP funded Transitional Rent into BHSA funded housing support with no break in assistance. When feasible, KCBH will seek to align lease terms and payment schedules so that MCP payments and BHSA payments are sequenced without a gap and will ensure that BHSA funds do not duplicate any portion of the Transitional Rent payment.**

**Fourth, KCBH and MCPs will use existing care coordination structures, such as joint case conferences, multidisciplinary team meetings, and warm handoff protocols, to monitor these transitions and address any issues that could cause a lapse in housing support (e.g., delays in subsidy approval, unit availability challenges), consistent with DHCS guidance on integrated housing and behavioral health care. KCBH will document these procedures in written policies and workflows so that County staff, contracted housing providers, and MCP partners understand the steps and roles involved in transitioning members from MCP housing services to BHSA Housing Interventions.**

**Through these processes, KCBH will seek to ensure that, to the extent BHSA resources are available, Medi-Cal members with significant behavioral health**

**conditions can move from MCP housing supports such as Transitional Rent into BHSA Housing Interventions without gaps in housing assistance.**

### Flexible Housing Subsidy Pools

1. Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county
   **No**
2. Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?
   **No**
3. Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of Flex Pool in addition to those described above
   **N/A**

## Behavioral Health Services Fund: Innovation Behavioral Health Pilot and Projects

1. Does the county's plan include the development of innovation programs or pilots?
   **Yes**

**Program #1**

1. **What Behavioral Health Services Act (BHSA) component will fund the innovation program?**
   ☐Housing Interventions
   ☐Full-Service Partnership
   ☑**Behavioral Health Services and Supports**
   a) Please describe how the innovation program or pilot will help build the evidence base for the effectiveness of new statewide strategies

   **This program is an MHSA-encumbered INN project and is located under BHSS Capital Facilities and Technological Needs.**

   b) Please describe intended outcomes of the project

   **This program is an MHSA-encumbered INN project and is located under BHSS Capital Facilities and Technological Needs.**

# Workforce Strategy

## Maintain an Adequate Network of Qualified and Culturally Responsive Providers

The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

1. Maintains and monitors a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and
2. Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.
3. The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.
    a) 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**
    b) 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

1. What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)? **10%**

2. Upload any data source(s) used to determine vacancy rate.
**[File upload_Kings County_Workforce_Gaps_Provider_Survey Results]**

3. For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates:

☐Advanced Emergency Medical Technicians
☐ Certified Nurse Specialist
☐ Community Health Workers (CHW) defined in the Enhanced Community Health Workers Services benefit
☐Community Paramedics
☐Emergency Medical Technicians
**☑Licensed Clinical Social Worker**
**☑ Licensed Marriage and Family Therapist**
**☑Licensed Professional Clinical Counselor**
☐Licensed Psychologist
☐Licensed Vocational Nurse
☐Medical assistant
☐Medi-Cal Certified Peer Support Specialist
☐Mental Health Rehabilitation Specialist
☐Nurse practitioner
☐Occupational Therapist
☐Pharmacist
☐Physician
☐Physician assistant
☐Psychiatric Technician (PT)
**☑Psychiatrist**
☐Registered nurse
**☑Substance Use Disorder Counselor**
☐Other: MH Specialist

4. Please describe any other key workforce gaps in the county

**Within Kings County Behavioral Health, the vacancy rate for county-operated positions is currently zero, as most clinical services are contracted to external providers. The only county-run program is the Children's Psychiatric Services Clinic, which is fully staffed, with psychiatric services within this program is provided via contract.**

**To assess workforce gaps within Kings County's contracted behavioral health network, Kings County Behavioral Health administered a Workforce Gap Provider Survey to contracted mental health and substance use disorder providers. Survey respondents were asked to identify the positions with the highest vacancy rates across their organizations. Among mental health**

**providers, the positions with the greatest reported shortages were Licensed Marriage and Family Therapists (LMFTs), Licensed Clinical Social Workers (LCSWs), Licensed Professional Clinical Counselors (LPCCs), Mental Health Rehabilitation Specialists, and Psychiatrists. Among substance use disorder (SUD) providers, the largest reported workforce gap was in Substance Use Disorder Counselors.**

**The overall county vacancy rate, including contracted providers, is 10%. Contracted providers reported that the majority of workforce gaps continue to occur in clinical LPHA positions, which remain the most difficult to recruit and retain. Providers noted that low pay, few incentives, and high job demands contribute to difficulty retaining licensed clinicians, who often have opportunities for higher compensation in less intensive roles. Staffing shortages increase caseload pressure, though morale and workload balance improve as teams become fully staffed. Some providers acknowledged recent improvements in hiring and retention, attributing these gains to increased support and collaboration from Kings County Behavioral Health. A supportive work environment and responsive county partnership were recognized as key factors in retention and job satisfaction. Additional gaps were identified in services for Transitional Age Youth (TAY), as youth transitioning from adolescent to adult programs often experience discomfort engaging in adult services. Providers also reported ongoing challenges recruiting qualified and bilingual SUD counselors.**

5. 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, the county anticipates significant shifts in workforce needs due to new and forthcoming requirements, including the implementation of additional evidence-based practices under Behavioral Health Transformation (BHT) and BH- CONNECT. Provider shortages in several geographic areas will require expanded training, increased support, and ongoing monitoring.**

   **Additional Behavioral Health staff will be needed to dedicate sufficient time to provide training and technical assistance. To meet fidelity standards for**

**Evidence-Based Practices and comply with new data-collection requirements, the county will need an additional Quality Assurance (QA) clinician or QA specialist (ASOC/MHSA). Program Coordinators (PCs) or unit Supervisors may also need to take on enhanced roles to support implementation and oversight. The county is exploring opportunities to expand CalMHSA contracts to reduce the administration burden associated with state reporting.**

**A key challenge, however, is securing County Administration approval for the additional positions required despite available funding, which may limit the county's ability to fully meet state mandates and maintain compliance without delays.**

### 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.

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

   a. Please explain any actions or activities the county is engaging in to leverage the program.

      **The County is actively leveraging the BH-CONNECT workforce initiative by disseminating information about the Behavioral Health Scholarship Program to all staff and encouraging participation.**

2. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?
   **Yes**

   b. Please explain any actions or activities the county is engaging in to leverage the program.

      **The county behavioral health system plans to leverage the BH-CONNECT Workforce Initiative by actively promoting the Medi-Cal Behavioral Health Student Loan Repayment Program to eligible county-operated and**

**county-contracted providers and supporting them in applying when application cycles are available.**

3. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
   **Yes**

   c. Please explain any actions or activities the county is engaging in to leverage the program.

      **The county behavioral health system intends to leverage the BH-CONNECT Workforce Initiative, including the Medi-Cal Behavioral Health Recruitment and Retention Program (MBH-RRP), to support recruitment and retention of the Medi-Cal behavioral health workforce. The county will review MBH-RRP eligibility criteria and funding cycles and, when feasible, will support county-operated and county-contracted organizations in submitting applications for recruitment and retention bonuses, supervision supports, and related workforce incentives.**

4. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?

   **No**

5. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
   **No**

6. Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training.

   **KCBH is implementing value-based workforce development funds that allow contracted providers who maintain EBP fidelity to receive additional dollars that must be reinvested in workforce development activities, such as recruitment, retention, and supervision supports. These funds are designed to strengthen provider capacity in high-needed programs and incentivize the hiring and retention of staff who can competently deliver EBPs. KCBH is also looking into offering a training focused on treating co occurring disorders involving intellectual disability, including autism, to enhance staff skills in working with individuals who have complex clinical and developmental needs. In addition to**

**this training, the county will provide other specialized trainings and will invest in these offerings as its financial situation allows and as specific needs for advanced or niche clinical skills are identified. At this time, beyond the value based workforce development funds and the planned training and other specialized trainings, KCBH does not have additional distinct workforce initiatives formally planned but will continue to assess workforce gaps and add strategies as resources and system priorities evolve.**

## Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this

1. Please upload the completed budget template. **See Appendix – budget template uploaded.**
2. Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template
    a. Behavioral Health Services and Supports (BHSS) **No excess prudent reserve**
    b. Full-Service Partnership (FSP) **No excess prudent reserve**
    c. Housing Interventions **No excess prudent reserve**
3. Enter date of last prudent reserve assessment: **05/11/2026**
4. Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan
    a. BHSS **No excess prudent reserve**
    b. FSP **No excess prudent reserve**
    c. Housing Interventions **No excess prudent reserve**

## Plan Approval and Compliance

### County Administrator or Designee Certification

**N/A**

### Behavioral Health Director Certification

**N/A**

## Board of Supervisor Certification

**Pending Board Approval**

# Appendix

## Appendix A. Kings County Behavioral Health Quality Assessment & Performance Improvement (QAPI) Work Plan

## Appendix B.  Kings County Workforce Gaps Provider Survey

## Appendix C. Budget Template

# APPENDIX A

# Kings County Behavioral Health Quality Assessment & Performance Improvement (QAPI) Work Plan

KINGS COUNTY
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Mental Health • Prevention and Early Intervention• Substance Use Disorders Prevention and Treatment

Lisa D. Lewis, PhD | Director of Behavioral Health | (559) 852-2444

# Kings County

# Behavioral Health

# Quality Assessment & Performance Improvement (QAPI) Work Plan

# FY 2024-2025

# with

# FY 2023-2024

## Evaluation

**Revised 9/10/2025**

*The Quality Assessment & Performance Improvement (QAPI) Work Plan is a required element of the Quality Management Program, as specified by the State Department of Health Care Services (DHCS) Mental Health Plan (MHP) contract with Kings County Behavioral Health (KCBH), and by the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.440*

# QAPI Revision Cover Sheet – FY 2024/2025

**Date of Revision:** September 10, 2025

This revision of the Kings County Behavioral Health QAPI Work Plan and Evaluation is being produced several months after the original submission to incorporate a newly adopted indicator: **Quality and Responsiveness of the 24/7 Access Line**.

At the time of the original QAPI submission, this indicator was planned but left blank pending further refinement. Since that time, QA has continued to conduct monthly test calls and compile quarterly results using the DHCS Step-2 State Report Form. These activities have now been formally integrated into the QAPI process for FY 24/25 to strengthen monitoring and improvement efforts related to access to care.

This revision includes:

- **Indicator Addition:** "Quality and Responsiveness of 24/7 Access Line" added where the prior placeholder existed.
- **Analysis:** Incorporates FY 23/24 baseline data from quarterly test calls, showing strengths in language access and urgent condition response, as well as challenges in problem resolution/fair hearing information and logging requirements.
- **Action:** Establishes FY 24/25 improvement activities, including targeted staff training, reinforced logging practices, and quarterly reporting to promote accountability.
- **Prior Year Action and Result:** Documents that in FY 22/23, test call monitoring was conducted by QA but not included in the QAPI framework, limiting its use for systematic monitoring and performance improvement.

This revision ensures the QAPI reflects a complete set of indicators, analysis, and planned actions, and brings the document current to the quality improvement activities that will guide the FY 24/25 cycle.

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## INTRODUCTION

In accordance with the California Code of Regulations (CCR), Title 9, Section 1810.440, Kings County Behavioral Health (KCBH) has a Quality Assurance (QA) Team that performs quality assessment and performance improvement (QAPI) activities pursuant to the Department of Health Care Services (DHCS) Mental Health Plan (MHP) Contract. As part of the required activities, KCBH produces an annual QAPI Work Plan via its Quality Improvement Committee (QIC), which is comprised of County and Contracted Mental Health providers and community and county partners.

The goal of the KCBH QAPI activities is to ensure Kings County beneficiaries have appropriate access to timely, quality specialty mental health services as demonstrated through measurable outcomes.

## PURPOSE AND STRUCTURE

Within KCBH's Administration Division is the Quality Assurance (QA) Team, which reports to the KCBH Deputy Director. The KCBH QA Team consists of a QA Manager, a QA Licensed Clinician, a Business Applications Specialist, two QA Specialists, and an Office Assistant.

The purpose of the KCBH QA Team is to establish a written description (QAPI Work Plan) by which the specific structure, process, scope and role of this plan is articulated. Beginning with fiscal year (FY) 2019-2020, significant revision took place to the KCBH QAPI Work Plan due to the transition of Managed Care operation and oversight from its previous County contracted provider to the County. Significant changes were also due to the incorporation of the Managed Care regulatory and reporting changes that occurred with DHCS' implementation of the 'Final Rule' that started in FY 2017-2018 continuing through 2018-2019. As such, starting fiscal year 2019-2020, the KCBH QA Team became the oversight for monitoring performance in the following areas, and began baseline development for future trend analysis:

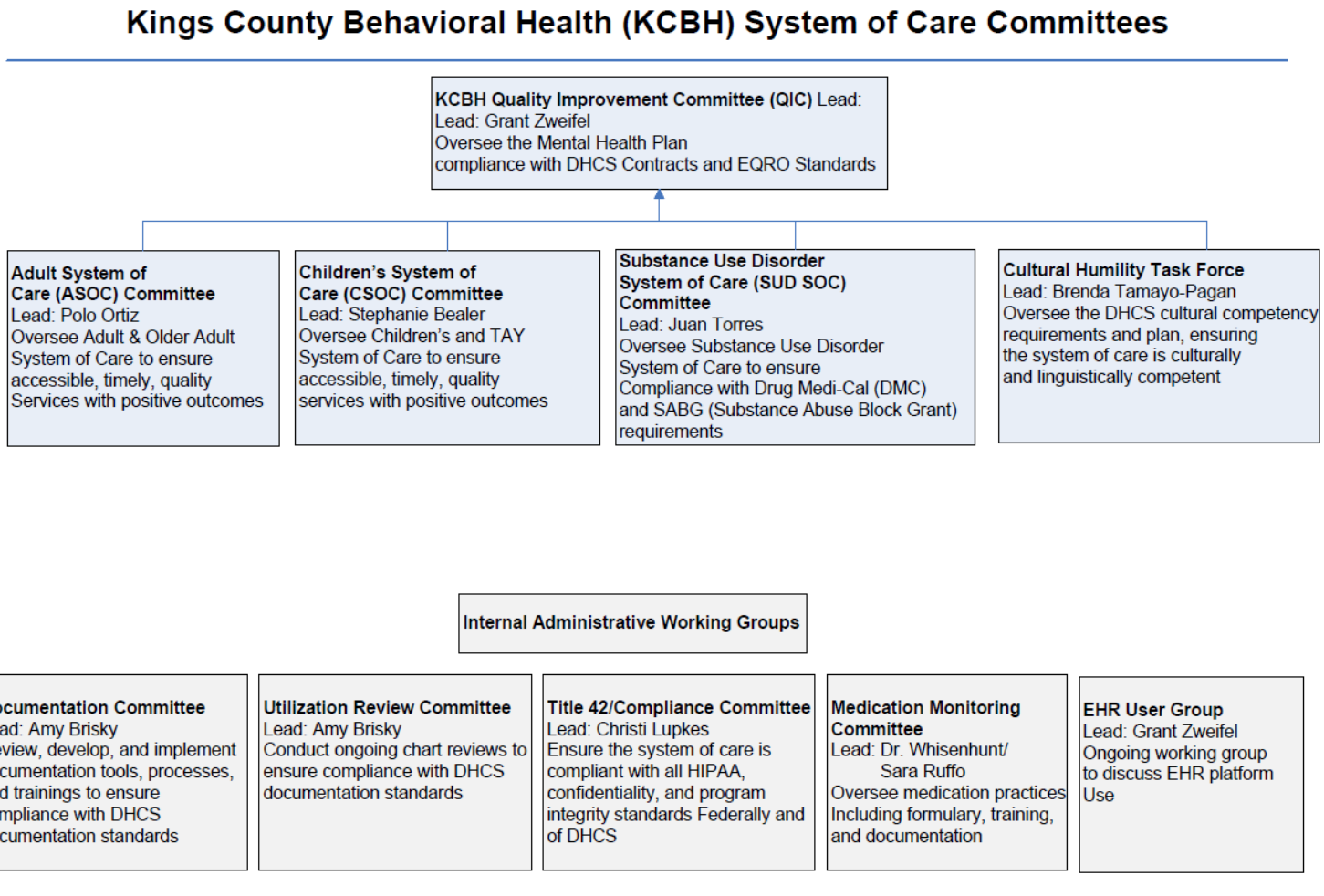
- Beneficiary and System Outcomes
    - Beneficiaries Served and Demographics
    - Timeliness of Services
    - 24/7 Access Line
    - ANSA data
    - CANS/PCS-35 Data
    - Consumer Perception Survey
    - Discharge Disposition
- Utilization Management and Utilization Review
    - Service Utilization (over- and under-utilization)
    - Claims Data
    - Engagement Rates
    - No-Show Rates
    - Chart Review
    - Medication Monitoring
    - Hospitalization Rate

- Provider Network Adequacy, Credentialing, and Monitoring
  - Network Adequacy Provider Counts
  - Time and Distance Standards
  - Provider (Re)Credentialing
- Beneficiary Protections
  - Grievances
  - Appeals
- Cultural and Linguistic Competency
  - Cultural Competency Training
  - Language Access Utilization
  - Community Outreach

Metric development is done on a continuous basis as these measures continue to be designed. Monitoring is conducted quarterly for the metrics developed and are reviewed and discussed at the KCBH Quality Improvement Committee (QIC). The measures are reconciled at fiscal year end into an annual evaluation of the QAPI Work Plan for use in development of the proceeding fiscal year annual QAPI Work Plan update.

## COMMITTEES

Kings County Behavioral Health has several committees that comprise the structure of oversight to the Behavioral Health System of Care. While some are specific to the operations of QA Unit, the workflow below depicts the larger oversight of key committees.



## PRIOR YEAR EVALUATION AND NEW YEAR FOCUS AREAS

KCBH evaluated the performance of the measures outlined within the fiscal year (FY) 2023-2024 MHP QAPI Work Plan and presented the results at the December 10, 2024 Quality Improvement Committee. Below is the summary of the results of that evaluation, as well as the focus areas identified for the FY 2024-2025 QAPI Work Plan.

### FY 2023-2024 EVALUATION SUMMARY

Kings County Behavioral Health Mental Health Plan met the following goals in FY 2023/2024:

- Met and exceeded state's timely access among first access to medication services and follow-up appointments post psychiatric hospitalization.
- Met and exceeded the state's timeliness to first offered SMHS appointment.
- Satisfaction rating of 4.46 (out of 5) among adults clients and 4.12 (out of 5) among child/youth clients and caregivers/parents.
- Hospital 30-day readmission rate remains below 10%.
- Network adequacy certification for provider ratios met state standards.
- Met and exceeded 90% compliance standard for medication monitoring.
- Network adequacy certification for provider ratios met state standards.

Below is a summary of the MHP's goals and outcomes detailed further within this Plan.

- ***Services are Accessible:*** ***Data not available***
    - *Due to changes in the state's external quality review organization and review processes in 2024, Kings County Behavioral Health (KCBH) did not have access to the historical Claims Data reports required to fully populate metrics related to the number served, penetration rates, and related breakdowns by age, race/ethnicity, and service type.*

- ***Services are Timely:*** ***Goal partially met***
  (Timeliness among 1st request and urgent conditions is outside state standards)
    - ***Timeliness among first entry into medication support services and re-entry from post-psychiatric hospitalization remains timely.*** *First entry into medication support services took on average 8.67 business days with 89% of all referrals meeting state standard of 15 business days, and the average length of re-entry post-psychiatric hospitalization took on average 4.29 calendar days with 88% meeting the HEIDIS standard of 7 calendar days.*
    - ***Timeliness from first request for specialty mental health services to first offered appointment*** *remain above the state standard (10 business day/80% met) landing at*

*5.19 business days on average with 89% of all requests meeting the 10-business day standard. Timeliness from first request for specialty mental health services to first rendered services land at 9.80 business days on average with only 73% of all requests meeting the 10-business day standard.*

- ***Timeliness for entry into services for those experiencing an urgent condition** is on average 73.64 hours (3.07 days) with 65.83% meeting the state's 48-hour (2 days) timeliness standard.*

- ***Services are of Quality to Consumers:* Goal partially met**
  *(Quality of Life domain in consumer perception survey remains just below 4.0 on the satisfaction scale of 1-5 with 5 being most satisfied)*
  - ***For the May 2023 Consumer Perception Survey, satisfaction among caregivers and youth consumers was generally positive, with a total satisfaction rating of 4.12 (out of 5) based on completed responses.** This included ratings of 4.18 (83.94%) for service understanding, 4.25 (87.34%) for perceived quality of services, and 3.85 (71.57%) for accessibility. Satisfaction among adult and older adult consumers was also positive, with a total satisfaction rating of 4.46 (86.93%) based on completed responses. This included ratings of 4.10 (79.03%) for service understanding, 4.26 (82.14%) for perceived quality of services, and 3.87 (65.76%) for accessibility.*

- ***Services Produce Measurable Outcomes:* Insufficient data for measuring**
  - ***While in prior year reports, children experienced a 70% reduction in actionable treatment needs** per the measurement comparison of the initial Child Adolescent Needs and Strengths (CANS) assessment at time of entry with the CANS completed at discharge, in FY 23/24 the MHP was unable to pull this report due to conversion to a new electronic health records (EHR) system.*
  - ***The Adult Needs and Strengths Assessment (ANSA) dashboard has not yet been developed.***

- ***Services are Appropriately Delivered:* Goal partially met**
  *(Number of beneficiaries receiving one SMHS remain well above that of the State, and hospitalizations continue to increase)*
  - *Due to changes in the state's external quality review organization and review processes in 2024, Kings County Behavioral Health (KCBH) did not have access to the historical **Claims Data** reports.*
  - ***Grievances decreased** with no identified pattern or trend.*

- ***Appeals experienced an increase.*** *This 23/24 fiscal year saw an 80% increase in appeal requests from FY 22/23 (from 5 appeal requests to 8 requests). However, due to the small sample size, this change is not significant.*
- ***Hospitalizations*** *experienced an increase of 23%, and readmissions within 30-days experienced an increase most notably among children's, although still under 10% readmission rate.*

- ***There is an Adequate Network of Providers:*** ***Goal Met***
  - *As of 2019, the MHP provider network significantly increased, and as such* ***received certification by DHCS during the 2019, 2020, 2021, 2022, and 2023 annual submission as meeting network adequacy*** *for provider ratio. This includes a children's reserve capacity contract.*

- ***Services are Documented in Accordance with State Standards:*** ***Goal Partially Met***
  - ***Chart review*** *compliance fell below the 90% compliance rate goal in total (84.42%), but medication monitoring compliance was (91.86%).*

- ***Services and Workforce are culturally and linguistically competent:*** ***Insufficient data for measuring***
  - *Data limitations have historically made it difficult to create meaningful measurements; however, the MHP will be leveraging the new EHR and Relias platform to improve data collection and develop meaningful metrics for Language Line utilization and cultural competency training in FY 24/25.*

## FY 2024-2025 FOCUS AREAS FROM FY 2023-2024 EVALUATION

For FY 2024-2025, Kings County Behavioral Health (KCBH) is building on the progress made during FY 2023-2024. A major milestone achieved was the successful conversion to the CalMHSA-hosted Streamline SmartCare electronic health records (EHR) system, replacing the Kings View-hosted Cerner Anasazi system as of July 1, 2023. To ensure continued access to historical data, the department has also established hosting for its legacy EHR system.

