BEHAVIORAL HEALTH SERVICES ACT
ALAMEDA COUNTY
INTEGRATED PLAN (DRAFT)
FY 2026-2029

BEHAVIORAL HEALTH SERVICES ACT (BHSA) DIVISION
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE DEPARTMENT
RELEASED FOR PUBLIC COMMENT: MARCH 19, 2026 - APRIL 20, 2026
HEARING: APRIL 20, 2026

Behavioral Health Department
Alameda County Health

Behavioral Health Department
Alameda County Health

ALAMEDA COUNTY
BEHAVIORAL HEALTH SERVICES ACT (BHSA)
INTEGRATED PLAN FISCAL YEARS 2026-2029 (DRAFT)

Public Comment Period: March 19, 2026 – April 20,2026

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Introduction

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. Whereas the Three-Year Program and Expenditure Plan required under the Mental Health Services Act (MHSA) focused exclusively on MHSA dollars, the BHSA establishes the IP to serve as a three-year prospective global spending plan that describes how county behavioral health departments plan to use all available behavioral health funding, including BHSA, 1991 and 2011 Realignment, federal grant programs, federal financial participation from Medi-Cal, opioid settlement funds, local funding, and other funding to meet statewide and local outcome measures, reduce disparities, and address the unmet need in their community. The Department of Health Care Services (DHCS) is developing an IP Template which will include the required elements for each county to submit in their IPs. Counties will submit the IP through a DHCS web-based county portal.

Integrated Plans require counties to conduct a thorough data-informed local service planning process and provide transparency into county planning for expending BHSA funding and all other behavioral health funding sources overseen by counties. All BHSA services and programming must be planned in accordance with local data. Integrated Plans will also facilitate local and statewide data collection by providing baseline data on services and planned expenditures and supporting analysis of county goals and outcomes.

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Executive Summary

Welcome to the BHSA Integrated Plan for Fiscal Years 2026-2029

The Alameda County Behavioral Health Department is pleased to present the Behavioral Health Services Act Integrated Plan for fiscal years 2026-2029. In March 2024, the California voters passed Proposition 1, which includes the Behavioral Health Services Act (BHSA). The Behavioral Health Services Act (BHSA) also known as Proposition 1 replaces the Mental Health Services Act (MHSA) beginning on July 1, 2026. BHSA is a one percent tax on personal annual incomes exceeding one million dollars. BHSA requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes.

BHSA funding components will replace MHSA funding components. The new BHSA funding components include (1) Housing Interventions (30%), (2) Full-Service Partnerships (35%) and (3) Behavioral Health Services & Supports (35%).

In accordance with the BHSA, the Integrated Plan provides a description of how Alameda County will plan expenditures across a range of behavioral health funding sources and deliver high-quality, culturally responsive, and timely care along the Behavioral Health Care Continuum for fiscal years 2026-2029. The Integrated Plan will also facilitate local and statewide data collection by providing baseline data on services and planned expenditures and supporting analysis of county goals and outcomes.

A Broader Behavioral Health System

The Behavioral Health Services Act aims to build upon existing efforts to support vulnerable populations with severe mental health conditions and substance use disorders (SUDs), focusing specifically on individuals with the most significant needs. BHSA shifts focus from shift from prevention, intervention, and treatment across the mental health spectrum to focus on the most severely mentally ill individuals. BHSA also introduces strategies and resources to address housing stability, substance use disorders, initiatives to increase accountability and transparency, and early intervention programming to prevent mental illness and substance use disorders from becoming severe and disabling.

- The Behavioral Health Services Act allows for the inclusion of substance use disorder (SUD) services as a core part of the system. The Integrated Plan details Alameda County's approach to strengthening coordination across SUD prevention, treatment,

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recovery, and crisis services to better meet community needs. Included are strategies to 1) Targeted outreach, 2) Mobile field based programs, and 3) Open-access clinics.

- Housing is a key part of behavioral health care, and under BHSA this will not be a separate service but integrated throughout behavioral health service offerings. The Integrated Plan focuses on housing supports paired with services for people with the highest behavioral health needs.

- Early Intervention which is a subcomponent focuses on reaching people before needs become more severe. Community based approaches are emphasized to support youth, families, and priority populations early on before behavioral health issues become debilitating. Early Intervention is separated in two different populations: Adults/Older Adults over 25 and TAY/Youth under 25 years old. Programs must offer: 1) Outreach, 2) Access and Linkage, and 3) Treatment Services and Supports.

- Although separate from BHSA but included in Proposition 1, the Behavioral Health Continuum Infrastructure Program (BHCIP) funds expansion and improvement of behavioral health facilities across Alameda County. These investments increase capacity and support services where gaps have been identified.

BHSA expansion of the Community Program Planning Process

The Integrated Plan requires a thorough data-informed local service planning process and to provide transparency into county planning for BHSA funding and all other behavioral health funding sources overseen by counties. BHSA requires community engagement with an expanded list of 24 stakeholder groups and 5 diverse viewpoints. To engage stakeholders, Alameda County conducted listening sessions, surveys, and key informant interviews throughout each Board of Supervisor district.

ACBHD is committed to incorporating meaningful stakeholders and community feedback in areas such as mental health and substance use disorder policy, program planning and implementation, monitoring, workforce, quality improvement, evaluation, health equity, and budget allocations.

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Fiscal Reporting

Whereas the Three-Year Program and Expenditure Plan required under the Mental Health Services Act (MHSA) focused exclusively on MHSA dollars, the BHSA establishes the Integrated Plan to serve as a three-year prospective global spending plan that describes how county behavioral health departments plan to use all available behavioral health funding, including BHSA, 1991 and 2011 Realignment, federal grant programs, federal financial participation from Medi-Cal, opioid settlement funds, local funding, and other funding to meet statewide and local outcome measures, reduce disparities, and address the unmet need in their community.

The BHSA fund is 20% of the overall ACBHD budget. ACBHD has set aside up to $164,470,669 million in budget authority.

Closing

The first Three Year Integrated Plan will be submitted to California Department of Health Care Services on July 1, 2026, following the review and approval by the Alameda County Chief Administrative Officer and the Alameda County Board of Supervisors. The Integrated Plan outlines funding, program oversight, transparency requirements and the new Community Program Planning Process. The Integrated Plan was publicly shared for comment from March 19, 2026-April 20, 2026.

The Alameda County Behavioral Health Department, similar to all counties in California, is traversing through the behavioral health transformation, a major transition, and we are prepared to implement the Behavioral Health Services Act in July 2026. BHSA brings both challenges and opportunities, including the strengthening of Full Service Partnerships, the inclusion of services for SUD clients, and the expansion of housing interventions to those in need. Throughout the MHSA to BHSA transition and the development of the first BHSA Integrated Plan, our priority remains building a sustainable system that supports the health and well-being of the people and the communities we serve.

The Integrated Plan reflects the voices of Alameda County's diverse communities, stakeholders, advocates and providers. We are grateful for this collective input and look forward to continuing the work together in partnership with our community as we move ahead.

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General Information

County, City, Joint Powers, or Joint Submission: **County**

Entity Name: **Alameda County**

Behavioral Health Agency Name: **Alameda County Behavioral Health Care Department**

Behavioral Health Agency Mailing Address: **2000 Embarcadero Cove, Suite 400 Oakland, CA 94606**

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Quality Assurance or Quality Improvement (QA/QI) lead

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County Behavioral Health System Overview

The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders.

Populations Served by County Behavioral Health System

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

Children and Youth

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

Table 5. Number of Children and Youth Served

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	**8,612**
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	**32**
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	**271**
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	**113**

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Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	**47**
Were chronically homeless or experiencing homelessness or at risk of homelessness	**101**
Were in the juvenile justice system	**652**
Have reentered the community from a youth correctional facility	**593**
Were served by the Mental Health Plan and had an open child welfare case	**771**
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	**10**
Have received acute psychiatric care	**685**

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Adults and Older Adults

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

Table 6. Adults and Older Adults Served

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	**3,309**
Received Medi-Cal Specialty Mental Health Services (SMHS)	**17,286**
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	**5,437**
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	**1,723**
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	**2,082**
Experienced unsheltered homelessness	**930**
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	**196**

Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	**170**
Were in the justice system (on parole or probation and not currently incarcerated)	**1,077**
Were incarcerated (including state prison and jail)	**7,084**
Reentered the community from state prison or county jail	**6,515**
Received acute psychiatric services	**3,933**

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

Admitted or detained for 72-hour evaluation and treatment rate	**12,748**
Admitted for 14-day and 30-day periods of intensive treatment	**2,850**
Admitted for 180-day post certification intensive treatment	**000**

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

Total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs	**19**

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

Total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)	**6**

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

FY23/24 data was used. For the 180 day post certification treatment, Alameda County was not using this type of hold.

County Behavioral Health Technical Infrastructure

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

Yes

Please select which of the following EHRs the county uses

Clinician's Gateway

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

https://www.acbhcs.org/plan-administration/health-records-request-digital-copy/

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

No

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?

No

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County Behavioral Health System Service Delivery Landscape

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**
- ☑ **Habilitation and Rehabilitation Services**
- ☑ **Outreach Services**
- ☑ **Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services**
- ☑ **Screening and Diagnostic Treatment Services**
- ☑ **Staff Training, including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services**

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

No

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Community Mental Health Services Block Grant (MHBG)

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

Yes

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

- ☑ **Discretionary/Base Allocation**
- ☑ **Dual Diagnosis Set-Aside**
- ☑ **First Episode Psychosis Set-Aside**

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 [multi-select list]

- ☑ **Adolescent/Youth Set-Aside**
- ☑ **Discretionary**
- ☑ **Perinatal Set-Aside**
- ☑ **Primary Prevention Set-Aside**
- ☑ **Syringe Services Program Allowance**

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

No

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Opioid Settlement Funds (OSF)

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

Yes

a. Please check all set asides the county behavioral health system participates in under OSF Exhibit E [multi-select list]

- ☑ **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)**
- ☑ **Prevent Misuse of Opioids**
- ☑ **Prevent Overdose Deaths and Other Harms (Harm Reduction)**
- ☑ **Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids**
- ☑ **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

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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:

☑ **Other Programs and Services**

Please describe:

N/A

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

No

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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 implementation challenges or concerns with the requirements under this program?

No

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Medi-Cal Specialty Mental Health Services (SMHS)

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

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

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

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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-ODS Program**

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

The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition). (no action required)

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

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

☑ **Enhanced Community Health Worker (CHW) Services**
☑ **Inpatient Services (ASAM Levels 3.7 & 4.0)**
☑ **IPS Supported Employment**
☑ **Recovery Incentives Program (Contingency Management)**

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

No

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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 and SUD programs

Program or service

Adult Recovery

Sobering Centers

Care Transitions

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

Yes

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

Yes

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Statewide Behavioral Health Goals

Population-Level Behavioral Health Measures

Priority statewide behavioral health goals for improvement

Counties are required to address the six priority statewide behavioral health goals in this section. For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Access to Care

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?

   a. For adults/older adults: Same
   b. For children/youth: Same

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

   ☑ **Age**
   ☑ **Gender**
   ☑ **Race or Ethnicity**
   ☑ **Spoken Language**
   ☑ **Sex**

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

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

   a. For adults/older adults: Below
   b. For children/youth: Below

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

- ☑ **Age**
- ☑ **Gender**
- ☑ **Race or Ethnicity**
- ☑ **Spoken Language**
- ☑ **Sex**

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: Not Applicable
b. For children/youth: Not Applicable

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: Same
b. For children/youth: Same

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

☑ **Race or Ethnicity**

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?

Above

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

☑ **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

The Department of Health Care Services (DHCS) provided disaggregated penetration rate data for Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS), and substance use disorder (SUD) treatment by age, race/ethnicity, gender, and language for fiscal years 2023-2024. Alameda County's analysis revealed disparities in behavioral health access across demographic groups.

Age disparities were identified. Alameda County penetration rate for SMHS youth was 4.6%. Adolescents (ages 12-17) had the highest SMHS engagement at 7.2%, early childhood groups ages 0-2 at .9%, and ages 3-5 at 1.7%. SMHS adults 65+ observed a 1.4% penetration rate versus the county rate of 2.9%. For NSMHS, children 0-2 had an unusually high rate of 33.6% likely due to developmental screenings. Youth ages 6-11 had a 7.7% penetration rate versus the county average of 14.3%. Older adults ages 57-68 and 69+ had lower penetration rates, pointing to access barriers for seniors.

Gender disparities were also observed. SMHS adult access was lower for females 2.8% than males 3.6%. NSMHS adult female access were higher at 11.7% than males at 7.5%. The CPPP community feedback identified gender specific barriers to accessing care, such as caregiving responsibilities for women, stigma, and a need for culturally responsive services for LGBTQ+ individuals.

Race/ethnicity disparities showed highest SMHS penetration among American/Alaska Native 5.4% and Black 5.8% populations, Hispanic 1.6% and Asian/Pacific Islanders 1.2% had the lowest. For Adult NSMHS, Asian/Pacific Islanders remained lowest 5.4% despite high rates among American Indian/Alaska Native 14.4% and White 13.4% populations. These disparities reflect cultural stigma, lack of culturally competent providers, and trust barriers.

SMHS Language disparities impacted Farsi 4.2%, English 3.9%, and Arabic 1.4% communities. For Youth NSMHS written language, other non-English, observed 28.8% far above the county average at 14.3%. Youth NSMHS written language disparities

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were found in Farsi 9.8%, Vietnamese 9.5% and Cantonese 8.5%. Barriers included difficulty navigating services and lack of cultural and linguistically appropriate care.

For Substance Use services Drug Medi-Cal Organized Delivery System (DMC-ODS), Alameda County had an adult penetration rate of 1.1% and a youth rate of .2%, compared to the Statewide rate at 1.7%. Native American was 2.7%, Hispanic/Latino .6% and Asian Pacific Islander .1%.

In conclusion, disparities by age, race/ethnicity, gender, and language reflect the need for early intervention, bilingual, and culturally responsive services, and improved system navigation. These efforts are vital to achieving equitable behavioral health care access across Alameda County.

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 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

Alameda County will expand programs that enhance access to care to target longstanding disparities. DHCS data shows low SMHS access among Asian/Pacific Islanders (1.2%), Hispanics, and seniors. Community Program Planning Process (CPPP) feedback highlights barriers for non-English speakers, people of color, family support, and LGBTQ+ individuals. Alameda County will partner with Medi-Cal Managed Care Plans (MCPs) and Community Based Organizations (CBOs) to improve cultural and linguistically responsive services and to support earlier identification of members needing SMHS or SUD treatment. Alameda County will prioritize interventions for groups with the lowest engagement and meet them where they are, especially adolescents and older adults. Alameda County will look to support the integration of services, enhance the Assertive Field Based SUD services and outreach efforts to ensure warm hand offs and referrals to care, housing instability, co-occurring mental health and SUD needs, system navigation, mobile clinics, and improve behavioral health screenings.

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A sample of several programs looking to increase access to care: FSP Homeless Action Engagement Team (HEAT), African American Wellness Hub, In-Home Outreach team (IHOT) (Housing Intervention Outreach programs), Older Adult Treatment Services and Support, LGBTQ Support Services, Re-entry programs, Crisis Response Program (CATT) and translation services.

A new program Alameda County is implementing is the ACCESS Care Coordination Team (ACCT). Through contract provider, Bay Area Community Services (BACS), the ACCT will provide interim mental health and/or co-occurring substance use disorder (SUD) services for clients who would otherwise be unable to access services through ACBHD or its contracted providers timely due to capacity issues within existing programs. BACS will implement two teams: one Outreach and Engagement (O&E) and one Case Management.

Alameda County strives to increase community access to mental health and substance use services, including housing interventions, community knowledge and education, language capacity, and successful connection to services. Alameda County aims to identify needs earlier and to reduce wait times. We will strive to reduce untreated conditions, better care experiences, and reductions in disparities and preventable crises.

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

- ☑ **BHSA Behavioral Health Services and Supports (BHSS)**
- ☑ **BHSA Full Services Partnership (FSP)**
- ☑ **BHSA Housing Interventions**
- ☑ **1991 Realignment**
- ☑ **2011 Realignment**
- ☑ **State General Fund**
- ☑ **Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)**
- ☑ **Community Mental Health Block Grant (MHBG)**
- ☑ **Other: Opioid Settlement Funds, AB109, Grants, Local Funding**

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Homelessness

Homelessness: Primary measures

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

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

Above

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

- ☑ **Age**
- ☑ **Gender**
- ☑ **Race or Ethnicity**
- ☑ **Sex**
- ☑ **Other: Veterans, Unaccompanied youth**

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?

- ☑ **Race or Ethnicity**
- ☑ **Other: African American, Hispanic/Latino, and Pacific Islander students are overrepresented in unstable and emergency housing situations.**

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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?

Above

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

- ☑ **Age**
- ☑ **Gender**
- ☑ **Race or Ethnicity**
- ☑ **Sex**

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?

Same

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

- ☑ **Age**
- ☑ **Gender**
- ☑ **Race or Ethnicity**
- ☑ **Sex**

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

1. How does your local CoC's rate compare to the average rate across all CoCs?

Below

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

- ☑ **Age**
- ☑ **Gender**
- ☑ **Race or Ethnicity**
- ☑ **Sex**

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

Alameda County's 2024 Point in Time (PIT) Count rate for people experiencing homelessness was 58.3 per 10,000 which is higher than the statewide rate of 48. Disparities are evident across multiple demographic and clinical subpopulations.

Most individuals experiencing homelessness are between ages 25-64. The highest rates were ages 35-44 (92 per 10,000), ages 45+ (65 per 10,000) and ages 18-34 (56 per 10,000). Seniors 64+ had a count of 659 individuals, while 397 were unaccompanied youth under 25, and 399 were children under 18 in family households. PIT Counts for men accounted for a rate of 76, significantly higher than women at 35. Transgender, non-binary, and others made up 1.1%, reflecting the need for inclusive and trauma informed services.

Black/African American rate was comprised 247 per 10,000 despite a smaller share of the general population. Asian or Asian American individuals had a rate of 8 per 10,000, and Native/Indigenous people, though small in absolute numbers (rate 309 per 10,000) were overrepresented relative to their population size.

Alameda County's PIT rate for Severe Mental Illness was 12.6 per 10,000 which is above the statewide rate of 11.5. There were 2,040 individuals with SMI, 88%, and were in emergency/unsheltered settings. The Chronic Substance Use rate for the County was 9.6 per 10,000 slightly below the statewide 11.0. The count for individuals

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identified with Chronic SUD was 1,559 and they were primarily unsheltered. Chronically homeless individuals numbered 3,832 and were 41% of total homeless. There were 524 homeless veterans and 551 victims of domestic violence. Alameda County's homeless student enrollment rate was 2.6%, which is below the state's 5.3%. African American and Hispanic experienced homelessness at the highest rates and Asian at the lowest.

These findings emphasize the need for coordinated, culturally responsive, and population specific interventions, particularly for Black residents, youth, veterans, and individuals with severe mental illness or substance use disorder.

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

Alameda County will aim to reduce homelessness among individuals living with severe mental illness (SMI), chronic substance use disorder (SUD), and co-occurring conditions. According to the 2024 Point in Time (PIT) Count, Alameda County's homelessness rate is 58.3 per 10,000 which is well above the statewide average of 48. Homeless populations are disproportionately high rates per 10,000: Black residents 247, Men 76, and individuals with SMI 12.6.

To address these disparities, Alameda County will expand interim housing units that offer intensive on site behavioral health services and invest in supporting housing models like the FSP Homeless Engagement Action Team (HEAT) and Services for Transitional Age Youth (STAY) programs, which serve high need populations including transitional age youth, veterans and older adults. Residential treatment and detox facilities will be expanded to support those experiencing acute behavioral health crises. Housing interventions through MCP transitional rent, BHSA Housing Interventions, Behavioral Health Continuum Infrastructure Program, Opioid

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Settlement and Measure W (local Alameda County funding) will fund housing and services for those who are homeless or at risk and struggling with SMI or SUD.

Alameda County will continue to partner with Community Based Organizations, including Building Opportunities for Self-Sufficiency (BOSS), BACS, Adobe, and Fred Finch Youth and Family Services, to provide trauma informed, culturally responsive care. Programs such as Alameda Connections and Housing Solutions for Health will offer integrated housing navigation and wraparound supports, while initiatives like Rental Assistance Landlord Engagement aim to increase landlord participation and reduce housing barriers. Alameda County will also focus on helping individuals exiting institutions or the criminal justice system by expanding forensic access points, pre-release planning, and workforce reentry supports. These levers and strategies, rooted in equity and evidence-based practices, help Alameda County focus on real needs, strengthen support, and move people toward stable housing and improve behavioral health outcomes.

Alameda County's intention is to reduce homelessness for people living with behavioral health needs, identifying housing instability early and to respond with coordinated care through behavioral health treatment, housing support and health services. We will strengthen re-entry planning and continue to use trauma informed approaches so people with behavioral health needs do not fall into homelessness. Preventing homelessness, shortening the time a person is unhoused, and reducing disparities will strengthen Alameda County's approach to homelessness.

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

- ☑ **BHSA Full Services Partnership (FSP)**
- ☑ **BHSA Housing Interventions**
- ☑ **Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)**
- ☑ **Other: Opioid Settlement Funds, AB109, Grants, Local Funding, Measure W funding**

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Institutionalization

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

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

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

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

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**

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

14-day involuntary detention rates per 10,000: Above
30-day involuntary detention rates per 10,000: Below
180-day post-certification involuntary detention rates per 10,000: Same

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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?

Temporary Conservatorships: Above

Permanent Conservatorships: Below

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

☑ **Age**
☑ **Gender**
☑ **Race or Ethnicity**
☑ **Sex**

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

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

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

1a. Crisis Intervention

For adults/older adults: Below
For children/youth: Above

1b. Crisis Residential Treatment Services

For adults/older adults: Below

For children/youth: Below

1c. Crisis Stabilization

For adults/older adults: Above

For children/youth: Above

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

- ☑ **Age**
- ☑ **Gender**
- ☑ **Race or Ethnicity**
- ☑ **Sex**
- ☑ **Spoken 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 the data that supported your analysis

In fiscal year 2023, disparities in Institutionalization for Inpatient Administrative Days were seen across age, race, and sex. Adults age 57-68 (16.3 days) and white adults (16.2) were above Alameda County's average of 15.1 days. Adult females (13.1) also had longer inpatient administrative days than males. For the Alameda County youth population, the average administrative days were 7.7. No disparity youth data for Inpatient Administrative Days was made available by DHCS. These disparities highlight step down placement need for culturally responsive, gender specific, and age appropriate community care options to reduce institutional stays and ensure the least restrictive environment.

For the supplemental measure of crisis intervention utilization total by minutes per beneficiary, disparities were identified among adults ages 57-69 (189.86), Hispanics (191.54), Asian/Pacific Islanders (192.44), Spanish writers (188.7) and Females (191.87) had higher crisis residential usage. For Children ages 6-11 (389.93), White youth (521.84), Female youth (334.14), and English writers (313.7) showed elevated crisis service usage.

Another supplemental measure, Crisis stabilization utilization by hours per beneficiary for adults, disparities identified were adults ages 45-56 (36.79), Alaskan Native or American Indian (52.69), Black (37.46), Female (34.16), English writers (34.51). For the youth, ages 12-17 (26.06), Black youth (30.96), Female (25.47) and English writers (25.1) had the highest usage.

The last supplemental measure Alameda County reports to DHCS is 14 day involuntary detention rate. Alameda County's rate was (32.2) which is over the state

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rate (10.2) by 3 times. The longer 30 days and 180-day detentions are 0.0 which shows disparities in short term use and possible reporting gaps. Alameda County reports temporary conservatorships and permanent conservatorships differently, that is why they are not included in the data.

Institutionalization: Cross-Measure Questions

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

County Psychiatric John George, Herrick Hospital.

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)

Alameda County will expand efforts to reduce institutionalization by improving timely access to community based care for residents most affected by long or repeated hospital stays. The county is below FY23 statewide rates for inpatient administrative days. Disparities were identified among adults ages 57-68, White Adults and Women. These disparities point to the need for stepdown services that are age appropriate, culturally responsive, and supportive of gender specific needs. Alameda County has increased utilization management activities related to subacute care and added administrative days to reduce average length of stay to increase access and decrease time spent in the most restrictive settings. The county contracts with Telecare, Abode and Fred Finch to provide wraparound services through Full Service Partnerships programs. Alameda County is anticipating an increase in involuntary detentions due to SB43 and WIC 5270 and plans to scale intervention programs like Safe Harbor Peer Respite (Housing Intervention Funded), Crisis Connect, and Triage Diversion. Alameda County partners with Telecare to provide FSP subacute, acute, crisis and residential programs such as Willow Rock PHF, Villa Fairmont MHRC, Jay Mahler Crisis

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Residential Program, and Alameda County Crisis Stabilization Unit. Telecare's ADROC and TAYROC teams provide short term outreach and engagement to help stabilize individuals before the crisis escalates. Mobile Crisis services will be expanded; the CATT team will begin operating during evenings and weekends and expand to Berkeley and Oakland schools. The implementation of Care Court aims to reduce ER use and law enforcement involvement by connecting people to treatment before crisis escalates. The county prioritizes equitable, timely and person centered community care, using institutional settings only when truly needed. Alameda County aims to reduce institutionalization by meeting behavioral health needs, strengthening crisis care, supporting safe transitions and using trauma informed approaches. Alameda County strives to reduce arrests, shorten institutional care stays, and lower recidivism for all communities.

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

- ☑ **BHSA Behavioral Health Services and Supports (BHSS)**
- ☑ **BHSA Full Services Partnership (FSP)**
- ☑ **BHSA Housing Interventions**
- ☑ **2011 Realignment**
- ☑ **State General Fund**
- ☑ **Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)**

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Justice Involvement

Justice-Involvement: Primary Measures

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

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

For adults/older adults: Below
For children/youth: Below

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

- ☑ **Age**
- ☑ **Gender**
- ☑ **Race or Ethnicity**
- ☑ **Sex**

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?

Below

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

- ☑ **Age**
- ☑ **Gender**
- ☑ **Race or Ethnicity**
- ☑ **Sex**

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

Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count

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excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

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

Below

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

Please describe other:

The metric means that fewer individuals in Alameda County are being determined to be Incompetent to Stand Trial under DSH funded Hospitals. Alameda County has strong diversion practices, behavioral health interventions and differences in determining who is unfit to stand trial.

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 Justice Involvement data revealed disparities by age, gender, race/ethnicity, and behavioral health status. Adults aged 20-39 arrest rate was 65% of all arrests. The 20-29 age group had a rate of arrests of 3,196 per 100,000 people, while the 40-69 group had the highest overall arrest rate 33% and led in felony drug and sex offenses. Youth age 18-19 had an arrest rate that was more than the 40-69 ages combined, indicating the need for youth supports.

Young adults 20-24 had a recidivism rate of 11.7%, reinforcing the need for recovery oriented behavioral health, housing, and employment services. Individuals age 45+ had the lowest recidivism rates.

Male arrest rate was 2,859 per 100,000 people, with a recidivism rate of 7.1% compared to female recidivism of 5.7%, signaling the need for trauma informed, male specific services. Women accounted 791 arrest rate per 100,000 people.

Black individuals were disproportionately impacted, accounting for a combined arrest rate of 5,865 per 100,000 people. They were three times more likely than whites to be stopped, searched, or arrested. Among youth, Black juveniles were five times and Hispanic youth nearly twice as likely to face felony arrests compared to White youth. Hispanic individuals had an arrest rate of 2,103 per 100,000 people. White individuals

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had the highest recidivism 10% and inpatient psychiatric participation 55.4%. American Indian/Alaska Native 45.3% and Pacific Islander 43.2% were overrepresented in correctional mental health programs. Language continues to affect individuals with limited English proficiency, emphasizing the need for culturally and linguistically responsive care. These disparities, supported by DOJ, CDCR, and IST data, highlight the need for equity focused population specific behavioral health strategies and cross sector collaboration to reduce justice involvement.

Justice-Involvement: Cross-Measure Questions

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

Alameda County is strengthening its portfolio of behavioral health treatment programs that reduce justice involvement through prevention, diversion, reentry, and culturally responsive engagement. Alameda County outperformed the state in key areas: adult arrest rates 1,765.5 vs. 2,440.2 per 100,000, juvenile arrest rates 297.5 vs. 371.5, recidivism 25.6% vs. 39.6%, and Incompetent to Stand Trial 5.3 vs. 14.3 per 100,000.

Alameda County's jail-based behavioral health reentry team coordinates care for incarcerated clients to community-based behavioral health providers upon release. Our community-based reentry treatment and forensic full service partnership teams assist justice impacted behavioral health clients so that they can continue their healing journey with the goal of reducing recidivism. Additionally, In Home Outreach Teams, operated by community partners provide mobile behavioral health outreach to adults and TAY with untreated mental illness.

The District Attorney's (CARES) Navigation Center partners with police departments to divert individuals from arrest and into treatment. The County also has a Center for Reentry Excellence to support individuals on probation, and a Diversion Triage Center to prevent arrest of individuals with substance use needs. Both the CARE Act Court

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and Behavioral Health Court target individuals with untreated SMI and at risk for incarceration or institutionalization.

Alameda County is utilizing AB109 funds to connect individuals to mental health prevention, navigation, and treatment services. In partnership with our Probation Department the new programs will be a Triage, Consultation and Wellness Response Team, Clinical Provider Team, and Service Provider Outreach and Training Team.

These efforts are anchored in the Care First, Jails Last policy, ensuring that Alameda County delivers a full continuum of care from prevention to step down services that prioritize treatment over incarceration.

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

- ☑ **BHSA Behavioral Health Services and Supports (BHSS)**
- ☑ **BHSA Full Services Partnership (FSP)**
- ☑ **2011 Realignment**
- ☑ **State General Fund**
- ☑ **Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)**
- ☑ **Other: Proposition 47, AB109**

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Removal of Children from Home

Removal Of Children from Home: Primary Measures

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

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

Below

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

- ☑ **Age**
- ☑ **Gender**
- ☑ **Sex**

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?

Above

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

- ☑ **Age**
- ☑ **Race or Ethnicity**
- ☑ **Sex**

Child Maltreatment Substantiations (CWIP), 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**

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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

Alameda County Behavioral Health Department conducted a disparities analysis using 2022 DHCS SMHS Penetration Rates, Child Welfare Indicators Project (CCWIP), and local/state data to identify drivers of child removal and inform equitable strategies.

Adolescents ages 12-17 show highest Child Welfare SMHS penetration at 57.4%, Transitional Age Youth (TAY) 18-21 account for 25.2% of Child Welfare and 60.4% of Probation cases. TAY face elevated risks of homelessness, unemployment, and prolonged system involvement, indicating the need for expanded transitional housing, wraparound services and life skills programs.

Black children are disproportionately represented in open Child Welfare case with a rate of 51.3% and Probation 52.1% and highest substantiation rate 6.3 per 1,000 vs. county average 1.5. Latino youth are also rising in both systems-Child Welfare 46.1% and Probation 33.3%. DHCS data shows high service usage among Black and Latino youth, reflecting unmet behavioral health needs and highlighting the importance of culturally responsive early interventions.

Gender disparities are also evident: girls represent a rate of 244 per 1,000 of children in foster, while boys compromise 79.2% of probation based foster care. Although SMHS access shows minimal gender gaps, these differences call for gender specific services focused on trauma, emotional wellbeing and school engagement.

Out of county placements are rising while relative/NREFM placements are declining, signaling local placement shortages. Permanent placements are trending upward, but continued monitoring is needed to ensure equity.

Alameda County strives to reduce child removals from home and will invest in culturally aligned early intervention services for Black and Latino families, strengthen supports for TAY, expand caregiver services, and reduce reliance on institutional placements. Alameda County will ensure that our programs are driven by equity and data in order to achieve family preservation.

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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

Alameda County will implement strategies to reduce child removals and address disparities across race, age, and geography guided by the 2023 Comprehensive Prevention Plan, 2022 DHCS SMHS penetration rates, and CCIP data.

Black children represent a rate of 51.3% of Child Welfare cases and have the highest maltreatment substantiation rate at 6.3 per 1,000 which is over four times the county average. To address this, Alameda County will invest in partnerships with providers such as Roots, Family Paths, and La Familia to deliver trauma informed care, parenting classes, and peer mentoring. Providers will support early intervention, strengthen family protective factors, and reduce involvement in child welfare and probation.

Current program utilization data reveals that Alameda County Child Welfare and Probation agencies are underutilizing Wraparound services. The Alameda County Behavioral Health Department (ACBHD), in partnership with Lincoln (county Wraparound services provider), will conduct quarterly outreach campaigns to Child Welfare and Probation staff to educate and inform them of the availability of Wraparound services for foster youth. ACBHD's Child and Young Adult System of Care will partner with ACBHD's Vocational Services Division to provide employment coaching and placement services to Transition Aged foster youth.

Alameda County will invest in Short-Term Residential Therapeutic Programs (STRTPs) and telehealth to reduce institutional care and promote family connection. Gender specific programs will be expanded, including school based coaching and mentorship for boys and trauma/emotional wellness programs for girls. Out of county placements and limited relative caregiver options present major challenges. Alameda County will invest in early intervention, full service partnerships, and respite care. Family Paths and Alameda Connections will provide wraparound supports. Housing programs like EveryOne Home and Bringing Families Home will stabilize families and aim to help prevent removals.

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

- ☑ **BHSA Behavioral Health Services and Supports (BHSS)**
- ☑ **BHSA Full Services Partnership (FSP)**
- ☑ **2011 Realignment**

Untreated Behavioral Health Conditions

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: Same

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

No Disparities Data Available

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

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?

No Disparities Data Available

Untreated Behavioral Health Conditions: Supplemental Measures

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

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

For the full population measured: Below

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

- ☑ **Age**
- ☑ **Gender**
- ☑ **Race or Ethnicity**
- ☑ **Sex**

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

Alameda County's performance on measures related to untreated behavioral health conditions shows both areas of relative strength and disparities. For the primary measure, Follow Up After Emergency Department Visit for Substance Use (FUA-30, year 2022 data), the county rate is 29.7%, which is slightly above the statewide rate of 28.8%, this indicates marginally better performance but still reflects that more than two thirds of clients do not receive timely follow-up care. For Follow Up After Emergency Department Visit for Mental Illness (FUM-30, year 2022 data), Alameda County's rate 48.3% is significantly higher than the statewide rate 38.2%. When it was broken down by Manage Care Plan for FUM-30, Alameda Alliance had 49.03% and Anthem Blue Cross 42.99% (although Anthem Blue Cross is no longer a MCP for the county, Kaiser is now). No demographic data level disparities data were available for this primary measure.

The supplemental measure, Adults needing help for emotional/mental health problems or alcohol/drug use who had no visits in the past year, shows pronounced disparities among adults needing help for emotional/mental health or alcohol/drug use who had no visits in the past year. Alameda County's unmet need rate of 45.4% is below the statewide rate of 48.4%, but disparities appear by race, gender, and age.

Females 39.6% report lower unmet needs than males 45.9%. Black residents 47.6%, Latino residents 55.5%, individuals Two or More Races have the highest unmet need 66.5%, far above Asian residents 37.9%, White 34.4%. By age, young adults 18-24 have the highest rate, 50.7% without visits, adults 25-64 show 40.2% and older adults 65+ report 38.2%. These results indicate significant barriers to care for Black and Latino

residents and younger adults, particularly those ages 18-24, a possible solution for this group could be targeted, culturally responsive interventions.

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)

Alameda County will implement integrated, culturally responsive interventions to reduce untreated behavioral health conditions, targeting residents with the highest unmet need. Black residents 47.6%, Latino residents 55.5%, and young adults ages 18-24 at 50.7%. These efforts address areas near or below the statewide median, including follow-up after Emergency Department visits for substance use 29.7% and adults with unmet mental health needs 45.4%. Alameda County will expand timely access through enhanced crisis stabilization, mobile crisis teams, and urgent care services, including Community Assessment Treatment Teams (CATT), Crisis Stabilization Unit, and Suicide prevention. Opioid settlement funded initiatives such as those led by Lifelong Medical Care, will integrate harm reduction, maternal health, and substance use disorder treatment to serve high need communities. Specialized outreach led by programs such as Telecare connect high utilizers of emergency/inpatient services, justice involved individuals, and transition age youth to rehabilitation, case management, housing navigation, and wraparound supports. The Bridge Clinic will ensure care continuity for individuals exiting incarceration through a telehealth model. Preventive and follow up care will expand through community partnerships, including Medication Assisted Treatment, suicide prevention services, and multilingual crisis lines. The ACCESS call center will improve navigation with cultural and linguistically appropriate screening and referrals.

These measures show where people fall through the cracks and point to the levers of access, warm hand offs, follow up and support. Alameda County will implement programs and strategies to help build service capacity, strengthen coordination, and connect behavioral and physical health care in a more consistent and integrated way.

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

☑ **BHSA Behavioral Health Services and Supports (BHSS)**

☑ **BHSA Full Services Partnership (FSP)**

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

Additional statewide behavioral health goals for improvement

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

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?

For adults/older adults: Same

For children/youth: Same

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

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

For adults/older adults: Above

For children/youth: Above

Engagement In School: Primary Measures

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

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

Above

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Engagement In School: Supplemental Measures

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

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

Below

Student Chronic Absenteeism Rate (Data Quest), 2022

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

Same

Engagement In Work: Primary Measures

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

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

Same

Engagement In Work: Supplemental Measures

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

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

Below

Overdoses: Primary Measures

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

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

For the full population measured: Below

For adults/older adults: Below

For children/youth: Below

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Overdoses: Supplemental Measures

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

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

For the full population measured: Below

For adults/older adults: Below

For children/youth: Below

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?

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

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

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?

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

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

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Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

For the full population measured: Same

For adults/older adults: Same

For children/youth: Same

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?

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?

For the full population measured: Same

For adults/older adults: Same

For children/youth: Same

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Same

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Suicides: Primary Measures

Suicide Deaths, 2022

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

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?

For the full population measured: Below

For adults/older adults: Below

For children/youth: Below

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County-selected statewide population behavioral health goals

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

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

Overdoses

1a. Please describe why this goal was selected

Alameda County has a deep and ongoing commitment to addressing the overdose crisis through inventive, community-based solutions, and we look forward to utilizing the Behavioral Health Services Act to do so.

According to the California Department of Public Health surveillance data (2023), Alameda County experienced 309 opioid-related overdose deaths in 2023. The annual age-adjusted mortality rate for 2023 was 21.82 per 100,000 residents, an increase of 65% from 2022. Synthetic opioid overdose deaths are on the rise and are largely related to fentanyl in California and Alameda County. Based on Alameda County's data (2020-2022), opioid deaths are increasing as a proportion of overall overdoses, with polydrug overdoses that include opioids and stimulants being the fastest growing segment. This rapid increase in overdoses in Alameda County started in 2017 and has maintained an upwards trajectory, with the highest mortality rate seen in cisgendered men. The availability of synthetic drugs such as fentanyl has also led to an unprecedented rise in unintentional synthetic drug use from people buying prescription opioids or other recreational drugs laced or mixed with the substance.