The focus for FY 2024-2025 includes several key initiatives aimed at improving data capabilities and reporting:

- **Enhancing EHR Data Collection Capabilities**:
  - Improve data collection processes within the new EHR system to support robust quality assurance reporting.
  - Ensure key metrics are accurate and readily available to facilitate data-driven decision-making.
- **Developing Alternate Data Sources**:
  - Address the loss of specific data previously provided by Behavioral Health Concepts (BHC), the State's former external quality review organization.
  - Prioritize the development of data sources for key areas, including:
    - Clients served, broken down by demographics.
    - Penetration rates.
    - Claims data related to clients served and services provided.
- **Advancing Reporting and Dashboards**:
  - Collaborate with a data/reports consultant to develop dashboards and reports for:
    - Child and Adolescent Needs and Strengths (CANS).
    - Adult Needs and Strengths Assessment (ANSA).
    - No-show rates.
    - Discharge disposition trends.
    - Network adequacy monitoring.
- **Improving Consumer Perception Surveys**:
  - Implement methods to reduce incomplete or missing responses in consumer perception surveys.
- **Integrating CertifyOS Provider Certification Dashboard**:
  - Leverage the CertifyOS platform to populate the QAPI Work Plan with meaningful metrics for provider certification and recertification processes.

These focus areas will ensure KCBH continues to enhance data collection and reporting capabilities while addressing key quality improvement priorities for FY 2024-2025.

## CURRENT YEAR PERFORMANCE MONITORING

KCBH will monitor performance of the aforementioned measures in a meaningful method that includes goals, objectives, indicators/measures, measurement and interpretation. It is the intent that these measures will be tracked over each fiscal year to identify any patterns or trends that reveal areas of success and areas of improvement needed.

### GOAL 1: BENEFICIARY AND SYSTEM OUTCOMES

Kings County MHP will provide accessible, timely, quality services that produce measurable results in promoting and sustaining wellness, recovery, and resiliency among individuals with serious emotional disturbances (SED) and severe mental illness (SMI).

#### OBJECTIVE 1.1: SERVICES ARE ACCESSIBLE

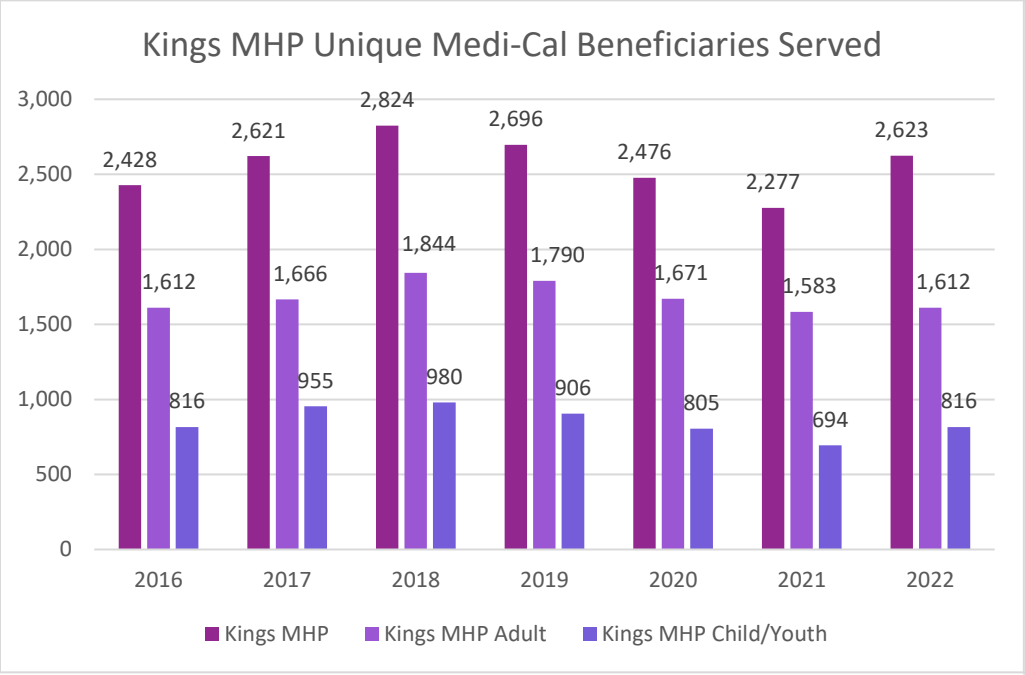
##### INDICATOR: COUNT AND PENETRATION RATES OF CONSUMERS SERVED, ALL AND BY AGE GROUP

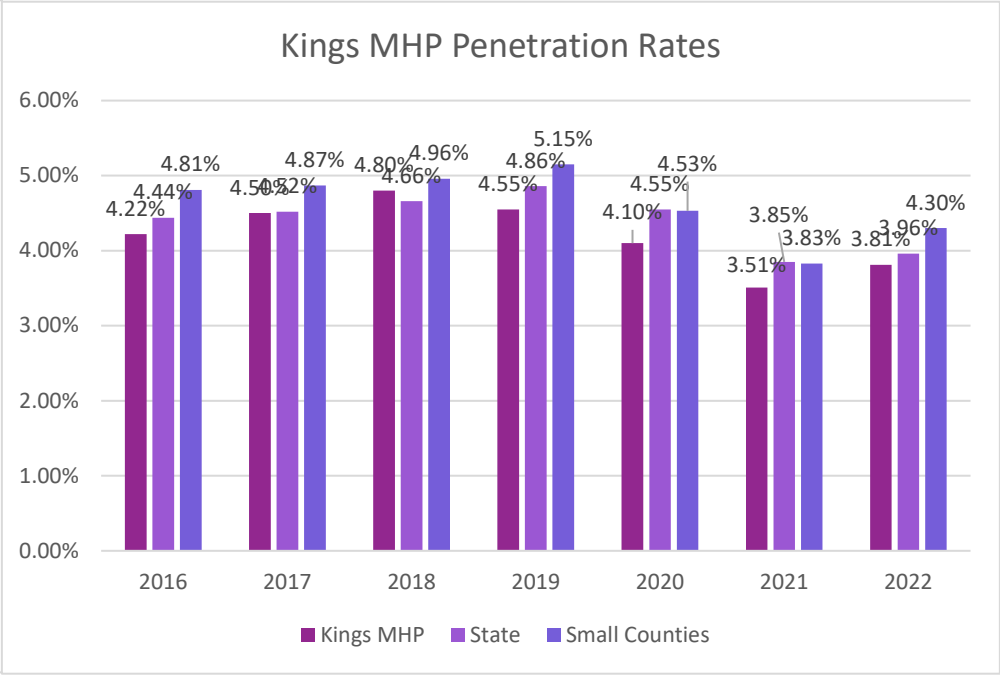
ANALYSIS: Due to changes in the state's external quality review organization and review processes in 2024, Kings County Behavioral Health (KCBH) did not have access to the historical Claims Data reports required to fully populate metrics related to the number served, penetration rates, and related breakdowns by age, race/ethnicity, and service type. KCBH is actively working with the state and the county's electronic health record (EHR) vendor and host to address these data gaps to ensure the timely and accurate reporting of these metrics in future QAPI Work Plans.

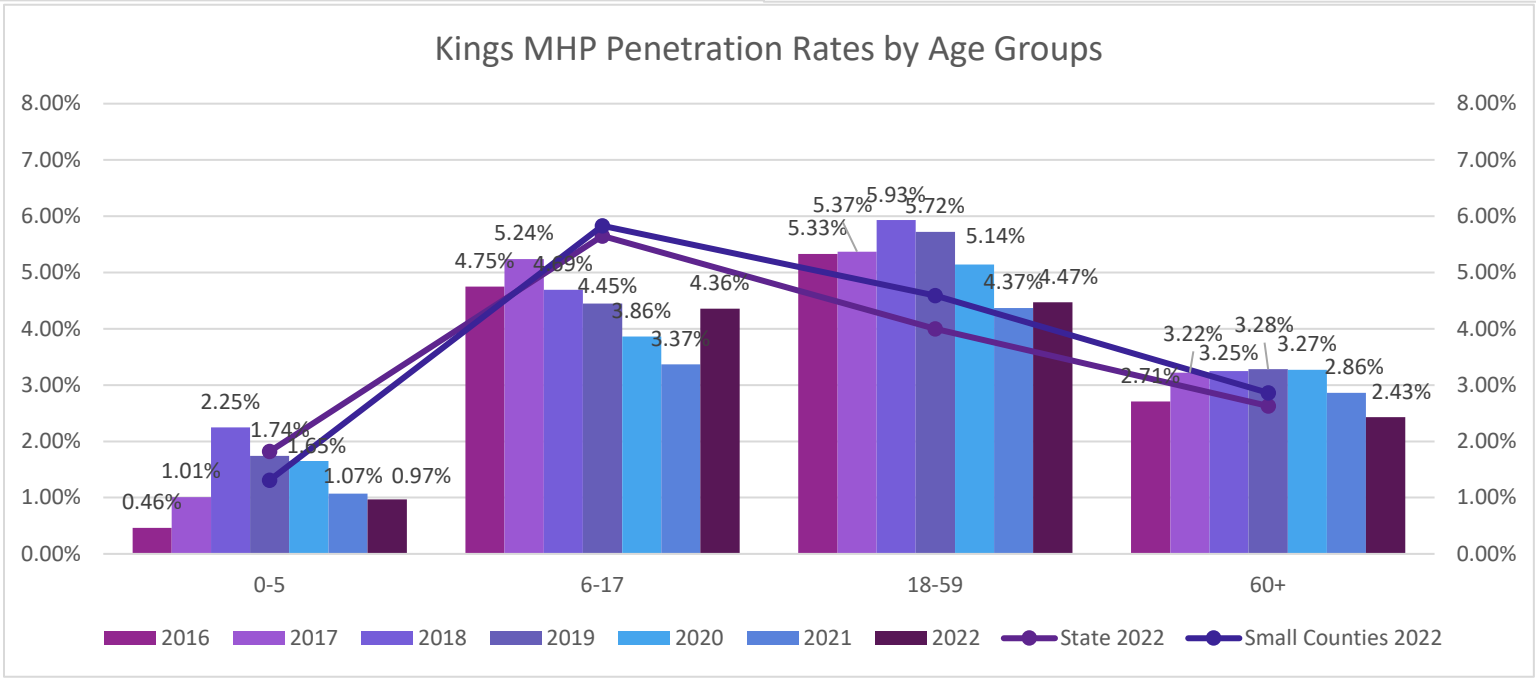
ACTION: Despite current data limitations, KCBH is committed to meeting the accessibility needs of our community and addressing historical disparities. Future QAPI reports will reflect updated metrics and an evaluation of progress once access to the necessary data is restored.

PRIOR YEAR ACTION AND RESULT: The low penetration rate among children ages 6-17 continued to be a focus of the KCBH Children System of Care Committee during fiscal year 2020/21 & 2021/22. During 2020/21 discussion, it was noted that with the reopening of schools post-COVID closure, school-based mental health services and referrals would be reinvigorated, and as such this measure was monitored for progress with impact anticipated in 2022 and beyond which per the 2022 claims data proved true. While data for 2023 was unavailable, the trends observed in 2022 suggested a continued recovery in service accessibility following the initial impacts of COVID-19. The number of individuals served increased by 15% across all ages and by 33% among 6- to 17-year-olds from 2021 to 2022.

**Unique Count of Medi-Cal Beneficiaries & Penetration Rates, by Age Group, Receiving SMHS *(with at least one approved claim)***



INDICATOR: CONSUMER SERVED AND PENETRATION RATE BY RACE/ETHNICITY

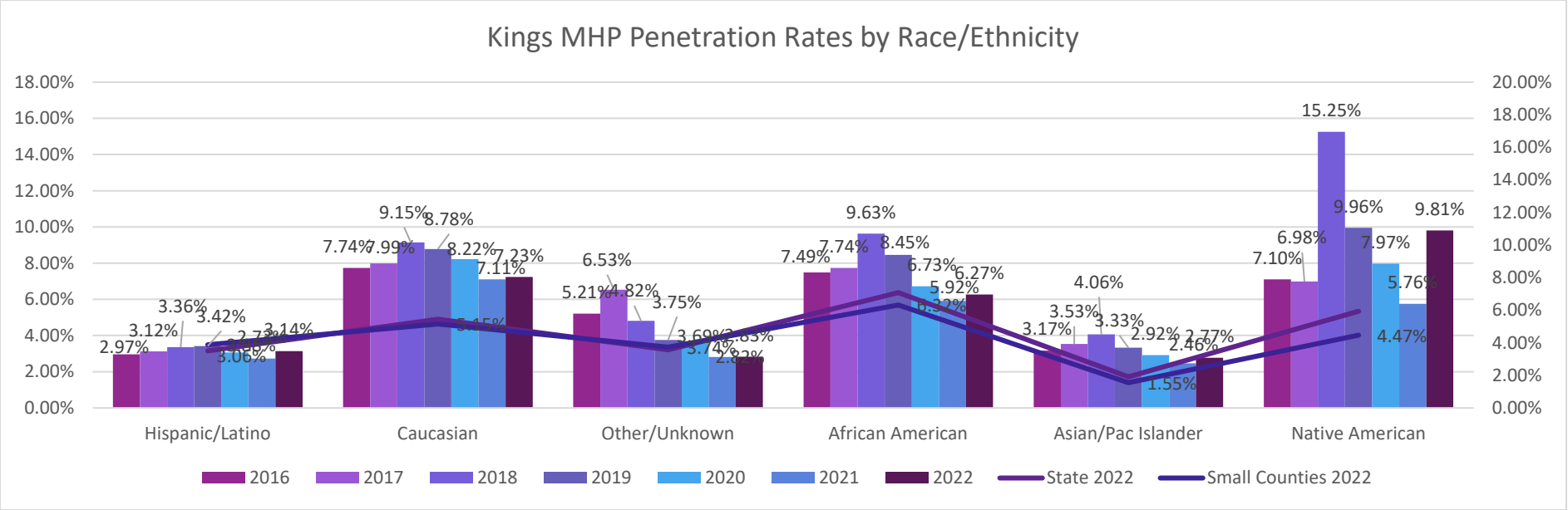
ANALYSIS: Due to changes in the state's external quality review organization and review processes in 2024, Kings County Behavioral Health (KCBH) did not have access to the historical Claims Data reports required to fully populate metrics related to the number served, penetration rates, and related breakdowns by age, race/ethnicity, and service type. KCBH is actively working with the state and the county's electronic health record (EHR) vendor and host to address these data gaps to ensure the timely and accurate reporting of these metrics in future QAPI Work Plans.

ACTION: Despite current data limitations, KCBH is committed to meeting the accessibility needs of our community and addressing historical disparities. Future QAPI reports will reflect updated metrics and an evaluation of progress once access to the necessary data is restored.

PRIOR YEAR ACTION AND RESULT: The MHP increased media campaigns and outreach in 2021/22 and 2022/23 to ensure the public was aware services were open and available to include telehealth options. It was anticipated any increase based on outreach would be seen potentially in 2022 claims data. The 2022 claims data has shown increased access in services, most notably among the Hispanic/Latino and Native American populations. Although data for 2023 was unavailable, trends observed in 2022 indicated a continued recovery, with service penetration rates improving from 3.51% in 2021 to 3.81% in 2022. The most notable increases were among Hispanic/Latino populations, which saw a 22% rise in individuals served.

**Unique Count of Medi-Cal Beneficiaries & Penetration Rates, by Race/Ethnicity, Receiving SMHS *(with at least one approved claim)***

| FY | Hispanic/ Latino Count/% | Pene. Rate | Caucasian Count/% | Pene. Rate | Other Count/% | Pene. Rate | African American Count/% | Pene. Rate | Asian/Pac. Islander Count/% | Pene. Rate | Native American Count/% | Pene. Rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016 | 1,133/47% | 2.97% | 772/32% | 7.74% | 253/10% | 5.21% | 204/8% | 7.49% | 53/2% | 3.17% | 13/.05% | 7.10% |
| 2017 | 1,205/46% | 3.12% | 779/30% | 7.99% | 366/14% | 6.53% | 212/8% | 7.74% | 44/2% | 3.53% | 15/.06% | 6.98% |
| 2018 | 1,316/47% | 3.36% | 866/31% | 9.15% | 294/10% | 4.82% | 262/9% | 9.63% | 50/2% | 4.06% | 36/1% | 15.25% |
| 2019 | 1,352/50% | 3.42% | 816/30% | 8.78% | 236/9% | 3.75% | 228/9% | 8.45% | 40/1% | 3.33% | 24/.09% | 9.96% |
| 2020 | 1,227/50% | 3.06% | 752/30% | 8.22% | 262/11% | 3.69% | 179/7% | 6.73% | 36/1% | 2.92% | 20/0.8% | 7.97% |
| 2021 | 1,161/51% | 2.73% | 669/29% | 7.11% | 240/11% | 2.82% | 160/7% | 5.92% | 33/1% | 2.46% | 14/1% | 5.76% |
| 2022 | 1,411/54% | 3.14% | 691/26% | 7.23% | 282/11% | 2.83% | 174/7% | 6.27% | 39/1% | 2.77% | 26/1% | 9.81% |

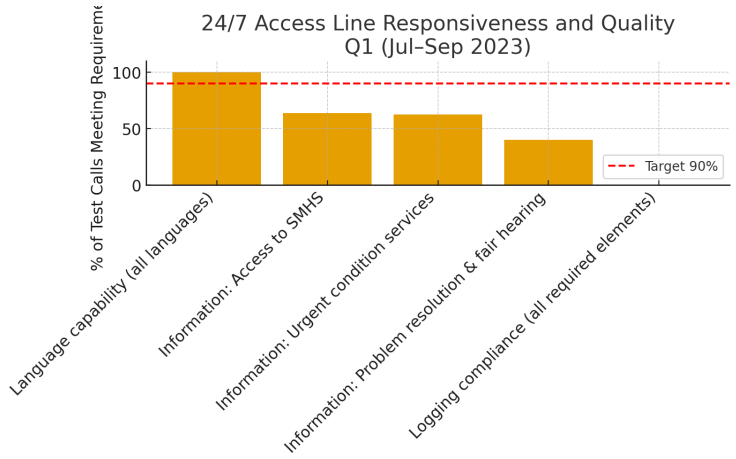

Kings MHP Penetration Rates by Race/Ethnicity
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
20.00%
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
2.97%
3.12%
3.36%
3.42%
3.06%
3.14%
7.74%
7.99%
9.15%
8.78%
8.22%
7.11%
7.23%
6.53%
5.21%
4.82%
3.75%
7.49%
7.74%
9.63%
8.45%
6.73%
5.92%
6.27%
3.17%
3.53%
4.06%
3.33%
2.92%
2.46%
2.77%
1.55%
7.10%
6.98%
15.25%
9.96%
7.97%
5.76%
9.81%
4.47%
Hispanic/Latino
Caucasian
Other/Unknown
African American
Asian/Pac Islander
Native American
2016
2017
2018
2019
2020
2021
2022
State 2022
Small Counties 2022

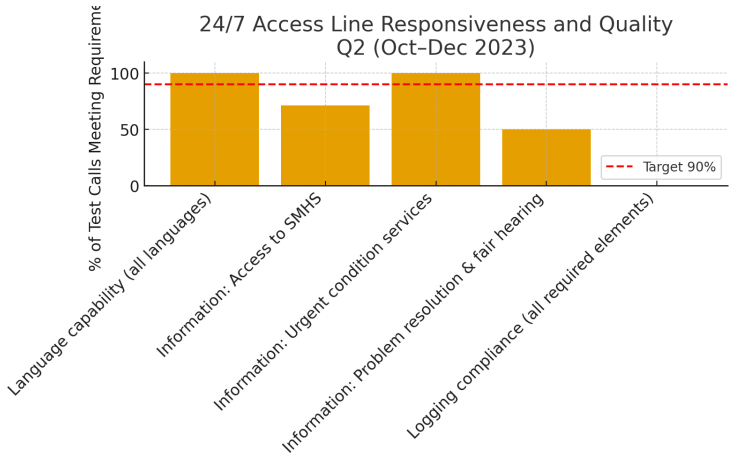
INDICATOR: QUALITY AND RESPONSIVENESS OF 24/7 ACCESS LINE

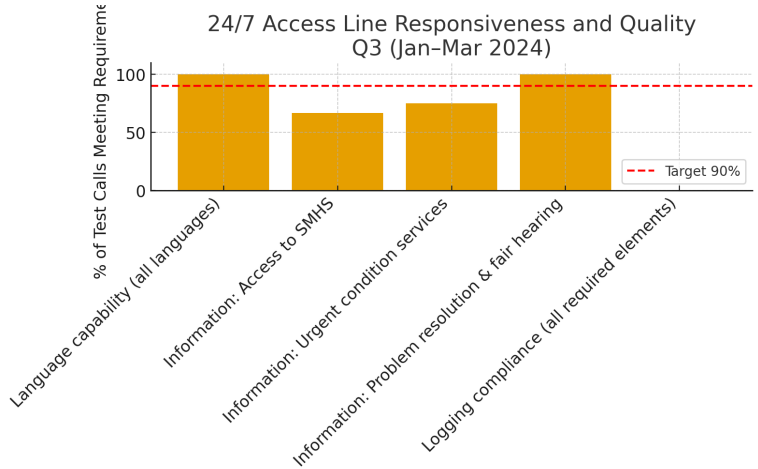
Analysis: Test call monitoring was conducted quarterly using the DHCS Step-2 State Report Form, and results for FY 23/24 showed variable compliance across categories. Language capability consistently achieved 100% compliance, and information about urgent conditions also performed strongly, reaching 90% or higher in multiple quarters. In contrast, categories requiring problem resolution and fair hearing information, as well as logging elements such as beneficiary name, request date, and disposition, showed persistent deficiencies, with compliance rates often ranging between 40% and 70%, well below the 90% goal. While performance improved modestly by Q4, notable gaps in documentation and communication of beneficiary rights remained evident.