Alameda County will use new funds awarded from the opioid settlement and the inclusion of substance use disorder treatments in BHSA to build upon county efforts to address the ongoing overdose crisis through innovative strategies. Together, this collaboration ensures that funding will be distributed to trusted, vetted, community-based providers that are equipped to ensure that resources are directed to those who need them most. The overdose crisis in Alameda County is a silent, devastating and pervasive challenge, impacting far more than those directly in addiction. Every overdose in our region is more than a statistic; it represents a family broken apart,

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children left without parents, loved ones bereaved, and a community left with a profound void.

1b. 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

A disparity analysis of the 2022 California Overdose Surveillance Dashboard prepared by the California Department of Public Health yielded results that were in line with Alameda County's own findings.

The overdose deaths are disproportionately higher among Black/African American residents 86 per 100,000 and Native American individuals 120 per 100,000 with overdose rates that were three-five times higher than White 30 per 100,000 and Hispanic populations 29 per 100,000. The Asian/Pacific Islander group experienced significantly lower rates 5 per 100,000 and had the narrowest confidence interval which suggests reliable overdose burden in this population. For emergency room overdose visits these trends remained consistent amongst the different race/ethnicities.

The highest overdose death rate is for individuals age 35-39 years old at a rate of 82 per 100,000. The death rates are low in children under age 15 reporting less than 6 total reported cases. Older adults ages 65-69 overdose death rate accounts for 28.2. For emergency room overdose visits the 30-34 years old age group had the highest rate at 285.7 per 100,000.

Black adults had a 382.9 emergency room visit rate for overdoses and Native Americans 209.7 vs the statewide rate of 122.8 per 100,000 visits. Asians had a emergency room overdose visit rate of 38.5.

Of the top five zip codes with the highest stable rate of overdoses, three were in Oakland, one was in Central Berkeley and one in Emeryville. The 94612 zip code had the highest stable rate of the emergency room overdose visits and the highest for overdose deaths.

For gender disparities, Men were more than three times more likely to have a drug overdose resulting in death and emergency room overdose visits (148 males vs 97.4 females).

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Alameda County data: Men with SUD Ages 24-74 experience the highest mortality rates from opioid overdoses, Unhoused Individuals experience 30% of overdose deaths by opioids in Alameda County, and Justice Involved Individuals are at high risk of overdosing after release.

1c. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Overdoses and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Alameda County is below the statewide rate for overdose deaths and overdose emergency room visits; however, we want to improve to save lives. Drug poisoning is the number one cause of death among adults ages 18-45. Data shows that communities of color are being disproportionately impacted, including individuals experiencing homelessness, and those involved with the justice system. The data also shows that non-fatal overdoses occur more frequently than deaths, this provides Alameda County opportunities for intervention. Alameda County is looking to expand field base mobile crisis teams that provide substance use treatment and follow-up care for those in shelters, encampments, and high risk community settings. These teams will focus on engagement within 24-72 hours after an overdose to provide support, education, and facilitate rapid access to medications for addiction treatment (MAT).

Alameda County will continue effective MAT programs like the Bridge Clinic at Highland Hospital that serves 1,300 patients a month and the nine methadone clinics which serve 2,000 patients monthly. Alameda County is expanding the placement of the over 2,000 naloxone boxes in libraries, schools, jails, and clinics to continue to support overdose prevention. Alameda County has numerous partners that work diligently to address overdoses, to name a few: H.A.A.R.T. provides MAT counseling along with methadone and buprenorphine; HEPPAC provides harm reduction based services in Santa Rita Jail.

The ACCESS system is expanding through BACS to provide interim mental health and/or co-occurring substance use services for clients who would otherwise be unable to access services through ACBHD or its contracted providers timely due to capacity issues within existing programs. Alameda County is committed to building a responsive, equitable, and data driven system of care to address overdoses through

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our substance use system of care, opioid settlement initiatives, and the BHSA inclusion of treating SUD.

Alameda County will focus on identifying substance use needs early and responding with evidence based treatment, medication and follow-up at the appropriate level of care. Alameda County will continue to provide naloxone access, strengthen screening, and connect high risk individuals to support and recovery services. Alameda County's goal is fewer overdose deaths, fewer repeat overdoses, and a reduction in disparities across communities most impacted.

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

- ☑ **BHSA Behavioral Health Services and Supports (BHSS)**
- ☑ **BHSA Full Services Partnership (FSP)**
- ☑ **State General Fund**
- ☑ **Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)**
- ☑ **Substance Use Block Grant (SUBG)**
- ☑ **Other: Opioid Settlement Funds**

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Community Planning Process

Stakeholder Engagement

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

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

- ☑ **County outreach through social media**
- ☑ **County outreach through Town Hall meetings**
- ☑ **County outreach through traditional media (e.g., television, radio, newspaper)**
- ☑ **Focus group discussions**
- ☑ **Key informant interviews with subject matter experts**
- ☑ **Meeting(s) with county**
- ☑ **Provided data to county**
- ☑ **Survey participation**
- ☑ **Training, education, and outreach related to community planning**
- ☑ **Workgroups and committee meetings**

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

Stakeholder Engagement	Engagement date
Training, education, and outreach related to community planning	2/10/2025
Focus group discussions	2/11/2025
Focus group discussions	2/11/2025
Survey participation	2/12/2025
Survey participation	2/13/2025
Focus group discussions	2/20/2025
Training, education, and outreach related to community planning	2/21/2025
Focus group discussions	2/21/2025
Survey participation	2/24/2025
Survey participation	2/25/2025
Survey participation	2/27/2025
Focus group discussions	2/28/2025
Survey participation	2/28/2025
Survey participation	3/1/2025

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Survey participation	3/5/2025
Survey participation	3/12/2025
Survey participation	3/12/2025
Focus group discussions	3/13/2025
Training, education, and outreach related to community planning	3/14/2025
Training, education, and outreach related to community planning	3/14/2025
Focus group discussions	3/18/2025
Survey participation	3/20/2025
Survey participation	3/20/2025
Focus group discussions	3/20/2025
Survey participation	3/20/2025
Survey participation	3/20/2025
Survey participation	3/20/2025
Focus group discussions	3/20/2025
Focus group discussions	3/20/2025
Focus group discussions	3/20/2025
Focus group discussions	3/20/2025
Survey participation	3/20/2025
Focus group discussions	3/20/2025
Survey participation	3/21/2025
County outreach through social media	3/21/2025
Survey participation	3/22/2025
Training, education, and outreach related to community planning	3/24/2025
Survey participation	3/25/2025
Survey participation	3/25/2025
Survey participation	3/25/2025
Survey participation	3/25/2025
Survey participation	3/26/2025
Focus group discussions	3/26/2025
Survey participation	3/27/2025
Survey participation	3/27/2025
Focus group discussions	3/28/2025
Focus group discussions	3/28/2025
Survey participation	4/2/2025
Survey participation	4/2/2025
Survey participation	4/2/2025
Focus group discussions	4/3/2025
Focus group discussions	4/8/2025
Survey participation	4/9/2025

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Focus group discussions	4/9/2025
Focus group discussions	4/10/2025
Survey participation	4/10/2025
Survey participation	4/14/2025
County outreach through traditional media (e.g., television, radio, newspaper)	4/14/2025
Survey participation	4/15/2025
Survey participation	4/15/2025
Focus group discussions	4/16/2025
Survey participation	4/17/2025
County outreach through traditional media (e.g., television, radio, newspaper)	4/18/2025
Survey participation	4/21/2025
Focus group discussions	4/23/2025
Survey participation	4/23/2025
Survey participation	4/23/2025
Training, education, and outreach related to community planning	4/24/2025
Training, education, and outreach related to community planning	4/24/2025
Training, education, and outreach related to community planning	4/25/2025
Survey participation	4/25/2025
County outreach through traditional media (e.g., television, radio, newspaper)	4/25/2025
Survey participation	4/29/2025
Focus group discussions	4/30/2025
Survey participation	5/1/2025
Survey participation	5/2/2025
Survey participation	5/5/2025
Focus group discussions	5/8/2025
Training, education, and outreach related to community planning	5/8/2025
Training, education, and outreach related to community planning	5/8/2025
Focus group discussions	5/12/2025
Focus group discussions	5/14/2025
Focus group discussions	5/16/2025
Focus group discussions	5/19/2025
Focus group discussions	5/21/2025
Focus group discussions	5/22/2025
Survey participation	5/29/2025

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

40 x 40 PAC, Alameda Alliance, Alameda County District Attorney, Alameda County Early Childhood Mental Health, Alameda County Emergency Medical Services, Alameda County Health OAD, Alameda County Housing and Homeless, Alameda County Office of Education, Alameda County Public Health Department, Alameda County Social Services, Alameda County Social Services Area Agency on Aging, Alameda County Superior Court, Alternative Family Services, Asian Health, Asian Health Services, Axis Community Health, BACS HEDCO Wellness, Bay Area Community Resources, Black Men Speak, BOSS, Cal State East Bay, Center for Independent Living, Chabot College, City of Berkeley, City of Fremont, City of Hayward, City of Livermore, City of Oakland, City of San Leandro, College of Alameda, Community Resources for Independent Living, Crisis Support Services, Disability Rights of California, Eastmont Neighborhood Council, EBAYC, Ed Roberts, Eden I&R, Eden Youth Family Center, Family Education Resource Center, Family Support Services, First 5 Alameda County, Fred Finch Youth Center, HAART, Health and Human Resource Education Center, HEPPAC, Hume Center, Jay Mahler Recovery Center, JBAY, Kaiser Permanente, Korean Community Center, La Clinica de la Raza, La Familia, Laney College, Lifelong Medical Care, Mental Health Association for Chinese Communities, Merritt College, MHAAC, NAMI Tri-Valley, Native American Health Center, Oakland LGBTQ Center, Ohlone College, Pacific Center, POCC Elders, POCC Veterans, RCD Housing, REACH AYC, Regional Center of the East Bay, Richmond Agency Multi Services, Ruby's Place, Satellite Affordable Housing, Second Chance, SEIU, St. Mary's Center, Stanford Medicine Youth Mental Health and Wellbeing, StarosVet, Swords to Plow Shares, Tiburcio Vasquez, Towne House Wellness, UC Berkeley, Washington Hospital, YMCA Early Childhood Impact, Youth Homeless Advisory Board, YouthAlive!

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

	City name
1	Oakland
2	Hayward
3	Fremont
4	San Leandro
5	Livermore

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

Yes

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:

The Community Program Planning Process (CPPP) was conducted in each Board of Supervisor district to acquire community input to guide the BHSA Integrated Plan. From February 1 to May 30, 2025, Alameda County residents were engaged through 28 Listening Sessions, 4 Community Engagement Meetings, and 613 Community Input Surveys conducted both in person and virtually, in English, Chinese, Farsi, Spanish, Tagalog, and Vietnamese. Additional engagement included key informant interviews, peer led focus groups, popup events, and ongoing planning meetings. Alameda County blended qualitative and quantitative community input analysis to ensure behavioral health priorities reflect community voices and needs. Stakeholder input was organized into a framework of 6 System Needs and 6 Population Needs. Top

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system needs include services for access, crisis, housing, workforce, SUD, and trauma. Top population needs include children, adults, older adults, disability, reentry, veterans, and family members.

Key community priorities included: culturally competent outreach and programs, peer support services, and navigation services to build trust. Wraparound supports: trauma services, caregiving, employment services, therapy, and peer groups. Crisis services: expansion of 24/7 mobile teams, detox shelters, and crisis stabilization. Early Intervention services: expanding community based programs, stigma reduction, and mental health navigators. Housing with integrated services: case management, peer support, and onsite care for adults, older adults, and justice involved individuals. Workforce development: support to reduce burnout, increase retention, loan forgiveness, and continuous training. The CPPP feedback was discussed with Alameda County Behavioral Health Department Systems of Care, Local Health Jurisdiction (LHJ) and Medical Managed Care Plans (MCPs), and the Behavioral Health Advisory Board to help guide planning. Data and information from statewide behavioral health goals were also reviewed and included in planning and the development of the Integrated Plan. The 30 day public comment period will further shape the Integrated Plan. Alameda County remains committed to community driven planning that reflects local needs and equity.

Local Health Jurisdiction (LHJ)

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)?

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:

The Alameda County Behavioral Health Department (ACBHD) worked in close partnership with the Local Health Jurisdiction (LHJ) and Medi-Cal Managed Care Plans (MCPs), including Alameda Alliance and Kaiser Permanente to develop the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). Several methods of collaboration included joint planning meetings,

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community advisory committees, alignment of priorities, data sharing, and joint participation in the Community Program Planning Process (CPPP). ACBHD, the LHJ and the MCPs identified shared goals and coordinated strategies to address access to care, housing, economic security, workforce development, crisis services, substance use disorder treatment, and community safety.
ACBHD, the LHJ and MCPs exchanged data to inform utilization, outcomes, and demographics to identify disparities by race/ethnicity, age, and geography. This included HEDIS measures, emergency department data, and non-specialty mental health utilization rates to identify gaps and inform interventions. Common barriers emerged such as language access, stigma, provider diversity, and social determinants to address both specialty and non-specialty behavioral health needs.
To align strategic planning Alameda County Board of Supervisors, ACBHD, LHJ, and both MCPs held a series of public committee advisory groups, listening sessions, and survey data sharing forums. Throughout 2024 and 2025 a quarterly public meeting, the Community Provider Advisory Group, met to develop and align county goals and priorities, participants included: providers, elected officials, and agency leadership. Through additional targeted community stakeholder forums and surveys, ACBHD, LHJ, and MCPs collaborated to obtain community input to directly shape services, the Integrated Plan, the CHA/CHIP and the MCP Public Needs Assessment.

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.**

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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**
- ☑ **Homelessness**
- ☑ **Institutionalization**
- ☑ **Justice Involvement**
- ☑ **Overdoses**
- ☑ **Removal of Children from Home**
- ☑ **Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)**

Please describe

The Alameda County Behavioral Health Department (ACBHD) met with the Medi-Cal Managed Care Plans (MCPs) and the Local Health Jurisdiction (LHJ) to discuss statewide behavioral health goals throughout the Integrated Plan Community Program Planning Process (CPPP). The MCP and the LHJ shared reports, needs assessments, and participated in ACBHD Listening Sessions. For instance, Alameda Alliance Outreach and Education Plan highlighted access to care as a top need which coincided with the feedback from ACBHD's CPPP and the LHJ's CHA/CHIP. ACBHD considered the NSMHS MCP data such as Medi-Cal enrollment, gender, race, and homeless with SMI, and emergency room visits.

ACBHD held recurring meetings with LHJ teams to inform the Integrated Plan development and the statewide behavioral health goals. ACBHD and LHJ exchanged data to ensure the Integrated Plan, and the CHA/CHIP identified community needs and social determinants. ACBHD discussed statewide behavioral health goals with the LHJ, in response the LHJ provided presentations, reports, data, and community forums. ACBHD held CPPP-Planning Committees and Mental Health Stakeholder Groups for community participants and invited the LHJ to share data and to discuss behavioral health program developments, demographic information, and community disparities. The identified community needs and the behavioral health goals were shared to contribute to the Integrated Plan and the development of the CHA/CHIP.

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Alameda County leadership created the Community Advisory Group (CPAG) which is a collaboration and data sharing initiative amongst county providers, ACBHD, LHJ and MCPs. During the public CPAG meetings the Alameda County Board of Supervisors led collaborative workshops. These collaborations helped ACBHD identify data, incorporate community input, to ensure programs are reflective of community needs, and led to ACBHD selecting overdoses as the additional statewide behavioral health goal.

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.**

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

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

Yes

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

When developing the Integrated Plan the Alameda County Behavioral Health Department (ACBHD) reviewed the Local Health Jurisdiction's (LHJ) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). The review focused on priorities linked to behavioral health: access to care, economic stability, and safe communities. ACBHD incorporated LHJ and DHCS data and information for the Integrated Plan's population behavioral health goals: access to care, emergency department use, overdose trends, reducing justice involvement, and family stability.

The Integrated Plan reflects shared priorities from the CHA and CHIP, including early screening for chronic conditions, culturally responsive care, language access, and nontraditional supports. The CHIP's focus on families and healthy communities aligns with prevention and family support strategies. Some LHJ priorities, such as food security, vaccination rates, and dental care, fall outside the behavioral health scope. Early life inequities were reviewed for relevant mental health connections.

CHA priorities connected to behavioral health include mental health, housing, employment, and safety. Some of the shared ACBHD and LHJ strategies include data driven planning, evidence based practices, aiming to change narratives, and improving policies to build healthier communities.

ACBHD and the LHJ align essential health services by assessing population needs, ensuring equitable access, supporting a diverse workforce, and mobilizing partnerships to address social determinants. The CHA/CHIP data on disparities and service gaps informed the Integrated Plan on target populations, interventions, and program coordination. The interagency data and meeting collaboration between ACBHD, LHJ and the California Department of Health Care Services (DHCS), along with community stakeholder input, allowed ACBHD to ensure the Integrated Plan reflects the needs of Alameda County residents and provides solutions to improve the overall health of our county residents.

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Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

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

Alameda Alliance for Health, 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?

As of the writing of the Integrated Plan, Alameda Alliance and Kaiser are still in progress completing their Community Reinvestment Plan. Alameda Alliance provided their Outreach and Engagement Plan and Kaiser their Community Health Needs Assessment. Through the provided MCP Assessments, joint meetings and data sharing, Alameda County observed alignment in community priorities, levers, and strategies. MCP discussions included topics such as expanding cultural and linguistically responsive service navigation, targeted follow up after emergency department visits for mental illness and substance use, linking members to outpatient treatment and reducing repeat visits.

MCPs identified workforce development as a priority to address staffing shortages, retention strategies, and career pathways, to grow a diverse, culturally competent provider base. The importance of localized care has led MCPs to explore hubs as well as the need to tighten collaboration efforts around SUD. MCP housing initiatives prioritize navigation programs, interventions, retention, flexible subsidies, planning and development. Early intervention programs offer trauma informed and age specific healing services. MCP and BHSA priority populations are aligned, and programming initiatives can alleviate health disparities.

Furthermore, MCPs discuss Alameda County's high unemployment rates and greater income inequality compared with that of the state. Medi-Cal participation rates are lower in the Oakland service area compared to the nation and the state, and neighborhoods of color, including Hispanic and Black neighborhoods have higher rates of uninsured populations. Key informants reported barriers to accessing care such as transportation, the cost of insurance and health care. Alameda County's Integrated Plan and the MCPs collaborative planning, shared data, and outreach to advance programs with the goals of closing service gaps to improve access, and ensure care is timely, coordinated, and culturally responsive.

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Comment Period and Public Hearing

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

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

3/19/2026

2. Date the stakeholder comment period closed

4/20/2026

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

4/20/2026

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

- ☑ **Link**
- ☑ **PDF, image, or other document**

Please provide the link to the public posting

https://www.acbhcs.org/plan-administration/mental-health-service-act/mhsa-doc-center/

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

- ☑ **Public Posting**
- ☑ **Email Outreach**

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

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Stakeholder group that provided feedback	Summarize the substantive revisions recommended this stakeholder during the comment period
To be added after the close of the Public Comment period.	**Forthcoming**

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

Substantive recommendations
Forthcoming. To be added after the close of the Public Comment period.

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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**

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County Provider Monitoring and Oversight

Medi-Cal Quality Improvement Plans

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

Please see the Appendix for the Alameda County Quality Improvement Work Plan.

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

No

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

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

Services Provided	Number of Contracted BHSA Provider Locations
Mental Health (MH) services only	**61**

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Substance Use Disorder (SUD) services only	**2**
Both MH and SUD services	**13**

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

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

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	**46**
DMC/DMC-ODS only	**2**
Both SMHS and DMC/DMC-ODS systems	**13**

All BHSA Provider Locations

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

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

13%

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:

Alameda County partners with Alameda Alliance and Kaiser Permanente to increase and support Medi-Cal Managed Care Plan (MCP) contracting at

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provider locations. Alameda County and the MCPs have identified disparities in diverse communities and are looking for opportunities for CBOs, regardless of size, to participate. Alameda County will strengthen coordination on housing and community supports with the MCPs by creating and enhancing data sharing methods. Alameda County and the MCPs anticipate working in partnership to address contract terms, billing practices, and to make sure rates align.

2. To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)
a. Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening
b. Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and
c. Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding
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 that:

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3a. Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)

Yes

3b. Do not participate in the county's Medi-Cal Behavioral Health Delivery System?

Yes

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Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS)

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

General

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

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

Children's System of Care

Children's System of Care (Non-Full Service Partnership (FSP)) Program #1

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care.

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

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2. Please describe the specific services provided

PROVIDER NAME: Alameda County Behavioral Health Department
PROGRAM NAME: Juvenile Justice Transformation of the Guidance Clinic
Program Description: Provides in-depth assessment and treatment for youth in the juvenile justice system. Coordinates referrals and linkages to mental health services in order to ensure seamless continuity of care when discharged from juvenile hall to community based providers.
Target Population: Youth ages 12-18 years old who are involved in the juvenile justice system and their families.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**350**
FY 2027 – 2028	**350**
FY 2028 – 2029	**350**

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

Alameda Couty used a mix of recent service data and reasonable assumptions to project the number of children expected to be served. Projections assume a stable level of juvenile justice involvement and consistent referral patterns from the Juvenile Justice Center. This estimate also considered language access capacity, staffing levels, and anticipated turnover. The projection reflects both historical trends, stakeholder feedback during the Community Program Planning Process, and Alameda

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County's expectation that youth reentry and assessment needs will remain steady over the next several years.

Children's System of Care (Non-Full Service Partnership (FSP)) Program #2

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Seneca Family of Agencies
PROGRAM NAME: Probation MST – Outpatient
Program Description: Multi-Systemic Therapy (MST) is a unique, goal-oriented, comprehensive treatment program designed to serve multi-problem youth in their community. MST interventions focus on key aspects of these areas in each youth's life. All interventions are designed in full collaboration with family members and key figures in each system- parents or legal guardians, schoolteachers and principals, etc. MST services are provided in the home, school, neighborhood and community by therapists fully trained in MST. Therapists work in teams and provide coverage for each other's caseloads when they are on vacation or on-call. MST therapists are available 24 hours a day, seven days a week through an on-call system (all MST therapists are required to be on-call on a rotating schedule). Treatment averages 3-5 months.
Target Population: Youth (ages 0-21) referred who are on probation in Alameda County and are at risk of out of home placement due to referral behavior and living at home with a parent or caretaker.

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

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

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

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

Alameda County relied on prior years' service data and realistic expectations around staffing and referrals to project the number of children to be served. Projections of 30-40 youth each year for FY26-29 assume stable referral levels from probation and community partners. These numbers also reflect stable staffing and filled vacant clinician positions. The estimates also reflect the intensive nature of MST, where each therapist serves a limited caseload but works deeply with families. Historical trends, program capacity, lead Alameda County to project that service numbers will remain consistent with this range. During the Community Program Planning Process stakeholder input was gathered, a recurring theme expressed was that program priorities incorporate equitable solutions that emphasize care with quality, continuity and intensive engagement over volume of individuals served.

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Children's System of Care (Non-Full Service Partnership (FSP)) Program #3

1. Please select the service types provided under Program

☑ **Mental health services**

☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic
PROGRAM NAME: Child and Youth Medication and Psychiatry Services
Program Description: Pathways to Wellness provides the following clinic-based services based on the acuity client of needs to promote successful transition of patients to primary care; 1. Medication Support Services; 2. Issuing medication prescription(s) for the right drug therapy; 3. Administration of injectable medication, when applicable; 4. Evaluation and monitoring; 5. Mental Health Services, and 6. Outreach efforts made in the field by a psychiatric nurse specifically in North County to meet client demand; 7. Children support services for medication and case management.
Target Population: Pathways to Wellness provides services to children (5-9 years old) and adolescents (10-17 years old) who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning. All clients must meet specialty mental health criteria with impairments in the moderate to severe range. All clients are referred by Alameda County Acute Crisis Care and Evaluations for System-Wide Services (ACCESS). Services are provided in North County, South County and East County, located in Oakland, Union City and Pleasanton.
3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**2,800**

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Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	2,800
FY 2028 – 2029	2,800

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

Alameda County projects the number of children and adolescents served based on historical utilization trends, referrals, and current service capacity. Increases in crisis stabilization, medication support, and outpatient services show increases in referrals and engagements. Projections assume that growth will be driven by community outreach, faster access to evaluations and coordination between crisis, school based and outpatient systems. Alameda County also anticipates staffing will stabilize, facility upgrades, and culturally response care will remain consistent to help reduce service delays. During the Community Program Planning Process stakeholders expressed the need for expanded child and adolescent crises and stabilization services to prevent behavioral health disorders from becoming destabilizing later in life.

Children's System of Care (Non-Full Service Partnership (FSP)) Program #4

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Telecare Corporation
PROGRAM NAME: Transition Age Youth Recovery, Outreach and Connection (TAY ROC)

Program Description: TAYROC is a short-term (90 days) outreach-evaluation-triage program serving TAY youth who are not already connected to the ACBHD System of

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Care. TAYROC members include transition age youth who are homeless or at risk of homelessness, have co-occurring substance use and/or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and/or have limited English proficiency. TAYROC conducts in-reach and engagement at local inpatient facilities, CSUs, and CRPs. The team also provides outreach and engagement to other locations and organizations where TAY experiencing mental health crises are likely to be found. TAYROC staff provide linkages, supports, and resources to help clients stay in the least-restrictive, most self-sufficient, and recovery-oriented settings; reduce the need for inpatient and emergency room care; and improve mental health outcomes. Services are delivered by a team of case managers, peer support specialists, a team lead, and a clinical director. Services provided by the TAYROC team include individual and group rehabilitation, crisis intervention, individual and group therapy, plan development and targeted case management. The latter service links the consumer to needed resources and supports in the community such as housing, benefits, medication, therapy, and medical/dental services. 80% of the TAYROC services are delivered in the community. TAYROC is located in the Eastmont Town Center in Oakland, CA.
Target Population: TAY ROC serves TAY youths 16 to 24 years of age who are Alameda County residents, who appear to be experiencing a mental health crisis; and/or are affiliated with one of the TAY ROC referral sources; and who are not already connected to the ACBH System of Care.

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

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

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

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Plan Period by FY	Projected Number of Individuals Served
FY 2028 – 2029	150

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

Alameda County projects the Telecare TAYROC program to have consistent or increased demand from TAY individuals with serious mental illness and or co-occurring conditions. This assumption was also made by factoring historical data and Medi-Cal expansion. Alameda County factored in provider capacity, staffing levels and outreach activities which reflect efforts to stabilize and reengage individuals at risk of institutionalization or homelessness. During the CPPP, community stakeholders voiced the need to expand efforts for TAY individuals as it relates to targeted case management, crisis intervention, peer support, recovery services and accessibility for individuals in an urban areas.

Children's System of Care (Non-Full Service Partnership (FSP)) Program #5

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: CalMHSA
PROGRAM NAME: Presumptive Transfer Project
Program Description: Funding to be transferred for the support of providing services to Alameda County foster youth being served outside of Alameda County.
Target Population: Foster youth receiving mental health services outside of Alameda County. This is a current mandate for all California Counties.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**95**
FY 2027 – 2028	**95**
FY 2028 – 2029	**95**

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

Alameda County based projections on last year's presumptive transfer data: 95 youth received services from other counties and 160 were placed out of county. These numbers were used to estimate similar levels for FY26-29, this accounts for steady caseload trends and the ongoing state requirement for foster youth transfers.

Children's System of Care (Non-Full Service Partnership (FSP)) Program #6

1. Please select the service types provided under Program

☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Healing Perspectives
PROGRAM NAME: Eating Disorder Consultant
Clinicians provide support for individuals with eating disorders and or disordered eating symptoms. Support can be provided by telephone, video conference, or in person. During these visits the clinician seeks to gain an increase in knowledge to provide treatment for clients that are diagnosed with eating disorders. Healing

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Perspectives will provide eating disorder assessments for referred individuals and provide recommendations for level of treatment.
Psycho-education topics may include but are not limited to screening measures to assess eating disorders, engagement strategies, working with families, evidenced-based treatments, body image issues, transference and countertransference issues, trauma and eating disorders, co-occurring diagnoses, cultural considerations, substance misuse, and working with LGBTQ+ communities. In addition, trainings by Healing Perspectives will be provided to ACBHD staff to learn more about how to screen for signs and symptoms of eating disorders and/or disordered eating and various treatment strategies for individuals with eating disorders.

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 10. Number of Individuals in the Children's System of Care (Non-FSP) Served During the Plan Period by Year

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

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

Projected numbers were calculated based on the workload capacity for the Eating Disorder Consultant. The Eating Disorder Consultant is a Licensed Clinical Social Worker (LCSW). One-time or ongoing consultation for individual clinicians around eating disorder (ED) treatment must be conducted via telephone, video conference, or in person. ACBH and ACBH contracted clinicians will call or email the Contractor to schedule a case consultation. Individuals will be referred to by the ACCESS hotline. Healing Perspectives must conduct ED consultation groups for ACBH and ACBH contracted clinicians working with individuals diagnosed with ED or seeking to

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develop experience and expertise in ED treatment. It is from this calculated workload and staff capacity that the projected number of individuals served was made.

Children's System of Care (Non-Full Service Partnership (FSP)) Program #7

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

Provider Name: Alternative Family Services, Inc.
Program Name: Pathways to Permanence Inroads to Independence
Pathways to Permanence Inroads to Independence provides the following clinic-based services based on the acuity client of needs to promote successful transition of patients to primary care; 1. Medication Support Services; 2. Issuing medication prescription(s) for the right drug therapy; 3. Administration of injectable medication, when applicable; 4. Evaluation and monitoring; 5. Mental Health Services, and 6. Outreach efforts made in the field by a psychiatric nurse specifically in North County to meet client demand; 7. Children support services for medication and case management.
Target Population: Children and youth who meet service necessity for specialty mental health services as defined by the California Department of Health Care Services (DHCS).

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**148**

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

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

Alameda County projects the Pathways to Permanence program to have consistent or increased demand from TAY individuals with serious mental illness and or co-occurring conditions. This assumption was also made by factoring historical data and Medi-Cal expansion. Alameda County factored in provider capacity, staffing levels and outreach activities which reflect efforts to stabilize and reengage individuals at risk of institutionalization or homelessness. During the CPPP, community stakeholders voiced the need to expand efforts for children and youth individuals as it relates to targeted case management, crisis intervention, peer support, recovery services and accessibility for individuals in an urban areas.

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Adult and Older Adult System of Care

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

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic
PROGRAM NAME: Adult Outpatient
Program Description: Pathways to Wellness provides the following clinic-based services based on the acuity client of needs to promote successful transition of patients to primary care; 1. Medication Support Services; 2. Issuing medication prescription(s) for the right drug therapy; 3. Administration of injectable medication, when applicable; 4. Evaluation and monitoring; 5. Mental Health Services, and 6. Outreach efforts made in the field by a psychiatric nurse specifically in North County to meet client demand; 7. Children support services for medication and case management.
Target Population: Pathways to Wellness provides services to adults (18-59 years old) who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning. All clients must meet specialty mental health criteria with impairments in the moderate to severe range. All clients are referred by Alameda County Acute Crisis Care and Evaluations for System-Wide Services (ACCESS).

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

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

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Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2,800
FY 2027 – 2028	2,800
FY 2028 – 2029	2,800

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

Alameda County projects the number of served adults based on historical utilization trends, referrals, and current service capacity. Alameda County anticipates stable demand driven by ongoing systemic factors such as violence, chronic stress, housing shortages, and prevalence of co-occurring conditions. Furthermore, there is a consistent need for psychiatric evaluation, culturally responsive care, and coordinated treatment.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #2

1. Please select the service types provided under Program

☑ **Mental health services**

☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Telecare Corporation
PROGRAM NAME: STEPS
Program Description: STEPS of Alameda County is a short term, intensive community support service for individuals who suffer from a mental illness, many of whom would otherwise require extended care in institutional settings. Services are designed to

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enhance the lives of individuals living with mental illness and guide them on their healing process. The mission of STEPS is to facilitate the transition of high risk, hard-to-place Alameda County Behavioral Health clients into the community while reducing their length of stay in Alameda County psychiatric facilities.
Target Population: Adults (ages 18-59) diagnosed with a severe mental illness. STEPS' goal is to serve high utilizers of Alameda County mental health services. Members referred to STEPS will have utilized at least three psychiatric emergency room visits and/or at least one month of inpatient psychiatric care within the past year. Priority will be given to members who have met these criteria for 2 years in a row.

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

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

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

As with most programs, Telecare continues to struggle with finding and securing affordable housing for participants. There is still a lack of affordable housing in Alameda County. Additionally, finding and securing supportive housing with medical services such as diabetes management and medication support continues to be challenging. Recently we have also struggled with connecting partners to primary care providers. The FQHCs in Alameda County are having a staffing crisis. Partners are waiting months to get established and requiring urgent care or emergency care while they wait. Despite these challenges, the projection reflects the ongoing demand for

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intensive, short term community support to help clients stabilize, reduce hospital stays, and build safer paths back into the community.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #3

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: R.E.F.U.G.E.
PROGRAM NAME: TAY 24 Hour Residential Program
Program Description: R.E.F.U.G.E. offers a 24-Hour facility for TAY consumers in crisis. A supervised residential facility for mental health treatment program that includes full-day social rehabilitation services for TAY who need additional support as they step down from a restrictive setting into the community. REFUGE has 13 beds and offers residential treatment for up to 6 months.
Target Population: R.E.F.U.G.E. serves TAY consumers between 18 years of age and 25th birthday who are living in Alameda County (including those who are homeless or at risk for becoming homeless); are enrolled in Health Program Alameda County (HealthPAC County) or Full-Scope Medi-Cal eligible; who meet medical and service necessity criteria for specialty mental health services; require a transitional period of adjustment after a psychotic episode, and/or stepping down from hospitalization/restrictive setting before returning to the community; are ambulatory and free of communicable diseases; are able to participate in 4+ hours of group programming daily; who have the ability to pay for room and board (program can support client in obtaining benefits); and have been authorized for services by ACBHD.

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

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

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

The projection for adults and older adults is informed by utilization and program capacity. REFUGE has a 70% program completion rate where the clients achieved treatment goals and secured permanent housing. R.E.F.U.G.E. has 13 beds and an average stay of up to 6 months. R.E.F.U.G.E. projects that TAY individuals will step down in their level of care from acute or restrictive settings. R.E.F.U.G.E. sees an ongoing demand from individuals experiencing homelessness or at risk of homelessness. Overall, the projection is capacity driven rather than growth oriented which ensures reliable access to short term residential support for the TAY population.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #4

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Bay Area Community Services, Inc.
PROGRAM NAME: Crisis Stabilization Unit (CSU) and Crisis Residential Treatment (CRT): Amber House

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Program Description: Amber House is a dual voluntary crisis stabilization unit (CSU) and voluntary crisis residential treatment (CRT) program. Amber House CSU is a 12-bed voluntary only CSU whose purpose is to assess individuals who are having a mental health crisis and are in need of assessment, stabilization, and brief treatment. The service is available to individuals for up to 24-hours. Amber House CRT has up to 14-beds for individuals in crisis who do not meet medical necessity criteria for hospitalization and would benefit from treatment and supportive programming. Amber House crisis services are available to only clients who are 18 and over and residents of Alameda County who possess and/or eligible for Medi-Cal.
Target Population: Amber House serves adults 18 years or older (18-59 years) experiencing a mental health crisis.

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**1,800**
FY 2027 – 2028	**1,800**
FY 2028 – 2029	**1,800**

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

The projection for adults and older adults is informed by utilization and program capacity. Amber House CSU is a 12 bed voluntary only and Amber House CRT has up to 14 beds for individuals in crisis. These numbers are expected to maintain given staffing levels stabilize, demand for crisis care continues to grow, and the number of Medi-Cal eligible individuals. During the Community Program Planning Process

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stakeholder input expressed the need to create better options for hospitalization, this also shaped the estimated projected number of individuals to be served.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #5

1. Please select the service types provided under Program

☑ **Mental health services**

☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Bay Area Community Services (BACS)
PROGRAM NAME: Re-entry Treatment Teams (RTT)
Program Description: The Re-entry Treatment Teams (RTT) are a multidisciplinary treatment and case management program that serves adults who were previously incarcerated or involved in the criminal justice system. The program pairs clinical staff with peer case managers with lived experience in systems impact from the criminal justice system to meet the broad range of client needs. The program uses an eighteen month "critical time intervention"-based framework, providing intensive services and wraparound resources during the initial stabilization phase and then transitions the client to community care and supports.
Target Population: Adults, 18-59 years old, who were involved in the criminal justice system and have a severe mental illness (SMI).

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

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

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

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

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

The projections rely on utilization trends, program capacity, and anticipated changes in demand. The Re-entry Treatment Teams provide intensive treatment and case management to individuals with serious mental illness who were justice involved. Alameda County assumes that retention and engagement will create modest growth as staffing turnover stabilizes and housing linkages improve. Future projections also factor in the program's 18 month intervention model, where clients transition over time to community based support. Alameda County predicts flatline or steady growth rather than rapid expansion. This will help ensure that the intensive model, client turnover, and realistic capacity meet the needs of adults with high service demands.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #6

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: La Familia Counseling Center
PROGRAM NAME: Re-entry Treatment Teams (RTT)
Program Description: The Re-entry Treatment Teams (RTT) are a multidisciplinary treatment and case management program that serves adults who were previously

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incarcerated or involved in the criminal justice system. The program pairs clinical staff with peer case managers with lived experience in systems impact from the criminal justice system to meet the broad range of client needs. The program uses an eighteen month "critical time intervention"-based framework, providing intensive services and wraparound resources during the initial stabilization phase and then transitions the client to community care and supports.
Target Population: Adults, 18-59 years old, who were involved in the criminal justice system and have a severe mental illness (SMI).

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

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

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

Alameda County's projections for adults and older adults served were based on caseload patterns and staffing capacity. The projections assume stable staffing, continued use of peer counselors, and integration of skill building strategies to manage higher client volumes. Historical data on service hours, client engagement, and housing barriers were also factored in. Alameda County assumes that retention will improve once vacancies are consistently filled and psychiatric evaluations are more consistently available. These combined inputs guided the county in setting a realistic estimate for the number of individuals the system can serve.