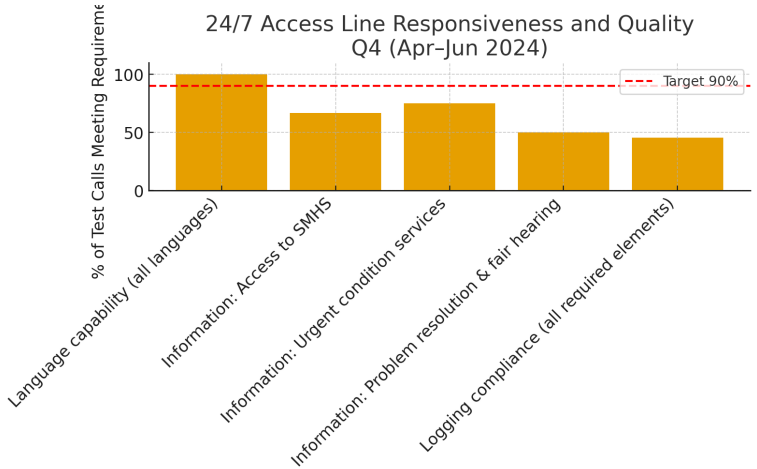
ACTION: For FY 23/24, monthly test calls were conducted by QA with quarterly aggregation and review; however, the results had not yet been incorporated into the QAPI framework. With the adoption of this measure into the FY 24/25 QAPI, the focus moving forward will be on using the data to drive improvement. Targeted staff training will address problem resolution and fair hearing requirements to ensure consistent scripting, and a logging checklist will be reinforced to strengthen documentation of the beneficiary's name, date, and disposition. The QAPI goal is set at achieving at least 90% compliance in each category, with an interim target of 85% mid-year. In addition, quarterly compliance results will be shared with Access Line staff and supervisors to promote accountability and ongoing performance improvement.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, test call monitoring was not part of the QAPI plan, and Access Line oversight relied primarily on call logs and consumer reports without standardized quality testing. As a result, gaps in systematic monitoring limited the ability to identify trends or staff training needs.


24/7 Access Line Responsiveness and Quality
Q1 (Jul–Sep 2023)
% of Test Calls Meeting Requirem
100
50
0
Target 90%
Language capability (all languages)
Information: Access to SMHS
Information: Urgent condition services
Information: Problem resolution & fair hearing
Logging compliance (all required elements)


24/7 Access Line Responsiveness and Quality
Q2 (Oct–Dec 2023)
% of Test Calls Meeting Requirem
100
50
0
Target 90%
Language capability (all languages)
Information: Access to SMHS
Information: Urgent condition services
Information: Problem resolution & fair hearing
Logging compliance (all required elements)


24/7 Access Line Responsiveness and Quality
Q3 (Jan–Mar 2024)
% of Test Calls Meeting Requirem
100
50
0
Target 90%
Language capability (all languages)
Information: Access to SMHS
Information: Urgent condition services
Information: Problem resolution & fair hearing
Logging compliance (all required elements)


24/7 Access Line Responsiveness and Quality
Q4 (Apr–Jun 2024)
% of Test Calls Meeting Requirem
100
50
0
Target 90%
Language capability (all languages)
Information: Access to SMHS
Information: Urgent condition services
Information: Problem resolution & fair hearing
Logging compliance (all required elements)

## OBJECTIVE 1.2: SERVICES ARE TIMELY

### INDICATOR: TIMELINESS OF FIRST ENTRY FOR CLINICAL SERVICE, NON-URGENT CONDITION

ANALYSIS: For FY 23/24, we were unable to obtain a full year of data due to the Electronic Health Record (EHR) conversion that happened at the beginning of Q1 and into Q2 and the unavailability of certain reports that were typically accessible in prior years. However, even with the data limitation, the length of time from initial request for service first offered service was an average of 5.19 business days for all ages of which 89% met the 10 business day DHCS standard. Additionally, the length of time from initial request for service to first kept appointment was an average of 9.80 business days for all ages of which 73% met the 10-business day DHCS standard.

ACTION: With ongoing updates and changes to the EHR, better data tracking will occur for the coming fiscal year to ensure accurate data reporting.

PRIOR YEAR ACTION AND RESULT: A Performance Improvement Project (PIP) for timeliness was in effect to focus on addressing timeliness for services. Despite the results of a performance improvement project, the lack of comprehensive data for the current period limits our ability to draw direct comparisons or assess trends in the same manner as in prior years. However, for FY 22/23, all areas were in compliance with DHCS standards for timeliness.

### 1ST REQUEST FOR SERVICE TO 1ST OFFERED APPOINTMENT (IN BUSINESS DAYS)–DHCS Standard: 10 Bus. Days/80% of Appts Must Meet Std

| | All Services | Adult Services | Children's Services | Foster Care |
|---|---|---|---|---|
| FY 18/19 | 4.68 Mean<br>1 Median<br>7.28 Std Dev.<br>95% Met Std | 2.27 Mean<br>1 Median<br>8.15 Std Dev.<br>98% Met Std | 2.88 Mean<br>1 Median<br>6.20 Std Dev.<br>90% Met Std | 8.91 Mean<br>7 Median<br>7.51 Std Dev.<br>70% Met Std |
| FY 19/20 | 1.61 Mean<br>0 Median<br>5.30 Std Dev.<br>96% Met Std | 1.15 Mean<br>0 Median<br>4.54 Std Dev.<br>96% Met Std | 2.47 Mean<br>0 Median<br>6.38 Std Dev.<br>92% Met Std | 8.42 Mean<br>7.5 Median<br>8.17 Std Dev.<br>67% Met Std |
| FY 20/21 | 7.5 Mean<br>6 Median<br>1-82 Range<br>79% Met Std | 6.3 Mean<br>5 Median<br>1-52 Range<br>83% Met Std | 9.5 Mean<br>8 Median<br>1-82 Range<br>71% Met Std | 8.7 Mean<br>8 Median<br>2-23 Range<br>75% Met Std |
| FY 21/22 | 15.04 Mean<br>13 Median<br>11.18 Std Dev<br>1-114 Range<br>43% Met Std | 12.57 Mean<br>11 Median<br>10.89 Std Dev<br>1-114 Range<br>50% Met Std | 17.26 Mean<br>17 Median<br>10.97 Std Dev<br>1-63 Range<br>36% Met Std | 13.93 Mean<br>9.50 Median<br>9.79 Std Dev<br>1-37 Range<br>53% Met Std |
| FY 22/23 | 14.68 Mean<br>12 Median<br>1-78 Range<br>46% Met Std | 11.68 Mean<br>11 Median<br>1-76 Range<br>48% Met Std | 17.49 Mean<br>12 Median<br>1-78 Range<br>45% Met Std | 20.89 Mean<br>15 Median<br>1-77 Range<br>35% Met Std |
| FY 23/24 | 5.19 Mean<br>4.00 Median<br>1-19 Range<br>89% Met Std | 2.95 Mean<br>2.00 Median<br>1-13 Range<br>99% Met Std | 7.54 Mean<br>8.00 Median<br>1-19 Range<br>77% Met Std | 8.22 Mean<br>10 Median<br>1-12 Range<br>78% Met Std |

### 1ST REQUEST FOR SERVICE TO 1ST KEPT APPOINTMENT (IN BUSINESS DAYS)–DHCS STANDARD: 10 BUS. DAYS/80% OF APPTS MUST MEET STD

| | All Services | Adult Services | Children's Services | Foster Care |
|---|---|---|---|---|
| FY 18/19 | 2.59 Mean<br>1 Median<br>8.34 Std Dev.<br>92% Met Std | 2.43 Mean<br>1 Median<br>8.97 Std Dev.<br>97% Met Std | 2.99 Mean<br>1 Median<br>6.61 Std Dev.<br>83% Met Std | 15.13 Mean<br>11 Median<br>13.45 Std Dev.<br>34% Met Std |
| FY 19/20 | 6.35 Mean<br>2 Median<br>12.19 Std Dev.<br>82% Met Std | 5.97% Mean<br>1 Median<br>13.09 Std Dev.<br>85% Met Std | 7.10 Mean<br>4 Median<br>10.14 Std Dev.<br>77% Met Std | 10.05 Mean<br>9 Median<br>8.22 Std Dev.<br>54% Met Std |
| FY 20/21 | 10.2 Mean<br>7 Median<br>1-275 Range<br>71% Met Std | 7.5 Mean<br>6 Median<br>1-61 Range<br>80% Met Std | 13.7 Mean<br>9 Median<br>1-275 Range<br>76% Met Std | 13.8 Mean<br>12 Median<br>2-54 Range<br>80% Met Std |
| FY 21/22 | 17.25 Mean<br>14 Median<br>14.85 Std Dev<br>1-114 Range<br>40% Met Std | 15.70 Mean<br>12 Median<br>15.58 Std Dev<br>1-114 Range<br>45% Met Std | 18.96 Mean<br>17 Median<br>13.79 Std Dev<br>1-85 Range<br>34% Met Std | 17.54 Mean<br>14 Median<br>14.10 Std Dev<br>2-57 Range<br>44% Met Std |
| FY 22/23 | 18.73 Mean<br>14 Median<br>1-144 Range<br>39% Met Std | 12.15 Mean<br>11 Median<br>1-76 Range<br>48% Met Std | 23.40 Mean<br>16 Median<br>1-120 Range<br>33% Met Std | 33.74 Mean<br>25 Median<br>1-144 Range<br>19% Met Std |
| FY 23/24 | 9.80 Mean<br>5.00 Median<br>1-115 Range<br>73% Met Std | 3.75 Mean<br>3.00 Median<br>1-34 Range<br>98% Met Std | 16.21 Mean<br>13.00 Median<br>1-115 Range<br>43% Met Std | 19.33 Mean<br>14.00 Median<br>2-64 Range<br>33% Met Std |

INDICATOR: TIMELINESS OF FIRST ENTRY FOR PSYCHIATRIC SERVICE, NON-URGENT CONDITION

ANALYSIS: For FY 23/24, we were unable to obtain a full year of data due to the Electronic Health Record (EHR) conversion that happened at the beginning of Q1 and into Q2 and the unavailability of certain reports that were typically accessible in prior years. Due to this, there is no accurate or sufficient data to report at this time.

ACTION: With ongoing updates and changes to the EHR, better data tracking will occur for the coming fiscal year to ensure accurate data reporting.

PRIOR YEAR ACTION AND RESULT: A Performance Improvement Project (PIP) for timeliness was in effect to focus on addressing timeliness for services. Despite the results of a performance improvement project, the lack of comprehensive data for the current period limits our ability to draw direct comparisons or assess trends in the same manner as in prior years. However, for FY 22/23, all areas were in compliance with DHCS standards for timeliness.

### 1ST REQUEST TO 1ST OFFERED PSYCHIATRY APPT (IN BUSINESS DAYS)–DHCS
Standard: 15 Bus. Days/80% of Appts Must Meet Std

| | All Services | Adult Services | Children's Services | Foster Care |
|---|---|---|---|---|
| FY 18/19 | 20.22 Mean<br>19 Median<br>12.37 Std Dev.<br>38% Met Std | 20.50 Mean<br>19 Median<br>12.85 StdDev<br>37% Met Std | 18.92 Mean<br>17 Median<br>9.45 Std Dev.<br>47% Met Std | 13.00 Mean<br>15 Median<br>7.07 Std Dev.<br>50% Met Std |
| FY 19/20 | 14.78 Mean<br>10 Median<br>13.39 Std Dev<br>65% Met Std | 15.07 Mean<br>9.5 Median<br>14.02 StdDev<br>64% Met Std | 13.52 Mean<br>10.5 Median<br>9.87 Std Dev<br>67% Met Std | 13.5 Mean<br>13.5 Median<br>10.53 StdDev<br>50% Met Std |
| FY 20/21 | 10.9 Mean<br>6 Median<br>1-267 Range<br>86% Met Std | 10.5 Mean<br>6 Median<br>1-264 Range<br>87% Met Std | 12.3 Mean<br>6 Median<br>2-267 Range<br>83% Met Std | 11 Mean<br>11 Median<br>3-19 Range<br>50% Met Std |
| FY 21/22 | 7.63 Mean<br>5 Median<br>7.15 Std Dev<br>1-43 Range<br>90% Met Std | 7.14 Mean<br>5 Median<br>6.80 Std Dev<br>1-43 Range<br>91% Met Std | 10.18 Mean<br>7 Median<br>8.34 Std Dev<br>2-40 Range<br>86% Met Std | 15 Mean<br>14 Median<br>8.60 Std Dev<br>5-26 Range<br>67% Met Std |
| FY 22/23 | 8.67 Mean<br>7 Median<br>1-61 Range<br>89% Met Std | 6.50 Mean<br>6 Median<br>2-54 Range<br>99% Met Std | 16.99 Mean<br>13 Median<br>2-61 Range<br>86% Met Std | 14.82 Mean<br>17 Median<br>1-28 Range<br>45% Met Std |

### 1ST REQUEST TO 1ST KEPT PSYCHIATRY APPT (IN BUSINESS DAYS)–DHCS
STANDARD: 15 BUS. DAYS/80% OF APPTS MUST MEET STD

| | All Services | Adult Services | Children's Services | Foster Care |
|---|---|---|---|---|
| FY 18/19 | *Length of time from first request to first kept psychiatry appt is a new measure added to EQRO Timeliness Report in FY 20/21; therefore, data began being measured in 20/21.* | | | |
| FY 19/20 | | | | |
| FY 20/21 | 20.3 Mean<br>13 Median<br>2-281 Range<br>55% Met Std | 23.9 Mean<br>18 Median<br>2-281 Range<br>45% Met Std | 8.4 Mean<br>6 Median<br>2-26 Range<br>85% Met Std | 0 Mean<br>0 Median<br>0 Range<br>0% Met Std |
| FY 21/22 | 13.49 Mean<br>7 Median<br>15.31 Std Dev<br>1-82 Range<br>73% Met Std | 13.94 Mean<br>6 Median<br>16.15 Std Dev<br>1-82 Range<br>71% Met Std | 11.36 Mean<br>9 Median<br>10.11 Std Dev<br>2-58 Range<br>85% Met Std | 15 Mean<br>14 Median<br>8.60 Std Dev<br>5-26 Range<br>67% Met Std |
| FY 22/23 | 12.15 Mean<br>10 Median<br>2-47 Range<br>75% Met Std | 11.16 Mean<br>9 Median<br>2-47 Range<br>81% Met Std | 16.35 Mean<br>14 Median<br>2-47 Range<br>56% Met Std | 19.83 Mean<br>18.50 Median<br>6-33 Range<br>75% Met Std |

INDICATOR: TIMELINESS OF FIRST ENTRY FOR URGENT CONDITION

ANALYSIS: For FY 23/24, we were unable to obtain a full year of data due to the Electronic Health Record (EHR) conversion that happened at the beginning of Q1 and into Q2 and the unavailability of certain reports that were typically accessible in prior years. This created an issue with reporting for Q1 only. However, even with the data limitation, the length of time from initial request for service for an urgent condition to rendered service where prior authorization was not required was an average of 73.64 hours (3.07 days) for all ages of which 65.83% met the 48-hour DHCS standard.

There is also an area where the MHP is to report on urgent conditions that require prior authorization for service; however, there were none meeting this requirement therefore no data to report.

ACTION: The non-clinical Performance Improvement Project (PIP) aimed at improving the definition, identification, process, and tracking of urgent conditions was successfully completed in October 2023. The intervention focused on standardizing the process for identifying and responding to urgent conditions across the MHP, which was implemented and approved by the Adults System of Care, Children's System of Care, and Documentation committees in October 2021. As a result of the project, a more consistent and timely approach for identifying beneficiaries with urgent conditions was established.

PRIOR YEAR ACTION AND RESULT: Although the intervention itself has been successfully completed, data tracking continues monthly across all MHP provider sites. Data is analyzed and reported quarterly to all relevant stakeholders, ensuring ongoing monitoring and evaluation to assess the effectiveness of the intervention and continued progress toward the PIP's goals.

AVERAGE LENGTH OF TIME FOR URGENT APPOINTMENT THAT DO NOT REQUIRE PRIOR AUTHORIZATION (IN HOURS)–DHCS Standard: 48 HOURS/80% of Appts Must Meet Std

| | All Services | Adult Services | Children's Services | Foster Care |
|---|---|---|---|---|
| FY 18/19 | 4.26 Mean<br>8 Median<br>3.43 Std Dev.<br>35% Met Std | 4.50 Mean<br>6 Median<br>3.59 Std Dev.<br>25% Met Std | 3.85 Mean<br>9 Median<br>3.91 Std Dev.<br>50% Met Std | 8 Mean<br>8 Median<br>0 Std Dev.<br>0% Met Std |
| Reported in hours as of FY 19/20 | | | | |
| FY 19/20 | 61.20 Mean<br>36 Median<br>85.82 Std Dev.<br>65% Met Std | 79.38 Mean<br>48 Median<br>98.17 StdDev<br>54% Met Std | 27.43 Mean<br>0 Median<br>44.75 Std Dev.<br>86% Met Std | 0 Mean<br>0 Median<br>0 Std Dev.<br>0% Met Std |
| FY 20/21 | 138 Mean<br>96 Median<br>0-840 Range<br>43% Met Std | 123.75 Mean<br>84 Median<br>0-672 Range<br>44% Met Std | 96 Mean<br>60 Median<br>0-312 Range<br>50% Met Std | 576 Mean<br>576 Median<br>312-840 Rg.<br>0% Met Std |
| FY 21/22 | 98.93 Mean<br>48 Median<br>175.50 Std Dev<br>0-840 Range<br>71% Met Std | 98.53 Mean<br>24 Median<br>191.98 Std Dev<br>0-840 Range<br>79% Met Std | 104 Mean<br>48 Median<br>162.16 Std Dev<br>0-696 Range<br>50% Met Std | 0 Mean<br>0 Median<br>0 Std Dev<br>0-0 Range<br>0% Met Std |
| FY 22/23 | 89.47 Mean<br>24 Median<br>0-1200 Range<br>63% Met Std | 38.82 Mean<br>24 Median<br>0-504 Range<br>82% Met Std | 136.74 Mean<br>72 Median<br>0-1200 Range<br>45% Met Std | 40 Mean<br>24 Median<br>24-72 Range<br>67% Met Std |
| FY 23/24 | 73.64 Mean<br>24 Median<br>0-624 Range<br>65.8% Met Std | 35.80 Mean<br>24 Median<br>0-264 Range<br>79.6% Met Std | 141.42 Mean<br>72 Median<br>0-624 Range<br>40.8% Met Std | 384 Mean<br>384 Median<br>288-480 Range<br>0% Met Std |

AVERAGE LENGTH OF TIME FOR URGENT APPOINTMENT THAT REQUIRES PRIOR AUTHORIZATION (IN HOURS)–DHCS STANDARD: 96 HOURS/80% OF APPTS MUST MEET STD

| | All Services | Adult Services | Children's Services | Foster Care |
|---|---|---|---|---|
| FY 16/17 | *No appts that require prior authorizations* | | | |
| FY 17/18 | | | | |
| FY 18/19 | | | | |
| FY 19/20 | | | | |
| FY 20/21 | | | | |
| FY 21/22 | | | | |
| FY 22/23 | | | | |
| FY 23/24 | | | | |

INDICATOR: TIMELINESS OF POST-PSYCHIATRIC INPATIENT DISCHARGE

ANALYSIS: In FY 23/24, Kings MHP had 355 post-psychiatric hospitalization appointments of which 312 (88%) of the follow-up appointments fell within the 7-calendar day HEIDIS standard, with the average number of calendar days for all follow-up appointments at 4.29 days. This decreased from 22/23 7.11 mean and remains within the 7-day HEIDIS standard.