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Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #7

1. Please select the service types provided under Program

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

2. Please describe the specific services provided

PROVIDER NAME: Bay Area Community Services (BACS)
PROGRAM NAME: ACCESS Outreach and Engagement Team
Bay Area Community Services, Inc. (BACS) will provide supportive services for clients referred through the ACBHD Acute Crisis Care and Evaluation for Systemwide Services (ACCESS). ACCESS is ACBHD's systemwide point of contact for information, screening, and referrals for behavioral health services for Alameda County residents. ACCESS strives to connect clients to care within ten days of referral. When a client is not connected promptly to a service provider, there is a risk of a client not receiving timely mental health services, and/or their condition deteriorating. Alameda County is responsible for developing, implementing, and staffing a System Care Coordination Team to improve linkages to community-based services across the County's behavioral health system. The ACCESS Care Coordination Team (ACCT) is part of the County's commitment to improving ACBHD's system. Through the ACCT, BACS will provide interim mental health and/or co-occurring substance use (SU) services for clients who would otherwise be unable to access services through ACBHD or its contracted providers timely due to capacity issues within existing programs. BACS will implement two teams: one Outreach and Engagement (O&E) and one Case Management. The O&E team will locate ACCESS referrals and complete a warm hand-off with the Case Management team who will provide time-limited interim mental health and co-occurring SU services while connecting clients to available and appropriate levels of care within the County mental health and SU systems.

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

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

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

This is a new program, and projected numbers were calculated based on workloads for Outreach Peer/Specialists and the Case Management Team. The Case Management team consists of 1 Program Manager, 6 Clinicians, 2 Outreach Peer Specialist. The Outreach & Engagement Team consists of 3 Outreach/Peer Specialist. BACS will serve individuals who meet eligibility requirements through ACBHD ACCESS to receive Specialty Mental Health Services (SMHS) and/or co-occurring SUD services and are unable to receive timely access services through other ACBHD contracted providers due to capacity issues.
Clients may include individuals who need outpatient therapy and are homeless or at risk of homelessness, have been involved in the criminal justice system, have co-occurring substance use and/or physical health disorders, have frequent use of hospitals and other emergency services, are at risk of institutionalization, and/or have limited English proficiency. BACS shall serve individuals who are sex offenders.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #8

1. Please select the service types provided under Program

☑ **Supportive services**

2. Please describe the specific services provided

Provider Name: Roots Community Health Center
Program Name: Santa Rita Safe Landing Center
Roots Community Health Center will outreach to individuals released from Santa Rita Jail who are in need of post-release support services or transition support services. The program will only serve individuals who: are Alameda County residents; are 18 years of age or older; and are released from Santa Rita Jail and are in need of post-release support services. Roots will administer a pre-screening tool to assess the needs of each client. In order to meet clients' immediate needs and connect them with services that will assist in stabilization, Roots will:
• Assist clients in meeting immediate needs such as the use of a phone or phone charging capabilities in order to call family or other contacts to make post-release arrangements;
• Provide essential needs such as food, clothing, and hygiene items;
• Connect clients to 2-1-1 housing support services and model how to use such services to connect to available resources independently in the future;
• Provide linkage to community-based resources for support services;
• Provide tailored linkage information to health resources in areas including, but not limited to: mental health treatment, health education, substance use disorder (SUD) treatment, primary medical care, dental services, and other health services;
• Support clients in understanding the process to receive public benefits for which they may be eligible such as Medi-Cal, Supplemental Security Insurance (SSI)/Social Security Disability Income, CalFRESH, General Assistance, and Veterans Administration benefits;
• Facilitate direct linkages to existing community based mental health providers, as appropriate.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**3,600**
FY 2027 – 2028	**3,600**
FY 2028 – 2029	**3,600**

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

This is a relative new program (less than three years in operation), and projected numbers were calculated based on workloads for Transitions Services Specialist, Transitions Services Coordinator, Operations Specialist, Behavioral Specialist, and Program Specialist.
Roots will receive referrals from Alameda County Health, Behavioral Health Department (ACBHD), the Adult Forensic Behavioral Health (AFBH) program at Santa Rita Jail, Alameda County Sheriff's Office, and self-referrals from clients who leave Santa Rita Jail and arrive at the mobile Santa Rita Safe Landing Center. Roots will conduct outreach with Santa Rita Jail staff to help develop direct referrals to adults who are released from jail. Roots will conduct general outreach to help community members become aware of the services provided.
The Santa Rita Safe Landing Center has capacity to serve at least 300 individuals per month and 3,600 individuals per year, this will be reviewed in subsequent years.

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Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #9

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Bay Area Community Services (BACS)
PROGRAM NAME: HEDCO House
Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity. Wellness Center personnel are trained in Harm Reduction and Trauma-Informed Care principles to meet the participant where they are at, in a whole person manner. Cultural responsivity is a core axiom of the care provided by the team as the program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.
Target Population: The BACS Wellness Centers provide services to adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24).

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

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

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Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	8,300
FY 2027 – 2028	8,300
FY 2028 – 2029	8,300

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

During the CPPP, the need and effectiveness of Wellness Centers were consistently voiced by stakeholders. Wellness Centers are a main entry point for clients and help alleviate the need of access to care. Projections were based on the FY23/24 from historical individuals and served trends in engagement and service utilization. Projections assume that there will be continued demand for peer wellness and housing support, and adjustments for seasonal fluctuations and increase homelessness or behavioral health challenges. These assumptions result in estimated individuals served as 8,300 clients in FY26/27, which aligns with historical program growth and anticipated service enhancements.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #10

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER: Alameda County Behavioral Health Department
Program Name: Crisis Response Program (CRP)

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Crisis Response Program (CRP) is a fully mobile crisis service that responds to 5150 calls, engages with consumers who are in crisis, assesses consumer needs and conducts follow up post crisis situations. Crisis Services has three mobile crisis teams.

Clinical staff work primarily out in the field, which increases community-based crisis prevention and early intervention services, thereby ensuring clients are referred to the appropriate type of mental health services. ACBHD clinical staff work on the Mobile Crisis Teams (MCT) for North County, East County, and South County. In addition, clinicians staff the Mobile Evaluation Team (MET), a partnership with Oakland Police Department and the Hayward Mobile Evaluation Team (HMET), a partnership with Hayward Police Department. Bonita House clinicians staff the third mobile crisis team, the Community Assessment and Transport Team (CATT) along with Alameda County's Emergency Medical Services and Falck. Post crisis follow up teams focus on follow up for clients who have recently been to John George Psychiatric Hospital's Psychiatric Emergency Services (JGPES) Department and the Geriatric Assessment and Response Team (GART) provide mental health linkages to ACBHD's older adult population.

Target Population: Crisis Services serves residents of Alameda County along the entire lifespan who are living with a serious and persistent mental illness and are in crisis. The MCT, MET, HMET, and CATT Programs provide on-the-spot crisis intervention, psychiatric assessment and evaluation to all ages and make referrals to other agencies and provide follow-up services. MCT Responds to calls from police, shelters, designated community agencies, and community members throughout Alameda County. The MET and HMET teams pair a police officer with an ACBHD clinician to respond to calls from police dispatch. The CATT teams pair a Bonita House clinician and EMT to respond to calls from dispatch as well.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**3,387**

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Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	3,387
FY 2028 – 2029	3,387

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

Alameda County's projections for adults and older adults served through Crisis Services were based on FY24/25 data which shows 3,000 individuals served. Crisis Services is expanding to East County and will see an increased number of calls from law enforcement, outpatient mental health providers, and community members. The projected estimates reflect the full staffing of mobile crisis teams and the extended 24/7 coverage. The historical utilization patterns and projections show a 3-7% annual growth which anticipates an increase in call volume. During the CPPP, stakeholders and providers expressed the need for additional crisis services and additional collaboration with law enforcement.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #11

1. Please select the service types provided under Program

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

2. Please describe the specific services provided

PROVIDER NAME: Alameda County Superior Court
PROGRAM NAME: 4 FTEs MH Clinician for Collaborative Courts

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Program Description: Telecare Alameda Court Collaborative (ACC) program supports the Office of Collaborative Court Services (OCCS) which manages eight treatment courts in Alameda County. These treatment courts serve an average of 180 justice involved clients at any given time (over 350 annually) who need substance abuse and mental health treatment services. The ACC team screens, refers, and coordinates mental health services within the Alameda County Behavioral Health system of care. This includes contacting clients to coordinate service linkage, completing written referrals, supporting warm handoffs to new providers, maintaining contact with clients and providers as needed, initiating treatment team meetings, engaging in court hearings and pre-court staffing meetings, and assisting clients with discharge planning.
Target Population: Justice involved adults age 18 and older with serious mental illness and cooccurring substance use disorder. Individuals must be eligible for diversion or re-entry services to the community. Consumers include Transitional Age Youth, Adults and Older Adults.

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

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

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

The need for treatment courts will expand as state and local policies balance growing concerns around the need for reduced reliance on incarceration and behavioral health

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treatment. There will be an increase in referrals for participants that have a high need for support around basic needs such as housing, physical and dental health, and employment. Alameda County anticipates that there will be an increase in usage to about 300 unique individuals in the next fiscal year. In FY 26/27 Alameda County projects providing direct services within residential and recovery residences to support the influx of those with co-occurring needs into the treatment courts.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #12

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Telecare Corporation
PROGRAM NAME: Adult & Older Adult HIP (AD ROC)
Program Description: AdROC is a short-term (90 days) outreach-evaluation-triage program serving adults who are not already connected to the ACBHD System of Care. AdROC members include individuals who are homeless or at risk of homelessness, have co-occurring substance use and/or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and/or have limited English proficiency. AdROC conducts in-reach and engagement at inpatient facilities, CSUs, and CRPs, and conducts outreach and engagement to community locations and providers. AdROC staff provide linkages, supports, and resources to help clients stay in the least-restrictive, most self-sufficient, and recovery-oriented settings; reduce the need for inpatient and emergency room care; and improve mental health outcomes. Services are delivered by a team of case managers, peer support specialists, a team lead, and a clinical director. Services provided by the AdROC team including individual and group rehabilitation, crisis intervention, plan development, individual and group therapy, and targeted case management. The latter service links the consumer to needed resources and supports in the community such as housing, benefits, therapy, medication, and medical/dental services. 80% of the AdROC services are delivered in the community. AdROC is located in the Eastmont Town Center in Oakland, CA.

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Target Population: AdROC serves adult Alameda County residents, 18 years of age and older, who appear to be experiencing a mental health crisis; and/or are affiliated with one of the AdROC referral sources; and who are not already connected to the ACBH System of Care.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**150**
FY 2027 – 2028	**150**
FY 2028 – 2029	**150**

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

Alameda County projects the Telecare AdROC program to have consistent or increased demand from individuals with serious mental illness and or co-occurring conditions. This assumption was also made by factoring historical data such as enrollment data, referral trends, and Medi-Cal expansion. Alameda County factored in provider capacity, staffing levels, facility constraints, outreach activities and the 90 day length of engagement. Projections reflect the baseline from FY23/24 and updated efforts to ensure consistent referral flows, stabilize and reengage individuals at risk of institutionalization or homelessness. During the CPPP, community stakeholders voiced the need to expand efforts for Adult and Older Adult individuals as it relates to targeted case management, crisis intervention, peer support, recovery services, linkages, and accessibility.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #13

1. Please select the service types provided under Program

☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Mental Health Association of Alameda County
PROGRAM NAME: African American Family Outreach Project
The African American Family Outreach Project (AAFOP) provides virtual and in-person workshops, evening events and a warmline with case management services for African American family caregivers. These culturally sensitive activities provide African American family members with peer support, education about mental health disorders, and information on how to access mental health services in Alameda County. We also operate a monthly support group for African American family caregivers. This monthly forum allows individuals to share their struggles and successes in advocating on behalf of their loved one. The importance of self-care as a means of stress reduction is highlighted in each support group meeting.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**67**
FY 2027 – 2028	**67**
FY 2028 – 2029	**67**

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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

Alameda County projects the African American Family Outreach Project program to have consistent demand based on prior year enrollment, utilization trends, and demographic shifts. This estimate also considered language access capacity, staffing levels, and anticipated turnover. The projection reflects both historical trends, stakeholder feedback during the Community Program Planning Process, and Alameda County's expectation that this stakeholder group will remain steady over the next several years.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #14

1. Please select the service types provided under Program

☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Mental Health Association of Alameda County
PROGRAM NAME: Certification Hearing Representative
This program will ensure patients (a mental health consumer who is in a psychiatric health facility) in an Alameda County Lanterman-Petris-Short (LPS)-designated psychiatric facility (Alameda County Medical Center Highland Hospital, John George Psychiatric Hospital, Alta Bates Medical Center's Ashby and Herrick Campuses, Fremont Hospital, Kaiser Permanente Fremont Medical Center – Psychiatry Unit, Telecare Heritage, Villa Fairmont, or Willow Rock Center Psychiatric Health Facility) understand the certification review hearing process, the right to representation, and the right to a writ of habeas corpus. This program will also ensure patients receive appropriate representation of their expressed interest with regard to their involuntary psychiatric hospitalization.
Target Population: Patients who have been certified for involuntary hospitalization in one of the LPS-designated psychiatric facilities, and who are entitled to a Certification Review Hearing and representation with regard to their continued involuntary hospitalization.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**3,750**
FY 2027 – 2028	**3,750**
FY 2028 – 2029	**3,750**

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

Alameda County's projections for individuals served through Certification Hearing Representative were based on staffing capacity and the range of 3,000-4,500 patients. The projected estimates reflect full staffing and extended coverage. The historical utilization patterns and projections show the range of patients served which anticipates LPS volume. During the CPPP, stakeholders and providers expressed the need for patient advocacy, crisis services, and additional collaboration.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #15

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

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PROVIDER NAME: Bay Area Community Health
PROGRAM NAME: Promoting Access to Health (PATH)
Program Description: Bay Area Community Health (BACH) operates a Federally Qualified Health Center (FQHC) to provide co-located services at the BACH Fremont location. The project provides coordinated, integrated health care to adults with serious mental illness. The project is called "Promoting Access to Health" (PATH) and has a Wellness Program to provide group health education and encourage socialization.
Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**90**
FY 2027 – 2028	**90**
FY 2028 – 2029	**90**

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

Alameda County's projections for individuals served through Bay Area Community Health were based on historical utilization, staffing capacity and the range of 90 adults. The projected estimates reflect full staffing and extended coverage. During the CPPP, stakeholders and providers expressed the need for integrated care to adults with serious mental illness.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #16

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: LifeLong Medical Care
PROGRAM NAME: Promoting Access to Health (PATH) at Eden Community Support Center
Program Description: LifeLong Medical Care operates a Federally Qualified Health Center (FQHC) to provide services at the Eden Community Support Center. The project provides coordinated, integrated health care to adults with serious mental illness. The project is called "Promoting Access to Health" (PATH) and has a Wellness Program to provide group health education and encourage socialization.
Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**150**
FY 2027 – 2028	**150**
FY 2028 – 2029	**150**

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

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Alameda County's projections for individuals served through Lifelong Medical Care were based on historical utilization, staffing capacity and the range of 150 adults. The projected estimates reflect full staffing and extended coverage. During the CPPP, stakeholders and providers expressed the need for integrated care to adults with serious mental illness.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP) Program #17

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: LifeLong Medical Care
PROGRAM NAME: Promoting Access to Health (PATH)
Program Description: LifeLong Medical Care operates a Federally Qualified Health Center (FQHC) to provide co-located services at the Oakland Adult Community Support Center (OACSC) operated by ACBHD. The project provides coordinated, integrated health care to adults with serious mental illness. The project is called "Promoting Access to Health" (PATH) and has a Wellness Program to provide group health education and encourage socialization.
Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**350**

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	350
FY 2028 – 2029	350

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

Alameda County's projections for individuals served through Lifelong Medical Care were based on historical utilization, staffing capacity and the range of 350 adults. The projected estimates reflect full staffing and extended coverage. During the CPPP, stakeholders and providers expressed the need for integrated care to adults with serious mental illness.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP) Program #18

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Alameda County Behavioral Health, Court Advocacy Program (CAP)
PROGRAM NAME: Behavioral Health Court (BHC), Mental Health Court Specialist (CAP)
Program Description: Alameda County Behavioral Health Court is a 12-24 month program of court oversight and community treatment for persons experiencing severe mental illness whose qualifying crimes result from their illnesses. The goals of BHC are to reduce recidivism and improve the quality of life, and assist severely mentally ill offenders by diverting them away from the criminal justice system and into community treatment with judicial oversight.

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The Mental Health Court Specialist CAP increases access to community mental health services and reduces recidivism through advocacy and release planning for the following services: 1. Identify and connect defendants with a mental illness to treatment services while in jail and refer to community treatment for post release follow up; 2. Involve community treatment providers in the court process for their clients and notify them of court status to ensure continuity of care; 3. Assist Judges, Public Defenders, District Attorneys & Probation in understanding mental illness and treatment resources; 4. Identify underlying issues leading to recidivism; i.e. Housing, Benefits, Medical Issues, Substance Abuse, etc.; 5. Advocate for specialty mental health treatment, such as hospitalizations for acutely ill, suicidal, and gravely disabled individuals; 6. Assist family members in navigating the courts and the mental health system of care.
Target Population: Justice involved adults age 18 and older with serious mental illness and cooccurring substance use disorder. Individuals must have pending criminal charges that were the result of their symptoms of mental illness. Consumers include Transitional Age Youth, Adults and Older Adults.

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**130**
FY 2027 – 2028	**130**
FY 2028 – 2029	**130**

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

Alameda County's projections for individuals served through the CAP program were based on historical utilization, staffing capacity and the range of 130 individuals. The

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projected estimates reflect full staffing and extended coverage. During the CPPP, stakeholders and providers expressed the need for integrated care to adults with serious mental illness.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP) Program #19

1. Please select the service types provided under Program

☑ **Mental health services**

☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Health & Human Resource Education Center
PROGRAM NAME: Health Equity Planning
Program Description: This program supports the Alameda County Behavioral Health Department Office of Health Equity with planning services and program supports. The goal is to increase participation in county programs. Example activities used to increase participation include peer and family member stipends, targeted outreach and engagement and activities & trainings in various threshold languages.
Target Population: Residents of Alameda County with a mental illness and or cooccurring substance use disorder.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**000**

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Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	000
FY 2028 – 2029	000

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

Alameda County's projections for individuals served through the Health Equity Program were based on historical utilization, staffing capacity of the Alameda County Behavioral Health Equity Planning team. The projected estimates reflect full staffing and extended coverage. During the CPPP, stakeholders and providers expressed the need for integrated care to adults with serious mental illness.

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP) Program #20

1. Please select the service types provided under Program

- ☑ **Mental health services**
- ☑ **Supportive services**

2. Please describe the specific services provided

PROVIDER NAME: Multi-Lingual Counseling for Adults
PROGRAM NAME: Community Mental Health Outpatient Services
Program Description: Multi-Lingual Counseling provides outpatient treatment services to low-income transition-age youth (TAY), adults, and older adults who have mental health issues and who have substantial impairment in their community functioning. Office locations include Oakland, San Leandro and Newark.

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Target Population: Adults age 18 and over. This program prioritizes serving multi-lingual and multi-cultural clients, including Afghan and Latinx immigrants and African Americans.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**130**
FY 2027 – 2028	**130**
FY 2028 – 2029	**130**

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

Alameda County's projections for individuals served through the Multi-Lingual Counseling Program were based on historical utilization and staffing capacity. The projected estimates reflect full staffing and extended coverage. During the CPPP, stakeholders and providers expressed the need for additional services for individuals in different languages.

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Early Intervention (EI)

Early Intervention (EI) Programs #1

1. Program or service name

Provider Name: Asian Health Services

Program Name: ACCESS Crisis Response and Outreach & Engagement

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

☑ **Outreach**

☑ **Access and Linkage: Screenings**

☑ **Access and Linkage: Assessments**

☑ **Access and Linkage: Referrals**

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

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

1. Increased access to mental health care and crisis support services, reduce gaps in behavioral health care.
2. Increased understanding of mental health issues and available resources for community members.
3. Increased timely support that improves and reduces the impact of mental health challenges.

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)

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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	**130**
FY 2027 – 2028	**130**
FY 2028 – 2029	**130**

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

Service utilization data and local community input through the CPPP process was used.

Early Intervention (EI) Programs #2

1. Program or service name

Provider Name: Multi-Lingual Counseling
Program Name: Early Intervention services for Alameda County residents.

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

- ☑ **Outreach**
- ☑ **Access and Linkage: Referrals**
- ☑ **Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**
- ☑ **Treatment Services and Supports: Other**

Please specify "other" type of Treatment Services and Supports

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Individual and Group treatment and case management services provided.

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
   1. Increased access to mental health care and crisis support services, reduce gaps in behavioral health care.
   2. Increased understanding of mental health issues and available resources for community members.
   3. Increased timely support that improves and reduces the impact of mental health challenges.

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	**130**
FY 2027 – 2028	**130**
FY 2028 – 2029	**130**

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

Service utilization data and local community input through the CPPP process was used.

Early Intervention (EI) Programs #3

1. Program or service name

Provider Name: Bay Area Community Health
Program Name: Early Intervention services for Alameda County residents.

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

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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

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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	**96**
FY 2027 – 2028	**96**
FY 2028 – 2029	**96**

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

Service utilization data and local community input through the CPPP process was used.

Early Intervention (EI) Programs #4

1. Program or service name

Provider Name: International Rescue Committee
Program Name: Early Intervention services for Alameda County residents.

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

☑ **Outreach**
☑ **Access and Linkage: Screenings**

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☑ **Access and Linkage: Assessments**

☑ **Access and Linkage: Referrals**

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

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.

2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.

3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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	**1,677**
FY 2027 – 2028	**1,677**

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Plan Period by FY	Projected Number of Individuals Served
FY 2028 – 2029	1,677

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

Service utilization data and local community input through the CPPP process was used.

Early Intervention (EI) Programs #5

1. Program or service name

Provider: Partnership for Trauma Recovery
Program Name: Early Intervention services for Alameda County residents.

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

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

5. Please describe intended outcomes of the program or service

1. Increased access for underserved communities to decrease disparities in behavioral health services.

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2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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	**213**
FY 2027 – 2028	**213**
FY 2028 – 2029	**213**

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

Service utilization data and local community input through the CPPP process was used.

Early Intervention (EI) Programs #6

1. Program or service name

Provider: La Clínica de la Raza

Program Name: Early Intervention services for Alameda County residents.

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

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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)

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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	**12,366**
FY 2027 – 2028	**12,366**
FY 2028 – 2029	**12,366**

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

Service utilization data and local community input through the CPPP process was used.

Early Intervention (EI) Programs #7

1. Program or service name

Provider: Asian Health Services

Program Name: Early Intervention services for Alameda County residents.

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

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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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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	**735**
FY 2027 – 2028	**735**
FY 2028 – 2029	**735**

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

Service utilization data and local community input through the CPPP was used.

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Early Intervention (EI) Programs #8

1. Program or service name

Provider: Center for Empowering Refugees and Immigrants
Program Name: Early Intervention services for Alameda County residents.

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

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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)

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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	**2,279**
FY 2027 – 2028	**2,279**
FY 2028 – 2029	**2,279**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #9

1. Program or service name

Provider: Korean Community Center of the East Bay
Program Name: Early Intervention services for Alameda County residents.

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

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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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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	**1,988**
FY 2027 – 2028	**1,988**
FY 2028 – 2029	**1,988**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #10

1. Program or service name

Provider: Richmond Area Multi Services (RAMS)
Program Name: Early Intervention services for Alameda County residents.

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

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

3. Please describe intended outcomes of the program or service

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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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	**896**
FY 2027 – 2028	**896**
FY 2028 – 2029	**896**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #11

4. Program or service name

   Provider: Afghan Coalition
   Program Name: Early Intervention services for Alameda County residents.

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

   ☑ **Outreach**
   ☑ **Access and Linkage: Screenings**

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☑ **Access and Linkage: Assessments**

☑ **Access and Linkage: Referrals**

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

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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	**7,388**
FY 2027 – 2028	**7,388**

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Plan Period by FY	Projected Number of Individuals Served
FY 2028 – 2029	7,388

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #12

1. Program or service name

Provider: Portia Bell Hume

Program Name: Early Intervention services for Alameda County residents.

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

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

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4. Please describe intended outcomes of the program or service

1. Increased access for underserved communities to decrease disparities in behavioral health services.

2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.

3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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	**837**
FY 2027 – 2028	**837**
FY 2028 – 2029	**837**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #13

1. Program or service name

Provider: Diversity in Health Training Institute

Program Name: Early Intervention services for Alameda County residents.

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

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.

2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.

3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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)

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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	**129**
FY 2027 – 2028	**129**
FY 2028 – 2029	**129**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #14

1. Program or service name

Provider: Beats, Rhymes, and Life (BRL)
Program Name: Early Intervention services for Alameda County residents.

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

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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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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	**988**
FY 2027 – 2028	**988**
FY 2028 – 2029	**988**

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

Service utilization data and local community input through the CPPP was used.

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Early Intervention (EI) Programs #15

1. Program or service name

Provider: Side by Side

Program Name: Early Intervention services for Alameda County residents.

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**

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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

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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	**510**
FY 2027 – 2028	**510**
FY 2028 – 2029	**510**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #16

1. Program or service name

Provider: Crisis Support Services
Program Name: Early Intervention services for Alameda County residents.

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

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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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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	**21,813**
FY 2027 – 2028	**21,813**
FY 2028 – 2029	**21,813**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #17

1. Program or service name

Provider: La Clínica de la Raza
Program Name: ACCESS Crisis Response and Outreach & Engagement

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

- ☑ **Outreach**
- ☑ **Access and Linkage: Screenings**
- ☑ **Access and Linkage: Assessments**
- ☑ **Access and Linkage: Referrals**
- ☑ **Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide**

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

1. Increased access to mental health care and crisis support services, reduce gaps in behavioral health care.
2. Increased understanding of mental health issues and available resources for community members.
3. Increased timely support that improves and reduces the impact of mental health challenges.

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

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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	**450**
FY 2027 – 2028	**450**
FY 2028 – 2029	**450**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #18

1. Program or service name

Provider: Pacific Center for Human Growth
Program Name: Early Intervention services for Alameda County residents.

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

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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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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	**206**
FY 2027 – 2028	**206**
FY 2028 – 2029	**206**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #19

1. Program or service name

Provider: A Better Way
Program Name: Early Intervention services for Alameda County residents.

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

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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)

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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	**75**
FY 2027 – 2028	**75**
FY 2028 – 2029	**75**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #20

1. Program or service name

Provider: La Familia
Program Name: Early Intervention services for Alameda County residents.

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

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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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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	**239**
FY 2027 – 2028	**239**
FY 2028 – 2029	**239**

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

Service utilization data and local community input through the CPPP was used.

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Early Intervention (EI) Programs #21

1. Program or service name

Provider: Geriatric Assessment and Response Team (GART)
Program Name: Early Intervention services for Alameda County residents.

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

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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

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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	**83**
FY 2027 – 2028	**83**
FY 2028 – 2029	**83**

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

Service utilization data and local community input through the CPPP was used.

Early Intervention (EI) Programs #22

1. Program or service name

PROVIDER NAME: Crisis Support Services of Alameda County
PROGRAM NAME: 24-Hr Crisis Line & After Hours Coverage for Access

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

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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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**40,000**
FY 2027 – 2028	**40,000**
FY 2028 – 2029	**40,000**

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

Alameda County's projections for individuals served through Suicide Prevention Crisis Line were based on historical utilization, staffing capacity and the range of 40,000 individuals. The projected estimates reflect full staffing and extended coverage. During the CPPP, stakeholders and providers expressed the need for integrated care to adults with serious mental illness.

Early Intervention (EI) Programs #23

1. Program or service name

PROVIDER NAME: Bonita House
PROGRAM NAME: Alternative Transport (CATT)

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

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.

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3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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 projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**3,100**
FY 2027 – 2028	**3,100**
FY 2028 – 2029	**3,100**

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

Alameda County's projections are based on recent service data, trends in demand, and system capacity. Using baseline projections modest growth was applied from previous years to reflect anticipated increases in referrals from law enforcement, outpatient providers, and community members. Crisis Services serves residents of Alameda County along the entire lifespan who are living with a serious and persistent mental illness and are in crisis. The MCT, MET, HMET, and CATT Programs provide on-the-spot crisis intervention, psychiatric assessment and evaluation to all ages and make referrals to other agencies and provides follow-up services.

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Early Intervention (EI) Programs #24

1. Program or service name

PROVIDER NAME: Telecare Corporation
PROGRAM NAME: Crisis Stabilization Unit (CSU): Willow Rock

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

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

1. Increased access for underserved communities to decrease disparities in behavioral health services.
2. Improved social emotional wellness due to participation in linguistically appropriate and culturally responsive behavioral health services.
3. Increased opportunities to connect with and participate in culturally responsive activities to reduce behavioral health needs and crisis interventions.

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

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

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

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

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

Alameda County projects the number of individuals served through the Willow Rock Crisis Stabilization Unit (CSU) by reviewing historical utilization trends. After the Youth CSU reopened there has been increased awareness and stable referral patterns from emergency departments, schools and community partners. Alameda County expects a rise in the number of children and youth served due to outreach expansion, staffing improvements, facility upgrades, increased communication with community partners, and expected reduction in wait times.

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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

CSC program name

Felton Institute: (re)MIND® and BEAM - Early Psychosis Programs (formerly PREP Alameda)

CSC program description:

PROVIDER NAME: Felton Institute
PROGRAM NAME: (re)MIND® and BEAM - Early Psychosis Programs (formerly PREP Alameda)
Program Description: The Felton Early Psychosis Programs - (re)MIND® and BEAM - formerly known as PREP Alameda, provide evidence-based treatment and support for transition age youth (TAY) who are experiencing an initial episode of psychosis or severe mood disorder. The programs provide outreach and engagement, early intervention, and outpatient mental health services that include the following categories: mental health services, case management/brokerage, medication support, crisis intervention. In addition, (re)MIND® and BEAM Alameda also provide Individual Placement and Support (IPS) supported employment and education services. The program goals of (re)MIND® and BEAM Alameda are designed to delay or prevent the onset of chronic and disabling psychosis and mood disorders; reduce individuals' hospitalizations and utilization of emergency services for mental health issues; improve the ability of program participants to achieve and maintain an optimal level of functioning and recovery as measured by functional assessment tools; connect participants with ongoing primary healthcare services and coordinate healthcare services with individuals' primary care providers; increase participants' educational and/or employment success; increase meaningful activity as defined by the individual; decrease social isolation; and assist participants with advocating for adjustment of medications to the minimum amount necessary for effective symptom control.
Target Population: Transition Age Youth (TAY) ages 15-24, who are experiencing the onset of first episode psychosis associated with serious mental illness (SMI) and severe mood disorder.

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

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

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**193**
Number of Uninsured Individuals	**15**
CSC Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	**25**
Number of Teams Needed to Serve Total Eligible Population	**6**

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

Table 14. Total Number of CSC Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	8	8	8
Total Number of Teams	2	2	2

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

Yes

Please list the other funding source(s) Separate funding sources by comma

Mental Health Block Grant, Medi-Cal

Outreach and Engagement

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

Care Court IHOT Team

2. Please describe the program or activity

PROVIDER NAME: Bay Area Community Services (BACS)
PROGRAM NAME: Care Court In-Home Outreach Team
Program Description: BACS will establish three closely coordinated CARE Court teams: two Outreach and Engagement Teams (O&E Teams) and one Case Management

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Team (CARE Team). These teams will work together to stabilize individuals in the community and support them with maintaining their Care Agreement/CARE Plan while being monitored by the CARE Court. BACS will provide community-based behavioral health and support services to eligible individuals who are not otherwise stabilized in the community through increased service options and enhanced care coordination and linkage. BACS will conduct assertive outreach and engagement in the community to locate the referred individuals wherever they may be, including but not limited to, client homes, community settings, acute care settings, shelters, encampments, jail, with family, or other places in the community. BACS will O&E Teams will assist clients with developing a Care Agreement/CARE Plan that includes, but is not limited to, recommended treatment, medication, and housing. The Court will review and adopt the Care Agreement/CARE Plan with both the individual and Contractor as party to the court order for up to 12 months (in certain situations, an additional year may be permitted by the Court). The CARE Team will encourage collaboration among the client, client's legal advocate from the collaborative courts, medical professionals, ACBHD, family members (at client's discretion), and other supports, monitor progress, and support the client with adhering to the Court approved CARE Agreement/CARE Plan. The CARE Team will provide outpatient services, including but not limited to case management, and partner with the client through the court processes and requirements for up to one year or until they graduate from CARE Court services and are released by the Court.

Target Population: Adults who meet Care Court criteria.

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

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

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

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

Projected clients served assume the Care Court Outreach & Engagement teams are able to develop an annual caseload of 300 individuals. Once clients are in the court system the CARE team has the capacity to serve 100 individuals annually with an active Care Agreement/Care Plan.

Outreach and Engagement (O&E) Program #2

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

Black Men Speak & Men of Color Speak

2. Please describe the program or activity

PROVIDER NAME: Black Men Speak
PROGRAM NAME: Black Men Speak & Men of Color Speak
Members of Black Men Speak, Inc, and Men of Color tell their personal stories of what it is like to be an African American and Man of Color, with mental health and substance abuse issues living in urban communities. This is done by relaying our individual roads to recovery.
Stories feature the success journeys of our members in Wellness and Recovery from the challenges of trauma, stigma, mental health, addiction, and social issues.
Program values are the importance of sharing stories with diverse audiences, participants do not represent themselves as speaking on behalf of the entire African American community.
Through storytelling, we present on topics such as:

- **Post-Traumatic Stress Disorder (PTSD)**
- **Family Issues**
- **Wellness and Recovery plans**
- **Community Violence**
- **Self-Esteem**
- **Spirituality and Mental Health**
- **Alternative Therapies**
- **The 8 Dimensions of Wellness**

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- **Re-Entry**
- **Single Parenting**
- **Health & Wellness**

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**1,145**
FY 2027 – 2028	**1,145**
FY 2028 – 2029	**1,145**

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

Alameda County projects the Black Men Speak program to have consistent demand based on prior year enrollment, utilization trends, and demographic shifts. This estimate also considered language access capacity, staffing levels, and anticipated turnover. The projection reflects both historical trends, stakeholder feedback during the Community Program Planning Process, and Alameda County's expectation that this stakeholder group will remain steady over the next several years.

Outreach and Engagement (O&E) Program #3

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

Faith based support & Training

2. Please describe the program or activity

PROVIDER NAME: PEERS
PROGRAM NAME: Faith based support & Training
PEERS confronts mental health stigma by delivering support groups, workshops, and community outreach. We are the premier peer-led mental health alternative for Alameda County residents. Hope & Faith is a partnership with PEERS and African American faith-based institutions where PEERS provides mental health education and outreach in the church. This campaign's purpose is to recognize that spirituality is an aspect of mental wellness, increase conversations of mental health, provide mental health facts, and provide support for those seeking to address their mental health concerns.

3. Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below
Table 11. Number of Individuals in the Adult and Older Adult Systems of Care (Non-FSP) Served During the Plan Period by Year

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**78**
FY 2027 – 2028	**78**
FY 2028 – 2029	**78**

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

Alameda County projects the PEERS Faith based support & Training program to have consistent demand based on prior year enrollment, utilization trends, and

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demographic shifts. This estimate also considered language access capacity, staffing levels, and anticipated turnover. The projection reflects both historical trends, stakeholder feedback during the Community Program Planning Process, and Alameda County's expectation that this stakeholder group will remain steady over the next several years.

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Workforce, Education, and Training (WET)

County Workforce, Education, and Training (WET) Program #1

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For related policy information, refer to 7.A.4 Workforce Education and Training.

1. Program or activity name

Mental Health Association of Alameda County, The Crisis Intervention Training (CIT)

2. Please select which of the following categories the activity falls under

☑ **Workforce Recruitment, Development, Training, and Retention**

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

The Crisis Intervention Training (CIT) program is an innovative first-responder model of police-based crisis intervention, coordinated by the ACBHD Crisis Division in partnership with the Oakland Police Department (OPD), and supported by Community Based Organizations (CBOs), Advocacy Groups, Families and Peers. CIT provides training for law enforcement officers in assisting individuals with mental health challenges and improves the safety of patrol officers, consumers, family members, and citizens in the community. The target participants are law enforcement officers in Alameda County police jurisdictions.

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County Workforce, Education, and Training (WET) Program #2

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For related policy information, refer to 7.A.4 Workforce Education and Training.

1. Program or activity name

African American Health & Wellness Steering Committee (AAWSC)/Annual Conference

2. Please select which of the following categories the activity falls under

☑ **Workforce Recruitment, Development, Training, and Retention**

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

Through the Health & Human Resource Education Center (HHREC), the African American Health & Wellness Steering Committee (AAWSC)/Annual Conference works to better support health and wellness for African American families in Alameda County. The African American Health & Wellness Steering Committee aims to ensure that Alameda County Behavioral Health System includes African Americans when shaping policies, programs, and services that affect their community. The steering committee and the conference help build a strong, culturally grounded workforce that can better support mental wellness and community services for Alameda County residents, in particular the African American community. The annual conference produced by the African American Steering Committee aligns with workforce, education, and training by supporting learning, connection, and healing in the African American community and with providers.

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County Workforce, Education, and Training (WET) Program #3

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For related policy information, refer to 7.A.4 Workforce Education and Training.

1. Program or activity name

Interim Virtual African American Wellness Hub Project

2. Please select which of the following categories the activity falls under

☑ **Workforce Recruitment, Development, Training, and Retention**

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

Through the Health & Human Resource Education Center (HHREC), the Interim Virtual African American Wellness Hub Project serves the African American community. The Hub is currently under construction and is operating virtually for community and provider training and planning. The Hub will be designed to serve as a space where those in need of services may walk in to receive and benefit from consistent, reliable and welcoming services that are culturally reflective and engaging. The overarching goal will be to support individuals through services that aim to prevent crises, or acute service needs, by facilitating a collaborative and person centered location with services provided by a team dedicated to equitable and culturally appropriate services.

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County Workforce, Education, and Training (WET) Program #4

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For related policy information, refer to 7.A.4 Workforce Education and Training.

1. Program or activity name

Medi-Cal Peer Support Specialist Training

2. Please select which of the following categories the activity falls under

☑ **Workforce Recruitment, Development, Training, and Retention**

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

Through CalMHSA, the Medi-Cal Peer Support Specialist training helps people use their lived experience to build careers in behavioral health. Participants work toward certification while learning practical, on the job skills that support peer services and strengthen the workforce.

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County Workforce, Education, and Training (WET) Program #5

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For related policy information, refer to 7.A.4 Workforce Education and Training.

1. Program or activity name

Health & Human Resource Education Center (HHREC) Workforce Staffing & Support

2. Please select which of the following categories the activity falls under

☑ **Workforce Recruitment, Development, Training, and Retention**

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

Health & Human Resource Education Center (HHREC) is the holder of training funds for Alameda County Behavioral Health Department. The Workforce Education and Training (WET) unit has transitioned to the Alameda County Health Equity Division. The WET team is focused on: 1) Skills development to ensure staff and partners are equipped to meet the needs of Alameda County's diverse populations. 2) Enhance internship and trainee/practicum programs to cultivate future behavioral health leaders. 3) Strengthen pipeline initiatives to address workforce shortages and diversify the field. 4) Deliver a range of workshops and toolkits to support professional growth and workforce competency. 5)Provide Continuing Education Units (CEUs) and certifications to advance staff knowledge and career development. 6) Increase engagement with the public through skill-building campaigns that promote behavioral health awareness and workforce growth.

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Capital Facilities and Technological Needs

Capital Facilities and Technological 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

Behavioral Health Management System-EHR Development and Implementation

2. Please select the type of project

☑ **Technological needs project**

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

Electronic Health Record System

3. Please describe the project

Purchase, installation and maintenance of a new Behavioral Health Management Information System (EHR), to include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of ACBH. Additional expenditures for the necessary support staff during the implementation process, and other projects that provide access to consumers and family members to their personal health information and other wellness and recovery supports.

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Capital Facilities and Technological Needs (CFTN) Program #2

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

African-American Wellness Hub

2. Please select the type of project

☑ **Capital facilities project**

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

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

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

No

3. Please describe the project

Alameda County has one capital project that is ongoing in the utilization of BHSA funds. The African American Wellness Hub Complex will be designed to serve as a space where those in need of services may walk in an receive and benefit from consistent, reliable and welcoming services in an effort to prevent crisis in culturally appropriate services.

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Capital Facilities and Technological Needs (CFTN) Program #3

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

TN Programming and Consulting Projects

2. Please select the type of project

☑ **Technological needs project**

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

☑ **Data Warehouse**
☑ **Monitoring**
☑ **Resources to support web content and mobile accessibility**
☑ **System maintenance costs**

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

No

3. Please describe the project

Under the category of Technological Needs, ACBHD will be utilizing BHSS/CFTN funds for the following items that continue to assist ACBHD in being more efficient and effective with utilization and outcome data: TN3a: Behavioral Health Management Contracting System (to assist with the contracting process), called Apttus (phases 1-4) • TN3b: Computer/Technology Technical Assistance • TN3c:Electronic File Storage and Document Imaging (Veeam Software) • TN3d: County Equipment and Software Update (includes Zoom, Teams and Panoramic software) • TN3e: Clinician's Gateway Interface and consulting services.

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Full Service Partnership Program

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

*These estimates came from the DHCS. Alameda County is reviewing these numbers to determine appropriate levels of staffing and care.

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

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

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**3,191**
Number of Uninsured Individuals	**65**

Total Adult FSP Eligible Population	Estimates
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	**1,659**

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

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

Table 17. Estimated Number of Individuals Eligible for ACT

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**369**
Number of Uninsured Individuals	**34**

Table 18. Estimated Number of Individuals Eligible for FACT

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	**184**

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

Table 19. Estimated 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	70
Number of Teams Needed to Serve Total Eligible Population	7

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. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

Table 20. Total Number of ACT and FACT Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	110	110	140
Total Number of Teams	11	11	14

***These estimates came from the DHCS. Alameda County is reviewing these numbers to determine appropriate levels of staffing and care.**

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

Eligible Population

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

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

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	2,580
Number of Uninsured Individuals	238

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FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	115
Number of Teams Needed to Serve Total Eligible Population	23

***These estimates came from the DHCS. Alameda County is reviewing these numbers to determine appropriate levels of staffing and care.**

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

Table 22. Total Number of FSP ICM Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	162	162	192
Total Number of Teams	19	19	22

***These estimates came from the DHCS. Alameda County is reviewing these numbers to determine appropriate levels of staffing and care.**

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High Fidelity Wraparound (HFW)

Eligible Population

1. Please input the estimates provided to the county in the table below
Note: HFW guidance is forthcoming; DHCS will provide these estimates in accordance with HFW guidance.
Table 23. Estimated Number of Individuals Eligible for HFW and Estimated Number of Teams Needed to Serve Total Eligible Population

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**1,006**
Number of Uninsured Individuals	**135**
HFW Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	**377**
Number of Teams Needed to Serve Total Eligible Population	**8**

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

Table 24. Total Number of HFW Practitioners and Teams

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

Individual Placement and Support (IPS)

Eligible Population

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

Table 25. 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	4,979
Number of Uninsured Individuals	477
IPS Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	342

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IPS Practitioners and Teams Needed	Estimates
Number of Teams Needed to Serve Total Eligible Population	137

***These estimates came from the DHCS. Alameda County is reviewing these numbers to determine appropriate levels of staffing and care.**

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 26. Total Number of IPS Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	32	32	32
Total Number of Teams	10	10	10

***These estimates came from the DHCS. Alameda County is reviewing these numbers to determine appropriate levels of staffing and care.**

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Full Service Partnership (FSP) Program Overview

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

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

No

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

Alameda County applies a whole-person, trauma-informed model across its Full Service Partnership (FSP) programs through several key approaches:
Wraparound & Community-Based Services: FSP Programs like Alameda Connections and HEAT (Homeless Engagement Action Team) provide services in natural environments (homes, parks, schools) and emphasize empowerment, voice, and choice. These models include natural supports as part of the treatment team, reduce isolation, and incorporate strengths-based and culturally responsive principles.
Natural Supports & Psychoeducation: FSP Programs like HEAT and Supportive Services for Transition Age Youth (STAY) involve families through psychoeducation, warm handoffs, and flexible engagement methods. STAY offers family partner services that support families in understanding mental health, reducing stigma, and enhancing their role in care.
Peer and Family Involvement: Many programs use peer staff and family partners with lived experience to promote trust and reduce stigma, particularly among vulnerable populations.

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

Alameda County has implemented a range of strategies aimed at reducing disparities:
Culturally Responsive Services: Programs utilize CLAS (Culturally and Linguistically Appropriate Services) standards. Staff are trained to understand systemic inequities and intersectionality, especially for communities of color and individuals with limited English proficiency.

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Language Access: Multiple FSPs provide services in multiple languages, using bilingual staff and county offered interpretation services through a free language interpretation/translation line.
Training and Awareness: Initiatives like the African American focused Proper Diagnosis & Medication Training program help providers understand disparities in healthcare use and outcomes for African Americans, supporting culturally sensitive care.
Targeted Outreach & Inclusion: Alameda County has created programs specifically designed for historically underserved groups such as TAY, older adults, justice-involved individuals, and African American youth. FSP Programs like STRIDES and JAMHR have shown high success rates among these populations.

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**
- ☑ **Overdoses**

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

Ongoing engagement services for FSP ICM clients include a variety of activities including:
Time dedicated to trust-building and use of motivational interviewing techniques to engage clients. Persistence and relational care are central to this model. Field-based services (meeting at home, libraries, parks, shelters). Meeting clients in locations where they feel comfortable and where there is ease of access helps to increase engagement.
Ongoing follow-up where case managers follow up with clients between therapy/psychiatry appointments to help with housing, benefits, transport, and crisis prevention/mitigation.

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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 (optional)

Ongoing engagement services for FSP clients include a variety of activities including:
Time dedicated to trust-building and use of motivational interviewing techniques to engage clients. Persistence and relational care are central to this model. Field-based services (meeting at home, libraries, parks, shelters). Meeting clients in locations where they feel comfortable and where there is ease of access helps to increase engagement.
Ongoing follow-up where case managers follow up with clients between therapy/psychiatry appointments to help with housing, benefits, transport, and crisis prevention/mitigation. FSP teams also include peers and family partners in the FSP team model. These staff conduct outreach calls, accompany clients to appointments, and check in if someone misses services. Family partners may also engage relatives to increase the likelihood of ongoing engagement in treatment services.

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

Alameda County will comply with BHSA requirements for Full Service Partnership (FSP) levels of care by maintaining a structured continuum that ensures the highest-intensity supports are available for individuals with the most significant needs, while offering clear pathways to lower-intensity care when clinically appropriate.
Eligibility and Enrollment: FSP will be reserved for individuals with serious mental illness and/or substance use disorders who meet high-need criteria such as repeated hospitalizations, crisis involvement, homelessness, or forensic system contact, in alignment with BHSA and county policy.
Levels of Care: Services will be tiered to include FSP ("whatever it takes" wraparound supports with 24/7 access, housing (as available), and non-clinical supports), intensive case management, and standard outpatient. Step-down and step-up will be guided by clinical criteria and individualized service planning.

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Integrated Services: Each FSP team will provide multidisciplinary supports, including housing navigation (as needed and available), peer services, crisis response, and linkages to employment/education. Services will integrate substance use treatment and housing interventions consistent with BHSA priorities.
Provider Accountability: All contracted providers must participate in the Medi-Cal network where applicable, adhere to county QA and fidelity reviews, and justify continued FSP placement annually. Outcomes and housing data will be entered into HMIS and county data systems for monitoring.
Through these mechanisms, Alameda County will ensure compliance with state requirements while maintaining fidelity to evidence-based models and preserving FSP capacity for those with the most acute needs.

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

Please see the following questions for responses to optional allowable services that Alameda County will utilize.

7a. Primary substance use disorder (SUD) FSPs

No

7b. Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)

Yes

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

Alameda County will utilize In-Home Outreach Team (IHOT) programs to provide outreach and engagement services to those individuals that are identified as in need of treatment and are homeless or at-risk of homelessness. These program budgets will be funded under the Housing Intervention component where counties can allocate up to 7% of funding for outreach services.

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These programs are designed to provide intensive outreach and engagement, mental health screening, in-home intervention, family education, and support and linkage to treatment for individuals who are not voluntarily engaging in services that connect them with ongoing mental health treatment. Alameda County will have a particular focus for individuals that are homeless or at risk of homelessness.

7c. 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 (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

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

During the Community Program Planning Process (CPPP), Alameda County conducted targeted Listening Sessions with youth individuals that are justice involved or at risk of being justice involved. Listening Sessions were also held with family members, law enforcement, and re-entry organizations. Alameda County distributed Community Input Surveys to organizations that serve youth individuals and those at risk of being involved with the juvenile justice system. The surveys were shared and completed by youths, support staff, and family members.
Alameda County reviewed the CPPP data to help create a robust Full Service Partnership (FSP) program outlined in the BHSA Integrated Plan. The results of these community engagements can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan. Furthermore, Alameda County reviewed DHCS provided data from the relevant Statewide Behavioral Health Goals (Justice

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Involved, Removal of Children from Home, and Institutionalization) to help guide planning for FSP programming.
During the Public Comment period, Alameda County shared the BHSA Integrated Plan with youth individuals, organizations, and family members to ensure that the plan is aligned with the community needs. Alameda County incorporated public comments and feedback into the Integrated Plan.

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

Alameda County abided by the Community Program Planning Process (CPPP) required stakeholders list and the required additional diverse populations list. Alameda County held dedicated CPPP engagement with LGBTQ community centers, the ACBHD Pride Coalition, and LGBTQ community-based organization staff. In-person or virtual Listening Sessions and Key Informant Interviews facilitated opportunities for individuals to voice the need for LGBTQ specific behavioral health. For LGBTQ organizations and individuals that could not host or attend a Listening Session, the Community Input Survey was made available. The Community Input Survey is inclusive and ensures that identify specific disparities are captured in a discrete setting.
Alameda County reviewed the CPPP data to help create a robust Full Service Partnership (FSP) program outlined in the BHSA Integrated Plan. The BHSA Integrated Plan was also reviewed by the Alameda County Behavioral Health Department - Health Equity Team to ensure an equity lens/perspective was considered in programming initiatives. The results of these community engagements can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan.
During the Public Comment period, Alameda County shared the BHSA Integrated Plan with LGBTQ+ individuals, organizations, and family members to ensure that the plan is aligned with the community needs. Alameda County incorporated public comments and feedback into the Integrated Plan.

In the child welfare system

Throughout the development of the BHSA Integrated Plan, Alameda County held planning discussions with community members, providers, family members, and county administrators of the child welfare system. Listening Sessions and Community Input Surveys were a vital piece of BHSA planning and satisfied the required BHSA CPPP stakeholder list. The CPPP captured needs around placement instability, trauma

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informed care, coordination gaps, and the importance of wraparound services. The results of these engagements were shared with the Alameda County Behavioral Health Department Systems of Care and can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan.
Furthermore, Alameda County reviewed DHCS provided data from the relevant Statewide Behavioral Health Goals (Justice Involved, Removal of Children from Home, and Institutionalization) to help guide planning for FSP programming.
During the Public Comment period, Alameda County shared the BHSA Integrated Plan with individuals, organizations, staff, and family members to ensure that the plan is aligned with the community needs. Alameda County incorporated public comments and feedback into the Integrated Plan.

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

Older adults

During the Community Program Planning Process (CPPP), Alameda County held Listening Sessions with older adult individuals at senior homes, older adult peer groups, as well as the support staff that serve older adults. Alameda County distributed Community Input Surveys to organizations that serve older adults, senior homes, and conducted outreach at older adult specific events. The surveys were shared and completed by older adults, support staff, and family members.
Alameda County reviewed the CPPP data to help create a robust Full Service Partnership (FSP) program outlined in the BHSA Integrated Plan. The results of these community engagements can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan. Furthermore, Alameda County reviewed DHCS provided data from the relevant Statewide Behavioral Health Goals (Access to Care, Untreated behavioral health conditions, Homelessness, Overdoses, Justice Involvement, and Institutionalization) to help guide planning for FSP programming.
The BHSA team also participated in various listening sessions for: CARES Act, SB43 and the Opioid Settlement.
Lastly, during the Public Comment period, Alameda County shared the BHSA Integrated Plan with older adult's peer groups, organizations that serve the older adult population, and family members to ensure that the plan is aligned with the community

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needs. Alameda County incorporated public comments and feedback into the Integrated Plan.

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

Alameda County abided by the CPPP required stakeholders and the required additional diverse populations. Alameda County held dedicated CPPP engagement with LGBTQ community centers, the ACBHD Pride Coalition, and LGBTQ community based organization staff. In-person or virtual Listening Sessions and Key Informant Interviews facilitated opportunities for individuals to voice the need for LGBTQ specific behavioral health. For LGBTQ organizations and individuals that could not host or attend a Listening Session, the Community Input Survey was made available. The Community Input Survey is inclusive and ensures that identify specific disparities are captured in a discrete setting.
Alameda County reviewed the CPPP data to help create a robust Full Service Partnership (FSP) program outlined in the BHSA Integrated Plan. The BHSA Integrated Plan was also reviewed by the Alameda County Behavioral Health Department - Health Equity Team to ensure an equity lens/perspective was considered in programming initiatives. The BHSA team also participated in various listening sessions for: CARES Act, SB43 and the Opioid Settlement. The results of these community engagements can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan.
During the Public Comment period, Alameda County shared the BHSA Integrated Plan with LGBTQ+ individuals, organizations, and family members to ensure that the plan is aligned with the community needs. Alameda County incorporated public comments and feedback into the Integrated Plan.

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

During the Community Program Planning Process (CPPP), Alameda County conducted targeted Listening Sessions with adults that are justice involved or at risk of being justice involved. Listening Sessions were also held with family members, providers, law enforcement, probation staff, and re-entry organizations. Alameda County distributed Community Input Surveys to organizations that serve justice involved individuals and those at risk of being involved with the justice system. The surveys were shared and completed by organizations, support staff, law enforcement, and family members.

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Alameda County reviewed the CPPP data to help create a robust Full Service Partnership (FSP) program outlined in the BHSA Integrated Plan. The results of these community engagements can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan. Furthermore, Alameda County reviewed DHCS provided data from the relevant Statewide Behavioral Health Goals (Access to Care, Justice Involved, Untreated behavioral health conditions, Homelessness, and Institutionalization) to help guide planning for FSP programming. The BHSA team also participated in various listening sessions for: CARES Act, SB43 and the Opioid Settlement.
Lastly, during the Public Comment period, Alameda County shared the BHSA Integrated Plan with youth individuals, organizations, law enforcement, and family members to ensure that the plan is aligned with the community needs. Alameda County incorporated public comments and feedback into the Integrated Plan.

Assertive Field-Based Substance Use Disorder (SUD) Questions

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

Targeted outreach

Existing programs

In-Home Outreach Team (IHOT)

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Program descriptions

The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engaging in mental health services. IHOT visits participants in their home, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support or their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. The teams schedule appointments with participants, family members, friends, and other providers, as well as assist with connections to community resources.

Current funding source

Opioid Settlement

BHSA changes to existing programs to meet BHSA requirements

This a new program brought about by the passage of Proposition 1 and the Opioid settlement.

Expected timeline of operation

Beginning January 2026. 2 year funding window.

Mobile-field based programs

Existing programs

Program descriptions

SUD In-Home Outreach Team (IHOT)

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Program descriptions

The SUD In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to engaging in mental health services. IHOT visits participants in their home, hospitals, jails, and in the community to encourage them to engage in mental health treatment. Their goal is to reduce the impact of untreated mental illness in these adults and provide support or their families. The intention of referral and linkage is to help prevent an increase in symptoms, added impairments, or need for more hospitalizations. The teams schedule appointments with participants, family members, friends, and other providers, as well as assist with connections to community resources.

Current funding source

Opioid Settlement

BHSA changes to existing programs to meet BHSA requirements

No changes.

Expected timeline of operation

Beginning January 2026. 2 year funding window.

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Open-access clinics

Existing programs

The Bridge Clinic at Alameda Health System.

Program descriptions

The Bridge Clinic at Highland Hospital provides low-barrier, same-day access to medications for addiction treatment, primarily buprenorphine. Patients can be started in person or via telehealth, where they can call in and receive a same-day prescription. The clinic initiates treatment directly from the emergency department and inpatient units, stabilizes patients, and links them to community-based care. Services include medical evaluation, MAT induction, follow-up, and navigation to longer-term providers. By reducing wait times, preventing gaps, and supporting continuity post-discharge, the Bridge addresses urgent needs and reduces overdose risk.

Medication Assisted Treatment (MAT) for substance use services onsite, utilizing a team of social workers to support patients with SUD services. In addition, the use of telehealth practices has improved access of patients to behavioral health services, in addition to the onsite service modality.

Current funding source

California Bridge Program, SAMSHA

BHSA changes to existing programs to meet BHSA requirements

No change in service provision due to BHSA requirements.

Expected timeline of operation

Bridge Clinic has been in operation since October 2018.

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New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs

N/A

Program descriptions

N/A

Planned funding

N/A

Planned operations

N/A

Expected timeline of implementation

N/A

Mobile-field based programs

New programs

N/A

Program descriptions

N/A

Planned funding

N/A

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Planned operations

N/A

Expected timeline of implementation

N/A

Open-access clinics

New programs

WellPath Clinic

Program descriptions

Alameda County is partnering with WellPath to provide long-acting injectable (LAI) and sublingual buprenorphine to inmates at Santa Rita Jail using an assertive treatment model that proactively identifies individuals in need of medication and ensures timely prescribing and administration.

Planned funding

Funding is through the Opioid Settlement and Alameda County Sheriff's Office which funds Wellpath. That was started in 2024.

Planned operations

Provides buprenorphine through long acting injectable to inmates with substance use disorder.

Expected timeline of implementation

Ongoing, starting in 2024.

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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 county MAT resources (including programs and providers) and MAT resources that can meet estimated needs

Through the use of HEDIS measures that are provided to the county in addition to partnerships with Bridge Clinic Substance Use Navigators. The Bridge Clinic, in addition to the Alameda County's TRUSTs clinic, serve as our same day services for MAT to start. The use of the SUD Outreach team will also be utilized to connect individuals' same day to MAT services.

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 FeeFor-Service (FFS) Medi-Cal**
- ☑ **Leverage telehealth model(s)**
- ☑ **Other strategy**

Please explain what other strategy the county will use

Alameda County is expanding access to long-acting injectable (LAI) buprenorphine for people experiencing homelessness through collaboration with Full Service Partnership (FSP) programs and the Healthcare for the Homeless Street Health Team. This partnership will deliver LAI buprenorphine directly in the field to improve access, adherence, and stability for individuals with opioid use disorder.

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

- ☑ **Buprenorphine**
- ☑ **Methadone**
- ☑ **Naltrexone**

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Housing Interventions

Planning

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

System Gaps

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

Supportive housing: **Large Gap**

Apartments, including master-lease apartments: **Medium Gap**

Single and multi-family homes: **Medium gap**

Housing in mobile home communities: **Not applicable**

(Permanent) Single room occupancy units: **Medium gap**
(Interim) Single room occupancy units: **Medium gap**

Accessory dwelling units, including junior accessory dwelling units: **Not applicable**

(Permanent) Tiny homes: **Not applicable**

Shared housing: **Medium gap**

(Permanent) Recovery/sober living housing, including recovery-oriented housing: **Medium gap**

(Interim) Recovery/sober living housing, including recovery-oriented housing: **Medium gap**

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Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care): **Medium gap**

License-exempt room and board: **Not applicable**

Hotel and Motel stays: **Medium gap**

Non-congregate interim housing models: **Medium gap**

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

Recuperative Care: **Medium gap**

Short-Term Post-Hospitalization housing: **Medium gap**

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units: **Medium gap**

Peer Respite: **Medium gap**

Permanent rental subsidies: **Large gap**

Housing supportive services: **Large 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?

> **Non-BHSA resources to be utilized include: the homeless management information system (HMIS) as a database source of record and repository; coordinated entry - the system of prioritization and matching to available resources within the homelessness response system; continuation of county partnerships between the Housing and Homelessness Services (H&H) and Alameda County Behavioral Health Department (ACBHD) utilization of state revenue sources (HHAP) to sustain housing options and access; utilization of a local tax revenue source to expand housing solutions and sustain programs from federal funding shortfalls or discontinuance. Utilization of the local Social Health Information Exchange (SHIE) for data mapping and reporting support. ACBHD will enhance partnerships with the MCPs for housing supports such as transitional rent and when applicable only use BHSA funds after the transitional**

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rent is exhausted or denied. ACBHD has utilized Bridge Housing, a short-term housing program that helps people experiencing homelessness and veterans find transitional and permanent housing.
ACBHD has been awarded funds from the Department of State Hospitals to expand residential care opportunities for up to 88 individuals who have been found Incompetent to Stand Trial (IST) after being charged with felony offenses. Alameda County will also utilize funds from local tax Measure W to fund supportive housing programs such as prevention, shelter, housing, access & coordination, and one time capital projects.
ACBHD used funds from the Behavioral Health Continuum Infrastructure Program (BHCIP) to fund partners to construct, acquire, and expand properties and invest in mobile crisis infrastructure related to behavioral health. BHCIP facilities in development: Adult Residential Treatment, Outpatient for Justice Involved TAY, Crisis Residential and Stabilization, Sobering and Detox Residential, Felony IST Diversion, Mental Health Rehabilitation, Medical/Psychiatric Hospital Units, and Medical Detox.

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?

Alameda County plans to fully implement the BHSA housing interventions to help our community become sheltered and housed. Alameda County Behavioral Health Department (ACBHD) will use BHSA funds in conjunction with Behavioral Health Bridge Housing, the Behavioral Health Continuum Infrastructure Program (BHCIP) and MCP community supports to expand housing options.
Alameda County uses the homeless management information system (HMIS) as a database source of record and repository. HMIS will help with the coordination of services and longitudinal tracking of clients served throughout the homelessness response system of care. ACBHD continues to work in partnership with the Alameda County Housing & Homelessness Department who serve as both the management entity for the HMIS and Coordinated Entry System (CES).
ACBHD will provide clients with multiple entry points to Housing Interventions throughout the behavioral healthcare continuum. When ACBHD clients are enrolled in various ACBHD programs, referral mechanisms such as ACCESS hotline and outreach/in-reach through caseworkers and clinical staff will help refer clients to housing interventions. This includes clients enrolled in the FSPs and Early Intervention programs, we identify clients' housing needs during initial screening assessments and ongoing program participation. In addition, Alameda County will utilize navigation and outreach to identify and assist

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individuals most in need to find housing and also to educate those eligible for housing resources.
Alameda County will leverage partnerships with county and city housing authorities, the different levels of the behavioral health continuum, tenancy services, and local flex pools to expand supply and ensure access.
Alameda County strives to create a seamless continuum from crisis to permanent housing while strengthening retention and improving recover outcomes.

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

Connection to Housing Resource Center (HRC) and 2-1-1 for clients to become assessed and connected to the Coordinated Entry queue and matched to permanent housing resources based upon acuity of need and local prioritization policies. As additional housing interventions come online (Flex Pool, Transitional Rent, Behavioral Health Bridge Housing), resources will be allocated and matched based upon eligibility and vulnerability. Retention of housing will be supported through connections to FSP teams, Enhanced Care Management (ECM), Housing Trio (Navigation, Tenancy Sustaining Services, Deposit Assistance), as eligible and needed.
The integration of behavioral health services and housing interventions will ensure that clients will have opportunities to access different housing settings. Alameda County programs and housing navigators will provide access, linkage, and resources to ensure that a client or homeless individual is informed on the housing options available to them. Alameda County will continue to partner with the MCPs to ensure warm handoffs are made available to individuals looking to enter a more permanent housing setting.
These housing focused supports promote permanent placement and help individuals stay housed as they work toward recovery and improved health.

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)?

Alameda County Behavioral Health Department (ACBHD) and Alameda County Housing and Homelessness Services (H&H), both within the Alameda County Health Agency, are in coordination and planning of implementation of a Flexible Housing Subsidy Pool (Flex Pool) to expand scattered-site permanent housing resources for clients experiencing homelessness. The Flex Pool will leverage multiple funding sources including BHSA for the expansion of landlord

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engagement, dedicated units, provision of rental subsidies, and linkages to supportive services. Additionally, the Flex Pool will embed Transitional Rent as a bridge to a longer term housing resource. Further, ACBHD continues to assess exhaustion rate of state MHSA operating reserves and BHSA backfill needed to retain the units.

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

Currently, the Alameda Behavioral Health Department (ACBHD) has two separate helplines. One for mental health (MH) and the other for substance use disorder (SUD) information, screening, and referrals to these services which will include housing services. The MH is staffed internally by ACBHD's Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) division. The SUD helpline is staffed by Center Point, a nonprofit county contractor. By July 2026, the county will have the ACBHD ACCESS Integration project created for a one system-wide point of access for MH and SUD and co-occurring MH/SUD needs for information, screening, and referrals. This single point of contact will have screenings done by licensed Clinical Review Specialists (CRS) trained in both MH and SUD screening and referral. ACCESS will continue to be the county's contractor. ACCESS will be renamed to reflect its new role as a single, system-wide point of access for MH and/or SUD information, screening, and referrals.

Eligible Populations

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

The MH is staffed internally by Alameda County Behavioral Health Department's (ACBHD) Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) division. The SUD helpline is staffed by Center Point, a nonprofit county contractor. By July 2026, the county will have the ACBHD ACCESS Integration project created for a one system-wide point of access for MH and SUD and co-occurring MH/SUD needs for information, screening, and referrals. This single point of contact will have screenings done by licensed Clinical Review Specialists (CRS) trained in both MH and SUD screening and referral. ACCESS will continue to be the county's contractor. ACCESS will be renamed to reflect its new role as a single, system-wide point of access for MH and/or SUD information, screening, and referrals.

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

Yes

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

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

During the Community Program Planning Process (CPPP), Alameda County conducted targeted Listening Sessions with youth individuals that are justice involved or at risk of being justice involved. Listening Sessions were also held with family members, law enforcement, and re-entry organizations. Alameda County distributed Community Input Surveys to organizations that serve youth individuals and those at risk of being involved with the juvenile justice system. The surveys were shared and completed by youths, staff, and family members. Alameda County reviewed the CPPP data to help create a robust Housing Interventions program outlined in the BHSA Integrated Plan. The results of these community engagements can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan.
Alameda County reviewed DHCS provided data from the relevant Statewide Behavioral Health Goals (Homelessness, Justice Involved, Removal of Children from Home, and Institutionalization) to guide planning for Housing Interventions.
During the Public Comment period, Alameda County shared the BHSA Integrated Plan with youth individuals, organizations, and family members to ensure that the plan is aligned with the community needs. Alameda County incorporated public comments and feedback into the Integrated Plan.
One program to highlight for youth that are on probation supervision and have housing needs is the Breaking Barriers program which provides assistance for household expenses and rent for up to 3 months to give a family a chance to get ahead on finances. For placement youth who are unhoused, probation uses family finding to seek relatives who can house the minor while on a Placement order. Currently, probation is advocating to reopen a local shelter that was used for children in crisis that was closed. In the meantime, a new assessment center has been open to help address the closing of the shelter.

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

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Alameda County abided by the Community Program Planning Process (CPPP) required stakeholders list and the required additional diverse populations list. Alameda County held dedicated CPPP engagement with LGBTQ community centers, the ACBHD Pride Coalition, and LGBTQ community-based organization staff. In-person or virtual Listening Sessions and Key Informant Interviews facilitated opportunities for individuals to voice the need for LGBTQ services. For LGBTQ organizations and individuals that could not host or attend a Listening Session, the Community Input Survey was made available. The Community Input Survey is inclusive and ensures that specific disparities are captured in a discrete setting.
Alameda County reviewed the CPPP data to help create a robust Housing Interventions program outlined in the BHSA Integrated Plan. Alameda County reviewed DHCS provided data from the relevant Statewide Behavioral Health Goals (Homelessness, Access to Care, Justice Involved, Removal of Children from Home, and Institutionalization) to guide planning for Housing Interventions.
The BHSA Integrated Plan was also reviewed by the Alameda County Behavioral Health Department - Health Equity Team to ensure an equity lens/perspective was considered in programming initiatives. The results of these community engagements can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan.

In the child welfare system

Throughout the development of the BHSA Integrated Plan, Alameda County held planning discussions with community members, providers, family members, and county administrators of the child welfare system. Listening Sessions and Community Input Surveys were a vital piece of BHSA planning and satisfied the required BHSA CPPP stakeholder list. The results of these engagements were shared with the Alameda County Behavioral Health Department Systems of Care and can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan.

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

Older adults

During the Community Program Planning Process (CPPP), Alameda County held Listening Sessions with older adult individuals at senior homes, older adult

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peer groups, as well as the support staff that serve older adults. Alameda County distributed Community Input Surveys to organizations that serve older adults and conducted outreach at older adult specific events. The surveys were shared and completed by older adults, support staff, and family members.
Alameda County reviewed CPPP data to help create a robust Housing Interventions program outlined in the BHSA Integrated Plan. The BHSA team also participated in various listening sessions for: CARES Act, SB43 and the Opioid Settlement.
The results of these community engagements can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan.
One such engagement was with HomeMatch, a service that connects homeowners with spare rooms to individuals seeking affordable housing. During the engagement session, HomeMatch staff stressed the need for effective coordination of services to help older adults navigate available resources and find the appropriate support for their needs. St. Mary's Center, who hosts peer-to-peer groups to help address depression, isolation, and loneliness, has indicated that they would like to see the county build modules in their immediate neighborhood to serve the older adult homeless populations.
Furthermore, Alameda County reviewed DHCS provided data from the relevant Statewide Behavioral Health Goals (Access to Care, Untreated behavioral health conditions, Homelessness, Overdoses, Justice Involvement, and Institutionalization) to help guide planning for Housing Interventions programming.
Lastly, during the Public Comment period, Alameda County shared the BHSA Integrated Plan with older adult's peer groups, organizations that serve the older adult population, and family members to ensure that the plan is aligned with the community needs. Alameda County incorporated public comments and feedback into the Integrated Plan.

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

During the Community Program Planning Process (CPPP), Alameda County conducted targeted Listening Sessions with adults that are justice involved or at risk of being justice involved. Listening Sessions were also held with family members, providers, law enforcement, probation staff, and re-entry organizations. Alameda County distributed Community Input Surveys to organizations that serve justice involved individuals and those at risk of being involved with the justice system.
Alameda County reviewed CPPP data to help create a robust Housing Interventions program outlined in the BHSA Integrated Plan. The results of

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these community engagements can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan. Furthermore, Alameda County reviewed DHCS provided data from the relevant Statewide Behavioral Health Goals (Access to Care, Justice Involved, Untreated behavioral health conditions, Homelessness, and Institutionalization) to help guide planning for Housing Interventions. The BHSA team also participated in various listening sessions for: CARES Act, SB43 and the Opioid Settlement.
Lastly, during the Public Comment period, Alameda County shared the BHSA Integrated Plan with individuals, law enforcement, organizations, program support staff, and family members to ensure that the plan is aligned with the community needs. Alameda County incorporated public comments and feedback into the Integrated Plan.
A few housing programs to highlight: Oakland Project Connect (OPC) provides an intensive, housing focused, care coordination role within the county's health and housing services provider networks to maintain permanent, safe, and supportive homes. Another program, the Mental Health Court Specialist contacts older adult clients to coordinate service linkage, complete written referrals, support warm handoffs to new providers, maintain contact with clients and providers as needed, initiate treatment team meetings, engage in court hearings and discharge planning.

In underserved communities

During the Community Program Planning Process (CPPP), Alameda County held Listening Sessions with underserved communities and support staff that serve them. Alameda County distributed Community Input Surveys to organizations that serve the underserved and conducted outreach at community events. The surveys were shared and completed by youth, adults, staff, and family members. Alameda County shared and collaborated with the Health Equity team in creating the Integrated Plan and ensuring ACBHD is inclusive to everyone.
Alameda County reviewed CPPP data to help create a robust Housing Interventions program outlined in the BHSA Integrated Plan. The results of these community engagements can be found in the Community Program Planning Process (CPPP) section of the BHSA Integrated Plan. Furthermore, Alameda County reviewed DHCS provided data from the relevant Statewide Behavioral Health Goals (Access to Care, Justice Involved, Untreated behavioral health conditions, Homelessness, and Institutionalization) to help guide planning for Housing Interventions. The BHSA team also participated in various listening sessions for: CARES Act, SB43, the Opioid Settlement, and the African American Wellness Hub.

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Lastly, during the Public Comment period, Alameda County shared the BHSA Integrated Plan with youth individuals, organizations, and family members to ensure that the plan is aligned with the community needs.
One program to highlight of many that serve the underserved: Alameda County has an Older Adult Service Team (OAST) which supports client recovery through a holistic and strength-based approach that considers overall bio-psycho-social needs of older adults. Creating a team to focus on the unique needs of older adults was a priority. Service teams are multi-disciplinary and coordinate community-based services to provide individually customized mental health care for people experiencing frequent setbacks or persistent challenges to their recovery, especially if they are justice-involved. OAST works with the Public Defender's office and probation to support clients with supportive housing and therapy.

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?

Alameda County Behavioral Health Department (ACBHD), along with the county's Housing and Homelessness Services division (H&H) is putting together a flexible housing pool. The implementation of the new Flexible Housing Subsidy Pool (Flex Pool) utilizes the CoC Coordinated Entry processes for matching and referral (complemented with data matching related to populations of focus). ACBHD continues to work in partnership with H&H who serves as both the management entity for the HMIS and CES systems. Both systems will be used for matching and database management. Additionally, ACBHD-connected constituents have been matched to CoC housing resources, while complemented with services from the ACBHD system of care. ACBHD will continue planning and coordination with CoC partners.

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

Local CoC

Alameda County Health (ACH) staff members serve on a variety of CoC committees. Alameda County Health, ACBHD continues to be a collaborative

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partner with internal and external agencies, including the Community Development Agency (CDA), Social Services Agency (SSA), General Services Agency and internal ACH partners (public health, environmental health). CalWORKS households may be matched to housing resources administered through joint partnership with H&H and SSA for the provision of rapid rehousing (time limited subsidies) and supportive services.

Public Housing Agency

Alameda County Health (both ACBHD and Housing and Homelessness Services - H&H) have had longstanding MOUs with local Housing Authorities for administration of housing subsidy payments. ACBHD continues to be a collaborative partner with internal and external agencies, including the Community Development Agency (CDA), Social Services Agency, General Services Agency and internal ACH partners (public health, environmental health). CalWORKS households may be matched to housing resources administered through joint partnership with H&H and SSA for the provision of rapid rehousing (time limited subsidies) and supportive services.

MCPs

Alameda County has two Managed Care Plans: Alameda Alliance and Kaiser Permanente.
Alameda County Health (both ACBHD and H&H) have written agreements and MOUs to serve in an intermediary role for administering the Housing Trio (Housing Navigation, Housing Deposits, and Tenancy Sustaining Services), including ECM. This administration will be expanded to include Transitional Rent as described in the BHSA Policy Manual and Community Supports Policy Guide, Volume 2. These agreements were initiated during the Whole Person Care (WPC) pilot program and progressed as CalAIM was implemented in 2022.

ECM and Community Supports Providers

Alameda County Health (both ACBHD and H&H) have written agreements and MOUs to serve in an intermediary role for administering the Housing Trio (Housing Navigation, Housing Deposits, and Tenancy Sustaining Services), including ECM. These agreements were initiated during the Whole Person Care (WPC) pilot program and progressed as CalAIM was implemented in 2022.

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

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Alameda County Health and Alameda Count Behavioral Health Department continue to be collaborative partners with internal and external agencies, including the Community Development Agency (CDA), Social Services Agency, General Services Agency and internal Alameda County Health partners (public health, environmental health). CalWORKS households may be matched to housing resources administered through joint partnership with H&H and SSA for the provision of rapid rehousing (time limited subsidies) and supportive services.

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?

Alameda Count Behavioral Health Department and the Alameda County Housing and Homelessness Services division released joint solicitation of interest (SOI) in hopes of eventually releasing an RFP. However, the county received no applications with the SOI. The county is reassessing when and whether to release another SOI in the near future.

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

No

BHSA Housing Interventions Implementation

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

Rental Subsidies (Chapter 7. Section C.9.1)

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

1. Is the county providing this intervention?

Yes

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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?

Currently, Alameda County has 245 individuals that will transition from MHSA to BHSA. The individuals in interim housing under MHSA who are not enrolled in an MCP will be transferred to BHSA Housing Interventions without eligibility redetermination. Under the county's Flex Housing Subsidy Pool, it is expected the county will serve an additional 250 individuals. Additionally, if anyone is chronically homeless when housed under MHSA and transferred to BHSA will be considered chronically homeless for purposes of the requirement to direct 50% of housing interventions to individuals who are chronically homeless.

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

346

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

149

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?

Alameda County's methodology involves both rent reasonableness and fair market rent. Alameda County uses both of these methodologies because of various situations of the individual. For example, an individual who is transitioning from incarceration, and has no income, will be assigned a flat rate or rate reasonableness for the setting in which they assigned. Another example would be if an individual who is aging out of the TAY age group and into "adult", with no income, would also be assigned a rent reasonableness for their assigned setting. FMRs are utilized for individuals or families who have some income and this income is used to determine rent amount.

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5. For which setting types will the county provide rental subsidies?