ACTION: Measures are within HEIDIS standard therefore no action is necessary.

PRIOR YEAR ACTION AND RESULT: There was no action identified in 23/24.

## AVERAGE LENGTH OF TIME FOR A FOLLOW-UP APPOINTMENT AFTER HOSPITAL DISCHARGE (IN DAYS)

| | All Services | Adult Services | Children's Services | Foster Care |
|---|---|---|---|---|
| FY 16/17 | 6.32 Mean<br>4 Median<br>8.04 Std Dev. | 6.17 Mean<br>4 Median<br>7.41 Std Dev. | 7.41 Mean<br>3 Median<br>11.77 Std Dev. | N/A |
| FY 17/18 | 3.48 Mean<br>1 Median<br>7.24 Std Dev. | 3.18 Mean<br>1 Median<br>7.07 Std Dev. | 7.89 Mean<br>4 Median<br>10.36 Std Dev. | 3.83 Mean<br>4 Median<br>3.97 Std Dev. |
| FY 18/19 | 7.18 Mean<br>5 Median<br>73% Met Std | 7.17 Mean<br>5 Median<br>73% Met Std | 7.46 Mean<br>5 Median<br>69% Met Std | 5.33 Mean<br>5 Median<br>100% Met Std |
| FY 19/20 | 2.97 Mean<br>2 Median<br>94% Met Std | 2.95 Mean<br>2 Median<br>93% Met Std | 3.14 Mean<br>3 Median<br>97% Met Std | 2.86 Mean<br>2 Median<br>86% Met Std |
| FY 20/21 | 5.27 Mean<br>3 Median<br>84% Met Std | 4.94 Mean<br>3 Median<br>86% Met Std | 5.97 Mean<br>4 Median<br>79% Met Std | 7.11 Mean<br>3 Median<br>72% Met Std |
| FY 21/22 | 5.29 Mean<br>3 Median<br>86% Met Std | 5.34 Mean<br>3 Median<br>87% Met Std | 5.14 Mean<br>3.5 Median<br>83% Met Std | 5.40 Mean<br>3.5 Median<br>70% Met Std |
| FY 22/23 | 7.11 Mean<br>3 Median<br>84.77% Met Std | 7.93 Mean<br>3 Median<br>82.45% Met Std | 4.31 Mean<br>2 Median<br>97.73% Met Std | 2 Mean<br>2 Median<br>100% Met Std |
| FY 23/24 | 4.29 Mean<br>2 Median<br>7.02 Std Dev.<br>87.89% Met Std | 4.27 Mean<br>2 Median<br>7.42 Std Dev.<br>89.58% Met Std | 4.31 Mean<br>2 Median<br>5.02 Std Dev.<br>81.36% Met Std | 4.63 Mean<br>4 Median<br>4.50 Std Dev.<br>75% Met Std |

## OBJECTIVE 1.3: SERVICES ARE OF QUALITY TO CONSUMERS

### INDICATOR: CONSUMER SATISFACTION SURVEY

ANALYSIS: For the May 2023 Consumer Perception Survey, assessing and comparing satisfaction among beneficiaries and caregivers was challenging due to a high percentage of consumers and family members not completing certain questions, marked as "N/A or Missing". The "# of Surveys" column shows the total number of surveys collected, while the percentages reflect only those who responded to each question. This provides a more accurate representation of respondents' perceptions of the services received.

ACTION: Continue with administering the survey in paper form for all those who have in-person services while in the lobby for their appointment and only offering online surveys to those who receive their service through telehealth, but ask clinics to have staff check in with survey takers to encourage completion of survey.

PRIOR YEAR ACTION AND RESULT: Increase number of individuals completing a survey by administering the survey in paper form for all those who have in-person services while in the lobby for their appointment and only offering online surveys to those who receive their service through telehealth. This was shown to significantly increase the number of individuals starting a survey, but did not reduce the number not completing a survey among adults.

### CONSUMER PERCEPTION SURVEYS (CPS) RESULTS

| Survey Date | # of Surveys | Question Category *(Likert scale 1 to 5, with 5 most satisfied)* | | | |
|---|---|---|---|---|---|
| | | Satisfaction | Access | Informed Consent/ Participation | Effectiveness/ Well-Being |
| May 2019 Adult/OA | 274 | 4.48 (89.6%) | 4.28 (87.4%) | 4.40 (85.2%) | 3.96 (77.0%) *(13.9% neutral)* |
| May 2019 C/Y & Family | 131 | 4.4 (84.4%) | 4.37 (79.6%) | 4.34 (84.0%) | 4.01 (65.1%) *(20.6% neutral)* |

| Survey Date | # of Surveys | Question Category | | | |
|---|---|---|---|---|---|
| | | Satisfaction | Access | Informed Consent/ Participation | Effectiveness/ Well-Being |
| Nov 2019 Caregiver (0-11) | 24 | 4.17 (81.9%) | 4.14 (87.5%) | 4.24 (86.6%) | 3.9 (72.7%) *(11% neutral)* |
| Nov 2019 Youth (12-17) | 28 | 4.22 (78.6%) | 4.15 (79.8%) | 4.26 (75.8%) | 3.89 (65.3%) *(20.1% neutral)* |
| Nov 2019 Adult (18-59) | 80 | 4.49 (90.4%) | 4.24 (79.6%) | 4.31 (81.4%) | 3.91 (59.0%) *(19.3% neutral)* |
| Nov 2019 Older Adult (60+) | 4 | 4.72 (91.7%) | 4.33 (83.3%) | 4.39 (84.1%) | 3.71 (59.4%) *(15.6& neutral)* |
| June 2020 Adult/OA | 51 | 4.20 (56.86%) *(38.56% N/A or Missing)* | 4.01 (50.65%) *(43.14% N/A or Missing)* | 4.24 (50.45%) *(43.85 % N/A or Missing)* | 3.62 (34.19%) *(43.63% N/A or Missing)* |
| June 2020 C/Y & Family | 32 | 4.32 (71.88%) *(23.96% N/A or Missing)* | 4.37 (80.21%) *(18.75% N/A or Missing)* | 4.39 (81.25%) *(16.32% N/A or Missing)* | 4.05 (61.08%) *(32.39% N/A or Missing)* |
| June 2021 Adult/OA | 27 | 4.89 (23.46%) *(53.09% N/A or Missing)* | 4.82 (23.46%) *(53.70% N/A or Missing)* | 4.79 (22.64%) *(57.09 % N/A or Missing)* | 4.67 (28.97%) *(58.18% N/A or Missing)* |
| June 2021 C/Y & Family | 26 | 4.23 (64.10%) *(28.21% N/A or Missing)* | 4.21 (65.38%) *(28.21% N/A or Missing)* | 4.10 (59.83%) *(31.20% N/A or Missing)* | 3.82 (55.94%) *(29.37% N/A or Missing)* |

| Survey Date | # of Surveys | Question Category *(Likert scale 1 to 5, with 5 most satisfied)* | | | |
|---|---|---|---|---|---|
| | | Satisfaction | Access | Informed Consent/ Participation | Effectiveness/ Well-Being |
| June 2022 Adult/OA | 120 | 4.18 (24.76%) *(71.11% N/A or Missing)* | 4.10 (23.89%) *(71.25% N/A or Missing)* | 4.11 (23.97%) *(71.30% N/A or Missing)* | 3.83 (20.48%) *(71.65% N/A or Missing)* |
| June 2022 C/Y & Family | 139 | 4.16 (59.71%) *(27.58% N/A or Missing)* | 4.22 (64.03%) *(26.62% N/A or Missing)* | 4.23 (61.31%) *(29.74% N/A or Missing)* | 3.90 (52.58%) *(29.37% N/A or Missing)* |
| May 2023 Adult/OA | 106 | 4.46 (86.93%) | 4.10 (79.03%)*)* | 4.26 (82.14%)*)* | 3.87 (65.76%) |
| May 2023 C/Y & Family | 180 | 4.12 (78.43%) | 4.18 (83.94%) | 4.25 (87.34%) | 3.85 (71.57%) |

## OBJECTIVE 1.4: SERVICES PRODUCE MEASURABLE OUTCOMES

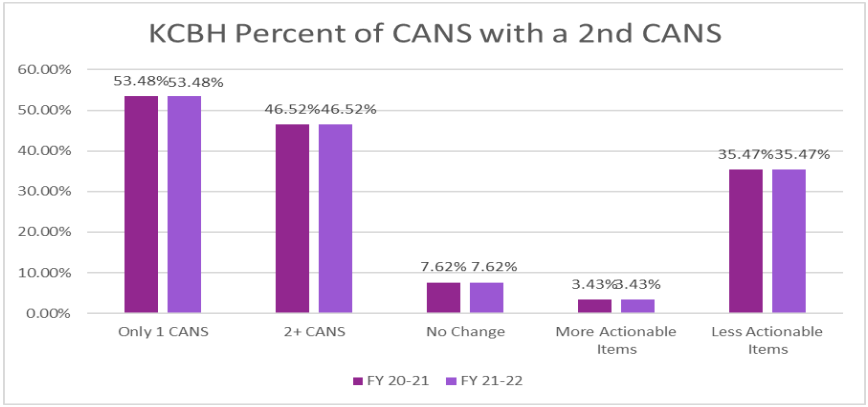
### INDICATOR: FUNCTIONAL IMPROVEMENT AMONG CHILD/YOUTH CONSUMERS, PER USE OF CANS/PCS-35

ANALYSIS: In FY 23/24, Kings County Behavioral Health (KCBH) has maintained its commitment to utilizing the Child and Adolescent Needs and Strengths (CANS) tool to assess and address the needs of children and youth up to 21 years of age. CANS assessments are administered at intake, every six months, and at discharge to evaluate actionable areas across key domains, including Child Behavioral and Emotional Needs, Life Domain Function, Risk Behaviors, and Cultural Factors. Progress continues to be measured by reductions in actionable areas (scores of 2 or 3) from intake to discharge.

Despite these ongoing efforts, the department has not yet achieved its goal of implementing a fully operational CANS dashboard within the new EHR system. While this remains a top priority, progress has been delayed due to resource constraints and the complexity of the EHR transition. Without a dashboard, the ability to efficiently track and analyze CANS data in real time is limited, and reporting relies heavily on manual processes and legacy data retrieval.

ACTION: Efforts will focus on securing necessary resources and collaborating to expedite the dashboard's completion.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, the department-initiated plans to create a CANS dashboard as part of the EHR transition. However, due to delays, this goal was not realized. The absence of a dashboard continues to impact data reporting and analysis, emphasizing the importance of making this a priority in FY 23/24.



## INDICATOR: FUNCTIONAL IMPROVEMENT AMONG ADULT CONSUMERS, PER USE OF ANSA

Metric to be developed

## INDICATOR: DISCHARGE DISPOSITION

Metric to be developed

## GOAL 2: UTILIZATION MANAGEMENT AND UTILIZATION REVIEW

Services are delivered in a manner that is appropriate to meet the level of care needs of each consumer

### OBJECTIVE 2.1: SERVICES ARE APPROPRIATELY DELIVERED

#### INDICATOR: SERVICE UTILIZATION BY LEVEL OF CARE BASED ON PROGRAM'S LEVEL OF CARE DELIVERY

Placeholder for Metric: Number of services by service code within each level of care program (ROS, FSP, ACT) in comparison with number of consumers served by program

#### INDICATOR: HIGH-UTILIZATION OF SERVICES

Placeholder for Metric: Count of consumers receiving high-use of crisis intervention or more than 5 services per month, who are not in an ACT, FSP, TBS, or IHBS program

#### INDICATOR: UNDER-UTILIZATION OF SERVICES

Placeholder for Metric: Count consumer with no contact for more than 30 days

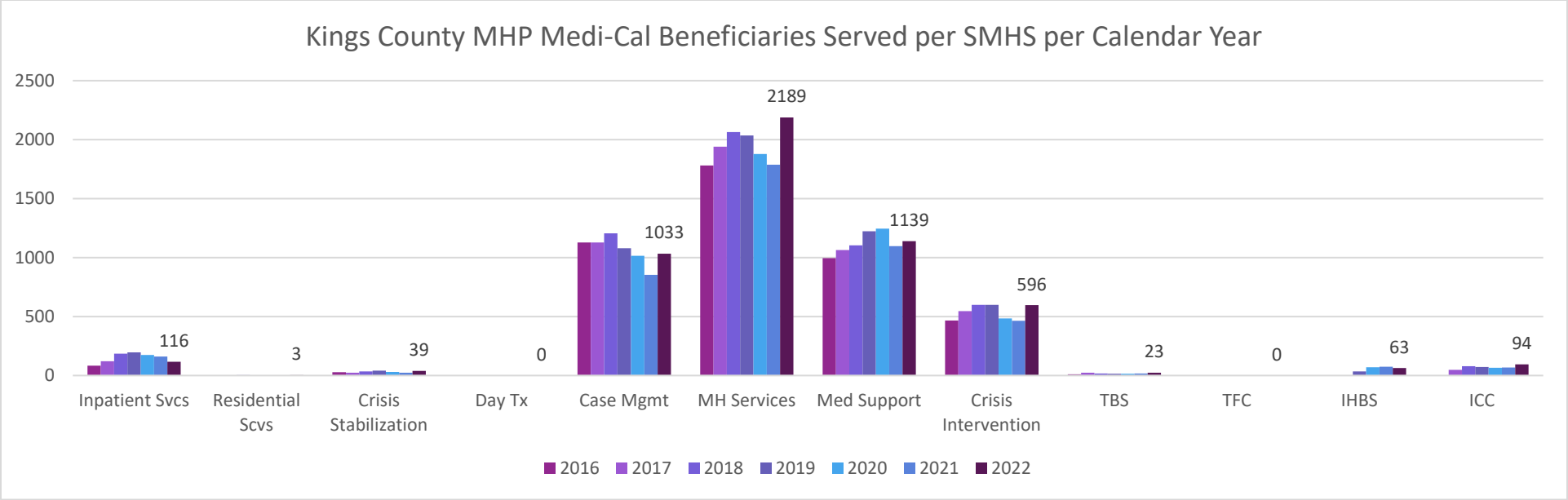
INDICATOR: SERVICES PROVIDED AS DEMONSTRATED THROUGH APPROVED CLAIMS

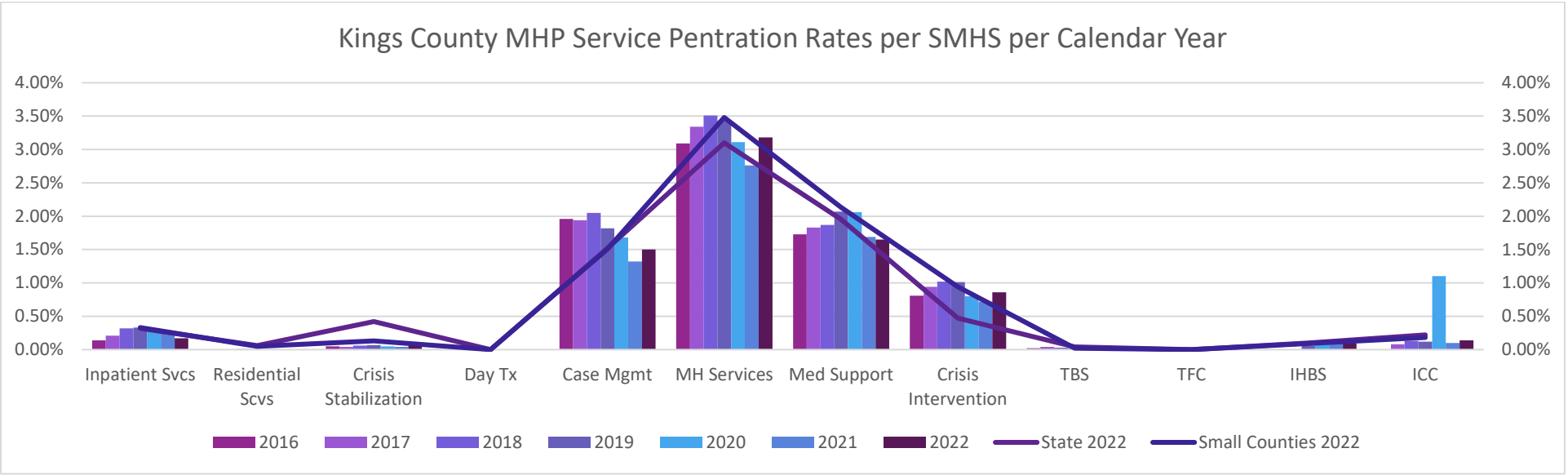
ANALYSIS: Due to the unavailability of claims data for FY 2023/24, a direct analysis of service provision trends for this period could not be conducted. However, the trends observed in calendar year 2022 provide valuable context. In 2022, the number of beneficiaries with claims increased across most Specialty Mental Health Services (SMHS) categories, with notable increases in crisis intervention services (+28%) and mental health services (+22%). These increases were consistent with an overall 16% rise in the number served across SMHS categories, aligning with the 15% increase in the total population served from 2021 to 2022.

While inpatient services saw a 27.5% decrease and Intensive Home-Based Services (IHBS) experienced a 15% decrease in 2022, these trends may reflect shifts in service utilization patterns, particularly the increased use of crisis intervention services, which could have mitigated inpatient service needs. Penetration rates across all service categories remained consistent with those of the state and other small counties, within a 0.5% range.

ACTION: No specific action is required at this time, as penetration rates remain aligned with state and small county averages. Moving forward, Kings County Behavioral Health is prioritizing enhancements to its data collection and reporting systems to ensure the timely availability of claims data for future analysis and reporting.

PRIOR YEAR ACTION AND RESULT: No action was identified for FY 22/23.


Kings County MHP Medi-Cal Beneficiaries Served per SMHS per Calendar Year
2500
2000
1500
1000
500
0
116
3
39
0
1033
2189
1139
596
23
0
63
94
Inpatient Svcs
Residential Scvs
Crisis Stabilization
Day Tx
Case Mgmt
MH Services
Med Support
Crisis Intervention
TBS
TFC
IHBS
ICC
2016
2017
2018
2019
2020
2021
2022


Kings County MHP Service Pentration Rates per SMHS per Calendar Year
4.00%
3.50%
3.00%
2.50%
2.00%
1.50%
1.00%
0.50%
0.00%
Inpatient Svcs
Residential Scvs
Crisis Stabilization
Day Tx
Case Mgmt
MH Services
Med Support
Crisis Intervention
TBS
TFC
IHBS
ICC
2016
2017
2018
2019
2020
2021
2022
State 2022
Small Counties 2022

INDICATOR: MEDI-CAL APPROVED CLAIMS AND SERVICES

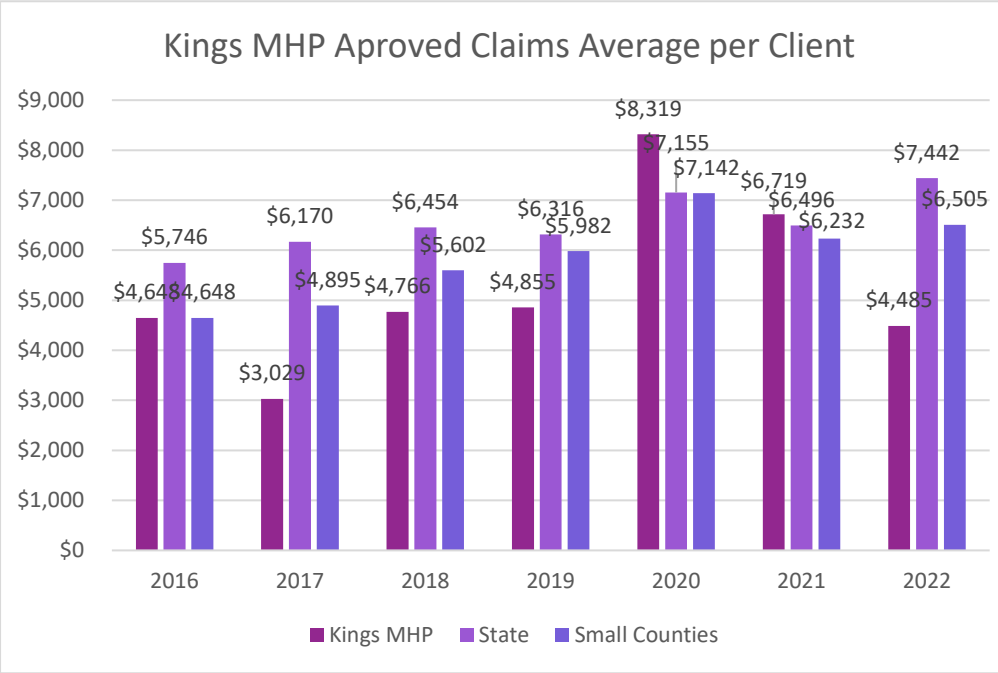
ANALYSIS: For FY 2023/24, claims data was unavailable due to the lack of access to historical reports following the state's transition to a new external quality review organization. As such, the trends from calendar year 2022 provide the most recent reference point.