Non-Time-Limited Permanent Settings:

☑ **Supportive housing**
☑ **Apartments, including master-leased apartments**
☑ **Single and multi-family homes**
☑ **Single room occupancy units**
☑ **Shared housing**
☑ **Recovery/Sober Living housing, including recovery-oriented housing**
☑ **Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)**
☑ **License-exempt room and board**

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

Alameda County plans to provide direct navigation to housing resources, especially for coordination of behavioral health services and housing resources for unsheltered individuals. This will be done in collaboration with other outreach and engagement efforts. Transportation costs for unsheltered people to service facilities or shelters, when necessary, along with reimbursement of travel by outreach workers, and other service providers during outreach on the streets. Housing Interventions such as pet deposits, non-landlord paid utilities, unit holds, damage reimbursement, and renter's insurance. This list is not exhaustive.

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

Coordinated Entry Systems will help identify all eligible candidates for supportive housing to utilize the flex housing subsidy pool. Currently there is a

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Behavioral Health referral pathway to housing. This pathway is being expanded to include paths to transitional rent or to BHSA housing interventions. Partnerships and collaborative efforts in the county have included MCPs, the county's housing division and behavioral health department, the procured flex pool operator and the provider who runs the county's coordinated mental health and substance use disorder point of entry. This point of entry will provide referrals to the appropriate mental health, substance use disorder, or co-occurring provider.

10. Total number of units funded with BHSA Housing Interventions per year

545

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 (optional)

N/A

Operating Subsidies (Chapter 7, Section C.9.2)

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

990

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

BHSA Housing Interventions will be used for pet deposits, utilities, landlord incentives, unit holds and or vacancy payments along with other occupancy costs that are not covered by housing deposits.

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5. For which setting types will the county provide operating subsidies?

Non-Time-Limited Permanent Settings:
☑ **Supportive housing**
☑ **Apartments, including master-leased apartments**
☑ **Single and multi-family homes**
☑ **Single room occupancy units**
☑ **Recovery/Sober Living housing, including recovery-oriented housing**
☑ **Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)**

6. Will this be a scattered site initiative?

No

7. Will this Housing Intervention accommodate family housing?

Yes

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

175

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 (optional)

N/A

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

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

14

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

The Rental Assistances and Landlord Engagement (RALE) (formerly called Landlord Liaison) Program is designed to cultivate and sustain relationships with property owners and property management companies (landlords) with the goal of encouraging them to accept additional tenants who are referred through the Coordinated Entry System when vacancies occur, and to recruit new landlords who are willing to make rental units available to homeless people with disabilities who are participating in scattered site PSH programs. The RALE Program operates a 24/7 hotline available to all owners and property management companies in the program that may be utilized for crisis needs, property management needs, and problem solving. Mitigation funds are used for damage reimbursement outside of usual wear and tear. Unit hold related costs and vacancy payments (if tenant leaves early) or if Project Based Housing unit is vacant for a specified number of days after sufficient marketing. Eviction prevention costs which may include financial assistance, back-rent, mediation, tenant education, legal costs and connection to resources if necessary for someone to maintain their housing or be relocated.

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

175

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 (optional)

N/A

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

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

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70

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

Outreach survival supplies; 1x emergency services such as a gift card, transportation vouchers, food or health and wellness supplies, pet needs or other problem solving supports. Removing barriers allowable costs: accessing documents for housing search, hygiene supplies, short term storage units, pet certification/documentation for housing and other pet needs, application fees and credit reports.

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

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

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

550

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

HTNS:
in securing housing, including the completion of housing applications and securing required documentation (e.g. Social Security card, birth certificate, prior rental history); assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process; identifying and securing available resources to assist with subsidizing rent; assisting with

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requests for reasonable accommodation, if necessary; assisting with arranging for and supporting the details of the move; establishing procedures and contacts to retain housing, including developing housing support crisis plan that includes prevention and early intervention services when housing is jeopardized; identifying, coordinating, securing or funding non-emergency, nonmedical transportation to assist consumer's mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

HTSS:

Providing early identification and interventions for behaviors that may jeopardize housing such as late rental payment, hoarding, and substance use; education and training on the roles, rights and responsibilities of the tenant and the landlord; coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy; coordination with the landlord and case management provider to address identified issues that could impact housing stability; assistance in resolving disputes with landlord and/or neighbors to reduce risk of eviction or other adverse action; advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized; assisting with benefits advocacy; assistance with annual housing recertification process; continuing assistance with tenant to review, update, and modify their housing support with activities related to household management.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

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

420

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

The outreach and engagement model will provide intensive, community-based support for adults with serious mental illness (SMI) or substance use issues who resist traditional services, using mobile teams with peers, clinicians, and

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family advocates to build trust, offer short-term counseling, and connect individuals to long-term care and housing resources in their communities, aiming to reduce hospitalizations, crises and homelessness. This is a collaborative model that links clients, families, and community partners, focusing on personalized engagement and goals, often for up to 120 days.

Capital Development Projects

(Chapter 7, Section C.10)

1. Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?

No

Please explain why the county is not providing this intervention

At this time, Alameda County Behavioral Health Department will focus on the development and launch of the flex pool and other housing services. Once the BHSA transition is complete Alameda County will focus on Capital Development Projects as needed.

3. How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?

0

Other Housing Interventions

1. If the county is providing another type of Housing Interventions not listed above, please describe the intervention (optional)

N/A

Is the county providing this intervention to chronically homeless individuals? (optional)

No

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Anticipated number of individuals served per year (optional)

000

Continuation of Existing Housing Programs

1. Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)

Behavioral Health Bridge Housing (BHBH) was utilized to purchase property to create a forensic peer respite. This peer respite, known as Safe Harbor, will be funded by BHSA housing interventions once its current funding stream of MHSA innovations ends in June 2027. Safe Harbor may be utilized as Short-Term Post Hospitalization Housing and/or Recuperative Care. This peer respite is staffed by Certified Peer Support Specialists.

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

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

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**
- ☑ **Transitional Rent**

2. For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?
Housing Transition Navigation Services

Yes

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

9/18/2025

Housing Tenancy and Sustaining Services

Yes

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

9/18/2025

Short-Term Post-Hospitalization Housing

Yes

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

9/18/2025

Recuperative Care

Yes

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

9/18/2025

Day Habilitation

No

Transitional Rent

Yes

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

1/1/2026

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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)?

Alameda County is integrating two separate helplines for mental health (MH) and substance use disorder (SUD) information, screening, and referrals. By July 2026, the county will have the ACBHD ACCESS Integration project created for a one system-wide point of access for MH and SUD needs for information, screening, and referrals. Alameda County will maintain ongoing communication to establish an ongoing process to collaborate with MCPs to confirm eligibility. Alameda County and the MCP will identify individuals during the screening process at a variety of locations such as FSPs, clinics, crisis services and through homeless outreach.

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

The Flex Pool Administrator, Alameda County Housing (H&H) will be providing weekly updates to the Flex Pool Operator about the number of upcoming referrals including household size and geographic priorities. MCPs will be coordinating with H&H starting with TR authorization requests to MCPs. MCPs would be referring clients to ECM if client isn't enrolled. It is at this junction in the workflow that the MCP is to notify H&H and Flex Pool operator of ECM assignment through the authorization status file. Due to these coordinated efforts, MCPs will be continually updated if changes to the contracted provider network for housing interventions are made.

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)?

Yes

Please describe the county behavioral health system's coordination efforts to align network development

Alameda County Health, Housing & Homelessness's umbrella agency holds an agreement with Alliance (a county MCP) for provision of some Community Supports (Housing Trio, Medically Supportive Food, Asthma Preventative, and Enhance Care Management) and will be expanding to include Transitional Rent. County BHD supports the development of a Flexible Housing Subsidy Pool,

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which will ensure availability and connection to both the Housing Trio (Navigation, Tenancy Sustaining Services, Deposit Assistance), and Enhanced Care Management (ECM). Currently, Alameda County Health, H&H, oversees a provider portfolio of 24 agencies providing Housing Trio services. Collectively, this information is captured in the Homelessness Management Information System (HMIS), which BHD also accesses.

6. What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?

Connection to Housing Resource Center (HRC) and 2-1-1 for clients to become assessed and connected to the Coordinated Entry queue and connected to Housing Navigation, or Tenancy Sustaining Services, and matched to permanent housing resources based upon acuity of need and local prioritization policies as additional housing.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource. Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.
For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools.

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

Yes

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1a. Is the county behavioral health system participating in or planning to participate in the Flex Pool?

Yes

1b. What role does the county behavioral health system have or plan to have in the Flex Pool?

☑ **Funder**

1c. What organization is serving as the Operator?

Abode Services

1d. Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?

Yes

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

- ☑ **Rental Subsidies**
- ☑ **Operating Subsidies**
- ☑ **Landlord Outreach and Mitigation Funds**
- ☑ **Participant Assistance Funds**
- ☑ **Housing Transition Navigation Services and Tenancy and Sustaining Services**
- ☑ **Outreach and Engagement (up to 7 percent)**
- ☑ **Capital Development Projects**

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

Alameda County Behavioral Health Department (ACBHD) will support documentation of eligibility for people who meet Specialty Mental Health Services (SMHS) and/or DMC-ODS access criteria. ACBHD will serve as a reviewer of the flex pool workflow to ensure that clients who meet SMHS/DMC-ODS access criteria but do not have services are coordinated properly to appropriate behavior heath settings.

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Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects.

1. Does the county's plan include the development of innovative programs or pilots?

No

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Workforce Strategy

For more information on this section, please see 6.C.2 Securing Medi-Cal Payment.

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

1. Maintains and monitors a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and

2. Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.

3. The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.

3a. 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

3b. 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

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Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

Assess Workforce Gaps

1. What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?

Enter a Percent value: 26%

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

- ☑ **Community Health Workers (CHW) defined in the Enhanced Community Health Workers Services benefit**
- ☑ **Licensed Marriage and Family Therapist**
- ☑ **Licensed Professional Clinical Counselor**
- ☑ **Mental Health Rehabilitation Specialist**
- ☑ **Physician**

4. Please describe any other key workforce gaps in the county

Key workforce gaps:

• Clinician shortages, especially at the Master's level: A lack of qualified mental health professionals leads to long wait times and limits access to essential services.

• Difficulty recruiting and retaining staff: Alameda County, similar to many California counties, struggles to attract and keep licensed clinical social workers, licensed marriage and family therapists, psychiatrists, and substance use disorder counselors. This challenge is further exacerbated for specialties like adolescent mental health or working with justice-involved individuals.

• Lack of cultural and linguistic diversity: The current behavioral health workforce does not adequately reflect the diverse backgrounds and languages of the community it serves.

• Compensation and retention issues: Compared to neighboring counties and the private sector, starting salaries for behavioral health professionals in Alameda County are often lower, contributing to staffing challenges.

• High turnover rates: Workforce shortages have led to high turnover, particularly in the Bay Area, impacting service continuity.

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• Burnout and job-related stress: The demand for services often exceeds the available workforce, contributing to staff exhaustion and stress.

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)?

BHT and BH-CONNECT will bring workforce shifts and use evidence based practices to improve service quality and outcomes. Alameda County will likely require training and upskilling for existing staff to deliver these new practices effectively; mental health professionals will need training in the specific methodologies and interventions designated as evidence based. Alameda County may need to prioritize hiring individuals already experienced in delivering these practices.

Alameda County will aim to expand access to community based services by strengthening the network of behavioral health providers. This suggests a need for more behavioral health providers in community settings, increasing the number of therapists, case managers, and support staff in local clinics, schools, and other CBOs. Furthermore, integration with broader care teams and expanded roles for paraprofessionals and peer support specialists, working in conjunction with medical and social service providers, will be crucial.

Alameda County will emphasize addressing high need populations such as children, youth, justice-involved individuals, and those experiencing or at-risk of homelessness. This also implies the need for: specialized training in working with these populations from professionals with expertise. Proposition 1 and the BHSA (part of BHT) will require a workforce that understands housing, homelessness, behavioral health care and can address the social determinants of health.

Alameda County recruitment and retention initiatives includes a Workforce Initiative with funding opportunities for scholarships, loan repayment programs, and other incentives to attract and retain qualified professionals.

In summary, Alameda County's behavioral health workforce will likely experience significant shifts in the coming years, requiring a concerted effort to address existing shortages, adapt to new models of care, and expand specialized services to meet the diverse needs of the community.

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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

Please explain any actions or activities the county is engaging in to leverage the program

Alameda County shared information about the Behavioral Health Scholarship Program directly to county system of care and operations staff as well as through general internal emails that went out to all Alameda County Behavioral Health (ACBHD) employees. ACBHD employees then shared with providers and their professional networks. Additionally, Alameda County posted the flyer to the official public social media channels.

2. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?

Yes

Please explain any actions or activities the county is engaging in to leverage the program

Alameda County shared information about the Behavioral Health Scholarship Program directly to county system of care and operations staff as well as through general internal emails that went out to all Alameda County Behavioral Health (ACBHD) employees. ACBHD employees then shared with providers and their professional networks. Additionally, Alameda County posted the flyer to the official public social media channels.

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3. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?

Yes

Please explain any actions or activities the county is engaging in to leverage the program

Alameda County shared information about the Medi-Cal Behavioral Health Recruitment and Retention Program (MBH-RRP) directly to county system of care and operations staff as well as through general internal emails that went out to all Alameda County Behavioral Health (ACBHD) employees. ACBHD employees then shared with providers and their professional networks. Additionally, Alameda County posted the flyer to the official public social media channels.

4. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?

Yes

Please explain any actions or activities the county is engaging in to leverage the program

Alameda County shared information about the Behavioral Health Community-Based Provider Training Program (MBH-CBPTP) directly to county system of care and operations staff as well as through general internal emails that went out to all Alameda County Behavioral Health (ACBHD) employees. ACBHD employees then shared with providers and their professional networks. Additionally, Alameda County posted the flyer to the official public social media channels.

Alameda County looks forward to the development of the community-based providers (Alcohol and Other AOD Counselors, Community Health Workers and Peer Support Specialists) through the training program.

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

Yes

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Please explain any actions or activities the county is engaging in to leverage the program

Alameda County shared information about the Medi-Cal Behavioral Health Residency Training Program (MBH-RTP) directly to county system of care and operations staff as well as through general internal emails that went out to all Alameda County Behavioral Health (ACBHD) employees. ACBHD employees then shared with providers and their professional networks. Additionally, Alameda County posted the flyer to the official public social media channels.

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

Alameda County Behavioral Health Department's Workforce Education and Training (WET) team provides training and technical assistance. WET conducts internal and external assessments with input from stakeholders and CBO agencies and meets with the system of care to update the specific needs, audiences and priorities of the training program. WET develops, researches, and provides a broad array of training related to mental health clinical practice, peer empowerment, cultural responsiveness, and wellness recovery & resilience.

Examples of training topics: SUD Provider trainings (such as Harm Reduction, Narcan, Fentanyl Use, De-Escalation for SUD, Co-Occurring Disorder screening, Motivational Interviewing, Trauma-informed care; Suicide Prevention with focus on Dual-Diagnosis), Youth and Adult mental health, Older Adult employment training, first aid, Peer Empowerment, Wellness in the Workplace series for all-staff, and cultural humility.

To address Provider staff burnout and a need for comprehensive training and support, WET will implement evidence-based and innovative solutions designed to equip staff and community-based organization (CBO) partners with the necessary tools to navigate these complexities.

WET also maintains several accreditations through which it provides continuing education for various clinical disciplines. Currently, WET maintains accreditations for BSS, CPA, CCAPP, BRN and assures that all training courses offer continuing education credits to follow standards.

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By prioritizing these efforts, the WET Training Unit fosters a more skilled, resilient, and compassionate workforce capable of delivering high-quality, equitable care. In fiscal year 2023 / 2024: (July 1, 2023 – June 30, 2024), WET provided or collaborated in a total of 59 training activities and trained 2171 people consisting of 476 ACBHD staff and 1695 contracted community-based organization (CBO) staff.

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Budget And Prudent Reserve

Please see below.

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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 39: 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 21 through 37.
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			Total Projected Expenditures on Children/Youth (under 21)			Projected Individuals to be Served Annually (May be duplicated)	
		Year One	Year Two	Year Three	Year One	Year Two	Year Three	Eligible Adults and Older Adults	Eligible Children/Youth
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☐	$ 993,170.43	$ 993,170.43	$ 993,170.43	$ 1,982,309.30	$ 1,982,309.30	$ 1,982,309.30	800.00	1005.00
Early Intervention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Outpatient Services	☑	$ 27,490,331.00	$ 27,490,331.00	$ 27,490,331.00	$ 3,375,161.00	$ 3,375,161.00	$ 3,375,161.00	4864	209.00
Intensive Outpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Crisis and Field-Based Services	☑	$ 3,884,102.00	$ 3,884,102.00	$ 3,884,102.00	$ -	$ -	$ -	1497	641.00
Residential Treatment Services	☐	$ 18,400,129.00	$ 18,400,129.00	$ 18,400,129.00	$ -	$ -	$ -	1171	#
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Mental Health (MH) Services									
Primary Prevention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Early Intervention Services	☑	$ 21,436,343.00	$ 21,436,343.00	$ 21,436,343.00	$ 20,218,346.94	$ 20,218,346.94	$ 20,218,346.94	18361	32944
Outpatient and Intensive Outpatient Services	☑	$ 161,686,940.00	$ 161,686,940.00	$ 161,686,940.00	$ 148,282,725.00	$ 148,282,725.00	$ 148,282,725.00	13044	7625
Crisis Services	☑	$ 39,518,655.00	$ 39,518,655.00	$ 39,518,655.00	$ 7,395,175.00	$ 7,395,175.00	$ 7,395,175.00	4237	487
Residential Treatment Services	☐	$ 8,753,126.21	$ 8,753,126.21	$ 8,753,126.21	$ 2,178,096.80	$ 2,178,096.80	$ 2,178,096.80	776	80
Hospital and Acute Services	☐	$ 63,749,487.00	$ 63,749,487.00	$ 63,749,487.00	$ 8,537,197.00	$ 8,537,197.00	$ 8,537,197.00	1808	231
Subacute and Long-Term Care Services	☐	$ 40,837,898.00	$ 40,837,898.00	$ 40,837,898.00	$ 551,250.00	$ 551,250.00	$ 551,250.00	317	#
Housing Services (MH + SUD)									
Housing Services	☑	$ 92,817,558.00	$ 92,817,558.00	$ 92,817,558.00	$ 790,259.40	$ 790,259.40	$ 790,259.40	12406	975
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 479,567,739.64	$ 479,567,739.64	$ 479,567,739.64	$ 193,310,520.44	$ 193,310,520.44	$ 193,310,520.44	59281	44197

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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 18 through 21: 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 23: total projected expenditures will be auto-populated from rows 18 through 21.

For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures**		
	Year One	**Year Two**	**Year Three**
Capital Infrastructure Activities	$ 3,000,000.00	$ -	$ -
Workforce Investment Activities	$ 2,546,601.00	$ 2,546,601.00	$ 2,546,601.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 107,619,934.00	$ 106,400,143.00	$ 107,224,722.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 31,628,342.00	$ 31,628,342.00	$ 31,628,342.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 144,794,877.00	$ 140,575,086.00	$ 141,399,665.00

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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	$ 164,470,669.00	$ 152,648,385.00	$ 148,404,635.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 83,697,978.93	$ 83,697,978.93	$ 83,697,978.93
2011 Realignment (Public Safety Realignment)	$ 135,833,303.64	$ 135,833,303.64	$ 135,833,303.64
State General Fund	$ 23,349,148.00	$ 23,349,148.00	$ 23,349,148.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 253,416,456.00	$ 261,018,949.00	$ 266,087,278.00
Projects for Assistance in Transition from Homelessness (PATH)	$ 278,105.00	$ 278,105.00	$ 278,105.00
Community Mental Health Block Grant (MHBG)	$ 1,518,818.00	$ 1,518,818.00	$ 1,518,818.00
Substance Use Block Grant (SUBG)	$ 9,123,443.00	$ 9,123,443.00	$ 9,123,443.00
Commercial Insurance	$ 52,474.00	$ 52,474.00	$ 52,474.00
County General Fund	$ 81,041,289.51	$ 81,041,289.51	$ 81,041,289.51
Opioid Settlement Funds	$ 9,023,548.00	$ 9,023,548.00	$ 9,023,548.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 2,503,400.00	$ 2,503,400.00	$ 2,503,400.00
Other state funding (including DSH funding)	$ 46,114,106.00	$ 46,114,106.00	$ 46,114,106.00
Other county mental health or SUD funding	$ 7,250,398.00	$ 7,250,398.00	$ 7,250,398.00
Other foundation funding	$ -	$ -	$ -
Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**
Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 817,673,137.09	$ 813,453,346.09	$ 814,277,925.09
Total Projected Expenditure Variance	$ 0.00	$ 0.00	$ 0.00
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 672,878,260.08	$ 672,878,260.08	$ 672,878,260.08
Auto-validation: Table 2: Other County Expenditures	$ 144,794,877.00	$ 140,575,086.00	$ 141,399,665.00

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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 39-41: input your county's base BHSA funding allocation by component and year.

Rows 45-54: this section will be auto-populated from the sections below it.

Rows 45, 50, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.

Rows 46, 51, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Row 47: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.

Row 48: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.

Rows 59, 82, and 105: the base funding amount for Housing Interventions will auto-populate from Column C, rows 39-41.

Rows 60, 83, and 106: 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 61, 84, and 107: 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 64, 87, 110: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 39-41.

Rows 69, 92, 115: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 39-41.

Rows 65, 70, 88, 93, 111, and 116: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.

Rows 66, 71, 89, 94, 112, and 117: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.

Rows 75, 98, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."

Rows 76, 99, 122: 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 77, 100, 123: 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 76) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.

Rows 78, 101, 124: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."

Rows 127-132: 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 133: the total dollar amount of MHSA Transfers to BHSA is auto-populated.

Row 136: enter the dollar amount of prior year prudent reserve ending balance

Row 137: enter the prudent reserve maximum for your county.

Row 138: 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 139-141: enter the amount of excess prudent reserve funds allocated to each component.

Row 142: 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	Full-Service Partnership	Behavioral Health Services and Support	Total
Year 1 Component Allocation (dollars)	$ 37,306,397.10	$ 43,524,129.95	$ 43,524,129.95	$ 124,354,657.00
Year 2 Component Allocation (dollars)	$ 41,735,347.80	$ 48,691,239.10	$ 48,691,239.10	$ 139,117,826.00
Year 3 Component Allocation (dollars)	$ 44,221,971.30	$ 51,592,299.85	$ 51,592,299.85	$ 147,406,571.00

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Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Year One				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 37,306,397.10	$ 43,524,129.95	$ 43,524,129.95	$ 124,354,657.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ -	$ 10,000,000.00	$ 66,317,330.00	$ 76,317,330.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -
Year Two				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 41,735,347.80	$ 48,691,239.10	$ 48,691,239.10	$ 139,117,826.00
Year Three				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 44,221,971.30	$ 51,592,299.85	$ 51,592,299.85	$ 147,406,571.00

Funding Transfer Request Allocations

Year 1

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 37,306,397.10
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 37,306,397.10
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 43,524,129.95
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 43,524,129.95
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 43,524,129.95
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 43,524,129.95

Transfers				
	Housing Intervention (1)	Full-Service Partnership	Behavioral Health Services and Support	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%

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Year 2		
Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 41,735,347.80
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 41,735,347.80
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 48,691,239.10
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 48,691,239.10
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 48,691,239.10
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 48,691,239.10

Transfers				
	Housing Intervention (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**	**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%

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Year 3		
Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 44,221,971.30
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 44,221,971.30
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 51,592,299.85
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 51,592,299.85
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 51,592,299.85
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 51,592,299.85

Transfers				
	Housing Intervention (1)	**Full-Service Partnership**	**Behavioral Health Services and Support**	**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%

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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	$ 4,249,609.00	$ -	$ -	$ 4,249,609.00
PEI	$ 26,015,968.00	$ -	$ 10,000,000.00	$ 16,015,968.00
Encumbered INN	$ 11,000,000.00	$ -	$ -	$ 11,000,000.00
Unencumbered INN	$ 26,646,626.00	$ -	$ -	$ 9,401,753.00
WET	$ 234,904.00			$ 2,150,000.00
CFTN	$ 8,170,223.00			$ 23,500,000.00
Total (auto-populated)	$ 76,317,330.00	$ -	$ 10,000,000.00	$ 66,317,330.00

Excess Prudent Reserve to BHSA Components	
Transfer from Prudent Reserve to BHSA Component Allocation	Amount
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 14,593,038.00
Local Prudent Reserve Maximum (2)	$ 14,593,038.00
Excess Prudent Reserve Funding that must be transferred	**$ -**
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.
4. W&I Code § 5892, subdivision (b)(6)(A) states counties must spend prudent reserve funds on Housing Intervention, FSP, and/or BHSS programs or services only.

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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 40-43: input the estimated total Housing Intervention component allocation received for each year. Row 40 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 41: 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 139 that you will be transferring excess PR funds to Housing Interventions please report them here.

Rows 49-66: input the projected expenditures for each Housing Intervention component service category or program for each year.

Row 48: 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 53: 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 65: input expenditures for BHSA-funded innovation pilots or projects.

Row 66: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 67: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

Row 69: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 71: 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 72: the overall total of Housing Intervention expenditures will be auto-populated from rows 67, 69, and 71.

Row 74: 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 75: 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 74.

Row 77: the proportion of funds dedicated to capital development will be auto-populated.

Row 78: the proportion of funds dedicated to the chronically homeless population will be auto-populated.

Row 79: the proportion of funds dedicated to Outreach and Engagement will be auto-populated.

Rows 81-82: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

Row 84: 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 (1)			
	Year 1	**Year 2**	**Year 3**
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 37,306,397.00	$ 41,735,347.00	$ 44,221,971.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -
Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 37,306,397.00	$ 41,735,347.00	$ 44,221,971.00

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Housing Interventions Category						
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only**			**Projected Expenditures - All Other Funding Sources**		
	Year 1	**Year 2**	**Year 3**	**Year 1**	**Year 2**	**Year 3**
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	$ 8,020,317.00	$ 8,020,317.00	$ 10,020,317.00	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 8,918,560.00	$ 10,318,560.00	$ 11,018,560.00	$ -	$ -	$ -
Operating Subsidies	$ 9,362,428.16	$ 9,811,203.61	$ 10,092,089.21	$ 224,491.04	$ 235,685.89	$ 235,685.89
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	65%	68%	69%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ 891,856.00	$ 1,031,856.00	$ 1,101,856.00	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 900,000.00	$ 900,000.00	$ 900,000.00	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 365,847.17	$ 365,586.83	$ 365,586.83	$ 5,206.83	$ 5,467.17	$ 5,467.17
Other Housing Supports: Outreach and Engagement (2)	$ 2,393,833.88	$ 2,373,338.82	$ 2,373,338.82	$ 1,110,835.12	$ 1,131,330.18	$ 1,131,330.18
Capital Development Projects	$ -	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 30,852,842.22	$ 32,820,862.26	$ 35,871,747.86	$ 1,340,532.98	$ 1,372,483.24	$ 1,372,483.24

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Housing Interventions Transfer Information	Year 1	Year 2	Year 3
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Administrative Information	**Year 1**	**Year 2**	**Year 3**
Housing Interventions Component Admin Expenses	$ 3,503,698.00	$ 3,503,698.00	$ 3,503,698.00
Total Housing Interventions Expenditures (auto-populated)	$ 34,356,540.22	$ 36,324,560.26	$ 39,375,445.86
Housing Interventions Populations to be Served	**Year 1**	**Year 2**	**Year 3**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 19,534,179.14	$ 21,522,317.13	$ 22,922,317.13
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 1,017,712.00	$ 1,017,712.00	$ 1,068,597.60
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	0.0%	0.0%	0.0%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	52.4%	51.6%	51.8%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	6.4%	5.7%	5.4%
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)	975	1024	1075
Eligible Adults/Older Adults	12406	13026	13678
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
MHSA "Encumbered" INN	$ -	$ -	$ -

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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.

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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 25-28: input the total estimated FSP component allocation received for each year. Row 25 will auto-populate from Tab Four in the BHSA Transfers tab.

Input unspent MHSA dollars carried over to this component into row 27. Row 28 will auto-populate the sum of rows 25-27 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 140 that you will be transferring excess PR funds to FSP please report them here.

Rows 33-42: 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 33-38. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 39-40, accordingly.

Row 41: input expenditures for BHSA-funded innovation pilots or projects.

Row 42: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 43: the subtotal of FSP programs/services will be auto-populated from rows 33-42.

Row 45: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.

Row 47: 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 48: total projected expenditures for FSP for each year will be auto-populated from rows 43, 45, and 47.

Rows 50 and 51: input the estimated unduplicated count of individuals that will be served across all FSP programs.

Row 53: 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 1	**Year 2**	**Year 3**
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 43,524,129.00	$ 48,691,239.00	$ 51,592,299.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$8,500,000.00	$1,500,000.00	$ -
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 52,024,129.00	$ 50,191,239.00	$ 51,592,299.00

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Full Service Partnership Category (1)									
Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - Federal Financial Participation			Projected Expenditures - All Other Funding Sources		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 27,957,380.31	$ 27,955,528.25	$ 27,955,528.25	$ 5,250,563.49	$ 5,252,415.54	$ 5,252,415.54	$ -	$ -	$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 8,024,740.86	$ 8,023,393.91	$ 8,023,393.91	$ 1,702,778.55	$ 1,704,125.50	$ 1,704,125.50	$ -	$ -	$ -
FSP Intensive Case Management	$ 9,334,449.20	$ 8,673,916.60	$ 8,673,916.60	$ 9,116,416.63	$ 8,862,321.15	$ 8,862,321.15	$ -	$ -	$ -
High Fidelity Wraparound	$ 1,095,624.02	$ 1,094,613.80	$ 1,094,613.80	$ 916,489.07	$ 917,499.28	$ 917,499.28	$ -	$ -	$ -
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 1,366,461.00	$ 1,366,461.00	$ 1,366,461.00	$ 1,161,212.00	$ 1,161,212.00	$ 1,161,212.00	$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ 2,744,437.03	$ 2,559,504.48	$ 2,559,504.48	$ 3,768,758.77	$ 3,564,703.62	$ 3,564,703.62	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 50,523,092.41	$ 49,673,418.05	$ 49,673,418.05	$ 21,916,218.51	$ 21,462,277.10	$ 21,462,277.10	$ -	$ -	$ -

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FSP Transfer Information	Year 1	Year 2	Year 3
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -
FSP Administrative Information	**Year 1**	**Year 2**	**Year 3**
FSP Component Admin Expenses	$ 1,419,783.27	$ 474,298.76	$ 474,298.76
Total Full Service Partnership Expenditures (auto-populated)	$ 51,942,875.68	$ 50,147,716.81	$ 50,147,716.81
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)	1012	1062	1115
Eligible Adults/Older Adults	254	267	281
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
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.

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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 27-30: input the total estimated BHSS component allocation received for each year. Row 27 will auto-populate from Tab Four in the BHSA Transfers tab.

Row 28: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 141 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 29. Row 30 will auto-populate the sum of rows 27-29.

Rows 35-48: input the projected expenditures for each BHSS service category or program for each year. Rows 37, 41, and 44 auto-populate from their sub rows.

Row 47: input expenditures for BHSA-funded innovation pilots or projects.

Row 48: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 49: the subtotal for projected expenditures will be auto-populated from rows 35 - 37, 40, 41, 44, 47, and 48.

Row 51: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.

Row 53: 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 54: the total for projected BHSS expenditures will be auto-populated from rows 49, 51, and 53.

Row 56: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.

Row 58: the proportion of EI funds will auto-populate from rows 30 and 37. Note: MHSA WET, INN, and CF/TN funds in Rows 67-69 will be deducted from the revenue (excluded from the denominator).

Row 59: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 37 and 56.

Rows 61-62: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.

Rows 64-65: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.

Rows 67-69: 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 1	Year 2	Year 3
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 43,524,129.00	$ 48,691,239.00	$ 51,592,299.00
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)	$ 36,650,000.00	$ 20,667,330.00	$ 9,000,000.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 80,174,129.00	$ 69,358,569.00	$ 60,592,299.00

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Behavioral Health Services and Supports Category (1)									
Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - Federal Financial Participation			Projected Expenditures - All Other Funding Sources		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ 2,151,943.58	$ 2,079,038.41	$ 2,079,038.41	$ 414,121.83	$ 420,196.58	$ 420,196.58	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 11,021,467.25	$ 10,245,942.93	$ 10,245,942.93	$ 11,748,550.38	$ 12,283,254.58	$ 12,283,254.58	$ -	$ -	$ -
Early Intervention Expenditures	$ 32,295,991.69	$ 31,983,201.32	$ 31,983,201.32	$ 6,255,807.31	$ 6,568,597.68	$ 6,568,597.68	$ -	$ -	$ -
Coordinated Specialty Care for First Episode Psychosis	$ 752,815.61	$ 714,050.29	$ 714,050.29	$ 775,306.39	$ 814,071.71	$ 814,071.71	$ -	$ -	$ -
All Other EI Expenditures	$ 31,543,176.08	$ 31,269,151.04	$ 31,269,151.04	$ 5,480,500.92	$ 5,754,525.96	$ 5,754,525.96	$ -	$ -	$ -
Outreach and Engagement	$ 887,299.60	$ 878,020.06	$ 878,020.06	$ 185,590.80	$ 194,870.34	$ 194,870.34	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 715,849.00	$ 715,849.00	$ 715,849.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ 715,849.00	$ 715,849.00	$ 715,849.00	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 11,682,571.25	$ 8,018,837.01	$ 3,775,087.01	$ 5,111,424.75	$ 5,248,870.99	$ 2,492,620.99	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ 11,682,571.25	$ 8,018,837.01	$ 3,775,087.01	$ 5,111,424.75	$ 5,248,870.99	$ 2,492,620.99	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 3,291,638.00	$ 3,291,638.00	$ 3,291,638.00	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 62,046,760.37	$ 57,212,526.74	$ 52,968,776.74	$ 23,715,495.07	$ 24,715,790.16	$ 21,959,540.16	$ -	$ -	$ -

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BHSS Prudent Reserve Transfer Information	Year 1	Year 2	Year 3
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -
BHSS Administrative Information	**Year 1**	**Year 2**	**Year 3**
BHSS Component Admin Expenses	$ 13,771,583.01	$ 6,846,128.03	$ 6,846,128.03
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 75,818,343.38	$ 64,058,654.77	$ 59,814,904.77
Youth-Focused Early Intervention Expenditures	**Year 1**	**Year 2**	**Year 3**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 18,076,446.26	$ 17,930,192.35	$ 17,930,192.35
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	74.2%	66.1%	61.9%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	56.0%	56.1%	56.1%
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)	36698	38533	40460
Eligible Adults/Older Adults	78909	82854	86997
Projected BHSS Funds transferred to WET or CF/TN	**Year 1**	**Year 2**	**Year 3**
BHSS transfer to WET	$ -	$ -	$ -
BHSS transfer to CF/TN	$ -	$ -	$ -
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
Estimated MHSA WET Funds	$ 2,150,000.00	$ 1,434,151.00	$ 718,302.00
Estimated MHSA CF/TN Funds	$ 23,500,000.00	$ 11,817,428.75	$ 3,798,591.74
MHSA "Encumbered" INN	$ 11,000,000.00	$ 7,708,362.00	$ 4,416,724.00

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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.

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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 31: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately.

Row 34: total projected annual revenues of the Local Behavioral Health Services Fund will be auto-populated.

Row 35: the proportion of funding used for improvement and monitoring will be auto-populated from rows 34 and 27.

Row 36: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 34.

Row 38-40: 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 1**	**Year 2**	**Year 3**
Total Projected Improvement and Monitoring Expenditures	$ 1,083,766.50	$ 1,064,106.08	$ 1,064,106.08
Total Projected County Integrated Plan Annual Planning Expenditures	$ -	$ -	$ -
New and Ongoing Administrative Costs	$ 2,052,555.95	$ 2,010,471.10	$ 1,710,471.10
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 169,504,655.00	$ 161,285,155.00	$ 156,406,569.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	0.6%	0.7%	0.7%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	0.0%	0.0%	0.0%
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.

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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 136-137.

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 139-141.

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 69, Tab 6 row 45, and Tab 7 row 51.

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 41, Tab 6 row 26, and Tab 7 row 28.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 14,593,038.00
Local Prudent Reserve Maximum (1)	$ 14,593,038.00
Excess Prudent Reserve Funds (auto-populated)	$ -
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).

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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 45, 50, 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 40; Tab 6, row 25; and Tab 7, row 27, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Rows 36, 43, and 50: 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 41; Tab 6, row 26; and Tab 7, row 28.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 4 row 133.

Rows 38, 45, and 52: estimated total available funding will be auto-populated from rows 35-37, 42-44 and 49-51.

Rows 39, 46, and 53: 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 69; Tab 6, row 45; and Tab 7, row 51.

Rows 40, 47, and 54: estimated expenditures for each component will be auto-populated from Tab 5, row 72; Tab 6, row 48; and Tab 7, row 54.

Rows 44 and 51: 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 57-59: 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	$ 37,306,397.00	$ 43,524,129.00	$ 43,524,129.00	$ 124,354,655.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 41,735,347.00	$ 48,691,239.00	$ 48,691,239.00	$ 139,117,825.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 44,221,971.00	$ 51,592,299.00	$ 51,592,299.00	$ 147,406,569.00

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BHSA Funding Summary	Housing Interventions	Full Service Partnerships	Behavioral Health Services and Supports	Totals
Year One				
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 37,306,397.00	$ 43,524,129.00	$ 43,524,129.00	$ 124,354,655.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ -	$ 10,000,000.00	$ 66,317,330.00	$ 76,317,330.00
Estimated Total Available Funding for Year One	$ 37,306,397.00	$ 53,524,129.00	$ 109,841,459.00	$ 200,671,985.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 34,356,540.22	$ 51,942,875.68	$ 75,818,343.38	$ 162,117,759.28
Year Two				
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 41,735,347.00	$ 48,691,239.00	$ 48,691,239.00	$ 139,117,825.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 2,949,856.78	$ 3,081,253.32	$ 54,690,445.62	$ 60,721,555.72
Estimated Total Available Funding for Year Two	$ 44,685,203.78	$ 51,772,492.32	$ 103,381,684.62	$ 199,839,380.72
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 36,324,560.26	$ 50,147,716.81	$ 64,058,654.77	$ 150,530,931.84
Year Three				
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 44,221,971.00	$ 51,592,299.00	$ 51,592,299.00	$ 147,406,569.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ 8,360,643.53	$ 1,624,775.50	$ 48,323,029.85	$ 58,308,448.88
Estimated Total Available Funding for Year Three	$ 52,582,614.53	$ 53,217,074.50	$ 99,915,328.85	$ 205,715,017.88
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 39,375,445.86	$ 50,147,716.81	$ 59,814,904.77	$ 149,338,067.44

BHSA Plan Admin Expenses				
Plan Admin Category	**Year One**	**Year Two**	**Year Three**	**Total**
Total Projected Improvement and Monitoring Expenditures	$ 1,083,766.50	$ 1,064,106.08	$ 1,064,106.08	$ 3,211,978.65
Total Projected County Integrated Plan Annual Planning Expenditures	$ -	$ -	$ -	$ -
Total Projected New and Ongoing Administrative Expenditures	$ 2,052,555.95	$ 2,010,471.10	$ 1,710,471.10	$ 5,773,498.15

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Plan Approval and Compliance

To be added soon.

DRAFT

Appendix

Appendix A: Statewide Behavioral Health Goals: **page 258**

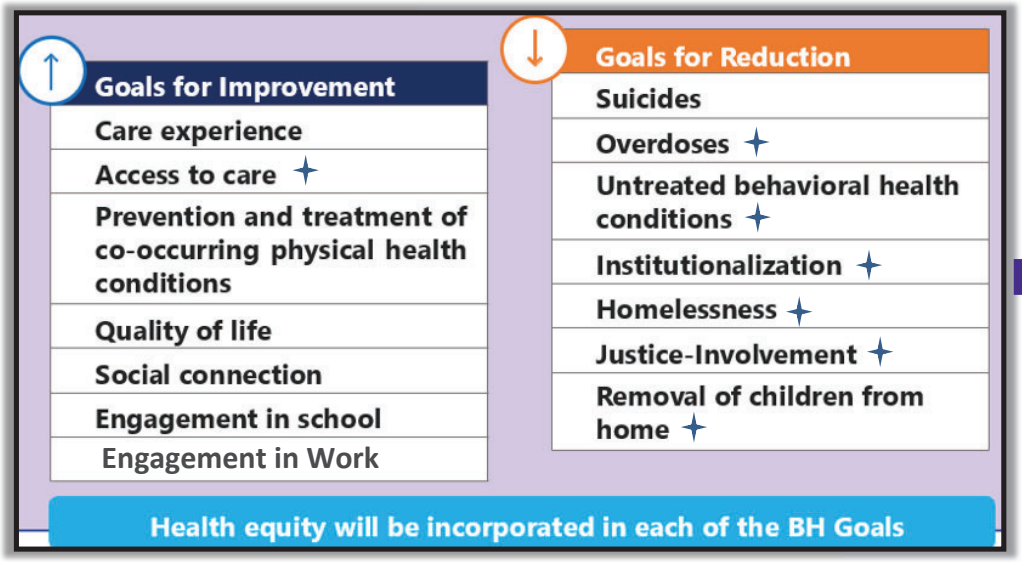
Appendix B: Quality Improvement Work Plan (QIWP) Fiscal Year 2025-2026: **page 271**

Appendix C: Community Program Planning Process: **page 292**

DRAFT

Appendix A: Statewide Behavioral Health Goals

Statewide Behavioral Health Goals:



DHCS has initiated a Behavioral Health Transformation committee: **Quality and Equity Advisory Committee (QEAC)** to determine metrics associated with each of these goals on which counties will then report.

In the Integrated Plans, counties are **required** to complete planning and data collection on all six priority goals *and* select one additional goal.

Behavioral Health Department
Alameda County Health

There are fourteen Behavioral Health Goals. Seven of the goals, DHCS is looking for improvement. Seven of the goals, DHCS is looking for reduction. On the following pages you will see where Alameda County is when compared to the statewide rate.

The green arrow pointing upwards symbolizes Alameda County is above the statewide rate.

The equal sign symbolizes Alameda County is equal to the statewide rate. Alameda County used a 1% variance to indicate equal.

The green arrow pointing downwards symbolizes Alameda County is below the statewide rate.

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Access to Care

Primary Measure	
County Name	**SMHS Penetration Rates for Adults**
Statewide Rate	3.4%
Statewide Median	3.8%
Alameda	2.9%

Primary Measure	
County Name	**SMHS Penetration Rates for Children & Youth**
Statewide Rate	4.2%
Statewide Median	4.1%
Alameda	4.6%

Primary Measure	
County Name	**NSMHS Penetration Rates for Adults**
Statewide Rate	10.6%
Statewide Median	12.4%
Alameda	8.1%

Primary Measure	
County Name	**NSMHS Penetration Rates for Children & Youth**
Statewide Rate	15.5%
Statewide Median	15.1%
Alameda	14.0%

Source Data: California Department of Health Care Services (DHCS)

Behavioral Health Department
Alameda County Health

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Access to Care - continued

Primary Measure		
County Name	DMC-ODS Penetration Rates, Adults	DMC-ODS Penetration Rates, Children and Youth
Statewide Rate	1.7%	0.4%
Statewide Median	1.6%	0.3%
Alameda	1.1%	0.2%

Supplemental Measure	
County Name	Initiation of Substance Use Disorder Treatment (IET-INI)
Statewide Rate	36.6%
Statewide Median	34.3%
Alameda	39.3%

Source Data: California Department of Health Care Services (DHCS)

Behavioral Hea Department
Alameda County Health

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Homelessness

Primary Measure	
County Name	**PIT Count Rate of People Experiencing Homelessness (Rate per 10,000 people by CoC Region)**
Statewide Rate	48.0
Statewide Median	42.7
Alameda	58.3

Primary Measure	
County Name	**Percent of K–12 Public School Students Experiencing Homelessness by County (Homeless Student Enrollment as a Share of Cumulative Enrollment)**
Statewide Rate	5.3%
Statewide Median	4.6%
Alameda	2.6%

Behavioral Health Department
Alameda County Health

Source Data: California Department of Health Care Services (DHCS)

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Homelessness - continued

Supplemental Measure	
County Name	**PIT Count Rate of People Experiencing Homelessness with Severe Mental Illness (SMI) (Rate per 10,000 people by CoC Region)**
Statewide Rate	11.5
Statewide Median	9.8
Alameda	12.6

Supplemental Measure	
County Name	**PIT Count Rate of People Experiencing Homelessness with Substance Use Disorder (SUD) (Rate per 10,000 people by CoC Region)**
Statewide Rate	11.0
Statewide Median	9.2
Alameda	9.6

Behavioral Health Department
Alameda County Health

Source Data: California Department of Health Care Services (DHCS)

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Homelessness - continued

Supplemental Measure	
County Name	**Rate of People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) (Rate per 10,000 people by CoC Region)**
Statewide Rate	91.2
Statewide Median	82.9
Alameda	84.2

Source Data: California Department of Health Care Services (DHCS)

Behavioral Health Department
Alameda County Health

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Institutionalization

Primary Measure	
County Name	Inpatient Administrative Days for Adults, Total Days per Beneficiary
Statewide Rate	25.6
Statewide Median	34.9
Alameda	15.1

Primary Measure	
County Name	Inpatient Administrative Days for Children and Youth, Total Days per Beneficiary
Statewide Rate	8.7
Statewide Median	5.9
Alameda	7.7

Source Data: California Department of Health Care Services (DHCS)

Behavioral Health Department
Alameda County Health

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Institutionalization

SUPPLEMENTAL SMHS Crisis Service Utilization - Crisis Residential Tx Services for Adults, Rate per 100,000		
Gender	County Performance	Statewide Rate
Male	18.7	11.7
Female	13.9	7.7

SUPPLEMENTAL SMHS Crisis Service Utilization - Crisis Intervention for Adults, Rate per 100,000		
Gender	County Performance	Statewide Rate
Male	32.4	64.3
Female	27.5	55.1

SUPPLEMENTAL SMHS Crisis Service Utilization - Crisis Stabilization for Adults, Rate per 100,000		
Gender	County Performance	Statewide Rate
Male	106.4	72.3
Female	67.3	51.1

SUPPLEMENTAL SMHS Crisis Service Utilization - Crisis Residential Tx Services for Children & Youth, Rate per 100,000		
Gender	County Performance	Statewide Rate
Male	0.9	0.4
Female	1.0	0.4

SUPPLEMENTAL SMHS Crisis Service Utilization - Crisis Intervention for Children & Youth, Rate per 100,000		
Gender	County Performance	Statewide Rate
Male	14.1	23.5
Female	20.0	37.0

SUPPLEMENTAL SMHS Crisis Service Utilization - Crisis Stabilization for Children & Youth, Rate per 100,000		
Gender	County Performance	Statewide Rate
Male	6.0	11.1
Female	7.1	17.5

Source Data: California Department of Health Care Services (DHCS)

Behavioral Health Department
Alameda County Health

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Institutionalization

SUPPLEMENTAL	
14-Day Involuntary Detention Rates, Rate per 10,000	
County Performance	Statewide Rate
32.2	10.2

SUPPLEMENTAL	
30-Day Involuntary Detention Rates, Rate per 10,000	
County Performance	Statewide Rate
0.0	0.9

SUPPLEMENTAL	
Temporary Conservatorship Rates, Rate per 10,000	
County Performance	Statewide Rate
*	0.7

SUPPLEMENTAL	
Permanent Conservatorship Rates, Rate per 10,000	
County Performance	Statewide Rate
*	2.8

SUPPLEMENTAL	
180-Day Post-Certification Involuntary Detention Rates, Rate per 10,000	
County Performance	Statewide Rate
0.0	0.0

Source Data: California Department of Health Care Services (DHCS)

Behavioral Health Department
Alameda County Health

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Removal of Children from home

Primary Measure	
County Name	**Children in Foster Care, Rate per 100,000**
Statewide Rate	525.1
Statewide Median	484.0
Alameda	278.6

Supplemental Measure	
County Name	**Open Child Welfare Case SMHS Penetration Rates**
Statewide Rate	43.0%
Statewide Median	39.5%
Alameda	49.7%

Source Data: California Department of Health Care Services (DHCS)

Behavioral Health Department
Alameda County Health

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Untreated Behavioral Health Conditions

Primary Measure	
County Name	**Follow-Up After Emergency Department Visit for Substance Use (FUA-30)**
Statewide Rate	28.80%
Statewide Median	30.30%
Alameda	29.70%

Primary Measure	
County Name	**Follow-Up After Emergency Department Visit for Mental Illness (FUM-30)**
Statewide Rate	38.20%
Statewide Median	37.30%
Alameda	48.30%

Source Data: California Department of Health Care Services (DHCS)

Behavioral Health Department
Alameda County Health

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Overdoses

Primary Measure	
County Name	**All Drug-Related Overdose Deaths, Rate per 100,000**
Statewide Rate	28.8
Statewide Median	31.0
Alameda	26.4

Supplemental Measure	
County Name	**All Drug-Related Overdose ED Visits, Rate per 100,000**
Statewide Rate	143.8
Statewide Median	148.6
Alameda	122.8

Source Data: California Department of Health Care Services (DHCS)

Behavioral Health Department
Alameda County Health

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Justice Involvement

Primary Measure		
County Name	**Arrests: Adults, Rate per 100,000**	**Arrests: Juveniles Adjusted, Rate per 100,000**
Statewide Rate	2,440.2	371.5
Statewide Median	2,645.8	394.8
Alameda	↓ 1,756.5	↓ 297.5

Supplemental Measure	
County Name	**Adult Recidivism Conviction Rate**
Statewide Rate	39.6%
Statewide Median	39.6%
Alameda	↓ 25.6%

Supplemental Measure	
County Name	Incompetent to Stand Trial (IST) Count, Rate per 100,000
Statewide Rate	14.3
Statewide Median	17.7
Alameda	↓ 5.3

Behavioral Health Department
Alameda County Health

Source Data: California Department of Health Care Services (DHCS)

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Appendix B: Quality Improvement Work Plan (QIWP) Fiscal Year 2025-2026

Behavioral Health Department
Alameda County Health

Integrated Mental Health & Substance Use Disorder
Quality Improvement Work Plan (QIWP)
Fiscal Year 2025-2026

Mission:

The mission of Alameda County Behavioral Health Department (ACBHD) is to maximize the recovery, the resilience and the wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol, or drug concerns.

Vision:

We envision communities where all individuals and their families can successfully realize their potential and pursue their dreams, and where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.

Quality Improvement Work Plan (QIWP):

The QIWP describes ACBHD's plan for continuous quality improvement (CQI) of its Mental Health Plan (MHP), Drug Medi-Cal Organized Delivery System (DMC-ODS), and overall systems. Through the QIWP, ACBHD will:

- Implement quality improvement activities across all systems,
- Increase the capacity of ACBHD's leadership and Quality Management staff to track key indicators addressing client outcomes, program development, and system change,
- Support decision-making based on performance outcome measures, and
- Increase quality improvement capability in programs operating across all systems of care.

As a living document, the QIWP is regularly reviewed, analyzed, and updated by ACBHD's Quality Improvement & Data Analytics Division with input from the Quality Improvement Committee (QIC) and other stakeholders.

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Alameda County Behavioral Health Department
Quality Improvement Work Plan FY 2025-2026

Section I. Quality Improvement Monitoring Activities

ACBHD Quality Improvement & Data Analytics Division works closely with Quality Management staff and other stakeholders to monitor the following activities on a regular basis to ensure meaningful improvement in clinical care and client services:

Area Monitored	Data Reviewed	Partners	FY 2025-2026 Objectives
Performance Data	Timeliness, network adequacy, and other performance measures	Quality Improvement & Data Analytics; Information Systems	ACBHD will improve its capacity to measure timeliness outcomes, network adequacy, and other required performance measures. ACBHD will set appropriate objectives based on benchmarks.
Utilization Data	Service modality, units of service, client demographics	Utilization Management; Quality Improvement & Data Analytics; Information Systems	ACBHD will improve the utilization data reporting system for both MHP and DMC-ODS delivery systems.
Beneficiary Grievances	Annual Beneficiary Grievances and Appeals Report	Quality Assurance	ACBHD will continue monitoring grievances and analyzing trends. ACBHD will establish an automated tracking system for grievances.
Appeals & Expedited Appeals	Annual Beneficiary Grievances and Appeals Report	Quality Assurance	ACBHD will continue monitoring appeals and analyzing trends.
Fair Hearings & Expedited Fair Hearings	Fair Hearings & Expedited Fair Hearings Log	Utilization Management	ACBHD will continue monitoring fair hearings and analyzing trends.

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Provider Appeals	Provider Appeals Log	Provider Relations; Quality Assurance; Fiscal; Utilization Management	ACBHD will continue monitoring provider problems and appeals and will create a system for tracking problems and appeals.

Area Monitored	Data Reviewed	Partners	FY 2025-2026 Objectives
Clinical Records Review	Federal, State, and County Audit Reports (e.g., summary reports, claims sheets, and recoupment) and utilization review findings (e.g., authorization determinations)	Quality Assurance; Utilization Management; Integrated Health Care Services	ACBHD will continue evaluating appropriateness and quality of services rendered and improve coordination of care. Training and technical assistance will be available to providers to ensure understanding of documentation standards, and to improve quality of documentation that reflects service and medical necessity.
Unusual Occurrences (UOs)	Unusual Occurrences Log	Quality Assurance	ACBHD will continue monitoring appeals and analyzing trends. ACBHD will establish a quarterly workgroup to analyze UOs and recommend system changes. ACBHD will create an automated system for tracking UOs.
Beneficiary Surveys	MH: Consumer Perception Survey (CPS) aka Mental Health Statistics Improvement Program (MHSIP) SUD: Treatment Perception Survey (TPS)	Quality Improvement & Data Analytics; Substance Use Disorder Continuum of Care	ACBHD will continue implementing and monitoring the results of the beneficiary surveys annually and analyzing trends based on demographics and services provided. ACBHD will work to improve participation across all providers, program types, and demographics to ensure representative responses. ACBHD will share survey results with providers.

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Section II. Quality Improvement Projects

ACBHD Quality Improvement Projects include both Performance Improvement Projects (PIPs) and Quality Improvement Projects (QuIPs); the latter address system improvement opportunities, but do not necessarily cover all of the formal federal and State PIP requirements and components.

A. Performance Improvement Projects (PIPs)

1. Clinical PIP – Mental Health

AREA:	Improving the Follow-Up After Emergency Department Visit for Mental Illness (FUM) Performance Measure Rate
OBJECTIVE:	Do targeted interventions improve the percentage of emergency department (ED) visits for Medi-Cal members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a mental health follow-up service within 30 days of the ED visit during the remeasurement period?
INDICATOR(S) & BASELINE:	▪ The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit within 30 days (the Follow-Up After Emergency Department Visit for Mental Illness, or FUM, HEDIS Measure). ▪ Number of ED visits by FUM PIP cohort ▪ Number of FUM PIP cohort who received care navigation ▪ Number of FUM PIP cohort ED visits that received care navigation ▪ Number of FUM PIP cohort who were connected to services (of those who received care navigation) *Baseline will be from CY 2025
ACTION STEPS:	▪ Create PIP cohort by developing a list of “Familiar Faces” based on agreed-upon criteria. ▪ Set up an ED alert system to notify Alameda Health System (AHS) and ACBHD’s contacts when someone on the list is admitted to the Emergency Department. ▪ Coordinate a rapid response between AHS and ACBHD to plan engagement. ▪ Engage the individual as soon as possible after ED admission and assess care needs in collaboration with ACCESS. ▪ Support warm handoffs and promote follow-up within the 7- or 30-day FUM window.

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MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring Customized reports – monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, Adult and Older Adult System of Care Director, County and Contracted MHS Providers

2. Non-Clinical PIP – Mental Health

AREA:	Improving Timely Access to Routine Psychiatry Services for Adults
OBJECTIVE:	Do targeted interventions improve the percentage of service requests for psychiatric services where the Medi-Cal member was offered a first available appointment within 15 business days during the remeasurement period?
INDICATOR & BASELINE:	▪ The percentage of service requests for psychiatric services where the Medi-Cal member was offered a first available appointment within 15 business days during the measurement period. ▪ The percentage of service requests for psychiatric services that successfully connect to medication support services following a referral ▪ Among referrals to the pilot provider, percentage that were offered a first available appointment within 15 business days ▪ Among referrals to the pilot provider, percentage that successfully connected to medication support services following the referral *Baseline will be from CY 2025
ACTION STEPS:	▪ ACCESS will inquire about members transportation needs during the screening process so it can be communicated in the referral. ▪ Sausal Creek Outpatient Clinic will inquire about the beneficiaries' transportation needs for every referral (including walk-ins) and if needed, provide the Modivcare information and assistance to the beneficiary.
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring Customized reports – monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, Office of the Medical Director, ACCESS, Sausal Creek, Modivcare

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3. Clinical PIP – Substance Use Disorder

AREA:	Improving the Pharmacotherapy for Opioid Use Disorder (POD) Performance Measure Rate
OBJECTIVE:	Do targeted interventions improve the percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among Medi-Cal members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event during the remeasurement period?
INDICATOR(S) & BASELINE:	▪ The percentage of OUD pharmacotherapy events that lasted at least 180 days (without an 8+ day continuous gap) among Medi-Cal members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event. ▪ Among those who received care navigation, number that maintained continuity of treatment for 180+ days without missing more than a week of medication ▪ Among those who received care navigation, number that maintained continuity of treatment for 30+ days without missing more than a week of medication ▪ Among those who received care navigation, number that maintained continuity of treatment for 60+ days without missing more than a week of medication *Baseline will be from CY 2025
ACTION STEPS:	▪ Substance Use Navigator (SUN) tracks a defined panel of patients who are new buprenorphine starts ▪ SUN monitors pharmacy refill data and flag gaps or missed refills ▪ SUN conducts proactive outreach (calls, texts, in-person), in collaboration with ACBHD's IHOT team, to support re-engagement before the 7-day POD threshold lapses ▪ SUN coordinates with prescribers and pharmacy systems to ensure continuity.
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, SUD System of Care Director, Contracted Providers

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4. Non-Clinical PIP – Substance Use Disorder

AREA:	Improving Timely Access to Substance Use Residential Treatment Services
OBJECTIVE:	Do targeted interventions improve the percentage of service requests for substance use residential treatment services where the Medi-Cal member was offered a first available appointment within 10 business days during the remeasurement period?
INDICATOR(S) & BASELINE:	• The percentage of service requests for substance use residential services where the Medi-Cal member was offered a first available appointment within 10 business days during the measurement period. • The percentage of service requests for substance use residential services that receive residential treatment services following the referral • Length of stay for substance use residential treatment discharges • Quarterly measurement of the number of substance use residential treatment referrals that receive residential treatment services following the referral • Quarterly measurement of the number of substance use residential treatment referrals that are offered an intake appointment within 10 business days *Baseline will be from CY 2025
ACTION STEPS:	▪ Assess and document findings for capacity, utilization, and connection to residential following referral ▪ Collect, document, communicate, and train on best practices in step-down processes. ▪ Facilitate regular meetings to monitor flow and resolve barriers collaboratively. ▪ Scope improvements to connection processes and tools ▪ Promote resources for accessing transportation resources (e.g., add links to transportation resources on ACHBD and providers' websites).
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, SUD System of Care Director, Contracted Providers

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B. Quality Improvement Projects (QuIPs)

ACBHD QuIPs address the following core domains: Access to Care (Services), Timeliness, and Quality of Care. Under these primary domains, QuIPs are further organized under the following priorities:

Section III: Timeliness
Section IV: Cultural and Linguistic Competence
Section V: Peer (Client) and Family Member Initiatives

QuIP Core Domains: Access to Care (Services), Timeliness, and Quality of Care

AREA 1:	Performance Measurement and Management
OBJECTIVE:	Distribute or improve access to performance dashboards for all contracted providers
INDICATOR & BASELINE:	▪ Number of providers (agencies) with access to Yellowfin: 18 ▪ Number of providers (individuals) with account-specific access to Yellowfin: 49 ▪ Number of providers (agencies) that log into Yellowfin at least once a month: 7 ▪ Number of providers (individuals) that log into Yellowfin at least once a month: 206 ▪ Number of Yellowfin Hour attendees: 5 ▪ Number of automated data broadcasts sent to contracted providers per month from ACBHD: 598 ▪ Number of individuals that receive automated data broadcasts per month from ACBHD: 477 ▪ Number of agencies that receive automated broadcasts/data emails per month: 34 ▪ How many users logged in at least one time during the year: 217 ▪ How many users are "engaged" with yellowfin as defined as at least five (5) distinct days of logging into yellowfin: 131 ▪ How many users are "active" with at least one log-in per calendar months: 117 ▪ How many total broadcast recipients have received at least five (5) broadcasts during the year: 137 ▪ How many broadcast recipients have received at least one broadcast during the year: 42 ▪ How many broadcast recipients have received at least (4) broadcast per calendar month: 48 Indicators from FY 24-25
ACTION STEPS:	▪ Create and improve Yellowfin dashboards that enable providers to review performance data for quality improvement

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	▪ Improve process and publish guide for connecting providers to Yellowfin accounts for provider-specific/client-level data, in coordination with Information Systems Network Team, Quality Improvement & Data Analytics/Quality Management, and Privacy Officer ▪ Distribute access to providers – both entities and individuals – who are not yet on Yellowfin ▪ Provide regular trainings for providers to support and improve utilization of Yellowfin data ▪ Create a public-facing County Behavioral Health Dashboard ▪ Implement a semi-annual survey for County and Contract Provider staff to evaluate effectiveness of Yellowfin
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – monthly Report on number of public website dashboard views – monthly
RESPONSIBLE PARTNERS:	Data Services, Information Systems, Contracted Providers, Quality Improvement & Data Analytics, Office of Privacy and Compliance

AREA 2:	Quality of Care
OBJECTIVE:	Reduce the number of deaths of clients across the system of care by wide distribution of Narcan by 5%
INDICATOR & BASELINE:	▪ Number and percent of discharges to death for opioid treatment programs: ▪ Number of providers signing on the purple boxes: Pending ▪ Number of test strips from distribution logs: Pending ▪ Population level opioid related overdose death: Pending Indicators from FY 23-24
ACTION STEPS:	▪ Increase distribution of overdose reversal medication (Narcan) in opioid treatment programs ▪ Increase reporting of outcome of increased Narcan distribution ▪ Participation in statewide Narcan distribution program ▪ Partner with CBO's for free fentanyl test strips distribution
MONITORING METHOD/ TIMEFRAME:	Yellowfin Reports – monthly monitoring
RESPONSIBLE PARTNERS:	Quality Assurance, Substance Use Disorder Continuum of Care, Contracted Providers

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Alameda County Behavioral Health Department
Quality Improvement Work Plan FY 2025-2026

AREA 3:	Access to Care/ Quality of Care
OBJECTIVE:	50% of older adult treatment providers will implement one EBP for each of the 4Ms.
INDICATOR & BASELINE:	▪ The number of providers surveyed on what EBP is currently in use for each of the 4M: ▪ Number of contracts updated: ▪ Number of trainings on the EBP for the 4M *Baseline data from FY 25-26
ACTION STEPS:	▪ Expand the use of the 4M framework in the AOASOC ▪ Train the provider on the EBP for the 4M ▪ Providers identify which of the EBP to implement ▪ Use the older adult provider meeting as well as provider monthly meeting to providers technical assistance ▪ Update contract to include the 4M in the quality outcomes. ▪ Have providers submit quarterly reports on their progress
MONITORING METHOD/ TIMEFRAME:	▪ Older adult meeting minutes, provider meeting minutes and provider quarterly reports
RESPONSIBLE PARTNERS:	Adults & Older Adult System of Care – Older Adult Division, Outpatient Division, County and Contracted Providers

AREA 4:	Access to Care/Quality of Care
OBJECTIVES:	Open at least 250 unique individuals to Vocational program services Maintain % caseload employed at 30%
INDICATOR & BASELINE:	▪ Number of adult and Transition Age Youth (16-24) clients with open episodes in Vocational Program: 301 ▪ Number of Job Starts: 89 ▪ Percent caseload employed: 40% ▪ Number of client referrals to Vocational Program: 174 YTD ▪ Number of Job Starts: 96 ▪ % caseload employed: 35% Indicators from FY 22-23

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ACTION STEPS:	▪ Reach out to clinical teams/case managers to discuss available Vocational Program services to support program referrals ▪ Present two client information sessions per year to clients in eligible programs to support client self-referrals ▪ Create Yellowfin report to monitor outcomes
MONITORING METHOD/ TIMEFRAME:	Yellowfin/Continuous Monitoring for Number of Episodes, Semi-Annually for Reduction in Hospitalizations
RESPONSIBLE PARTNERS:	Adult & Older Adult System of Care- Vocational Services Division, Outpatient Division; Child & Young Adult System of Care- Transition Age Youth Division; Quality Management

AREA 5:	Involve Law Enforcement in Crisis Services Education and Training (Quality of Care)
OBJECTIVES:	Update and expand our Crisis Intervention Training (CIT) for law enforcement and other first responders.
INDICATOR & BASELINE:	▪ Number of CIT participants: 409 ▪ Number of CIT participants who complete the training: 409 ▪ Number of mobile crisis requests by law enforcement: 1065 ▪ Number of CIT evaluations: 409
ACTION STEPS:	▪ Individual and overall class evaluations; satisfaction at 70% or better for 90% of participants. ▪ Update and improve trainings to ensure every class imparts knowledge, teaches applied skills, and builds empathy. ▪ Secure primary and back-up SME for specific training topics ▪ Invite individuals with history of mental health challenges, substance use disorders, and/or incarceration to participate on the CIT consumer family panel. ▪ Add new legislation to current course (SB43 and Care Court SB1338)
MONITORING METHOD/ TIMEFRAME:	Continuous monitoring, QI, class evaluations
RESPONSIBLE PARTNERS:	Crisis Services, Oakland Police Department, Child Support Services, Child and Youth System SOC, Adults and Older Adult SOC, Office of Ethnic Services, Black Men Speaks, Mental Health Association of Alameda County

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Alameda County Behavioral Health Department
Quality Improvement Work Plan FY 2025-2026

AREA 6:	Access to Care/Quality of Care
OBJECTIVES:	Increase the use of voluntary crisis services throughout the County by 5%
INDICATOR & BASELINE:	▪ Number of tabling events and presentations marketing crisis services: 87 ▪ Number Mobile Crisis Teams interventions: 5,122 ▪ Average length of stay in CSU/CRT: Jay Mahler: 11, Amber House: 25, Woodroe Place: 48 ▪ Recidivism within 7 days: new change in utilizers by N of -4 ▪ Recidivism within 30 days: net change in utilizers by N of -133 ▪ Number of Mobile Crisis teams responding throughout the county: 14 ▪ Number of clients transported by the Crisis Services: Pending
ACTION STEPS:	▪ Develop baseline metrics for Mobile Crisis ▪ Analyze crisis stabilization unit and crisis residential treatment data for recidivism ▪ Educate the community about voluntary low barrier prevention and early intervention services ▪ Linkage to voluntary crisis services ▪ Recruitment and retention of mobile, outreach and engagement team staff and continue intern program. ▪ Increase the number of County Cars in the Fleet from 7-12
MONITORING METHOD/ TIMEFRAME:	Continuous monitoring, Yellowfin
RESPONSIBLE PARTNERS:	Crisis Services, Crisis Support Services, Quality Improvement & Data Analytics, CBOs

AREA: 7	Access to Care
OBJECTIVE:	Increase the number of Medi-Cal youth participating in SUD treatment with the goal of improving our penetration rate, which as of CY2023-24 was 0.14%, to be 0.29%, which would mean an estimated 136 members served and is in line with the States' expectation for similar sized counties.
INDICATOR(S) & BASELINE:	▪ Number of members served; ages 12-17 years old: 180 ▪ Number of members eligible, ages 12-17 years old: 53,621 ▪ Current penetration rate: 0.30% *All data is from CY 24

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ACTION STEPS:	1) Refine SUD providers' Outreach and Engagement plans • Outreach to Principals and/or site administration 2) Increase school district connections – • Establish Centralized School District Administration connection for each district, develop quarterly meetings to support in school district SUD needs assessment and service negotiation with the assigned provider • Explore expansion of involvement with COST teams. Can La Familia's current strong connections with school-based behavioral health sites be brought to additional schools. • Refine referral process between school-based health centers and SUD treatment • Invite SUD Providers to CYASOC SBBH Fall Planning Meetings in Aug and Sept • Develop and present appropriate materials that describe what is available and referral processes 3) Look into how ODS .5 services are connected to adolescent treatment 3) Look into how ODS .5 services are connected to adolescent treatment 4) Collaborate with ACBHD SOCs to identify training topics related to co-occurring MH/SUD issues related to children, young adults, and their families. 5) Reach out to our Office of Medical Director to determine if Naloxone stands can be placed in the School-based Behavioral Health Centers.
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, SUD System of Care Director, Contracted Providers

AREA: 8	Case Management: SUD Residential Services
OBJECTIVE:	Increase care coordination/case management service delivery and improve treatment outcomes for beneficiaries in substance use residential treatment
INDICATOR(S) & BASELINE:	▪ Percent of residential clients with care coordination services: 59% ▪ Percent of residential clients with positive discharge: 58.2%

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	▪ Percent of residential clients with successful transition plan: 25.8% Data from FY 24-25
ACTION STEPS:	▪ Train contracted providers to properly code case management ▪ Update dashboard to monitor case management service delivery and client outcomes ▪ Analyze data and draw conclusions to improve interventions
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly
RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, SUD System of Care Director, Contracted Providers

AREA: 9	Access to care/ Quality of Care/ Coordination of Care
OBJECTIVE:	Improve 30-day follow-up rates after emergency department visit for alcohol and other drug use/abuse (AOD) (FUA HEDIS Metric) for clients not connected to care at the time of ED discharge
INDICATOR(S) & BASELINE:	▪ Number of beneficiaries not currently connected to care who discharged from the ED with an AOD ED diagnosis who received an outreach call: 319 ▪ Number of outreach calls where the beneficiary was reached: 38.56% (58/319) ▪ Number of beneficiaries reached who were screened and referred: 5.2% (3/58) ▪ Number of disconnected beneficiaries who receive a service following their ED visit: 5.2% (3/58) *Baseline data are from FY 24-25
ACTION STEPS:	▪ Use encrypted email alert system to notify Center Point about beneficiaries not currently connected to care who discharged from the ED with an alcohol and other drug use/abuse (AOD) ED diagnosis ▪ Center Point conducts outreach to screen and refer ED discharged clients to SU treatment services ▪ Center Point tracks calls and call outcomes ▪ Analyze data and draw conclusions to improve interventions
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards- continuous monitoring Customized reports- monthly

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Alameda County Behavioral Health Department
Quality Improvement Work Plan FY 2025-2026

RESPONSIBLE PARTNERS:	Quality Improvement & Data Analytics, SUD System of Care Director, Contracted Providers

AREA: 10	Access to Care/ Quality of Care
OBJECTIVE:	Improve outreach effectiveness and coordination of care, and reduce opioid overdose deaths, by developing a data-driven approach to support the SUD IHOT team's outreach to members who have had an opioid overdose. Problem: There is a limited coordination of care system in place to ensure people who had an opioid overdose are promptly connected to care immediately following their overdose incident; indicating they are at higher risk for overdose death.
ACTION STEPS:	• Determine feasibility and method of using ADT feed and Emergency Medical Services (EMS) data sources • Develop criteria to identify locations of opioid overdose and poisoning incidents and prioritize individuals based on available data sources • Develop client level reports • Develop summary reports Provide orientation and hand-off of reports to stakeholders (by target date, October 31, 2025)
INDICATOR & BASELINE:	Indicators of project success: • Outreach criteria developed, identifying who to prioritize for outreach, based on history of opioid overdoses or poisonings and other factors. • Dashboard developed that includes summary information and client list of individuals prioritized for follow up per criteria.
MONITORING METHOD/ TIMEFRAME:	Review data and reports with stakeholders on a regular basis as needed, leading up to the launch of IHOT team (January 31, 2026 is launch deadline)
RESPONSIBLE PARTNERS:	Substance Use Disorder Continuum of Care, Office of the Medical Director

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Section III. Timeliness

AREA 1:	Responsiveness for 24 Hour Toll-Free Number / Access to After Hours Care – Mental Health
OBJECTIVE:	Improve the number of abandoned calls
INDICATOR & BASELINE:	▪ Test call response time for the ACCESS number (during business hours and in languages other than English): 2.42 ▪ Test call response time for the ACCESS number (after business hours and in languages other than English):1.19 ▪ Number of abandoned calls monthly and for the FY: Pending Indicators from FY 24-25
ACTION STEPS:	▪ Train ACCESS and after-hours staff on how to answer client questions more effectively regarding how to access SMHS services, including how to assess whether medical necessity is met, provide information to beneficiaries about services available to treat a client's urgent condition ▪ Review and revise ACCESS Protocol as necessary and provide to staff ▪ Remind staff on an ongoing basis about the importance of documenting all initial requests made by telephone (including 24/7 line) through a written log that includes the name of the client, the date of the request, and the initial disposition of the request ▪ ACCESS Division Director will track all missing, insufficient, incorrect, or out of compliance items on each clinician's test calls, and supervisors will provide monthly feedback to staff and discuss any necessary improvements that are to be made ▪ Review monthly test calls for accuracy and completeness of information given to beneficiaries. ACCESS Division Director reviews all test calls, sends reports to QA and follows up with ACCESS staff and after-hours supervisor with results of test calls ▪ Adjust five9 workflow as needed
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring
RESPONSIBLE PARTNERS:	Substance Use Disorder Continuum of Care, Quality Improvement & Data Analytics, Quality Assurance, Quality Improvement Committee – Network Adequacy & Timely Access Workgroup

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Alameda County Behavioral Health Department
Quality Improvement Work Plan FY 2025-2026

AREA 2:	Responsiveness for 24 Hour Toll-Free Number / Access to After Hours Care – Substance Use
OBJECTIVE:	Reduce the response time for the 24-hour toll-free number by 30%, including after hours.
INDICATOR & BASELINE:	▪ Average call response time for Center Point's SUD helpline (during business hours and in languages other than English): 17.12 seconds ▪ Average response time between after-hours call to Crisis Support Services and follow up by SUD Helpline staff (in threshold languages): 8.24 hours Indicators from FY 24-25
ACTION STEPS:	▪ Remind Crisis Support Services on an ongoing basis about the importance of documenting all calls coming into the 24/7 line, including caller/client name ▪ Provide Crisis Support Services with written updates to inform staff scripts in order to ensure information is accurate and up to date ▪ Conduct and review monthly test calls for accuracy and completeness of information given to beneficiaries. Provide results and feedback to CenterPoint and Crisis Support Services for quality improvement ▪ Provide regular training and feedback from test calls to Center Point's SUD Helpline counselors and/or Crisis Support Services staff in staff meetings, individual supervision, and/or via written communication ▪ Train SUD Helpline staff with monthly American Society of Addiction Medicine (ASAM) case consultation to improve Level of Care screening and referral
MONITORING METHOD/ TIMEFRAME:	SUD Helpline Response Time reports – monthly, Average after-hours call response time reports – monthly
RESPONSIBLE PARTNERS:	Substance Use Disorder Continuum of Care, Contracted Providers, Crisis Support Services, Quality Management

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Section IV. Cultural & Linguistic Competence

Improving cultural and linguistic competence is a critical component of ACBHD's Quality Assessment and Performance Improvement efforts. The following objectives were developed in coordination with the ACBHD Health Equity Division (HED) and based on ACBHD's Cultural Competence Plan.