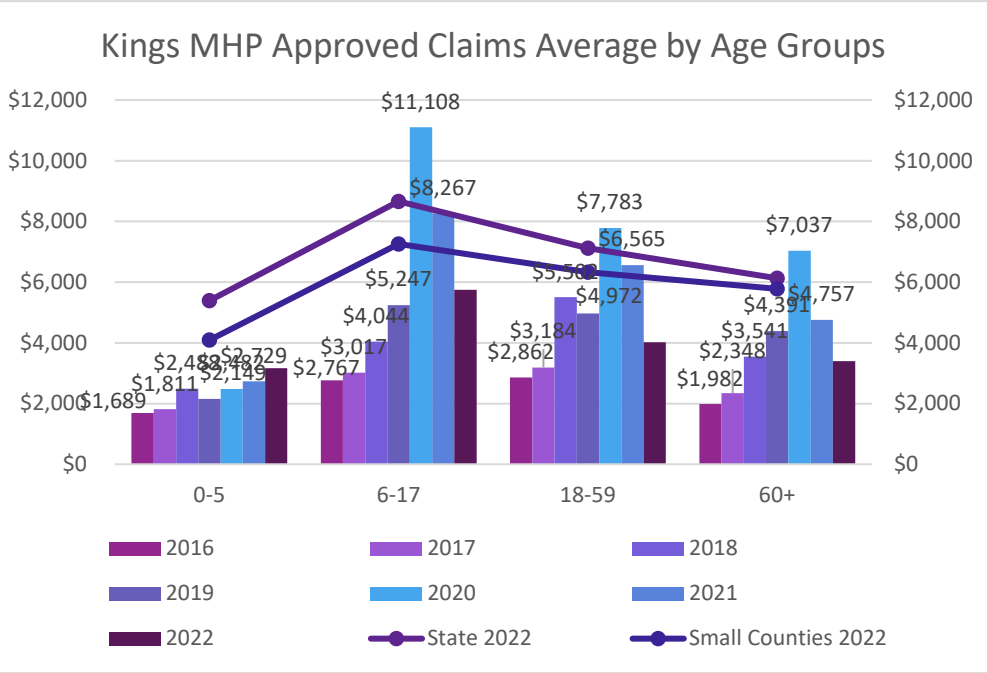
In 2022, the average approved claim for Kings County Behavioral Health (KCBH) returned to $4,485 per beneficiary, aligning closely with the historical average of approximately $4,500, except for the significant but temporary increase observed during FY 2020-2021 due to the adoption of COVID-adjusted rates. These inflated rates, which were intended to support MHPs in managing pandemic-related costs, cannot be used for accurate year-to-year or cross-county comparisons, as not all counties opted to apply these adjusted rates.

Kings County's average approved claim remains significantly below that of the state and other small counties. However, this difference largely reflects the absence of certain service categories in Kings County that have higher costs, such as Day Treatment (state average $11,927, small county average $28,504) and Therapeutic Foster Care (state average $22,796, small county average $5,487). Therefore, direct comparisons to state and small county averages should be interpreted with caution, as Kings County's service mix differs substantially.

ACTION: No action is recommended, as the average approved claims are consistent with historical patterns and reflect the specific service availability in Kings County.

PRIOR YEAR ACTION AND RESULTS: No action was identified in FY 2022/23, and no further action is proposed for FY 2023/24.


Kings MHP Aproved Claims Average per Client
$9,000
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
$4,648
$5,746
$4,648
$3,029
$6,170
$4,895
$4,766
$6,454
$5,602
$4,855
$6,316
$5,982
$8,319
$7,155
$7,142
$6,719
$6,496
$6,232
$4,485
$7,442
$6,505
2016
2017
2018
2019
2020
2021
2022
Kings MHP
State
Small Counties


Kings MHP Approved Claims Average by Age Groups
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0
$1,689
$1,811
$2,729
$2,767
$3,017
$4,044
$5,247
$11,108
$8,267
$2,862
$3,184
$4,972
$6,565
$7,783
$1,982
$2,348
$3,541
$4,391
$7,037
$4,757
0-5
6-17
18-59
60+
2016
2017
2018
2019
2020
2021
2022
State 2022
Small Counties 2022

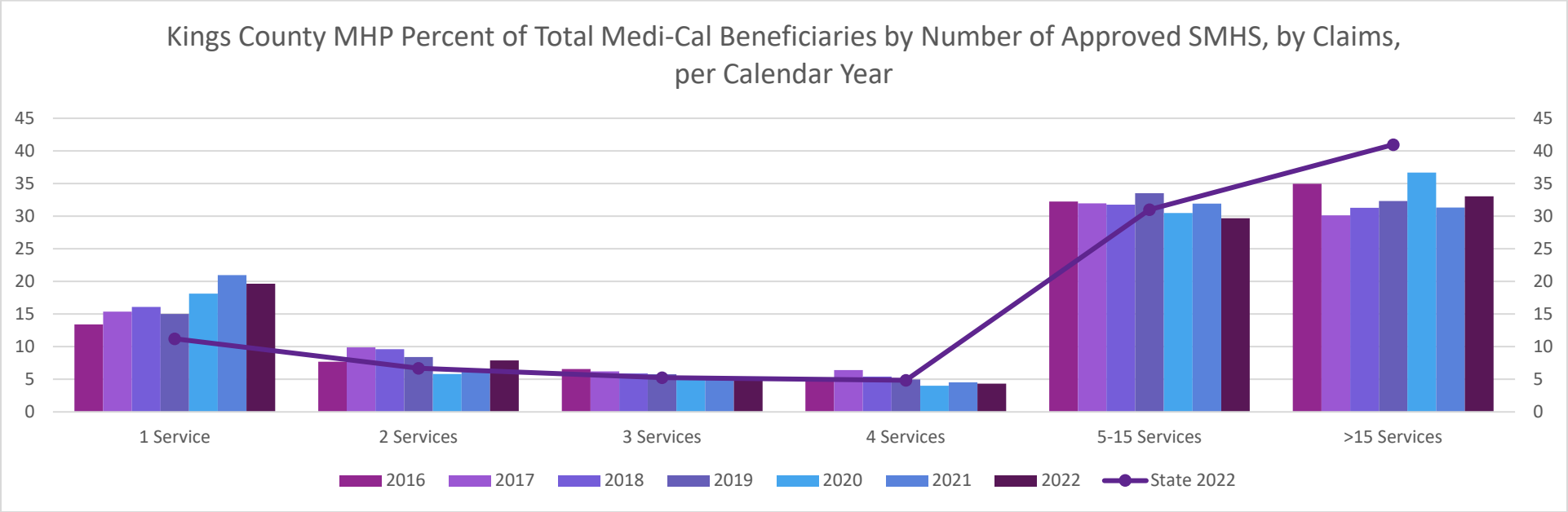
INDICATOR: ENGAGEMENT RATES OF CONSUMERS

ANALYSIS: Due to the lack of available claims data for FY 2023/24, current trends could not be analyzed. However, previous data indicates that Kings County MHP continues to have more beneficiaries receiving only one Specialty Mental Health Service (SMHS) compared to the state rate, and fewer beneficiaries receiving more than 15 SMHS than the state rate. Beneficiaries receiving between 2 and 15 SMHS remain consistent with the state rate.

ACTION: The MHP will continue exploring methods to analyze this trend through available data, while also engaging providers in discussions to better understand the factors contributing to the higher proportion of beneficiaries receiving only one SMHS and the lower proportion receiving 15 or more.

PRIOR YEAR ACTION AND REMAINS THIS YEAR'S ACTION: In FY 2022/23, the MHP committed to developing reports to assess whether beneficiaries are engaging in the most appropriate level of care and successfully discharging after sufficient program engagement. This action has not yet been completed and remains a priority for FY 2024/25.

Additionally, the MHP intended to review other counties' QAPI Work Plans to compare rates of Notices of Adverse Benefit Determination (NOABD) related to medical necessity denials at assessment. This review would help determine if the higher rate of beneficiaries receiving only one SMHS is linked to a higher rate of beneficiaries not meeting medical necessity at assessment. This review also remains an ongoing priority.



INDICATOR: NO-SHOW RATE FOR CLINICAL AND PSYCHIATRY SERVICES

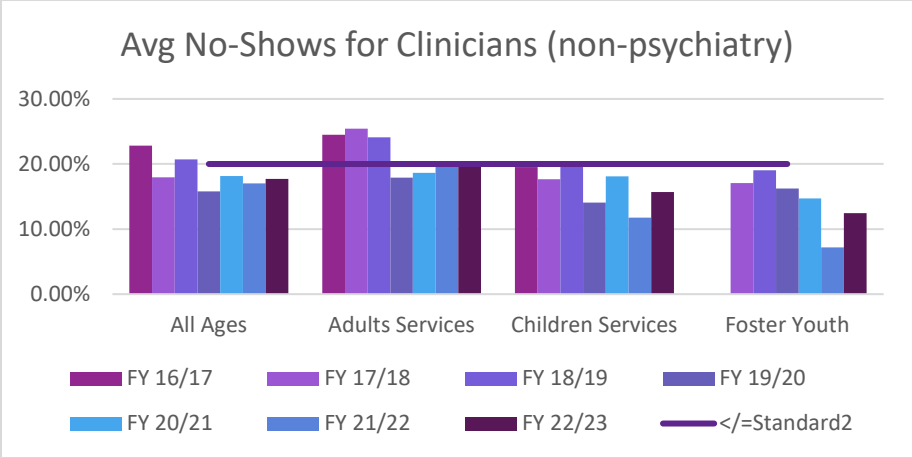
ANALYSIS: During FY 23/24, the transition to our new EHR system and the associated challenges with the calendar functionality prevented us from accurately tracking no-show rates for both clinical and psychiatry services. Providers' use of the calendar feature did not align with the system's intended data capture methods, making it impossible to compile reliable no-show data. However, the workflow issues have since been identified and addressed. With these improvements in place, the plan is to develop a direct reporting mechanism within the EHR that can pull no-show data directly from providers' calendars, ensuring comprehensive and accurate reporting in the future.

ACTION: Collaborate with EHR vendor and internal IT staff to develop a report that captures no-show rates directly from provider calendars. Provide training and guidance to providers on calendar usage to ensure consistency and accuracy of data. Once the reporting tool is finalized, begin regular data collection and analysis to re-establish a baseline no-show rate and identify areas for improvement.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, the MHP successfully tracked no-show rates and identified areas requiring improvement for psychiatry services. The data informed targeted action items, including forwarding the psychiatry no-show rate to the Medical Director for review. However, with the EHR conversion, these established data-tracking processes were disrupted, prompting the current focus on restoring and improving no-show data collection methods for FY 23/24 and beyond.

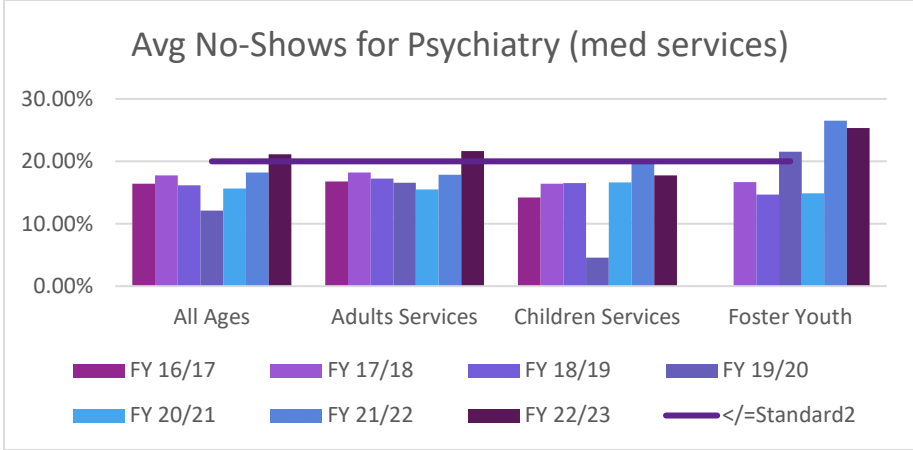
## AVERAGE NO-SHOWS FOR CLINICIANS OTHER THAN PSYCHIATRISTS

MHP Standard: </=20%




## AVERAGE NO-SHOWS FOR PSYCHIATRISTS

MHP Standard: </=20%



## OBJECTIVE 2.2: SERVICES ARE DOCUMENTED ACCORDING TO STATE STANDARDS OF CARE

### INDICATOR: CHART REVIEW/UTILIZATION REVIEW

ANALYSIS: In FY 23/24, Kings County MHP had a 84.42% utilization review (UR) compliance rate after reviewing 104 charts. This is a significant decrease from FY 22/23 total compliance of 93.7%, and is below the compliance goal of 90%. In July 2023, the MHP transitioned from our former Electronic Health Record, Cerner Anasazi to the new Semi-Statewide E.H.R. SmartCare. Utilization Review was suspended from July until December 2023 to allow providers to complete E.H.R. training and become familiar with the new system. The MHP UR audit tool was revised in November 2023 to better align with CalAIM Documentation Redesign standards, reduce question redundancy, and streamline the tool. This tool went live in December 2023.

UR is broken out into 6 categories seen in the graph below wherein all but one category fell below the MHP goal of 90% compliance. The only area above 90% compliance was Billing. The MHP UR audit tool was revised in November 2022 to align with CalAIM Documentation Redesign making comparison of data across fiscal year 22/23 to be difficult as many UR categories, including Assessment, Access Criteria, and Problem List were changed significantly. For this reason, there is an unavoidable data limitation which should be considered.

Throughout the fiscal year, the MHP has implemented various initiatives with the goal of addressing documentation challenges, improving operational procedures, and providing ongoing E.H.R. support for all users. Some of these initiatives have included virtual training on Screening and Transition of Care Tools (9/20/23) and CalAIM Documentation Standards (1/31/24), email blasts addressing documentation of chart review time (2/23/24) and Certified Peer Support service codes (2/23/24), as well as a series of five optional in-person clinics focusing on topics identified through UR findings (6/4 (Assessment, 6/11 Care Planning, 6/18 Certified Peer Support Specialist, 6/24 Screening/Transition of Care Tools, 7/9 NOABDs).

Despite these efforts, the MHP saw a drop in the compliance rate of many Utilization Review Categories throughout the fiscal year including Assessment, Problem List, Other Documentation (Informing Materials), and Billing.

While the UR audit tool has changed from the previous fiscal year, we can generally compare compliance rates in some categories. Assessment compliance rate decreased from 93.47% in FY 22/23 to 87.62% (5.85% decrease). Problem List compliance dropped from 91.6% in FY 22/23 to 86.76% in FY 23/24 (a 4.84% decrease). Progress Notes decreased 7.48% from 95.2% in FY 22/23 to

87.72% in FY 23/24. Finally, the Other Documentation category which monitors compliance with service timeliness standards as well as informing materials and consent forms decreased from 75.39% in FY 22/23 to 62.48% in FY 23/24 (a 12.91% drop).

ACTION: Other Documentation and Specialized Services categories will remain areas of focus for improvement at the UR Committee in FY 24/25.

PRIOR YEAR'S ACTION AND RESULTS:

The MHP UR audit tool was revised in November 2022 to align with CalAIM Documentation Redesign making comparison of data across fiscal year 22/23 to be difficult as many UR categories, including Assessment, Access Criteria, and Problem List were changed significantly. For this reason, there is an unavoidable data limitation which should be considered when reviewing the following analysis.

The MHP saw significant changes in the compliance percentages of many categories throughout FY 22/23 which are trending in a positive direction. In Q3, it was discovered that due to an E.H.R. limitation, providers were not able to edit/ correct the Problem List fields (specifically the area in which a diagnosis is "identified by") completed by another MHP program. This issue had persisted since the implementation of Documentation Redesign in August 2022. This resulted in findings of Problem Lists being out of compliance with little/ no opportunity for correction. The MHP attempted to ameliorate this in Q4 by only recording Problem List deficiencies if the error was made by the current treating provider who had opportunity to enter/correct the diagnosis/problem. This issue is likely the reason for the 5.55% compliance decrease in the Problem List category as no other question in this category yielded significant or persistent findings.

Although the Consent category is under the compliance percentage goal of 90% and continues to be an area of focus for the MHP, there has been a 8.72% increase in compliance throughout the fiscal year.

## CHART REVIEW RESULTS

| FY | Total Charts Reviewed | Items Compliant | Items Not-Compliant | Total % Compliant |
|---|---|---|---|---|
| **FY 22/23** | 187 | 8,7,57 | 589 | 93.7% |
| **FY 23/24** | 106 | 4,504 | 831 | 84.42% |

| **Categories** | **Total Yes** | **Total No** | **FY 22/23 YTD Compliance Percentage** |
|---|---|---|---|
| Consents | 386 | 126 | 75.39% |
| Assessment | 2,076 | 145 | 93.47% |
| SMHS Access Criteria | 322 | 0 | 100.00% |
| Problem List | 1,177 | 108 | 91.60% |
| Progress Notes | 1,667 | 84 | 95.20% |
| Documentation Summary | 307 | 14 | 95.64% |
| Compliance | 1,771 | 88 | 95.27% |
| Recoupment | 1,051 | 24 | 97.77% |
| **Total (Overall)** | **8,757** | **589** | **93.70%** |
| **Categories** | **Total Yes** | **Total No** | **FY 23/24 YTD Compliance Percentage** |
| Assessment | 1,231 | 174 | 87.62% |
| Problem List | 367 | 56 | 86.76% |
| Progress Notes | 1,000 | 140 | 87.72% |
| Other Documentation (Consents) | 353 | 212 | 62.48% |
| Specialized Services | 303 | 227 | 57.17% |
| Billing | 1,250 | 22 | 98.27% |
| **Total (Overall)** | **4,504** | **831** | **84.42%** |

INDICATOR: MEDICATION PRACTICES

## MEDICATION MONITORING CHART REVIEW RESULTS

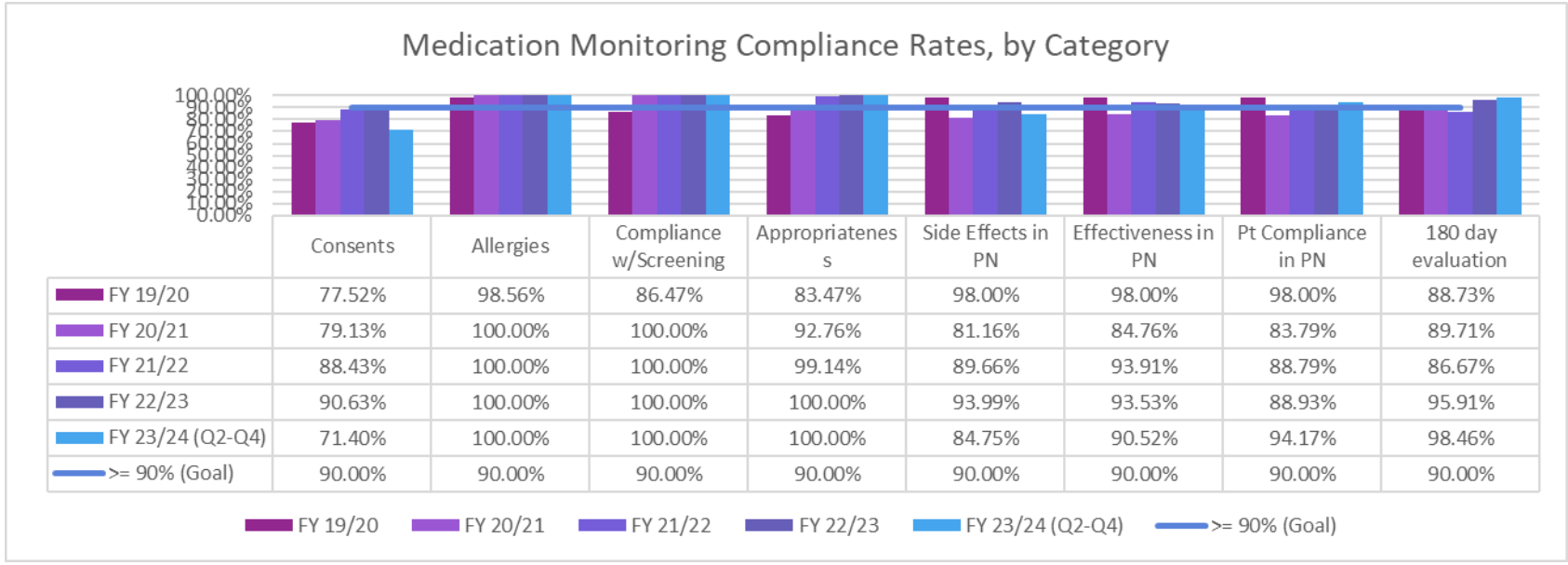
ANALYSIS: In FY 23/24, Kings MHP achieved a 91.86% medication monitoring compliance rate after reviewing 114 charts totaling 884 chart items. The medication monitoring review was divided into 8 compliance categories, as depicted in the graph below. Notably, six of the eight categories met or exceeded the MHP goal of 90% compliance. However, compliance for *consents present in chart* (71.40%) and *noting the presence/absence of side effects* (84.91%) fell below this target, highlighting areas for improvement in these critical aspects of medication management. Through medication monitoring reviews and committee meetings, it was discovered that changes resulting from the adoption of a new Electronic Health Record (EHR) system played a significant role in the decreased compliance rates. Specifically: 1. The new EHR system introduced changes to how medication consent forms are documented and scanned, leading to inconsistencies in workflow and errors in tracking consent documentation. 2. The documentation for allergic reactions or side effect presence/absence was affected due to differences in how the new system handles these fields, creating confusion among prescribers and support staff. These workflow challenges appear to have directly contributed to the lower compliance rates compared to prior years.