AREA 1:	Enhance Behavioral Health Access and Engagement for Asian American, Native Hawaiian and Pacific Islander (AANHPI) Communities in South County and Older Adult AANHPI Population
OBJECTIVE:	Increase ACBHD services to the older adult AANHPI population by enhancing our existing partnership with the City of Fremont ▪ Increase services to older adult AANHPI clients by providing services in community settings. ▪ Establish a presence in the two (2) Age Well Centers and in the two (2) Senior Housing Complexes whose residents are primarily AANHPI. ▪ Improve penetration rates within Alameda County for individuals in the older adult AANHPI communities, with a focus on those residing in South Alameda County (Fremont, Newark, Union City). ▪ Develop a curriculum that is culturally appropriate and responsive to AANHPI needs.
INDICATOR & BASELINE:	▪ Number of AANHPI older adults served by the Older Adult program: 19 ▪ Number and percentage of field-based services provided by the Older Adult program: 602 (25% of 2,426) ▪ Number of group outreach sessions provided by the Older Adult program:60 *Baseline data: July 2023-June 2024
ACTION STEPS:	▪ Expand the contract with the City of Fremont Older Adult Program ▪ Hire 2-4 additional bilingual full-time clinicians to provide Specialty Mental Health services ▪ Establish an ongoing presence at the City of Fremont Age Well Centers ▪ Establish an ongoing presence at three Senior Housing Complexes ▪ Facilitate stakeholder meetings to explore additional community locations, such as ethnic faith-based facilities ▪ Create maps of older AANHPI Medi-Cal beneficiaries to facilitate targeted outreach
MONITORING METHOD/ TIMEFRAME:	Contract expansion to be completed by beginning of FY 23/24

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	ACBHD and the City of Fremont will hold monthly meetings to assess deliverables, successes and challenges. A survey will also be developed and used to gather client centered data. Service data from SmartCare will be used to establish both baseline and post contract augmentation metrics.
RESPONSIBLE PARTNERS:	Adult and Older Adult System of Care – Older Adult Division

AREA 2:	Enhance health equity for AANHPI communities, through increasing access and utilization of behavioral health services and improved health outcomes for Alameda County residents who have emerging to persistent, severe mental health conditions
OBJECTIVE:	▪ Create an AANHPI Advisory Committee in February 2024 to strategize increase of utilization through outreach and engagement, identifying and addressing barriers to service provision, and development or support of relevant and appropriate service provision to/within communities.
INDICATOR & BASELINE:	▪ Number of people/organizations participating in the AANHPI Advisory Group: 59 people / 16 organizations ▪ Number of AANHPI related community engagement events: 5 *Data FY 24-25
ACTION STEPS:	▪ Create an AANHPI Advisory Committee in February 2024 to increase utilization through outreach and engagement, identify and address barriers to service provision, and develop or support relevant and appropriate service provision to/within communities. ▪ Provide AANHPI focused Behavioral Health related training for providers, ACBHD staff and advisory committee members.
MONITORING METHOD/ TIMEFRAME:	▪ Recruitment and engagement of AANHPI providers/partners- September to December 2023 ▪ AANHPI Advisory Committee- February 2024 ▪ Community Engagement Activities- May to June 2024
RESPONSIBLE PARTNERS:	Health Equity Division, Office of the Medical Director, and all Systems of Care (SUD, Children and Youth, Adult, Forensics)

AREA 3:	Enhance Behavioral Health Access and Engagement for AANHPI Communities within Primary Care Settings/ Integration of Primary Care and Behavioral Health Care Services

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Alameda County Behavioral Health Department
Quality Improvement Work Plan FY 2025-2026

OBJECTIVE:	Enhance health equity for the AANHPI communities, through increasing access and utilization of behavioral health services within a primary care setting: Bay Area Community Hospital (BACH), and improve health outcomes for Alameda County residents who have emerging to persistent, severe mental health conditions ▪ Increase the percentage of adult AANHPI BACH patients referred to behavioral health services at BACH by 20% ▪ Increase the percentage of adult AANHPI BACH patients receiving at least one behavioral health service at BACH by 15% ▪ Reach at least 300 AANHPI adult residents in AANHPI-focused health outreach activities
INDICATOR & BASELINE:	▪ Number and percentage adult AANHPI BACH patients referred to behavioral health services at BACH: 220 ▪ Number and percentage of adult AANHPI BACH patients receiving at least one behavioral health service at BACH: 17 and 2.23% ▪ Number of adult AANHPI residents participating in AANHPI-focused outreach health activities: 42 and 17.36% *Baseline data April – June 2025
ACTION STEPS:	▪ Implement recurring AANHPI-focused community health outreach events ▪ Build AANHPI behavioral health capacity at BACH to serve AANHPI residents
MONITORING METHOD/ TIMEFRAME:	Outreach Activities to begin in October 2023 AANHPI Advisory Board by February 2024 Data from SharePoint, OCHN Epic
RESPONSIBLE PARTNERS:	Office of the Medical Director, Health Equity Office, BACH

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Section V. Peer (Client) and Family Member Initiatives

Peer and Family Member stakeholder participation is central to quality improvement efforts. In addition to the projects identified above, the following objectives were developed in coordination with the Quality Improvement Committee Peer Workgroup and Family Member Workgroup, as well as the Health Equity Division/Office of Peer Support Services and Office of Family Empowerment.

AREA 1:	Outcomes Components
OBJECTIVE:	Alameda County Behavioral Health Care Services (ACBHD) will work with the Health Equity Division to support trainings and certification for peer support specialists to be integrated throughout the ACBHD system of care.
INDICATOR & BASELINE:	▪ Number of trainings hosted: N/A ▪ Number of individuals attending peer trainings: 300 ▪ Number of individuals receiving peer certification: 131 ▪ Number of peer support specialist (PSS) hired and employed by CBOs: Pending ▪ Number of Certified Peer Support Specialists (PSS) hired and employed by CBOs: Pending ▪ Number of Peer Support Specialists (PSS) trained as a certified Family Support Specialist: Pending ▪ Number of clients receiving services from Certified and Non-certified Peers: Pending ▪ Hours of services provided by Certified and Non-certified Peers: Pending ▪ Number of agencies with Certified and Non-certified Peers providing services: Pending *Baseline data FY 25-26
ACTION STEPS:	▪ Partner with stakeholders throughout the system to engage in on-going process ▪ Monitor and support the development of the peer support specialist (PSS) classification ▪ Develop and implement peer certification program ▪ Develop and implement peer support trainings ▪ Recruit, hire, and onboard the PSS position
MONITORING METHOD/ TIMEFRAME:	• HCSA Human Resources, InSyst, Yellowfin -- annually • Tracking through customized database -- monthly • Health Equity Division Office Training logs
RESPONSIBLE PARTNERS:	Health Equity Division: Office of Peer Support Services; Office of Family Empowerment

*** Due to SmartCare delays and Medi-Cal 12-months claiming window, we are still collecting data for the FY 24-25.**

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Appendix C: Community Program Planning Process

Behavioral Health Department
Alameda County Health

BEHAVIORAL HEALTH SERVICES ACT (BHSA)

CPPP Planning Committee & Mental Health Stakeholders Group
CALENDAR 2025

Community Program Planning Process (CPPP) – Planning Committee
Mental Health Stakeholders Group (MHSA-SG)

DATE	TIME	LOCATION	MEETING THEMES
January 24, 2025	1:00pm-3:00pm	Zoom	*Mental Health Stakeholders Group:* • Review of new DHCS policies on BHSA CPPP • Review of Analysis on MHSA SG representation breakdown • Review of BHSA CPPP Outreach Plan • BHSA Survey development • BHSA Listening Session development
January 30, 2025	3:30pm-4:30pm	Teams	*CPPP-Planning Committee:* • BHSA CPPP new DHCS guidance • Survey development • Outreach plan, engagement planning
February 28, 2025	1:00pm-3:00pm	Zoom	*Mental Health Stakeholders Group:* • Presenter: Stephanie Montgomery (ACBHD Health Equity) • Discussion of MHSA Plan FY25/26 Public Comment Outreach • BHSA Listening Sessions and Survey outreach • Recommendations for BHSA event outreach
March 20, 2025	3:00pm-4:00pm	Teams	*CPPP-Planning Committee:* • Review CPPP engagement of organizations • BHSA event outreach • Ongoing community input analysis
March 28, 2025	1:00pm-3:00pm	Zoom	*Mental Health Stakeholders Group:* • Presenter: Noah Gallo (ACBHD Senior Planner) • BHSA Listening Session • MHSA FY25/26 Marketing Plan Public Comment • ACPHD (LHJ) Presentation & Engagement
May 1, 2025	3:30pm-4:30pm	Teams	*CPPP-Planning Committee:* • Progress of BHSA CPPP Listening Sessions and Surveys • Ongoing community input analysis • Community outreach recommendations

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May 23, 2025	1:00pm-3:00pm	Zoom	*Mental Health Stakeholders Group:* • Presenter: La Familia: Clinical Leaders • BHSA Policy Updates • BHSA CPPP Outreach Updates
June 15, 2025	3:30pm-4:30pm	Teams	*CPPP-Planning Committee:* • BHSA CPPP Ends • Review of BHSA CPPP results

Community Program Planning Process Planning Committee (CPPP-PC):

The CPPP Planning Committee consists of 13 members of ACBHD employees, Providers and Community Stakeholders who meet regularly to guide and discuss CPPP activities. The CPPP-PC helps prepare, coordinate and participate in the BHSA community outreach efforts. The CPPP-PC provides input, expertise, and their professional network to ensure the continuity of services, implement assessment instruments and promote administrative transparency for all community outreach efforts.

Mental Health Stakeholders Group:

The Mental Health Stakeholders Group (MHSA SG) consists of 22 mental health peers that are adults and seniors with severe mental illness, families, providers of services, law enforcement agencies, education, substance use providers, social service agencies and other important interests. The MHSA SG meets on the 4th Friday of the month and has met 4 times in 2025.

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Behavioral Health Department
Alameda County Health

Alameda County BHSA CPPP Required Stakeholder List

Required Stakeholder Group	Agency	Fulfilled
1. Adults and older adults who are either: a. Meet the criteria to receive specialty mental health services or	POCC Elders (Listening Session, 2/11/2025), Jay Mahler Recovery Center (Listening Session, 3/18/2025)	Yes
1. Adults and older adults who are either: b. Have a substance use disorder	Second Chance (Listening Session, 3/20/2025), Jay Mahler Recovery Center (Listening Session, 3/18/2025), La Familia (Listening Session, 3/20/2025), HEPPAC (Survey, 2/27/2025), St. Mary's Center (Education and Engagement, 3/26/2025), Ruby's Place (Survey 4/2/2025), Hume Center Nepalese Community (Listening Session, 5/22/2025)	Yes
2. Families of individuals (all ages)	FERC (Listening Session, 3/20/2025), NAMI Tri-Valley (Survey, 2/19/2025)	Yes
3. Youths or youth mental health or substance use disorder organizations	HRREC (Listening Session, 3/20/2025, Survey, Education and Engagement), YouthAlive! (Survey, 3/21/2025), Fred Finch (Survey, 3/27/2025), REACH AYC (Survey, 4/29/2025), Alternative Family Services (Survey, 3/25/2025), Eden Youth Family Center (Survey, 3/20/2025)	Yes
4. Providers of mental health services and substances use disorder treatment services	Jay Mahler (Listening Session, 3/18/2025), Second Chance (Listening Session, 3/20/2025), HEPPAC (Survey, 2/27/2025), Bay Area Community Resources (Survey, 3/1/2025), HRREC (Survey, Listening Session, 3/20/2025), Lifelong Medical Care (Survey), Asian Health Services (Listening Session, 4/23/2025, Survey), La Familia, (Listening Session, 3/20/2025), La Clinica (Survey, 3/22/2025), HAART (Survey, 3/25/2025), BOSS (Survey, 2/24/2025), Hume Center (Listening Session, 5/19/2025)	Yes

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5. Public safety partners	City of Fremont (Survey, Listening Session 3/20/2025), City of Hayward (Survey, Listening Session 4/8/2025), Superior Court (Survey 2/25/2025, Listening Session 3/20/2025), Crisis Support Services (Survey, Listening Session 3/26/2025), All Alameda County Law Enforcement Agencies in a Listening Session on a Alameda County District Attorney monthly call (Listening Session, 5/21/2025)	Yes
6. Local education agencies	Alameda County Office of Education (Survey, 4/15/2025)	Yes
7. Higher education partners	Ohlone College (Listening Session 2/21/2025, 4/10/2025), UC Berkeley (Listening Session 2/28/2025, Survey), Laney College (Education and Engagement 2/21/2025), Cal State East Bay (Survey 2/24/2025), College of Alameda (Education and Engagement 2/10/2025), Chabot College (Education and Engagement 4/24/2025), Merritt College (Survey, Education and Engagement 5/8/2025), Stanford Medicine Youth Mental Health and Wellbeing(Survey 4/10/2025)	Yes
8. Early childhood organizations	YMCA Early Childhood Impact (Education and Engagement, 4/25/2025, Survey, 4/25/2025), Alameda County Early Childhood Mental Health (Education and Engagement, 5/12/2025), EBAYC (Survey, 3/20/2025), First 5 (Listening Session, 5/14/2025)	Yes
9. Local public health jurisdictions	ACPHD (Survey, Listening Session, 3/20/2025)	Yes
10. County social services & child welfare agencies	Family Support Services (Listening Session, 4/3/2025), Alameda County Social Services (Survey, 5/1/2025)	Yes
11. Labor representative organizations	SEIU (Survey, 5/2/25)	Yes
12. Veterans	POCC Veterans (Listening Session, 2/11/2025), Swords to Plow Shares (Listening Session, 2/11/2025), StarosVet (Survey, 5/29/2025)	Yes
13. Representatives from veterans' organizations	POCC Veterans (Listening Session, 2/11/2025), Swords to Plow Shares (Listening Session, 2/11/2025), StarosVet (Survey, 5/29/2025)	Yes

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14. Health care organizations	ACPHD (Survey, Listening Session, 3/20/2025), La Clinica (Surve,y 4/17/2025, Education and Engagement, 3/6/2025), Asian Health Services (Listening Session, 4/23/2025), Lifelong Medical Care (Survey, 3/12/2025), Washington Hospital (Education and Engagement, 3/24/2025), Axis Community Health (Survey, 4/2/2025), Tiburcio Vasquez (Survey, 4/9/2025)	Yes
15. Health care service plans	Alameda Alliance (Survey, 3/26/2025, Listening Session, 4/16/2025), Alameda County Health OAD (Survey, 3/12/2025)	Yes
16. Disability insurers	Alameda Alliance (Survey, Listening Session 4/16/2025), CRIL (Listening Session, 4/30/2025), Ed Roberts Disability Campus (Listening Session, 3/28/2025), Disability Rights California (Listening Session, 3/28/2025), Ohlone College Disability Class (Listening Session, 2/21/2025, 4/10/2025)	Yes
17. Tribal and Indian Health Program	Native American Health Center (Survey, 4/15/2025)	Yes
18. The five most populous cities	Oakland (Education and Engagement, 3/10/2025, Listening Session, Survey, 4/23/2025), Berkeley (Survey), San Leandro (Survey, 2/12/2025), Hayward (Listening Session, 4/8/2025), Fremont (Listening Session, 3/20/2025, Survey), Livermore (Survey, 3/5/2025)	Yes
19. Area agencies on aging	Alameda County Social Services - Area Agency on Aging (Survey, 4/18/2025)	Yes
20. Independent living centers	Center for Independent Living (Listening Session, 3/28/2025)	Yes
21. Continuums of care, including representatives from the homeless service provider community	Youth Homeless Advisory Board (Listening Session, 2/20/2025), Alameda County Health Care for the Homeless (Survey, 3/12/2025), SAHA (Survey, 4/2/2025), RCD Housing (Listening Session, 5/16/2025), JBAY (Listening Session 5/8/2025), RCD Housing (Listening Session, 5/16/2025)	Yes
22. Regional centers	Regional Center of the East Bay (Survey 5/5/25)	Yes
23. Emergency medical services	Alameda County Emergency Medical Services (Survey, 4/21/2025), Eden I&R (Survey, 5/1/2025)	Yes

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24. Community-based organizations serving culturally & linguistically diverse constituents	BACS - HEDCO, Towne House (Education and Engagement, 3/14/2025), Pacific Center (Listening Session, 3/13/2025), Korean Community Center (Survey 2/13/2025, Listening Session), MHAAC (Survey 3/25/2025), HRREC (Listening Session, 3/20/25), 40 x 40 PAC (Survey, 3/27/2025), Black Men Speak (Survey 4/14/2025), Eastmont Neighborhood Council (Survey, 4/23/2025), Oakland LGBTQ Center (Survey, 3/20/2025), RAMS (Survey, 3/20/2025), MHACC (Survey, 1/26/2025, Listening Session, 5/12/2025)	Yes

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YOUR VOICE MATTERS!

Make a Difference and Influence Change in Alameda County's Mental Health and Substance Use Services!

Community Input Survey

Alameda County Behavioral Health Services Act FY26-29 Integrated Plan

ALAMEDA COUNTY invites you to take the Community Input Survey

SURVEY IS AVAILABLE IN THRESHOLD LANGUAGES

Select the language of your choice on the right side of the beginning portion of the survey

CLICK HERE TO TAKE THE SURVEY

Or scan QR Code to take the survey

Behavioral Health Department
Alameda County Health

HHREC
HEALTH & HUMAN RESOURCE EDUCATION CENTER

For more information go to www.ACMHSA.org

Behavioral Health Department
Alameda County Health

Categorized Areas of Community Need in Alameda County

System Needs

1. Access, Coordination and Navigation to Services to Mental Health or Substance Use Services

This category captures the needs of diverse cultures and identities such as race/ethnicity, language, LGBTQIA+, veteran status and age related to accessing mental health and substance use services, including community knowledge and education, language capacity, and successful connection to services after an emergency.

2. Behavioral Health Workforce

This category captures the needs related to recruiting, developing, supporting and maintaining a sufficient multilingual clinical and peer workforce.

3. Crisis Services

This category captures needs related to mental health and substance use crisis response with an emphasis on non-law enforcement response, community-based supports, early assessment of suicide risk, and stabilization during and after a crisis.

4. Housing Interventions

This category captures the housing needs for individuals living with behavioral health challenges ranging from housing interventions and support needed to maintain housing.

5. Substance Use Disorder Prevention and Treatment Services

This category captures the increasing need for substance use services and support that are *accessible, integrated and coordinated* with mental health services.

6. Community Violence and Trauma

This category captures gun violence, domestic violence, human trafficking, gang violence, immigration trauma, poverty, pervasive racism and homophobia, family conflict and stress, school safety and bullying, and post-traumatic stress disorder (PTSD).

Population Needs

7. Needs of Children (ages 0-5), Youth (ages 6-15), Transitional Age Youth (ages 16-25)

This category captures mental health and substance use challenges for school to transition-age youth, it also includes specific needs of children 0-5 and their families, respite services, ongoing increased suicide rates, youth runaways, juvenile justice involvement, human trafficking, gang violence, lack of support on how to access services, needs of LGBTQ+, pervasive racism, needs of bi-cultural children, lack of training on the part of schools for students with MH challenges.

continued

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Population Needs

8. Needs of Adults (ages 25-59), Older Adults (ages 60 and over)

This category captures mental health and substance use challenges for adults and older adults including social isolation, depression, complex chronic health issues (including Alzheimer's and dementia), general poor mental health outcomes for those living with a severe mental illness, suicide rates, alternatives to incarceration, pervasive racism, LGBTQ+, immigration stress, gun violence, elder abuse, traumatic impact of social unrest-fear.

9. Needs of Family Members

This category captures the ongoing stress, frustration and isolation family members can feel in taking care of their loved ones including navigation issues, need for 24/7 access to inpatient and outpatient psychiatry services, suicide prevention, caregiving support, and other related trauma services.

10. Needs of Disability Community

This category addresses the needs of individuals with developmental disabilities and their families, focusing on providing resources and support required to achieve lives of quality and satisfaction.

11. Needs of Veterans

This category captures the mental health and housing needs of Veterans: Alameda County has the 4th highest number of homeless veterans, and 2nd highest of unsheltered homeless veterans in California. Veterans have a higher rate of poor mental health, high suicide rates, mental health stigma, lack of navigation support, lack of veteran support groups and social isolation.

12. Needs of the Re-entry Community

This category addresses the needs of both Adults and Youth in the Re-entry Community.

Summary of Areas

Access, Coordination and Navigation to Services

Behavioral Health Workforce

Crisis Services

Housing Interventions

Substance Use Disorder Prevention and Treatment Services

Community Violence and Trauma

Needs of Children (ages 0-5), Youth (ages 6-15), Transitional Age Youth (ages 16-25)

Needs of Adults (ages 25-59), Older Adults (ages 60 and over)

Needs of Family Members

Needs of the Disability Community

Needs of Veterans

Needs of the Re-entry Community

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Behavioral Health Services Act Community Education & Input Meeting

BHSA Integrated Plan FY 26-29

Presented by:

Alameda County Behavioral Health – BHSA Division

Noah Gallo, ACBHD BHSA Senior Planner

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BHSA Listening Session Agenda

Listening Session Purpose: Education and Information sharing about MHSA, Stakeholder Engagement and Information Gathering

Meeting Process for Today:

- Why we are here
- Looking at the many known behavioral health needs
- Wanting to identify/rank problems or areas of need and then focus on *solutions*
- Conducting a ranking process
- Talking about the top 3 areas
- Time for any other comments and feedback
- Demographic Survey
- Wrap Up

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Meeting and Presentation Agreements

1. BE PRESENT
2. SPEAK FROM YOUR OWN EXPERIENCE
3. ONE VOICE AT A TIME
4. STEP UP, STEP BACK
5. SEEK TO UNDERSTAND AND THEN BE UNDERSTOOD
6. HOLD QUESTIONS TO THE END OF THE PRESENTATION

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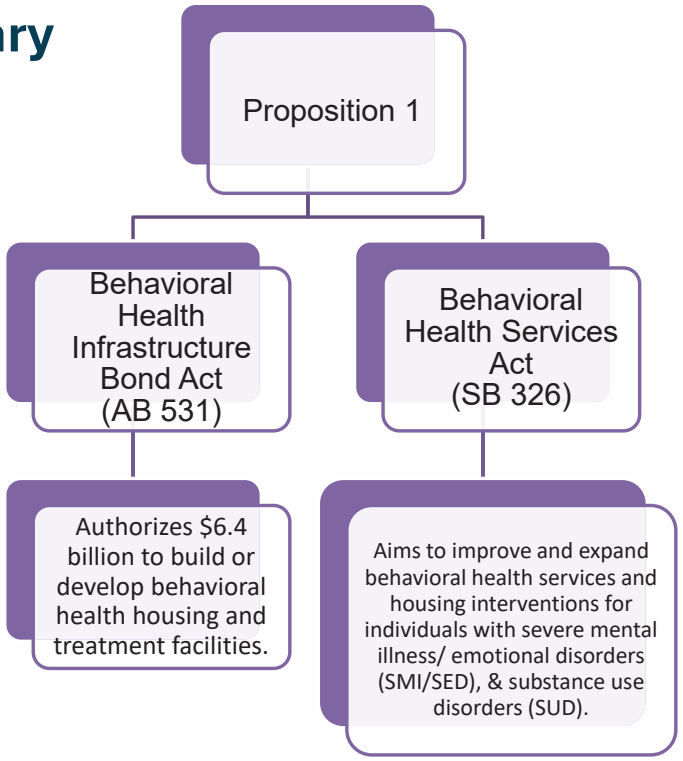
Proposition 1: High-Level Summary

- Philosophical shift from prevention, intervention, and treatment across the mental health spectrum to focus on the most severely mentally ill individuals.
- Inclusion of eligible programming for those with substance use conditions.
- Services and supports primarily focused on housing.
- Statewide focus on increased accountability and transparency



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Proposition 1: System Change

BHSA Funding Breakdown

Total BHSA revenue is distributed between county and state-wide allocations.

90% County Allocations

- **30%** Housing Interventions
- **35%** Full-Service Partnership Programs
- **35%** Behavioral Health Services & Supports
  - Early Intervention
    - Individuals 0-25

10% State-Wide Investments

- 3% State Admin — DHCS California Department of Health Care Services
- 3% Workforce — HCAi Department of Health Care Access and Information
- 4% Prevention — CDPH California Department of Public Health

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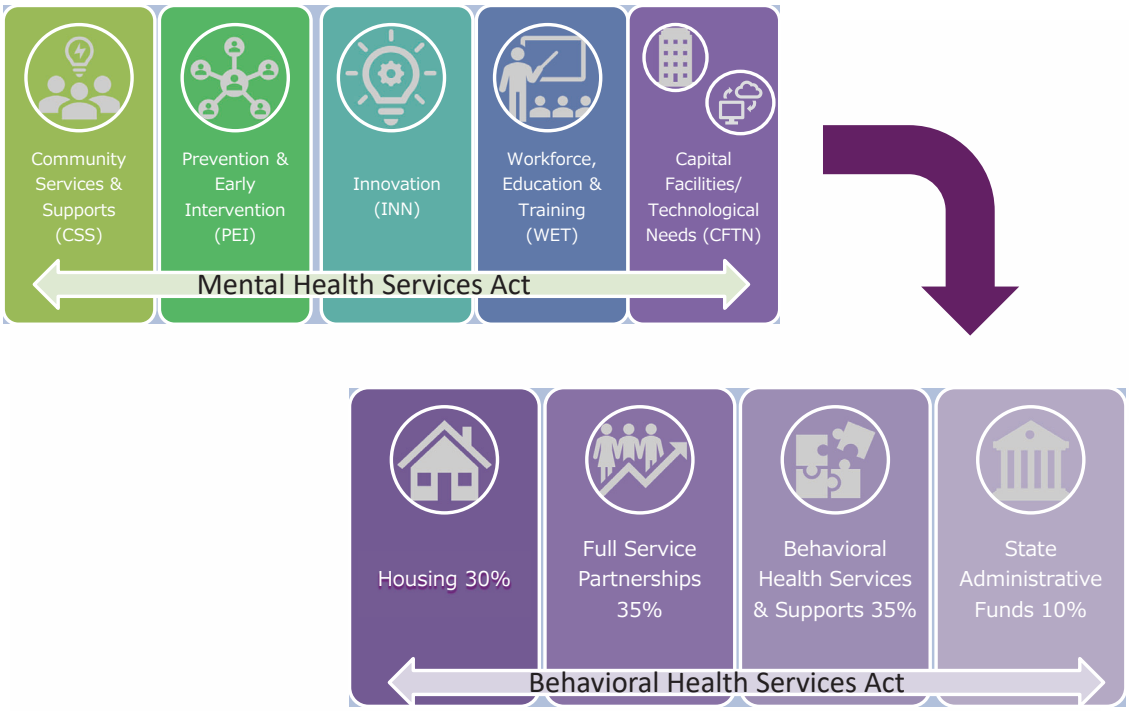
BHSA Funding Categories



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BHSA Funding Category Descriptions

30% Housing:

•Interventions to include rental subsidies, operating subsidies, shared housing, family housing for eligible children and youth, and the non-federal share of certain transitional rent.

- Half of this amount (50%) is prioritized for housing interventions for the chronically homeless.
- Up to 25% may be used for capital development.

35% Full-Service Partnerships:

•Comprehensive and intensive care for people at any age with the most complex needs (also known as the “whatever it takes” model).

35% Behavioral Health Services and Supports (BHSS):

•Includes early intervention; outreach and engagement; workforce; education and training; capital facilities and technological needs; and innovative pilots and projects.

- A majority (51%) of this amount must be used for intervention in the early signs of mental illness or SUDs.
- A majority (51%) of early intervention services and supports must be for people 25 years of age and younger.

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Community Program Planning Process (CPPP)

The County shall provide for a CPPP (also known as Community Listening Sessions or Community Input) as the basis for developing the Three-Year Program and Expenditure Plans and Plan Updates*.

The CPPP shall, at a minimum, include:

- Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process.
- Participation of diverse stakeholders.
- Training/Education on BHSA.

Alameda's Community Listening sessions will conclude May 30, 2025

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Community Engagement and Timeline Process

- **The yearly Community Program Planning Process (CPPP).**
- **Stakeholder Engagement.**
- **Involvement of Clients, Providers, Peers and Family Members**

January 2025 – February 2025
- Review regional strategies, evaluations, and reports
- Utilize BHSA Stakeholder Group and CPPP Planning Committee to plan and implement community input process

February 2025 – May 2025
- Listening Sessions
- Key Informant Interviews
- Community Input Surveys

June 2025 – June 2026
- Integrated Plan Development
- 30-day Public Comment
- Public Hearing at Behavioral Health Advisory Board
- BOS Health Committee & full BOS approval
- ACBHD implementation

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BHSA Required Stakeholder Engagement List

All age groups	Individuals with lived experience	Families	Providers, including racial/ethnic pop.	Public Safety
Education	Early childhood	Local Health Jurisdictions	Social Services	Labor Organizations
HealthCare/Hospitals	Veterans	Managed Care Plans	Disability Groups	Tribal and Indian Health
5 largest Cities	Area Agencies on Aging	Regional Centers	Emergency Medical Services	Homeless Community

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Stakeholder Engagement Methods

Counties must demonstrate a partnership with constituents and stakeholders as part of their community planning processes. Examples of meaningful partnership with stakeholders may include the following types of stakeholder engagement:

- Public comment
- Public hearings
- Stakeholder workgroups and committees
- Listening Sessions
- Surveys
- Key informant interviews or engaging with subject matter experts
- Training, education, and outreach related to community planning

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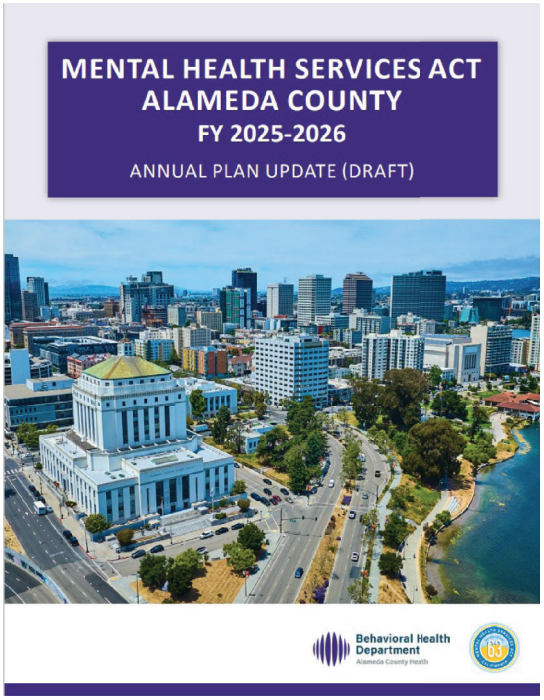
MHSA Community Input from *FY25/26*



- **Plan Budget:** $220M (16% increase from FY 23/24)
  - Five program components for FY 25/26.
- Public Comment: April 1st-May 15th 2025.
- Mental Health Advisory Board Public Hearing: May 19, 2025.
- Increased Community Engagement:
  - 28 Listening Sessions attended by 265 Community Members.
  - 777 Survey Responses.
- Multiple Improvements have been made to make the Plan:

  Easy to find **Easy to use** **Easy to understand**

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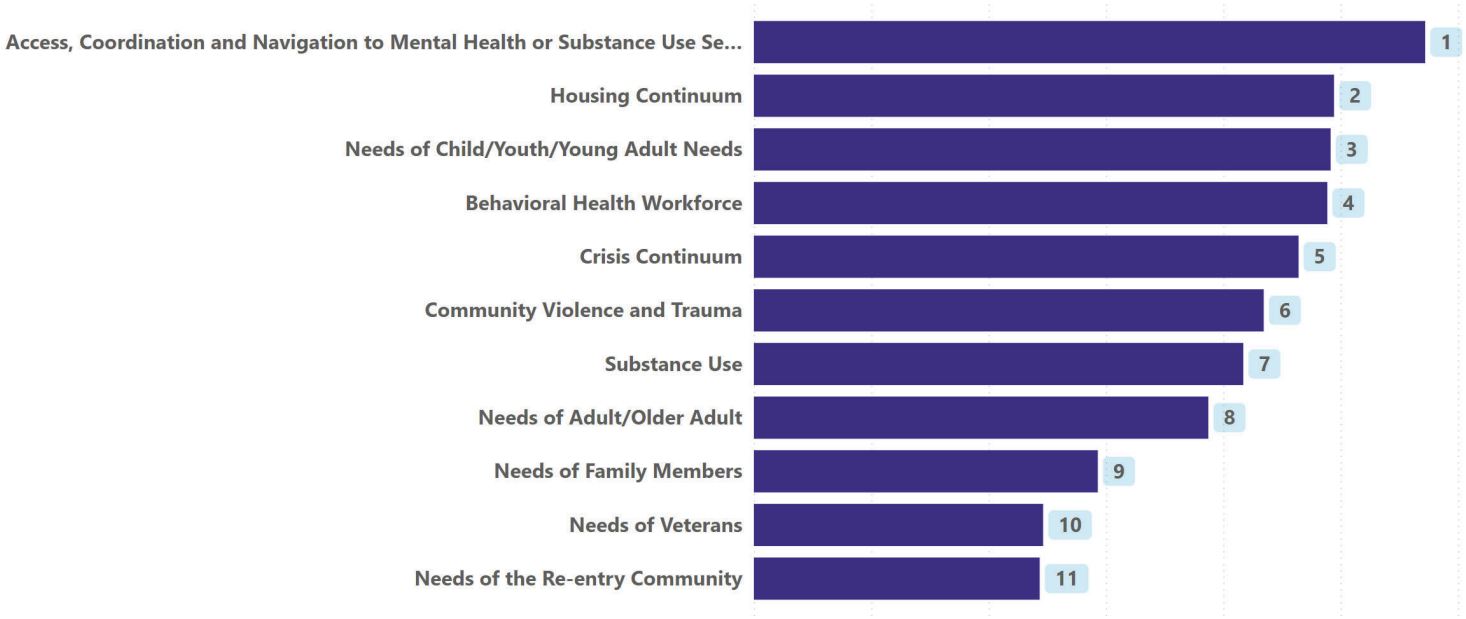
Top Needs of Survey Respondents



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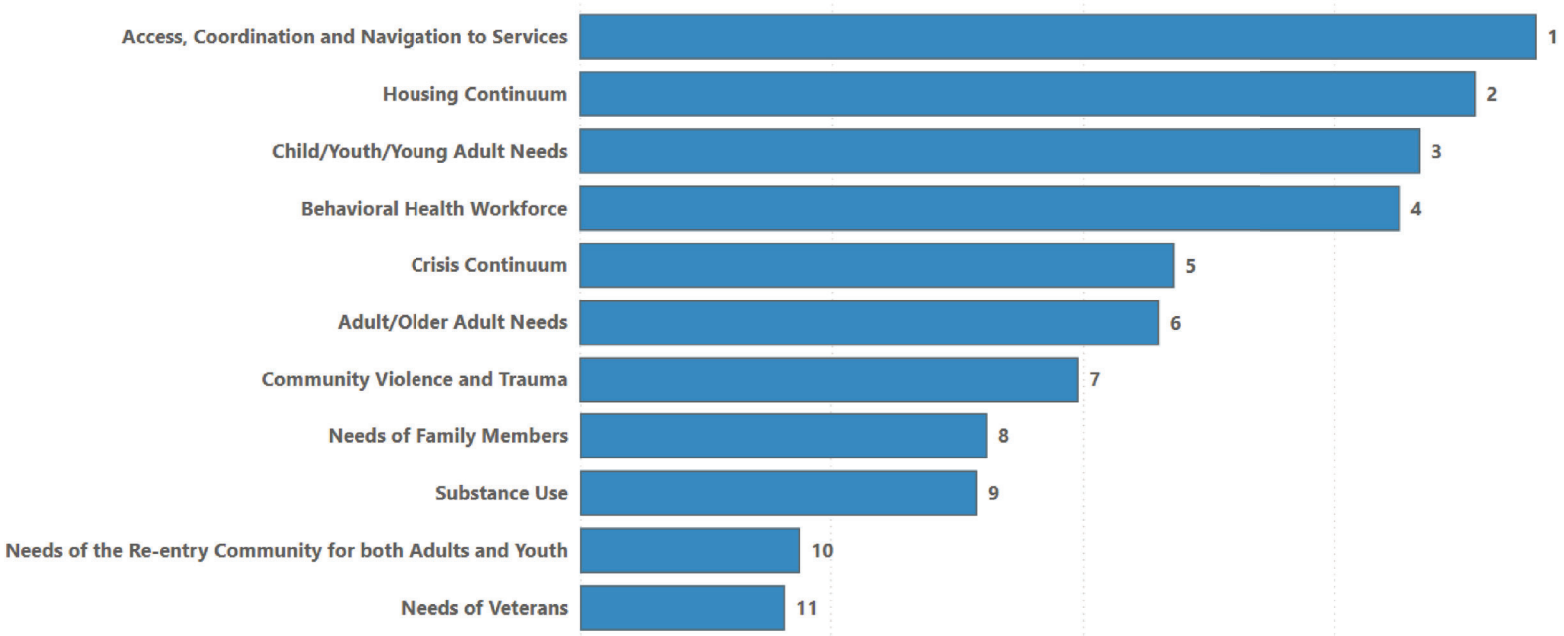
Top Needs of Listening Session Participants



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Listening Session

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System Needs

Rank the Three (3) Community Need Areas you would like to talk about today:

1. Access, Coordination and Navigation to Services to Mental Health or Substance Use Services
2. Behavioral Health Workforce
3. Crisis Services
4. Housing Interventions
5. Substance Use Disorder Prevention and Treatment Services
6. Community Violence and Trauma

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Population Needs

Rank the Three (3) Community Need Areas you would like to talk about today:

7. Needs of Children (ages 0-5), Youth (ages 6-15), Transitional Age Youth (ages 16-25)
8. Needs of Adults (ages 25-59), Older Adults (ages 60 and over)
9. Needs of Family Members
10. Needs of the Disability Community
11. Needs of Veterans
12. Needs of the Re-entry Community

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For more information email us at BHSA@acgov.org or visit us at www.ACMHSA.org

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Ongoing Commitment & Acknowledgements

- **Ongoing Stakeholder feedback** will be critical.
- Transitions from MHSA to Proposition 1/ BHSA impact programs, county networks, and service delivery and **will require partnership** with community based organizations.
- **Other legislative changes**, including those associated with Proposition 1/BHSA, also impact Departmental planning and strategy.
- **ACBHD will continue to provide updates** relative to this process, and the impacts to funding, services, and the broader county in the months to come.