ACTION: To address these gaps, the MHP shall continue monitoring compliance of prescribers' documentation regarding medication consent and side effect status. The following targeted actions will be implemented: Continue to conduct focused training sessions as needed for prescribers and support staff on the EHR workflows related to consent documentation and allergic reaction/side effect charting. Medication Monitoring reviews will continue to deliver prescriber-specific feedback, ensuring timely identification and resolution of workflow issues.

PRIOR YEAR ACTION AND RESULTS: In FY 22/23, the MHP convened monthly medication monitoring committee meetings with all psychiatrists and med support staff to discuss and review compliance metrics. These meetings were instrumental in maintaining high compliance rates in most categories. However, the transition to a new EHR system introduced unanticipated workflow challenges that negatively impacted compliance in documenting medication consents and allergic reactions. While the meetings helped address some of these challenges, the data highlights the need for ongoing focused training sessions and prescriber-specific feedback through Medication Monitoring reviews to further refine EHR workflows and resolve these issues in the upcoming year.

## MEDICATION MONITORING RESULTS

| FY/Qtr | Total Charts Reviewed | Items Compliant | Items Not-Compliant | Total % Compliant |
|---|---|---|---|---|
| **FY 18/19 (Q3&4)** | 47 | 283 | 17 | 94.33% |
| **FY 19/20** | 159 | 955 | 113 | 89.42% |
| **FY 20/21** | 156 | 990 | 92 | 90.71% |
| **FY 21/22** | 149 | 909 | 65 | 93.33% |
| **FY 22/23** | 166 | 1,131 | 54 | 95.23% |
| **FY 23/24** | 114 | 802 | 82 | 91.86% |




| | Consents | Allergies | Compliance w/Screening | Appropriateness | Side Effects in PN | Effectiveness in PN | Pt Compliance in PN | 180 day evaluation |
|---|---|---|---|---|---|---|---|---|
| FY 19/20 | 77.52% | 98.56% | 86.47% | 83.47% | 98.00% | 98.00% | 98.00% | 88.73% |
| FY 20/21 | 79.13% | 100.00% | 100.00% | 92.76% | 81.16% | 84.76% | 83.79% | 89.71% |
| FY 21/22 | 88.43% | 100.00% | 100.00% | 99.14% | 89.66% | 93.91% | 88.79% | 86.67% |
| FY 22/23 | 90.63% | 100.00% | 100.00% | 100.00% | 93.99% | 93.53% | 88.93% | 95.91% |
| FY 23/24 (Q2-Q4) | 71.40% | 100.00% | 100.00% | 100.00% | 84.75% | 90.52% | 94.17% | 98.46% |
| >= 90% (Goal) | 90.00% | 90.00% | 90.00% | 90.00% | 90.00% | 90.00% | 90.00% | 90.00% |

INDICATOR: HOSPITALIZATION AND RE-HOSPITALIZATION RATES

ANALYSIS: In FY 23/24, there were 606 total psychiatric hospitalizations (includes all involuntary psychiatric hospitalizations in Kings County regardless of insurance type). This is an increase from 493 in FY 22/23. In reviewing the number of hospitalizations (606) against the total County population (152,682), the County had less than a 1% (0.4%) Hospitalization Rate. Among readmission rates within 30-days of hospital discharge, there was an increase in beneficiaries hospitalized but a decrease in percentage rate from 9.13% (45) in FY 22/23 to 8.91% (54) in FY 23/24. The primary increase in readmissions remains among adults.

ACTION: Data will continue to be monitored through FY 24/25 at the quarterly reporting meetings at QIC to identify trends and determine if the increase stabilizes or aligns with the average across prior fiscal years.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, data was monitored, and no significant interventions were implemented. Monitoring revealed an increase in readmissions with a decrease in the readmission rate.

HOSPITALIZATION RATES

| | All Services | Adult Services | Children's Services | Foster Care |
|---|---|---|---|---|
| FY 16/17 | 210 | 11 | 28 | N/A |
| FY 17/18 | 203 | 180 | 13 | 10 |
| FY 18/19 | 308 | 259 | 44 | 5 |
| FY 19/20 | 463 | 378 | 72 | 13 |
| FY 20/21 | 434 | 354 | 56 | 24 |
| FY 21/22 | 477 | 367 | 110 | 18 |
| FY 22/23 | 493 | 399 | 88 | 6 |
| FY 23/24 | 606 | 500 | 98 | 8 |

*Data Limitation: Although there appears to be a significant increase from prior fiscal years (16/17, 17/18 and 18/19), it was noted that the methodology for which hospitalizations were captured changed in FY 19/20 and as a result it accounted for the increase in hospitalization. As such, the increase was not attributed to an increase in individuals being hospitalized, rather an administrative change in reporting.*

## RE-HOSPITALIZATION WITHIN 30-DAYS OF HOSPITAL DISCHARGE

| | All Services | Adult Services | Children's Services | Foster Care |
|---|---|---|---|---|
| FY 16/17 | 15/14% | 14/12.93% | 1/29%% | N/A |
| FY 17/18 | 27/13.30% | 24/13.33% | 2/15.38% | 1/10%% |
| FY 18/19 | 43/13.96% | 35/13.51 | 5/11.36 | 3/60.00% |
| FY 19/20 | 35/7.56% | 30/7.94% | 3/4.17% | 2/15.38% |
| FY 20/21 | 34/7.83% | 29/8.19% | 2/3.57% | 3/12.50% |
| FY 21/22 | 24/5.03% | 16/4.36% | 8/7.27% | 0/0% |
| FY 22/23 | 45/9.13% | 41/10.28% | 4/4.55% | 0/0% |
| FY 23/24 | 54/8.91% | 44/8.80% | 8/8.16% | 2/25% |

## HOSPITALIZATION BY CONSUMER STATUS: ACTIVE, FORMER, NEW

Metric to be developed

## HOSPITALIZATION BY CONSUMER PAYOR SOURCE: MEDI-CAL, MEDICARE, UNINSURED, PRIVATE INSURANCE

Metric to be developed

## GOAL 3: PROVIDER NETWORK ADEQUACY, CREDENTIALING, AND MONITORING

The MHP will ensure all provider and provider sites are enrolled, credentialed, and/or certified in compliance with Medi-Cal requirements.

### OBJECTIVE 3.1: THERE IS AN ADEQUATE NETWORK OF PROVIDERS

#### INDICATOR: PROVIDER STAFFING

ANALYSIS: During FY 23/24, the conversion to our new EHR and the adoption of the DAT file format for state reporting presented challenges in tracking compiled provider Full-Time Equivalencies (FTEs). While we can confirm data accuracy as it enters our EHR, we do not currently have a method to review the aggregated FTE totals post-compilation. Our reliance on the EHR's DAT output means we cannot isolate final provider type totals at this time. Despite this limitation, the state has continued to accept our quarterly reports, and we remain in compliance with required provider FTE measures. We are actively working with our EHR vendor and a report developer to create a functional reporting mechanism, and we will backfill these FTE totals once the necessary capability is established.

ACTION: Collaborate with the EHR vendor and a report developer to establish a reliable reporting method that allows for the extraction and review of compiled FTE totals. Maintain ongoing verification of provider data inputs to ensure ongoing compliance, even as we work toward generating final FTE compilations. Once the reporting tool is available, backfill FY 23/24 FTE data and update all relevant documentation accordingly.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, the MHP successfully tracked and reported provider FTE data as outlined previously. The established processes allowed for accurate monitoring of direct and reserve provider FTEs, resulting in the timely submission of quarterly reports that met DHCS standards. During that period, the MHP could easily verify compiled data, ensuring a smooth and compliant reporting cycle. These past achievements provide a baseline for current efforts to restore full data oversight and reporting accuracy within the new EHR environment.

FULL-TIME EQUIVALENCY (FTE) BY PROVIDER TYPE

| Time Period | Child/Youth Psychiatry *(includes NP)* | Adult Psychiatry *(includes NP)* | Child/Youth Medical Personnel *(i.e. RN, PT)* | Adult Medical Personnel *(i.e. RN, PT)* | Child/Youth Therapists | Adult Therapists | Child/Youth Other Qual. Prov. *(Rehab Spc, Case Mgr, PSS)* | Adult Other Other Qual. Prov. *(Rehab Spc, Case Mgr PSS)* | TOTAL |
|---|---|---|---|---|---|---|---|---|---|
| **Jan 2019** | 5.0 | | 5.0 | | 43.0 | | 16.0 | | 69.0 |
| **April 2019** | 1.0 | 2.7 | 1.0 | 6.0 | 16.1 | 25.2 | 14.7 | 20.7 | 87.4 |
| **July 2019** | 0.9 | 4.0 | 0.7 | 4.3 | 19.8 | 24.1 | 19.5 | 19.7 | 93.0 |
| **Oct 2019** | 0.9 | 4.1 | 0.9 | 6.1 | 21.1 | 24.5 | 24.2 | 18.1 | 99.9 |
| **Jan 2020** | 2.5 | 5.1 | 0.9 | 6.1 | 27.1 | 22.5 | 40.1 | 19.2 | 123.5 |
| **April 2020** | 2.9 | 6.1 | 0.9 | 7.1 | 25.1 | 22.5 | 39.1 | 18.3 | 122 |
| **April 2021** | 2.29 | 4.36 | 0.9 | 8.10 | 18.55 | 21.00 | 21.70 | 13.65 | 89.65 |
| **July 2022** | 2.94 *(excludes NP & Reserve)* | 1.91 *(excludes NP)* | 1.25 *(includes NP)* | 6.40 *(includes NP)* | 27.95 *(excludes Reserve)* | 16.00 | 27.65 | 11.80 | 94.90 *(excludes Reserve)* |
| **Nov 2023** | 1.04 *(excludes NP & Reserve)* | 3.96 *(excludes NP)* | 0.00 *(includes NP)* | 6.90 *(includes NP)* | 27.50 *(excludes Reserve)* | 24.75 | 22.20 | 17.10 | 103.45 *(excludes Reserve)* |

| DHCS NETWORK ADEQUACY PROVIDER RATIO FINDINGS | | | | | | |
|---|---|---|---|---|---|---|
| **Provider Category** | **Date** | **DHCS Standard** | **DHCS Estimated Need Population** *(Medi-Cal Eligible X Prevalence)* | **# of FTE Providers Needed to Meet the Ratio Standard** | **# of FTE Providers Reported by the MHP** | **DHCS Findings (Pass/ Conditional Pass)** |
| **Psychiatry Provider Capacity - Adults** | **Nov 2023** | 1:457 | 1697.11 | 3.71 | 4.96 | Met |
| | **July 2022** | 1:524 | 1535 | 2.93 | 4.46 | Pass |
| | **Apr 2021** | 1:524 | 1414 | 2.70 | 3.31 | Pass |
| | **Apr 2020** | 1:524 | 1272 | 2.43 | 5.09 | Pass |
| | **Apr 2019** | 1:524 | 1,272 | 2.43 | 3.25 | Pass |
| **Psychiatry Provider Capacity -Children/ Youth** | **Nov 2023** | 1:267 | 705.28 | 2.64 | 2.64 | Met |
| | **July 2022** | 1:323 | 684 | 2.12 | 2.54 *(includes 1 FTE Reserve)* | Pass |
| | **Apr 2021** | 1:323 | 665 | 2.06 | 2.19 | Pass |
| | **Apr 2020** | 1:323 | 572 | 1.77 | 2.82 | Pass |
| | **Apr 2019** | 1:323 | 572 | 1.77 | 1.10 | Conditional Pass |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Outpatient SMHS Provider Capacity - Adults** | **Nov 2023** | 1:85 | 2533 | 29.8 | 49.45 | Met |
| | **July 2022** | 1:85 | 2292 | 26.96 | 29.45 | Pass |
| | **Apr 2021** | 1:85 | 2110 | 24.82 | 41.70 | Pass |
| | **Apr 2020** | 1:85 | 1898 | 22.33 | 47.75 | Pass |
| | **Apr 2019** | 1:50 | 1,898 | 37.96 | 44.37 | Pass |
| **Outpatient SMHS Provider Capacity -Children/ Youth** | **Nov 2023** | 1:49 | 2432 | 49.63 | 53.75 | Met |
| | **July 2022** | 1:43 | 2357 | 54.82 | 55.55 *(includes 21 FTE Reserve)* | Pass |
| | **Apr 2021** | 1:43 | 2292 | 53.30 | 39.35 | Pass |
| | **Apr 2020** | 1:43 | 1972 | 45.87 | 61.34 | Pass |
| | **Apr 2019** | 1:30 | 1,972 | 65.74 | 28.04 | Conditional Pass |

INDICATOR: GEOGRAPHIC DISTRIBUTION OF PROVIDERS

TIME AND DISTANCE STANDARDS

ANALYSIS: All beneficiaries within Kings County are within the DHCS time and distance standards of 75 minutes and 45 miles to the nearest MHP provider, as the county as a whole geographically is no larger from any given point to another than that of the time and distance standards. As such, DHCS found the Kings MHP to be in compliance in prior network adequacy certifications and it is anticipated that this will continue to be found in compliance as the time and distance standards have not changed nor has the county jurisdictional area.

ACTION: No action to be taken.

INDICATOR: PROVIDER CREDENTIALING/RE-CREDENTIALING

ANALYSIS: During FY 23/24, the MHP faced challenges maintaining the fidelity required for consistent credentialing and re-credentialing processes due to the EHR conversion and additional state reporting responsibilities. As a result, prior methods of tracking and verifying credentialing timelines and compliance were disrupted. In September of FY 23/24, the MHP implemented a new contracted third-party credentialing solution, CertifyOS. This platform is expected to streamline credentialing workflows and provide a centralized dashboard for data monitoring. Moving forward, the MHP will leverage the CertifyOS dashboard to develop standardized metrics, ensuring comprehensive and accurate oversight of provider credentialing activities.

ACTION: Collaborate with CertifyOS representatives to establish a clear metric that can be monitored via the dashboard. Provide training to administrative and QA staff on navigating and extracting data from CertifyOS tools. Begin regular data collection and analysis by Q3 FY 23/24, using the dashboard metrics to evaluate performance and identify areas needing improvement.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, the MHP acknowledged the need for a reliable credentialing and re-credentialing metric but did not finalize one due to competing priorities and system conversions. Although no formal data were collected, this experience highlighted the importance of a streamlined process and contributed to the decision to contract with CertifyOS. With this partnership now in place, the MHP is positioned to implement effective tracking measures and improve the fidelity of its credentialing activities.

## GOAL 4: BENEFICIARY PROTECTIONS

### OBJECTIVE 4.1: THE MHP WILL PROVIDE A GRIEVANCE SYSTEM FOR CONSUMERS

#### INDICATOR: COUNT AND TYPE OF GRIEVANCES AND APPEALS

ANALYSIS: In FY 23/24, Kings MHP Patient Rights Advocate processed 58 grievances, a decrease from FY 22/23 (87); and the Kings MHP Quality Assurance Clinician processed 8 appeals, an increase from FY 22/23 (5). However, due to the small sample size, this change is not significant. No trend or pattern arose during the FY among grievances nor appeals.

ACTION: The Patient Rights Advocate and Quality Assurance Clinician continue to assess grievances and appeals on a quarterly basis to identify any trends or patterns that may need to be addressed. No further action is required at this time, but the continued use of timely access NOABDs will be closely monitored.

PRIOR YEAR ACTION AND RESULT: There was no identified action for FY 23/24.

## GRIEVANCES

| Time Period | Grievance Categories | | | | | | | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Access | | Quality of Care | | Change of Provider | | Confidentiality Concern | | Other | | |
| | PRA | Exempt | PRA | Exempt | PRA | Exempt | PRA | Exempt | PRA | Exempt | |
| **FY 19/20** | 11 | 2 | 21 | 17 | 0 | 0 | 0 | 0 | 16 | 6 | **73** |
| **FY 20/21** | 2 | 1 | 3 | 23 | 0 | 1 | 0 | 1 | 11 | 24 | **66** |
| **FY 21/22** | 3 | 5 | 8 | 17 | 0 | 0 | 1 | 1 | 8 | 20 | **63** |

| ABGAR Changed to MCPAR 22/23 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Cust Service | Case Mgmt | Access to Care | Quality of Care | Cunty Communication | Payment/ Billing | Suspected Fraud | Abuse/ Neglect/ Exploitation | Untimely Response | Denial of Exp. Appeal | Other | Total |
| **FY 22/23** | 3 | 3 | 7 | 14 | 0 | 3 | 0 | 0 | 0 | 0 | 6 | **36** |
| **FY 23/24** | 3 | 14 | 8 | 18 | 0 | 0 | 0 | 0 | 0 | 0 | 15 | **58** |

APPEALS RESULTING FROM NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD)

| FY | Categories | | | | | | | TOTALS |
|---|---|---|---|---|---|---|---|---|
| | **Denial or Limited Service** | **Modif. or Term of Services** | **Payment Denial** | **Service Timeliness** | **Untimely Response to Appeal of Griev.** | **Denial of Bene Request to Dispute Financial Liab.** | **Delivery System***(ABGAR only, ended in 22/23)* | |
| **18/19** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **19/20** | 3 | 5 | 0 | 0 | 0 | 0 | 4 | **12** |
| **20/21** | 0 | 8 | 5 | 0 | 0 | 0 | 6 | **19** |
| **21/22** | 0 | 10 | 8 | 0 | 0 | 0 | 1 | **19** |
| **22/23** | 3 | 2 | 0 | 0 | 0 | 0 | N/A | **5** |
| **23/24** | 0 | 4 | 0 | 0 | 0 | 0 | 4 | **8** |

## GOAL 5: CULTURAL AND LINGUISTIC COMPETENCE

### OBJECTIVE 5.1: CULTURALLY AND LINGUISTICALLY COMPETENT WORKFORCE

#### INDICATOR: TYPE OF CULTURAL COMPETENCY TRAINING AND ATTENDANCE

ANALYSIS: In FY 23/24, the MHP began offering the "Improving Cultural Competency for Behavioral Health Professionals" online training to all Kings County Behavioral Health providers, including contracted staff, as of July 24, 2023. This 5-hour course meets the current state requirement for enhancing cultural competency. While the training remains continuously available to accommodate new hires, the MHP initially had no mechanism to verify and track completion rates across its provider network. However, the recent implementation of the Relias online training platform will now enable systematic tracking of training participation. With this tool, the MHP can begin collecting and analyzing data on attendance and completion, paving the way for the development of meaningful metrics to measure cultural competency training compliance and its impact on service delivery.

ACTION: The MHP will fully integrate the cultural competency training into the Relias platform's tracking system, enabling the collection of attendance and completion data for all providers. Through this integration, the MHP can begin systematically monitoring and verifying that new hires, as well as existing staff, complete the required training. With these data in hand, the MHP will develop a standardized metric by Q3 FY 24/25 to measure compliance and guide ongoing efforts to ensure a culturally and linguistically competent workforce.

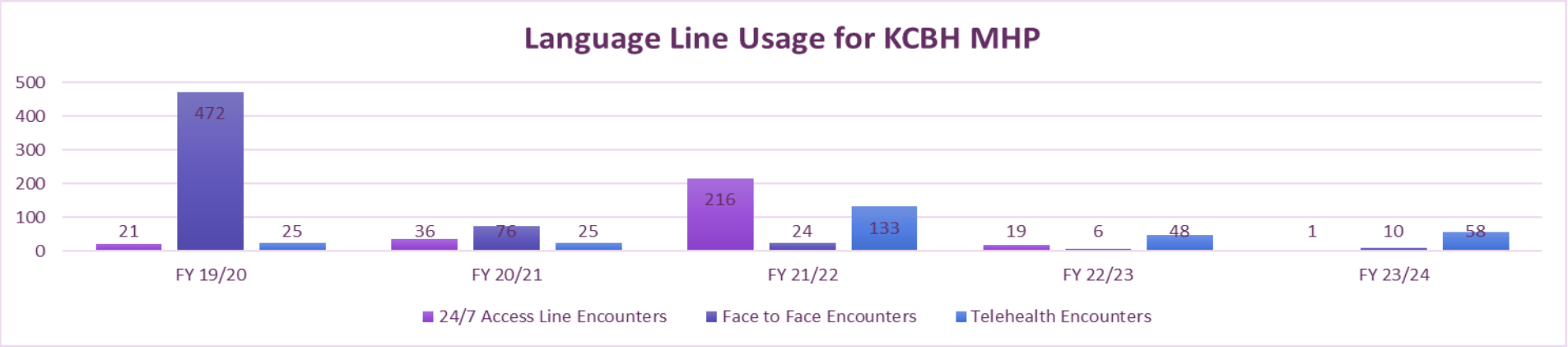
PRIOR YEAR ACTION AND RESULT: In FY 22/23, no formal metric existed for tracking cultural competency training. The MHP recognized the need for a measurable indicator but did not finalize or implement one. These lessons have informed the current strategy, resulting in the adoption of an online training platform capable of providing the necessary data to establish and monitor meaningful measures moving forward.

INDICATOR: LANGUAGE LINE UTILIZATION

ANALYSIS: Over the past five fiscal years, reported Language Line usage across the 24/7 Access Line, face-to-face, and telehealth encounters has fluctuated. FY 21/22 saw a spike in Access Line and telehealth usage, while face-to-face encounters declined steadily since FY 19/20. However, this data relied solely on self-reported provider numbers, likely underestimating true usage due to cumbersome tracking methods and a lack of integrated tools in the legacy EHR.

ACTION: The new EHR includes a dedicated field in both access logs and progress notes to capture Language Line usage, enabling the MHP to begin accurately tracking this data. To support this effort, the EHR and Quality Assurance teams will collaborate closely with providers, offering training and guidance to ensure proper documentation practices are understood and followed. In parallel, a new report is being developed to compile and interpret the collected data. Combined, these initiatives aim to unveil meaningful trends, highlight service gaps, and inform data-driven improvements moving forward.

PRIOR YEAR ACTION AND RESULT: In FY 22/23, the MHP recognized the need for a reliable metric but could not establish one due to reliance on self-reported data and the limitations of the legacy EHR. While the issues were acknowledged, no concrete action was taken ahead of the planned EHR transition. These challenges directly influenced the current year's strategy, leading to the EHR's new tracking capabilities and a clearer path toward meaningful data collection and analysis.

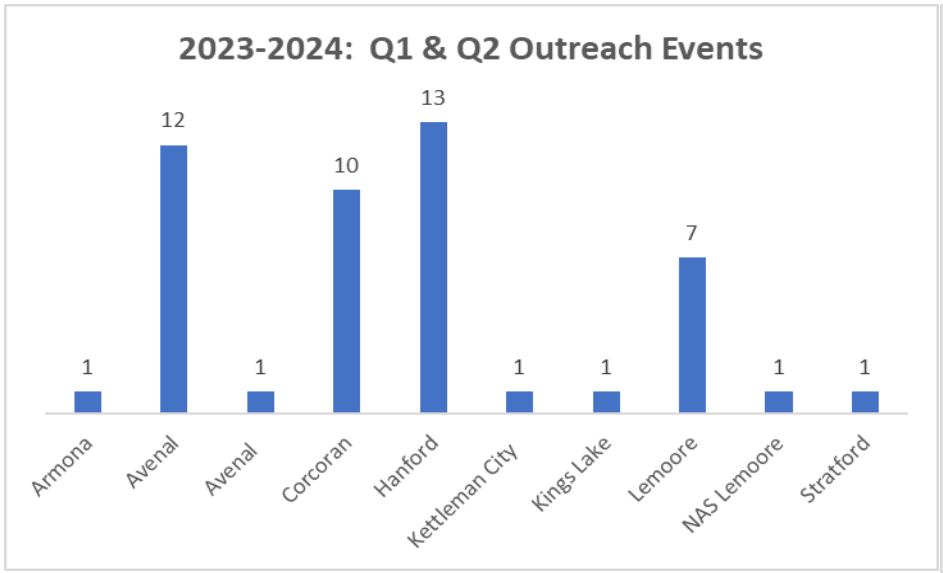



INDICATOR: COMMUNITY OUTREACH

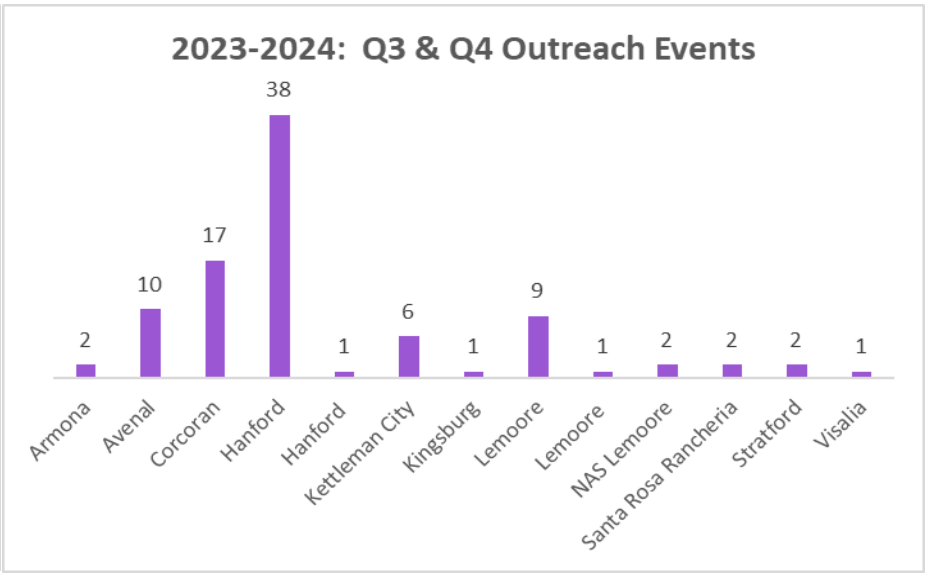
ANALYSIS: During FY 2023-2024 KCBH participated in a total of **140 OUTREACH EVENTS** throughout Kings County. The charts below show the number of events that were attended in Q1/Q2 & Q3/Q4 by city/community. Most of the outreach events occurred in the communities of Avenal, Corcoran, Hanford, and Lemoore. In Q3/Q4, there was an increase of outreach events attended in the target area of Kettleman City, as well as 2 outreach events at the Santa Rosa Rancheria.

ACTION: A metric for community outreach is still being determined, however the goal of the outreach team is to attend events targeting the most underserved and vulnerable populations, specifically where there is limited access to care, such as Avenal, Kettleman City, and Corcoran. Also, populations such as the Santa Rosa Rancheria and NAS Lemoore.

PRIOR YEAR ACTION AND RESULT: There was a significant increase in our participation at Community Outreach events, with 63 total events attended in FY 22-23 and 140 total events in FY 23-24.




TOTAL OF **48 OUTREACH EVENTS** ATTENDED IN Q1/Q2.




TOTAL OF **92 OUTREACH EVENTS** ATTENDED IN Q3/Q4.

# APPENDIX B

# Kings County Workforce Gaps

# Provider Survey

**BHSA Kings County Providers**
**Workforce Gaps Survey**

| Contracted Provider Name | Contact Name | Please select the current five positions with the greatest vacancy rates. | Please describe any other key workforce gaps in your programs contracted through Kings County Behavioral Health. |
|---|---|---|---|
| Turn BHS- KIND Center | Tracey Casillas | Licensed Marriage and Family Therapist;Licensed Clinical Social Worker;Mental Health Rehabilitation Specialist;Licensed Professional Clinical Counselor; | The majority of the vacancies that occurr are clinical LPHA positions, they are also the most challenging to fill once vacant. |
| Kings View | Lisa Rogers | Licensed Marriage and Family Therapist;Licensed Clinical Social Worker;Licensed Professional Clinical Counselor;Psychiatrist;Nurse Practitioner; | We need more clinicians to serve the consumers and licensed clinicians to assist with supervision. |
| TURN Kings County ACT | Deidriana Munguia | Licensed Clinical Social Worker;Licensed Marriage and Family Therapist;Licensed Professional Clinical Counselor;Medi-Cal Certified Peer Support Specialist; | Difficulty in retaining staff due to low pay and demanding job requirements. For licensed clinicians, there is a concern about significantly lower pay and low incentives to remain with KCA considering the intensity of services provided. As we gather more staff, morale does go up and the intensity of work to be done reduces with a more even caseload. During ramp up of hiring, it is difficult to treat clients while also supporting staff. I think there has been great improvements in hiring, for whatever reason, and we have been able to retain staff members coming up on one year of employment. We have gotten more county support on some client issues that makes staff feel supported as well. Having a helpful and supportive work environment goes a long way in this field so keeping the positive support from KCBH is a great way to help providers. Appreciate the time taken to get provider feedback on this issue. |
| WestCare | Sara Florez | Substance Use Disorder Counselor; | Lack of services for TAY population. Youth who age out from adolescent services and still need support in their recovery do not feel comfortable participating in adult programs. |
| Champions Recovery Alternative Prog | Jessika Schneider | Licensed Marriage and Family Therapist;Substance Use Disorder Counselor;Licensed Clinical Social Worker; | In the past, Champions has had difficulty recruiting qualified SUD counselors, especially bilingual counselors. It is difficult to contract with and retain licensed clinicians to serve as LPHAs in our program. |

# APPENDIX C

# Budget Template

**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 | ☑ | $ 256,618.39 | $ 264,316.94 | $ 272,246.45 | $ 153,971.04 | $ 158,590.17 | $ 163,347.87 | 200.00 | 120.00 |
| Early Intervention Services | ☑ | $ 14,727.88 | $ 15,169.72 | $ 15,624.81 | $ 1,794.96 | $ 1,848.81 | $ 1,904.27 | 100 | 80.00 |
| Outpatient Services | ☑ | $ 2,886,499.91 | $ 2,973,094.91 | $ 3,062,287.76 | $ 393,652.06 | $ 405,461.63 | $ 417,625.47 | 256 | 38.00 |
| Intensive Outpatient Services | ☑ | $ 14,616.71 | $ 15,055.21 | $ 15,506.87 | $ 27,406.33 | $ 28,228.52 | $ 29,075.38 | 20 | 100.00 |
| Crisis and Field-Based Services | ☐ | $ - | $ - | $ - | $ - | $ - | $ - | | |
| Residential Treatment Services | ☑ | $ 2,067,274.67 | $ 2,129,292.91 | $ 2,193,171.69 | $ - | $ - | $ - | 46 | 1.00 |
| Inpatient Services | ☐ | $ - | $ - | $ - | $ - | $ - | $ - | | |
| **Mental Health (MH) Services** | | | | | | | | | |
| Primary Prevention Services | ☐ | $ - | $ - | $ - | $ - | $ - | $ - | 0 | 0 |
| Early Intervention Services | ☑ | $ 1,721,217.98 | $ 1,755,642.34 | $ 1,790,755.18 | $ 244,873.81 | $ 249,771.28 | $ 254,766.71 | 4972 | 6323 |
| Outpatient and Intensive Outpatient Services | ☑ | $ 11,440,063.13 | $ 11,733,015.02 | $ 12,033,750.47 | $ 10,491,696.73 | $ 10,752,251.30 | $ 11,019,538.57 | 1624 | 1339 |
| Crisis Services | ☑ | $ 5,911,630.62 | $ 6,088,979.54 | $ 6,271,648.92 | $ 2,248,595.70 | $ 2,316,053.57 | $ 2,385,535.17 | 489 | 186 |
| Residential Treatment Services | ☐ | | | | | | | | |
| Hospital and Acute Services | ☑ | $ 5,038,530.87 | $ 5,189,686.80 | $ 5,345,377.40 | $ 903,460.71 | $ 930,564.53 | $ 958,481.47 | 145 | 26 |
| Subacute and Long-Term Care Services | ☑ | $ 7,863,211.71 | $ 8,099,108.06 | $ 8,342,081.30 | $ 1,391,718.89 | $ 1,433,470.45 | $ 1,476,474.57 | 226 | 40 |
| **Housing Services (MH + SUD)** | | | | | | | | | |
| Housing Services | ☐ | $ 4,325,718.83 | $ 4,455,490.40 | $ 4,589,155.11 | $ - | $ - | $ - | 250 | |
| **Total Projected Expenditures and Individuals Served** | | | | | | | | | |
| Total Projected Expenditures and Individuals Served (auto-populated) | | $ 41,540,110.70 | $ 42,718,851.84 | $ 43,931,605.97 | $ 15,857,170.22 | $ 16,276,240.25 | $ 16,706,749.48 | 8328 | 8253 |

**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 | $ - | $ 595,763.22 | $ 607,678.49 |
| Workforce Investment Activities | $ 4,997.00 | $ 5,096.94 | $ 5,198.88 |
| Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities) | $ 1,746,162.21 | $ 1,798,547.08 | $ 1,852,503.49 |
| Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs) | $ 4,208,692.21 | $ 4,292,866.05 | $ 4,378,723.37 |
| **Total Projected Expenditures** | | | |
| Total Projected Expenditures (auto-populated) | $ 5,959,851.42 | $ 6,692,273.29 | $ 6,844,104.23 |

**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 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 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 | $ 17,610,415.00 | $ 12,013,471.00 | $ 12,373,874.00 |
| 1991 Realignment (Bronzan-McCorquodale Act) | $ 5,653,587.44 | $ 5,823,195.06 | $ 5,997,890.92 |
| 2011 Realignment (Public Safety Realignment) | $ 6,898,137.29 | $ 7,105,081.41 | $ 7,318,233.85 |
| State General Fund | $ 1,740,449.51 | $ 1,792,663.00 | $ 1,846,442.89 |
| FFP (SMHS, DMC/DMC-ODS, NSMHS) | $ 26,313,977.11 | $ 27,590,536.81 | $ 28,286,854.57 |
| Projects for Assistance in Transition from Homelessness (PATH) | $ 41,160.00 | $ 41,160.00 | $ 41,160.00 |
| Community Mental Health Block Grant (MHBG) | $ 493,071.00 | $ 493,071.00 | $ 493,071.00 |
| Substance Use Block Grant (SUBG) | $ 884,480.00 | $ 884,480.00 | $ 884,480.00 |
| Commercial Insurance | $ 56,067.00 | $ 57,749.01 | $ 59,481.48 |
| County General Fund | $ 34,551.00 | $ 34,551.00 | $ 34,551.00 |
| Opioid Settlement Funds | $ 13,100.00 | $ - | $ - |
| **Other Funding Sources** | **Total Annual Projected Expenditures (Year One)** | **Total Annual Projected Expenditures (Year Two)** | **Total Annual Projected Expenditures (Year Three)** |
| Other federal grants | $ 17,682.00 | $ 17,682.00 | $ 17,682.00 |
| Other state funding (including DSH funding) | $ 1,586,252.00 | $ 1,633,839.56 | $ 1,682,854.75 |
| Other county mental health or SUD funding | $ 1,222,848.00 | $ 1,259,533.44 | $ 1,297,319.44 |
| 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)** | $ 62,565,777.35 | $ 58,747,013.29 | $ 60,333,895.89 |
| **Total Projected Expenditure Variance** | $ (791,355.00) | $ (6,940,352.10) | $ (7,148,563.80) |
| **Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures** | $ 57,397,280.93 | $ 58,995,092.10 | $ 60,638,355.46 |
| **Auto-validation: Table 2: Other County Expenditures** | $ 5,959,851.42 | $ 6,692,273.29 | $ 6,844,104.23 |

**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) | $ 3,499,069.62 | $ 4,082,247.89 | $ 4,082,247.89 | $ 11,663,565.39 |
| Year Two Component Allocation (dollars) | $ 3,604,041.70 | $ 4,204,715.32 | $ 4,204,715.32 | $ 12,013,472.35 |
| Year Three Component Allocation (dollars) | $ 3,712,162.96 | $ 4,330,856.78 | $ 4,330,856.78 | $ 12,373,876.52 |

| 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) | $ 3,499,069.62 | $ 4,082,247.89 | $ 4,082,247.89 | $ 11,663,565.39 |
| Unspent Mental Health Services Act (MHSA) to BHSA | $ 833,489.94 | $ 2,212,399.03 | $ 2,900,964.98 | $ 5,946,853.95 |
| Excess Prudent Reserve (PR) to BHSA | $ - | $ - | $ - | $ - |

| BHSA Transfers<br>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) | $ 3,604,041.70 | $ 4,204,715.32 | $ 4,204,715.32 | $ 12,013,472.35 |

| BHSA Transfers<br>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) | $ 3,712,162.96 | $ 4,330,856.78 | $ 4,330,856.78 | $ 12,373,876.52 |

**Funding Transfer Request Allocations**

| Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption<br>(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% | $ 3,499,069.62 |
| Percentage Reduced | 0% | $ - |
| Percentage Added | 0% | $ - |
| New Housing Interventions Base Percentage (auto-populated) | 30% | $ 3,499,069.62 |
| **Transferred To/From** | **Full Service Partnership Percentage (Year One)** | **Full Service Partnership Funds (Year One)** |
| Base Percentage and Funding | 35% | $ 4,082,247.89 |
| Percentage Reduced | 0% | $ - |
| Percentage Added | 0% | $ - |
| New FSP Base Percentage (auto-populated) | 35% | $ 4,082,247.89 |
| **Transferred To/From** | **Behavioral Health Services and Support Percentage (Year One)** | **Behavioral Health Services and Support Funding (Year One)** |
| Base Percentage and Funding | 35% | $ 4,082,247.89 |
| Percentage Reduced | 0% | $ - |
| Percentage Added | 0% | $ - |
| New BHSS Base Percentage (auto-populated) | 35% | $ 4,082,247.89 |

| 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% | $ 3,604,041.70 |
| Percentage Reduced | 0% | $ - |
| Percentage Added | 0% | $ - |
| New Housing Interventions Base Percentage (auto-populated) | 30% | $ 3,604,041.70 |
| **Transferred To/From** | **Full Service Partnership Percentage (Year Two)** | **Full Service Partnership Funds (Year Two)** |
| Base Percentage and Funding | 35% | $ 4,204,715.32 |
| Percentage Reduced | 0% | $ - |
| Percentage Added | 0% | $ - |
| New FSP Base Percentage (auto-populated) | 35% | $ 4,204,715.32 |
| **Transferred To/From** | **Behavioral Health Services and Support Percentage (Year Two)** | **Behavioral Health Services and Support Funding (Year Two)** |
| Base Percentage and Funding | 35% | $ 4,204,715.32 |
| Percentage Reduced | 0% | $ - |
| Percentage Added | 0% | $ - |
| New BHSS Base Percentage (auto-populated) | 35% | $ 4,204,715.32 |

| 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% | $ 3,712,162.96 |
| Percentage Reduced | 0% | $ - |
| Percentage Added | 0% | $ - |
| New Housing Interventions Base Percentage (auto-populated) | 30% | $ 3,712,162.96 |
| **Transferred To/From** | **Full Service Partnership Percentage (Year Three)** | **Full Service Partnership Funds (Year Three)** |
| Base Percentage and Funding | 35% | $ 4,330,856.78 |
| Percentage Reduced | 0% | $ - |
| Percentage Added | 0% | $ - |
| New FSP Base Percentage (auto-populated) | 35% | $ 4,330,856.78 |

| Transferred To/From | Behavioral Health Services and Support Percentage (Year Three) | Behavioral Health Services and Support Funding (Year Three) |
|---|---|---|
| Base Percentage and Funding | 35% | $ 4,330,856.78 |
| Percentage Reduced | 0% | $ - |
| Percentage Added | 0% | $ - |
| New BHSS Base Percentage (auto-populated) | 35% | $ 4,330,856.78 |

| Funding Transfers (Year Three) | | | | |
|---|---|---|---|---|
| | Housing Intervention (Year Three) (1) | Full-Service Partnership (Year Three) | Behavioral Health Services and Support (Year Three) | Validation |
| Base Percentage after Housing Intervention Component Exemption (auto-populated) | 30% | 35% | 35% | Row Equals 100% |
| Amount Transferring Out | 0% | 0% | 0% | Row Does Not Exceed 14% |
| Amount Transferring In | 0% | 0% | 0% | Transfers Out and In Equal |
| New Base Percentage after Funding Transfer Request (auto-populated) | 30% | 35% | 35% | Row Equals 100% |

| MHSA Transfers to BHSA | | | | |
|---|---|---|---|---|
| MHSA Component | Available Unspent BHSA Funds | Transferred to Housing Intervention | Transferred to Full-Service Partnership | Transferred to Behavioral Health Services and Support |
| CSS | $ 2,212,399.03 | $ - | $ 2,212,399.03 | $ - |
| PEI | $ 3,279,537.34 | $ 833,489.94 | $ - | $ 2,446,047.40 |
| Encumbered INN | $ 454,917.58 | $ - | $ - | $ 454,917.58 |
| Unencumbered INN | $ - | $ - | $ - | $ - |
| WET | $ - | | | $ - |
| CFTN | $ - | | | $0.00 |
| Total (auto-populated) | $ 5,946,853.96 | $ 833,489.94 | $ 2,212,399.03 | $ 2,900,964.98 |

| 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 | $ 1,184,797.32 |
| Local Prudent Reserve Maximum (2) | $ 3,102,252.25 |
| Excess Prudent Reserve Funding that must be transferred | **$ (1,917,454.93)** |
| 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) | $ 3,499,069.00 | $ 3,604,041.00 | $ 3,712,162.00 |
| Transfers into Housing Intervention component from Local Prudent Reserve | $ - | $ - | $ - |
| Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds) | $ 833,489.94 | $ - | $ - |

| Total Estimated Housing Intervention Funding (BHSA + MHSA Funds) | $ 4,332,558.00 | $ 3,604,041.00 | $ 3,712,162.00 | | | |
|---|---|---|---|---|---|---|
| **Housing Interventions Category** | | | | | | |
| **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 - 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 | $ - | $ - | $ - | $ - | $ - | $ - |
| Operating Subsidies | $ - | $ - | $ - | $ - | $ - | $ - |
| Bundled Rental and Operating Subsidies | $ 236,410.40 | $ 241,138.61 | $ 245,961.38 | $ - | $ - | $ - |
| % of Rental and Operating Subsidies Administered through Flex Pools | 0% | 0% | 0% | 0% | 0% | 0% |
| Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2) | | | | | | |
| Rental Subsidies | $ - | $ - | $ - | $ - | $ - | $ - |
| Operating Subsidies | $ - | $ - | $ - | $ - | $ - | $ - |
| Bundled Rental and Operating Subsidies | $ 2,520,437.22 | $ 2,570,845.96 | $ 2,622,262.88 | $ - | $ - | $ - |
| % of Rental and Operating Subsidies Administered through Flex Pools | 0% | 0% | 0% | 0% | 0% | 0% |
| **Other Housing Interventions** | | | | | | |
| Other Housing Supports: Landlord Outreach and Mitigation Funds (2) | $ 703,274.60 | $ 703,274.60 | $ 703,274.60 | $ - | $ - | $ - |
| Other Housing Supports: Participant Assistant Funds (2) | $ 56,263.23 | $ 57,388.50 | $ 58,536.27 | $ - | $ - | $ - |
| Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2) | $ - | $ - | $ - | $ - | $ - | $ - |
| Other Housing Supports: Outreach and Engagement (2) | $ - | $ - | $ - | $ - | $ - | $ - |
| Capital Development Projects | $ - | $ - | $ - | $ - | $ - | $ - |
| Housing Flex Pool Expenditures (start-up expenditures) | $ - | $ - | $ - | $ - | $ - | $ - |
| BHSA Innovative Housing Intervention Pilots and Projects | $ - | $ - | $ - | $ - | $ - | $ - |
| MHSA INN Projects | $ - | $ - | $ - | $ - | $ - | $ - |
| **Subtotal (auto-populated)** | $ 3,516,385.45 | $ 3,572,647.67 | $ 3,630,035.13 | $ - | $ - | $ - |
| **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 | $ 625,988.67 | $ 638,508.45 | $ 651,278.62 |
| **Total Housing Interventions Expenditures (auto-populated)** | $ 4,142,374.12 | $ 4,211,156.12 | $ 4,281,313.75 |
| **Housing Interventions Populations to be Served** | **Year One** | **Year Two** | **Year Three** |
| Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5) | $ 3,143,506.89 | $ 3,206,377.03 | $ 3,270,504.57 |
| Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5) | $ - | $ - | $ - |
| **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) | 0.0% | 0.0% | 0.0% |
| Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated) | 72.6% | 89.0% | 88.1% |
| Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated) | 0.0% | 0.0% | 0.0% |
| **Projected Individuals to be Served (Unduplicated)** | **Year One** | **Year Two** | **Year Three** |
| Eligible Children/TAY (25 years and younger) | 20 | 20 | 20 |
| Eligible Adults/Older Adults | 200 | 200 | 200 |
| **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) | $ 4,082,247.00 | $ 4,204,715.00 | $ 4,330,856.00 |
| Transfers into Full Service Partnership component from Local Prudent Reserve | $ - | $ - | $ - |
| Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds) | $ 2,212,399.03 | | |
| **Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)** | $ 6,294,646.00 | $ 4,204,715.00 | $ 4,330,856.00 |

**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) | $ 402,705.66 | $ 418,361.21 | $ 426,728.43 | $ 1,061,678.55 | $ 1,102,952.28 | $ 1,125,011.32 | $ 72,375.44 | $ 72,375.44 | $ 72,375.44 |
| Forensic Assertive Community Treatment (FACT) Fidelity (2) | $ 202,905.19 | $ 209,180.60 | $ 213,364.22 | $ 534,931.85 | $ 551,476.14 | $ 562,505.66 | $ 36,187.72 | $ 36,187.72 | $ 36,187.72 |
| FSP Intensive Case Management | $ 1,366,734.99 | $ 1,304,003.28 | $ 1,327,388.07 | $ 4,023,946.88 | $ 4,148,398.85 | $ 4,231,366.82 | $ 272,216.84 | $ 272,216.84 | $ 272,216.84 |
| High Fidelity Wraparound | $ 195,584.75 | $ 201,633.76 | $ 205,666.44 | $ 515,632.52 | $ 531,579.92 | $ 542,211.52 | $ - | $ - | $ - |
| Individual Placement and Support (IPS) Model of Supported Employment (2) | $ 261,677.01 | $ 269,527.32 | $ 277,613.14 | $ - | $ - | $ - | $ - | $ - | $ - |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Assertive Field-Based Initiation for SUD Treatment Services | $ 1,300,000.00 | $ 800,000.00 | $ 800,000.00 | $ - | $ - | $ - | $ - | $ - | $ - |
| Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define | $ 285,693.90 | $ 294,264.72 | $ 303,092.66 | $ - | $ - | $ - | $ 285,693.90 | $ 294,264.72 | $ 303,092.66 |
| BHSA Innovative FSP Pilots and Projects | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| MHSA INN Projects | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| **Subtotal (auto-populated)** | $ 4,015,301.49 | $ 3,496,970.89 | $ 3,553,852.95 | $ 6,136,189.81 | $ 6,334,407.18 | $ 6,461,095.32 | $ 666,473.90 | $ 675,044.72 | $ 683,872.66 |

| **FSP Transfer Information** | **Year One** | **Year Two** | **Year Three** |
|---|---|---|---|
| Transfers out of FSP component into Local Prudent Reserve | $ - | $ - | $ - |

| **FSP Administrative Information** | **Year One** | **Year Two** | **Year Three** |
|---|---|---|---|
| FSP Component Admin Expenses | $ 1,903,647.05 | $ 1,941,719.99 | $ 1,980,554.39 |
| **Total Full Service Partnership Expenditures (auto-populated)** | $ 5,918,948.54 | $ 5,438,690.88 | $ 5,534,407.34 |

| **Projected Individuals to be Served (Unduplicated)** | **Year One** | **Year Two** | **Year Three** |
|---|---|---|---|
| Eligible Children/TAY (25 years and younger) | 248 | 248 | 248 |
| Eligible Adults/Older Adults | 550 | 550 | 550 |

| **Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)** | **Year One** | **Year Two** | **Year Three** |
|---|---|---|---|
| MHSA "Encumbered" INN | $ - | $ - | $ - |

| **References** |
|---|
| 1. W&I Code § 5892, subdivision (a)(2)(A) states 35% of BHS funds distributed to counties shall be used for Full Service Partnership Programs. |
| 2. May be bundled or un-bundled depending on county BH-CONNECT opt-in. |

**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 Components**

| | Total Behavioral Health Services and Supports (BHSS) Funding (Year One) | Total Behavioral Health Services and Supports (BHSS) Funding (Year Two) | Total Behavioral Health Services and Supports (BHSS) Funding (Year Three) |
|---|---|---|---|
| Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds) | $ 4,082,247.00 | $ 4,204,715.00 | $ 4,330,856.00 |
| 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) | $ 2,900,964.98 | $ - | $ - |
| **Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)** | $ 6,983,211.00 | $ 4,204,715.00 | $ 4,330,856.00 |

**Behavioral Health Services and Supports Category (1)**

| Type of Service | Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One) | Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two) | Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three) | Projected Expenditures - Federal Financial Participation (Year One) | Projected Expenditures - Federal Financial Participation (Year Two) | Projected Expenditures - Federal Financial Participation (Year Three) | Projected Expenditures - All Other Funding Sources (Year One) | Projected Expenditures - All Other Funding Sources (Year Two) | Projected Expenditures - All Other Funding Sources (Year Three) |
|---|---|---|---|---|---|---|---|---|---|
| **BHSS Programs/Services** | | | | | | | | | |
| Children's System of Care-Non FSP (25 years and younger) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP | $ 274,852.50 | $ 224,007.81 | $ 228,487.97 | $ - | $ - | $ - | $ - | $ - | $ - |
| Early Intervention Expenditures | $ 3,600,068.70 | $ 2,865,105.17 | $ 2,917,989.26 | $ - | $ - | $ - | $ - | $ - | $ - |
| Coordinated Specialty Care for First Episode Psychosis | $ 220,901.00 | $ 220,901.00 | $ 220,901.00 | | | $ - | $ - | $ - | $ - |
| All Other EI Expenditures | $ 3,379,167.70 | $ 2,644,204.17 | $ 2,697,088.26 | $ - | $ - | $ - | $ - | $ - | $ - |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Outreach and Engagement | $ 303,939.03 | $ 310,017.81 | $ 316,218.17 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Workforce Education and Training (WET) | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Dedicated BHSA WET funds | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Dedicated MHSA WET funds | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Capital Facilities and Technological Needs (CFTN) | $ - | $ 595,763.22 | $ 607,678.49 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Dedicated BHSA CF/TN funds | $ - | $ 595,763.22 | $ 607,678.49 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| Dedicated MHSA CF/TN funds | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| BHSA Innovative BHSS Pilots and Projects | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| MHSA INN Projects | $ 584,081.59 | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - | $ - |
| **Subtotal (auto-populated)** | $ 4,762,941.83 | $ 3,994,894.02 | $ 4,070,373.88 | $ - | $ - | $ - | $ - | $ - | $ - | $ - |

| **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 | $ 912,816.43 | $ 771,683.90 | $ 787,117.58 |
| Total Behavioral Health Services and Supports Expenditures (auto-populated) | $ 5,675,758.26 | $ 4,766,577.92 | $ 4,857,491.46 |

| **Youth-Focused Early Intervention Expenditures** | **Year One** | **Year Two** | **Year Three** |
|---|---|---|---|
| Total Youth-Focused (25 years and younger) Early Intervention Expenditures | $ 1,956,074.46 | $ 1,765,530.73 | $ 1,800,841.35 |

| **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) | 55.1% | 66.1% | 65.4% |
| Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3) | 54.3% | 61.6% | 61.7% |

| **Projected Individuals to be Served (Unduplicated)** | **Year One** | **Year Two** | **Year Three** |
|---|---|---|---|
| Eligible Children/TAY (25 years and younger) | 9366 | 6472 | 6472 |
| Eligible Adults/Older Adults | 6814 | 3221 | 3221 |

| **Projected BHSS Funds transferred to WET or CF/TN** | **Year One** | **Year Two** | **Year Three** |
|---|---|---|---|
| BHSS transfer to WET | $ - | $ - | $ - |
| BHSS transfer to CF/TN | $ - | $ 595,763.22 | $ 607,678.49 |

| **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 | $ - | $ - | $ - |
| MHSA "Encumbered" INN | $ 454,917.58 | $ (129,164.01) | $ (129,164.01) |

| References |
| --- |
| 1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS). |
| 2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs. |
| 3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger. |
| 4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds. |
| 5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion. |

**Instructions**

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in 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 Administration | | | |
|---|---|---|---|
| **INTEGRATED PLAN ADMINISTRATION AND MONITORING** | **Year One** | **Year Two** | **Year Three** |
| Total Projected Improvement and Monitoring Expenditures | $ 56,922.00 | $ 58,630.00 | $ 60,389.00 |
| Total Projected County Integrated Plan Annual Planning Expenditures | $ 378,868.00 | $ 390,234.00 | $ 401,941.00 |
| New and Ongoing Administrative Costs | $ 77,287.00 | $ 79,606.00 | $ 81,994.00 |
| **Select County Population Size:** | Less than 200k | | |
| **Administrative Information Validation** | | | |
| Total Projected Annual Revenues of Local Behavioral Health Services Fund | $ 13,780,435.00 | $ 13,130,343.00 | $ 13,490,746.00 |
| Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated) | 0.4% | 0.4% | 0.4% |
| Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated) | 2.7% | 3.0% | 3.0% |
| **Admin Spending Overages (in Dollars)** | | | |
| Improvement & Monitoring | $ - | $ - | $ - |
| Planning | $ - | $ - | $ - |
| **Total** | **$ -** | **$ -** | **$ -** |

| References |
|---|
| 1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision. |

**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 | $ 1,184,797.32 |
| Local Prudent Reserve Maximum (1) | $ 3,102,252.25 |
| Excess Prudent Reserve Funds (auto-populated) | $ (1,917,454.93) |
| 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 | $ 3,499,069.00 | $ 4,082,247.00 | $ 4,082,247.00 | $ 11,663,563.00 |
| **Year Two** | | | | |
| Allocation Percentage, with Transfers | 30% | 35% | 35% | 100% |
| Component Allocations | $ 3,604,041.00 | $ 4,204,715.00 | $ 4,204,715.00 | $ 12,013,471.00 |
| **Year Three** | | | | |
| Allocation Percentage, with Transfers | 30% | 35% | 35% | 100% |
| Component Allocations | $ 3,712,162.00 | $ 4,330,856.00 | $ 4,330,856.00 | $ 12,373,874.00 |

| BHSA Funding Summary (Year One) | | | | |
|---|---|---|---|---|
| | Housing Interventions (Year One) | Full Service Partnerships (Year One) | Behavioral Health Services and Supports (Year One) | Year One Totals |
| Estimated Year One Component Allocations *(BHSA Funding Only)* | $ 3,499,069.00 | $ 4,082,247.00 | $ 4,082,247.00 | $ 11,663,563.00 |
| Transfers From PR Into Component | $ - | $ - | $ - | $ - |
| Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)* | $ 833,489.94 | $ 2,212,399.03 | $ 2,900,964.98 | $ 5,946,853.95 |
| Estimated Total Available Funding for Year One | $ 4,332,558.94 | $ 6,294,646.03 | $ 6,983,211.98 | $ 17,610,416.95 |
| Transfers from Component Into PR | $ - | $ - | $ - | $ - |
| Estimated Total Year One Expenditures | $ 4,142,374.12 | $ 5,918,948.54 | $ 5,675,758.26 | $ 15,737,080.91 |

| BHSA Funding Summary (Year Two) | | | | |
|---|---|---|---|---|
| | Housing Interventions (Year Two) | Full Service Partnerships (Year Two) | Behavioral Health Services and Supports (Year Two) | Year Two Totals |
| Estimated New Year Two Component Allocations *(BHSA Funding Only)* | $ 3,604,041.00 | $ 4,204,715.00 | $ 4,204,715.00 | $ 12,013,471.00 |
| Transfers From PR Into Component | $ - | $ - | $ - | $ - |
| Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) | $ 190,184.82 | $ 375,697.49 | $ 1,307,453.73 | $ 1,873,336.04 |
| Estimated Total Available Funding for Year Two | $ 3,794,225.82 | $ 4,580,412.49 | $ 5,512,168.73 | $ 13,886,807.04 |
| Transfers from Component Into PR | $ - | $ - | $ - | $ - |
| Estimated Total Year Two Expenditures | $ 4,211,156.12 | $ 5,438,690.88 | $ 4,766,577.92 | $ 14,416,424.91 |

| BHSA Funding Summary (Year Three) | | | | |
|---|---|---|---|---|
| | Housing Interventions (Year Three) | Full Service Partnerships (Year Three) | Behavioral Health Services and Supports (Year Three) | Year Three Totals |

| | | | | |
|---|---|---|---|---|
| Estimated New Year Three Component Allocations *(BHSA Funding Only)* | $ 3,712,162.00 | $ 4,330,856.00 | $ 4,330,856.00 | $ 12,373,874.00 |
| Transfers From PR Into Component | $ - | $ - | $ - | $ - |
| Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) | $ (416,930.30) | $ (858,278.39) | $ 745,590.81 | $ (529,617.87) |
| Estimated Total Available Funding for Year Three | $ 3,295,231.70 | $ 3,472,577.61 | $ 5,076,446.81 | $ 11,844,256.13 |
| Transfers from Component Into PR | $ - | $ - | $ - | $ - |
| Estimated Total Year Three Expenditures | $ 4,281,313.75 | $ 5,534,407.34 | $ 4,857,491.46 | $ 14,673,212.55 |

| **BHSA Plan Admin Expenses** | | | | |
|---|---|---|---|---|
| **Plan Admin Category** | **Year One** | **Year Two** | **Year Three** | **Total** |
| Total Projected Improvement and Monitoring Expenditures | $ 56,922.00 | $ 58,630.00 | $ 60,389.00 | $ 175,941.00 |
| Total Projected County Integrated Plan Annual Planning Expenditures | $ 378,868.00 | $ 390,234.00 | $ 401,941.00 | $ 1,171,043.00 |
| Total Projected New and Ongoing Administrative Expenditures | $ 77,287.00 | $ 79,606.00 | $ 81,994.00 | $ 238,887.00 |

| Budget Template Updates | | | |
|---|---|---|---|
| **Version** | **Revision Date** | **Description of Changes** | **Effective Date of Change** |
| 2.0 | 10/25/2025 | Tab 10 (BHSA Summary): Formula updated to avoid double counting of MHSA unspent carryover funds. | 10/25/2025 |
| 2.0 | 10/25/2025 | Tab 7 (BHSS): EI Threshold calculation should exclude MHSA transferred WET and CFTN funds as they are exempt from suballocation requirements, formula revised to remove WET and CFTN. Added a BHSS transfer to WET/CFTN for reversion tracking. | 10/25/2025 |
| 2.0 | 10/25/2025 | Tab 8 (BHSA Plan Admin): Updated instructions to clarify DHCS will not pre-populate data for "Total Projected Annual Revenues of BHSF". Counties must enter in the data. | 10/25/2025 |
| 2.0 | 10/25/2025 | Tab 5, 6, 7 (BHSA Conponents): Added unspent MHSA funds row for year 1, 2 and 3. | 10/25/2025 |
| 2.0 | 10/25/2025 | Tab 7 (BHSS): Added separate rows for unspent MHSA WET/CFTN expenditures. | 10/25/2025 |
| 2.0 | 10/25/2025 | Tabs 1-10: Fixed formula and instruction errors | 10/25/2025 |
| 3.0 | 2/18/2026 | Tab 4 (BHSA Transfers): Added Year 2 and Year 3 for exemption requests | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 4 (BHSA Transfers): Added validation check for funding transfers | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 4 (BHSA Transfers): Added two new rows for unspent MHSA “Encumbered” INN Funds and unspent MHSA “Unencumbered” INN Funds. | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 5, 6 and 7 (BHSA Components): Moved transfers from prudent reserve into the BHSA component funding section to be included with total revenue | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 5, 6 and 7 (BHSA Components): Added a row for projected MHSA “Encumbered” INN Project expenditures. | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 5 (Housing Interventions): Removed projected encumbered MHSA INN fund expenditures from the 50% HI funds dedicated to chronically homeless suballocation requirement calculation. | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 7 (BHSS): Removed projected encumbered MHSA INN fund expenditures from the 51% BHSS funds dedicated to Early Intervention suballocation requirement calculation | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 8 (BHSA Plan Admin): Updated to include a validation check for “Improvement and Monitoring” (2% or 4%) and “Planning” (5%) | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 9 (Prudent Reserve Assessment): Updated PR validation checks to “No Excess” or “Reduce Excess” | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 10 (BHSA Summary): Included component percentage breakdowns for all three years | 2/18/2026 |
| 3.0 | 2/18/2026 | Tab 10 (BHSA Summary): Include total administrative and planning expenditures from tab 8 | 2/18/2026 |