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NEW Resources

- Transitions website: Behavioral Health Transformation (ca.gov)
- New State website: Mental Health for All: https://mentalhealth.ca.gov/
- Alameda County Behavioral Health Department MHSA website: https://acmhsa.org/bhsa/
- California Association of Counties (CSAC): https://www.counties.org/proposition-1

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BHSA Integrated Plan FY 26-29
Listening Session - Results

Presented by:

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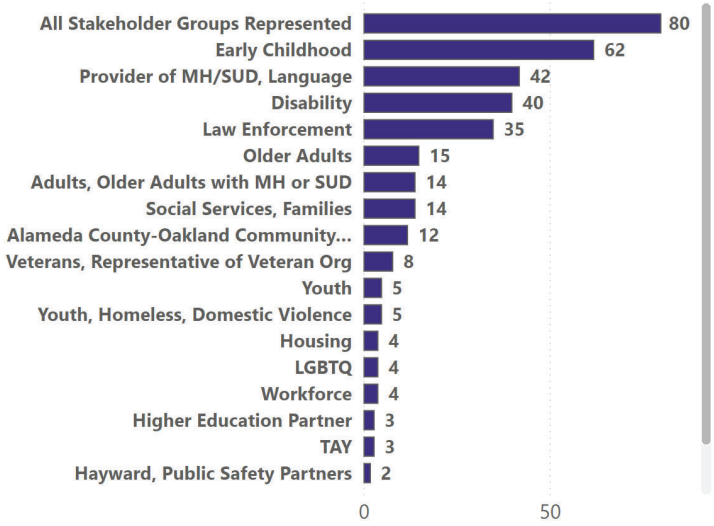
Listening Session Participants

355

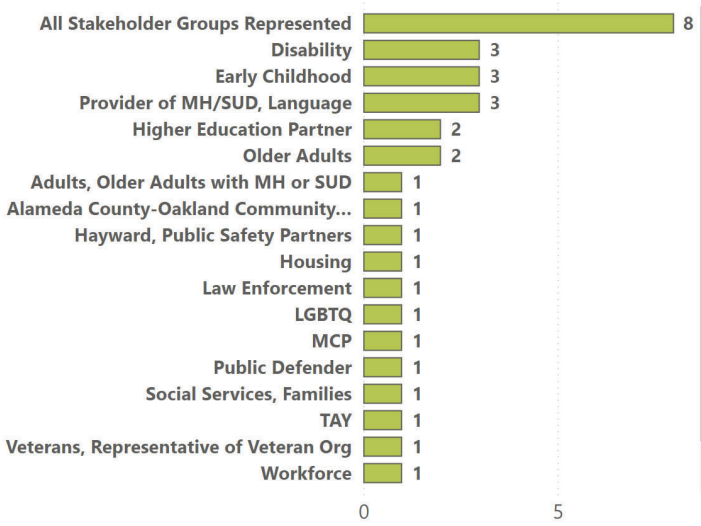
Listening Sessions

35

Participants by Stakeholder Group



Listening Sessions by Stakeholder Group Type



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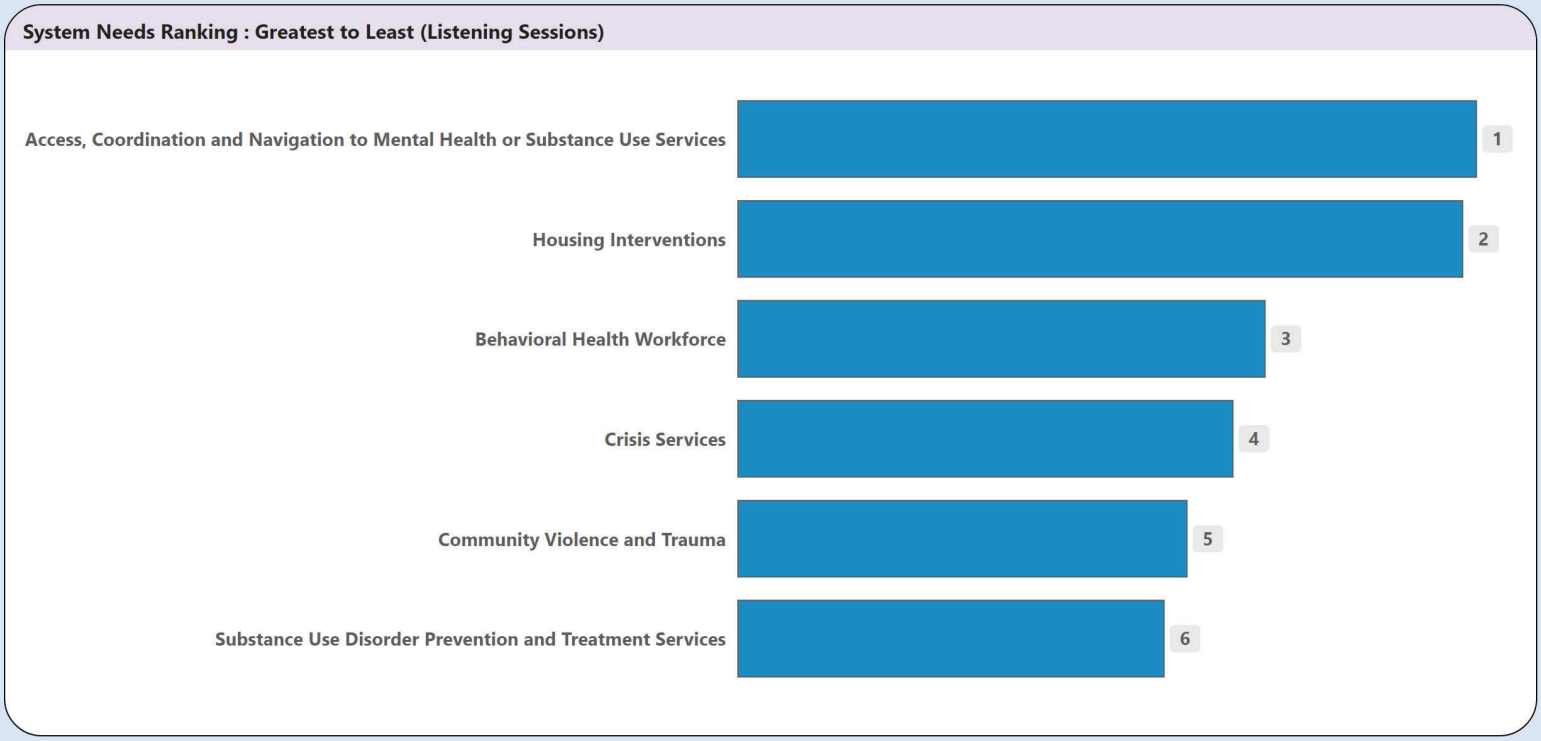

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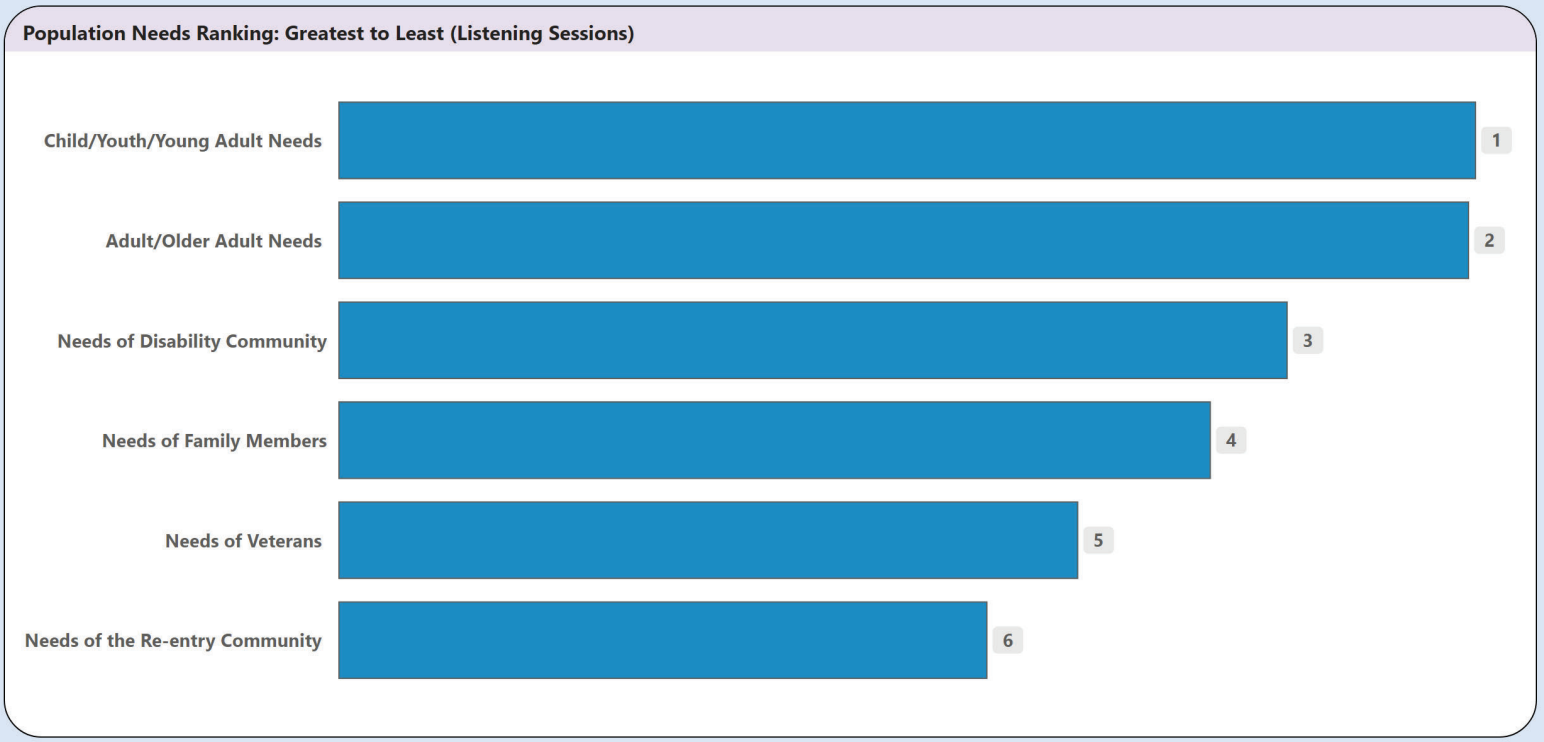

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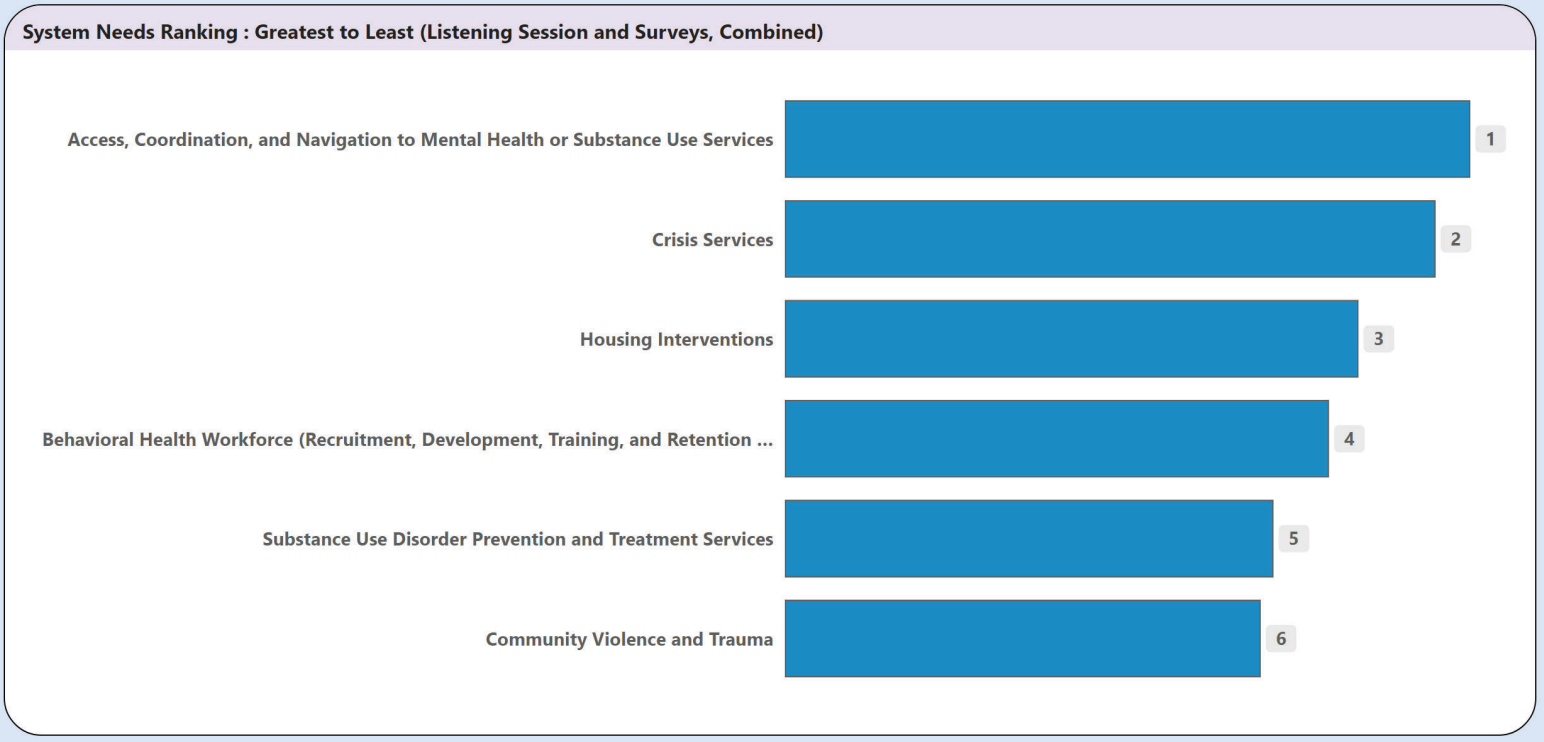

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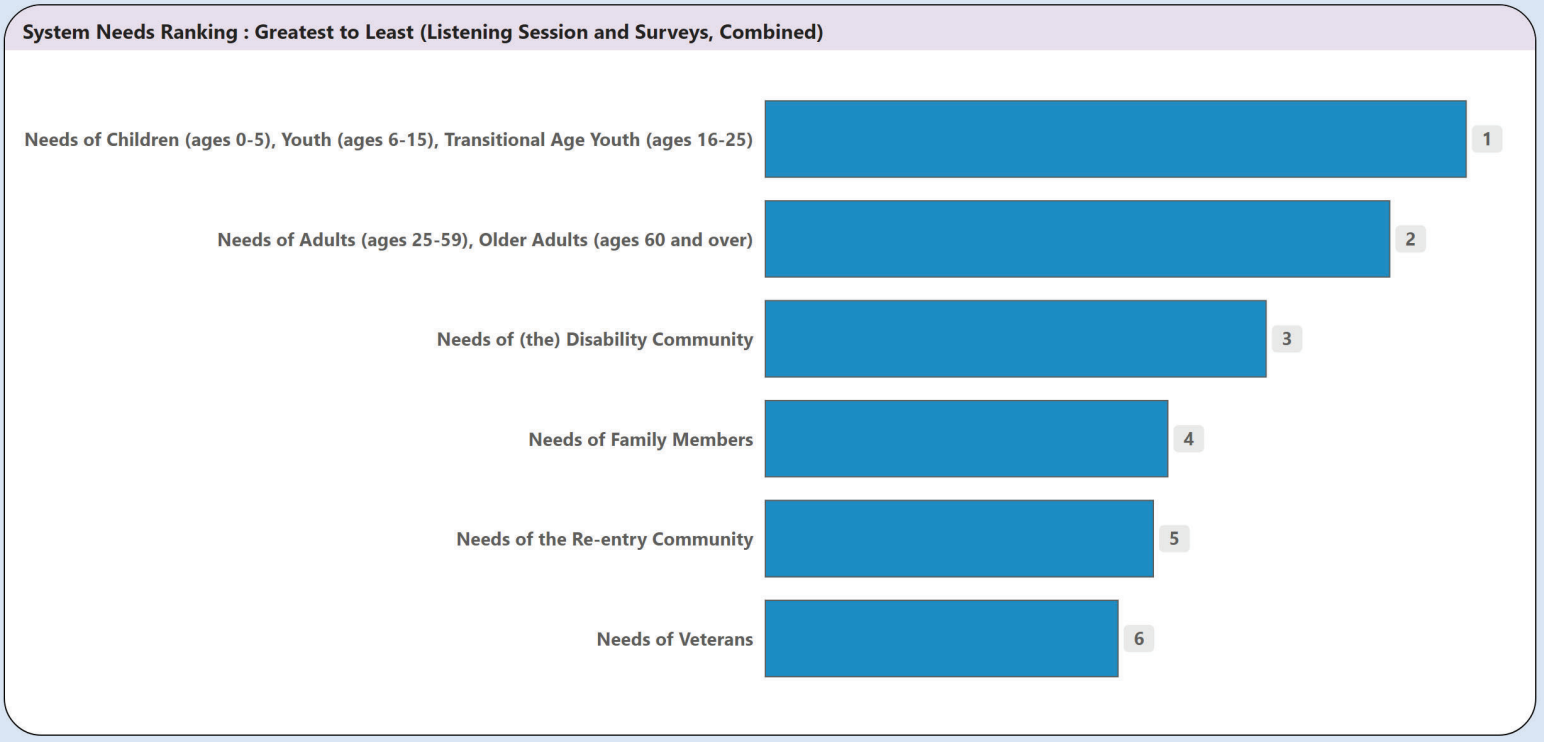

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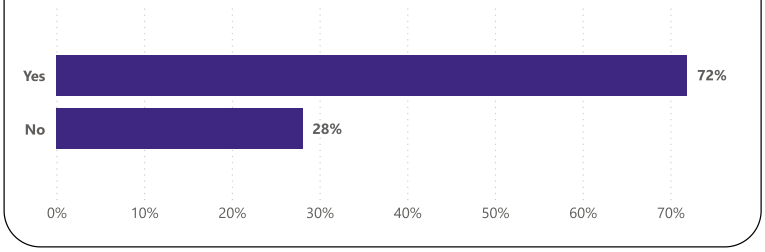
Distinct Survey Respondents*

57

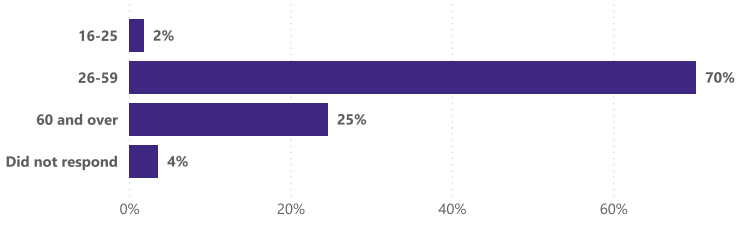
Distinct Zip Codes

35

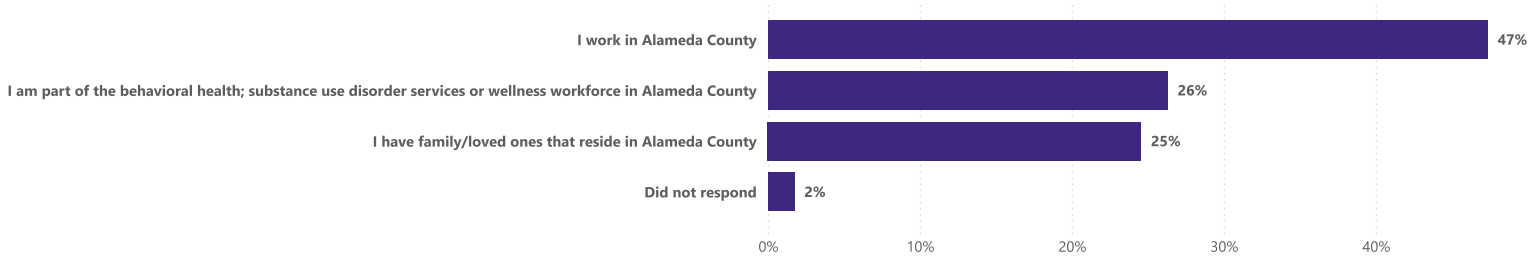
Are you a resident of Alameda County?



My Age Range is:



Please select the one that best applies to you:



Note :* While 355 total respondents participated in the listening sessions, only 57 of these respondents opted to take the Listening Session Demographic Survey.

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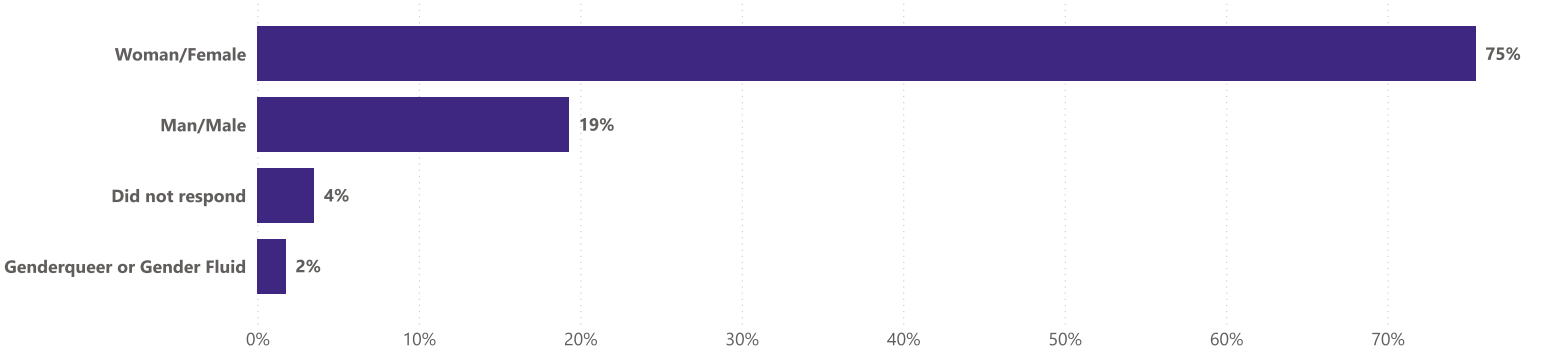
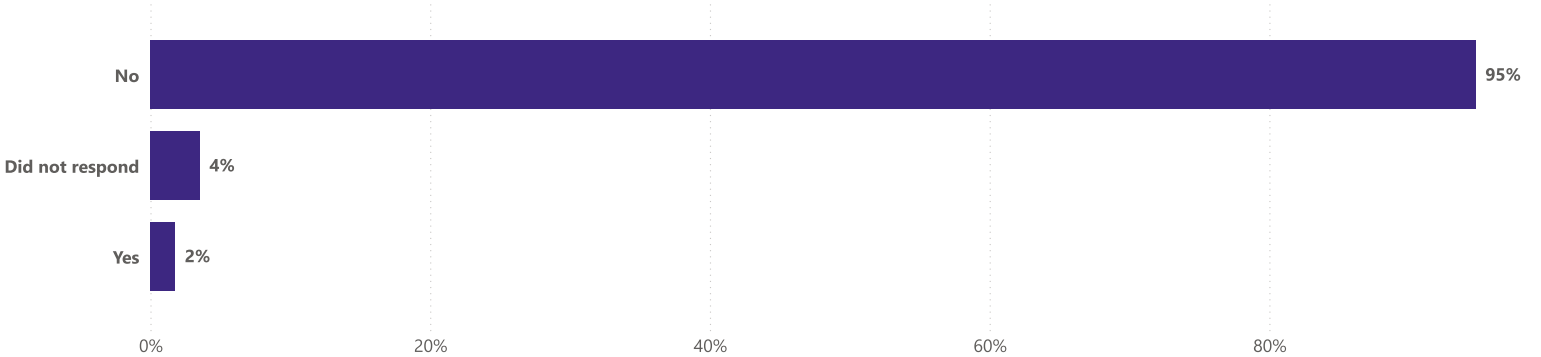
What is your current GENDER IDENTITY?



Do you speak any other language(s) at home besides English?



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What is your current GENDER IDENTITY?	Respondent
Did not respond	2
Genderqueer or Gender Fluid	1
Man/Male	11
Woman/Female	43
Total	**57**

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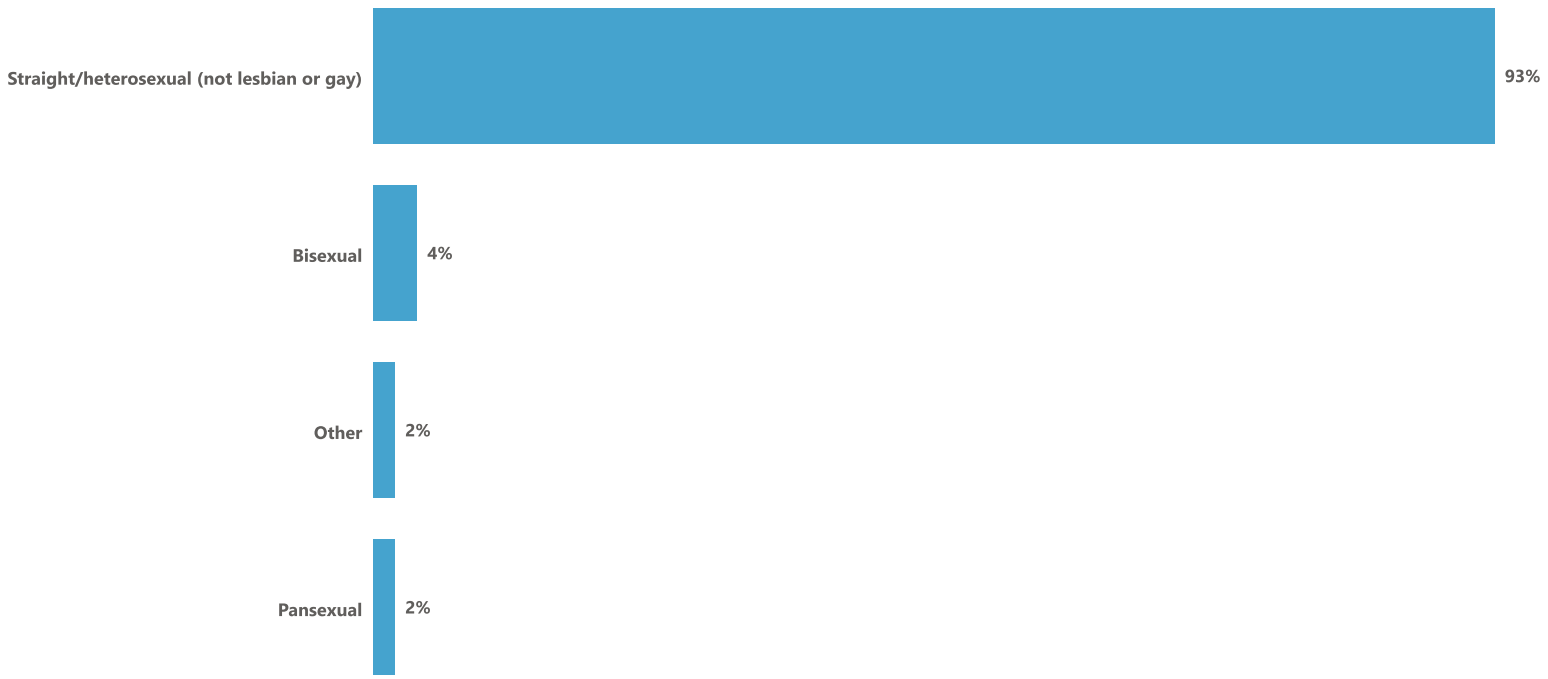
Which of the following BEST REPRESENTS how you think of yourself?



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Which of the following BEST REPRESENTS how you think of yourself? - Other (please specify)	# Respondent
Fluid	1
Total	**1**

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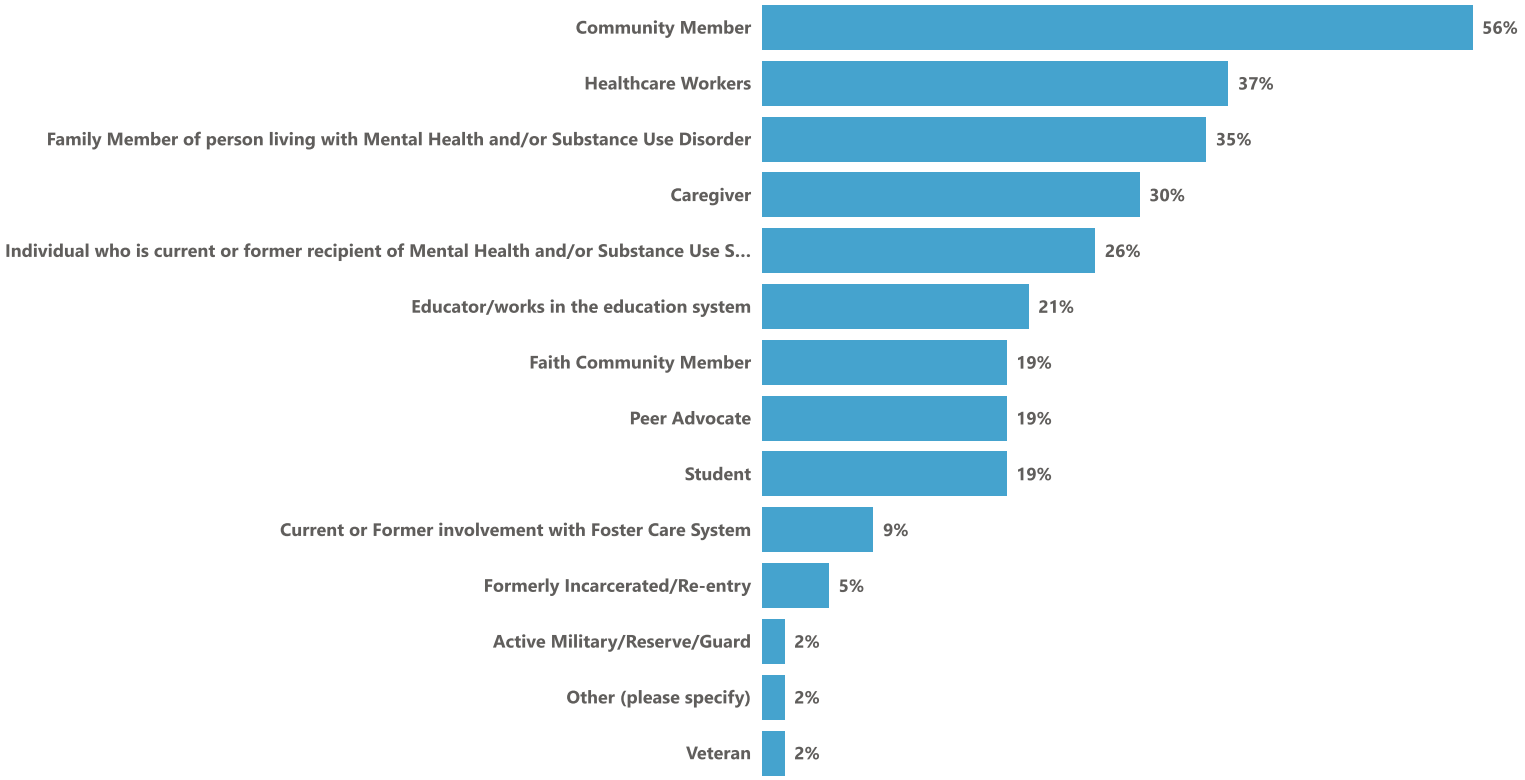
Which category/categories describe you? Mark all that apply AND add details. You may report more than one group.



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Specify Stakeholder Type	# Respondents
community based organization	1
Total	**1**

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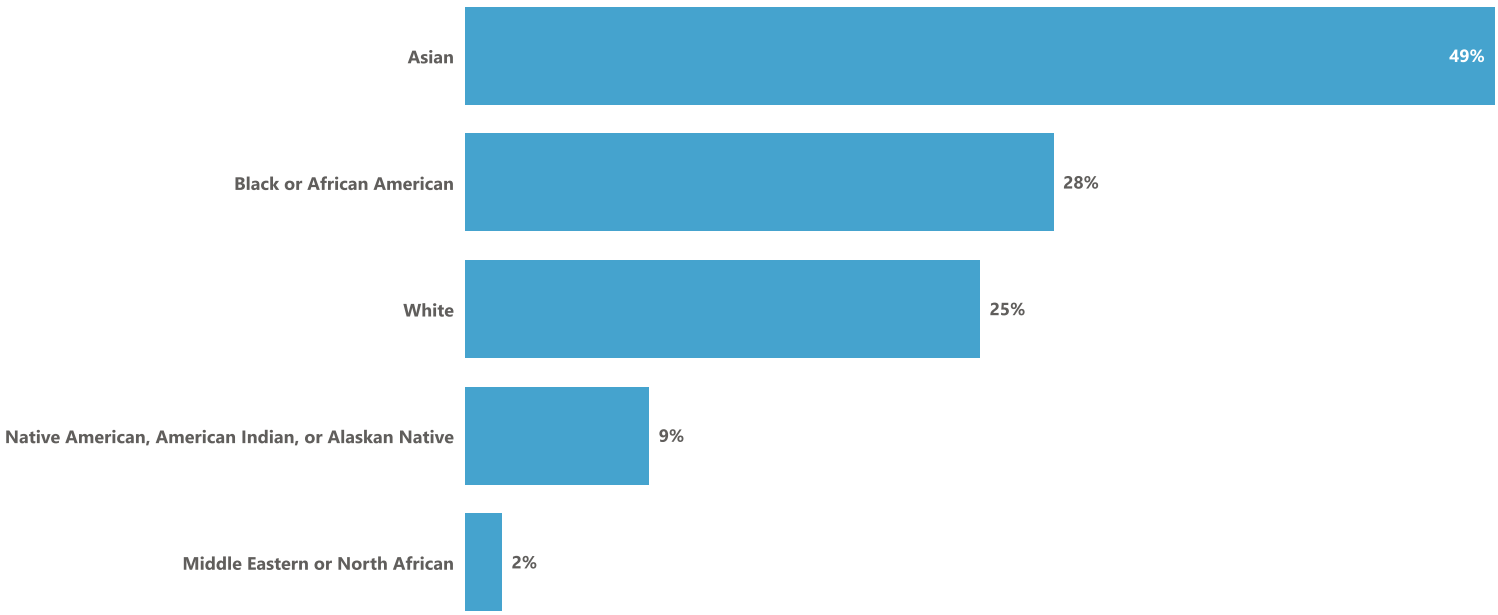
Which category/categories describe you? Mark all that apply AND add details. You may report more than one group.



Note: the values show the percentage of the total number of respondents taking the survey, not the percentage of race response values. Multiple responses results in percentages being greater than 100%.

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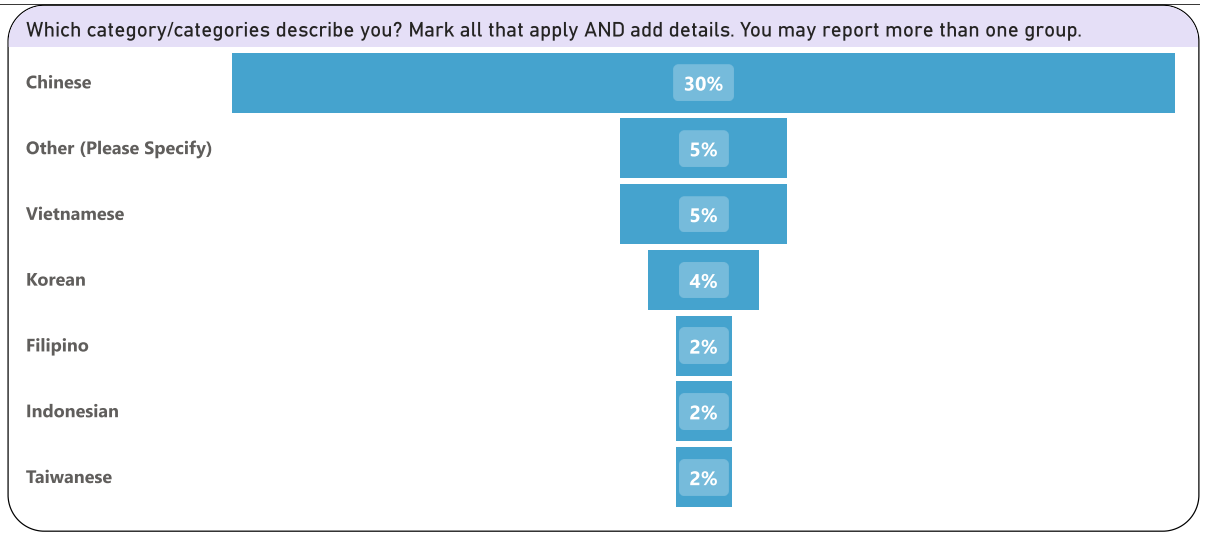
Race

- Asian
- Black or African American
- Middle Eastern or North A...
- Native American, America...
- White



Other Specify	% Race
Other Asian - Hong Kong	49%
hispanic	49%
Cambodian	49%
Total	**49%**

**Note:* The percentage values in the funnel visual indicate the percentages of respondents answering the race questions, not just the percentage specific to racial category.

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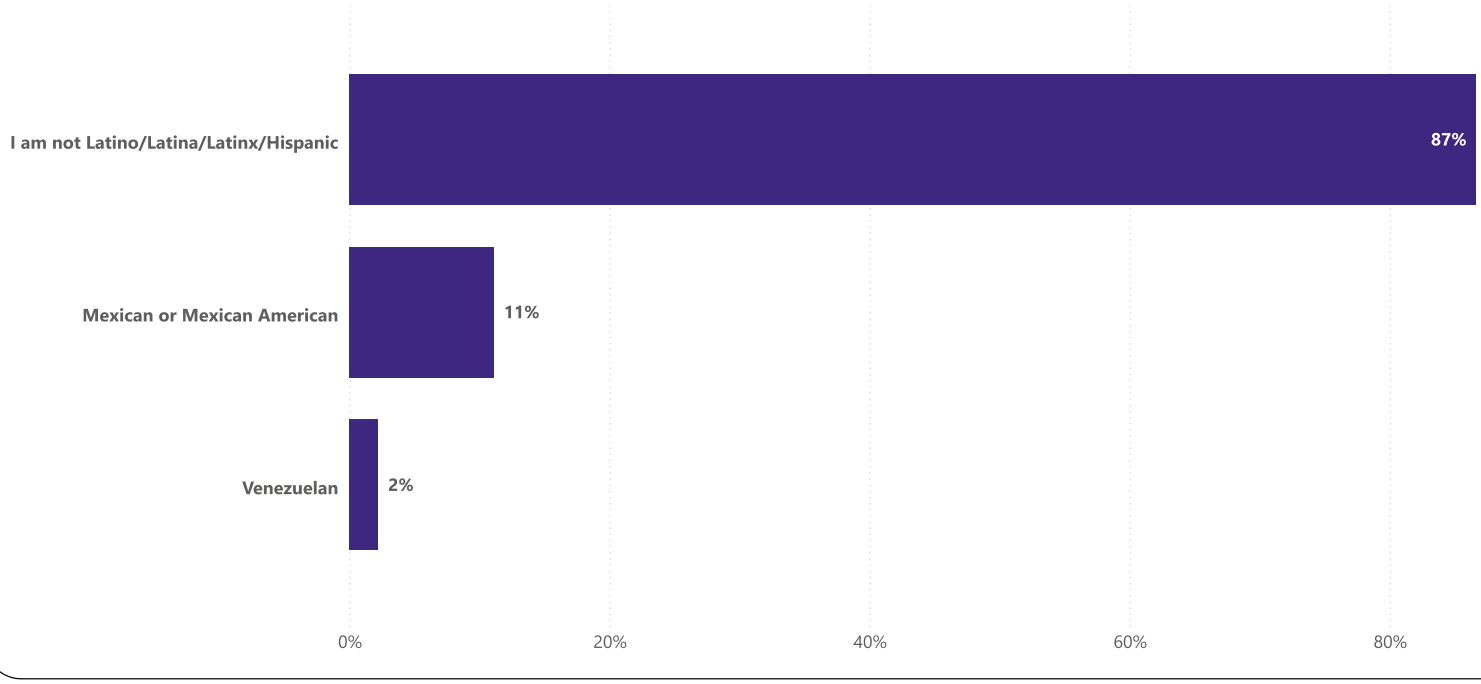
Respondents Reporting Latino/a/x Ethnicity

6

Respondents Reporting Latino/a/x Ethnicity

11%

Which category/categories describe you? Mark all that apply AND add details. You may report more than one group.



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BHSA Integrated Plan FY 26-29
Community Input Survey - Results

Presented by:

Alameda County Behavioral Health – BHSA Division

Noah Gallo, ACBHD BHSA Senior Planner

Behavioral Health Department
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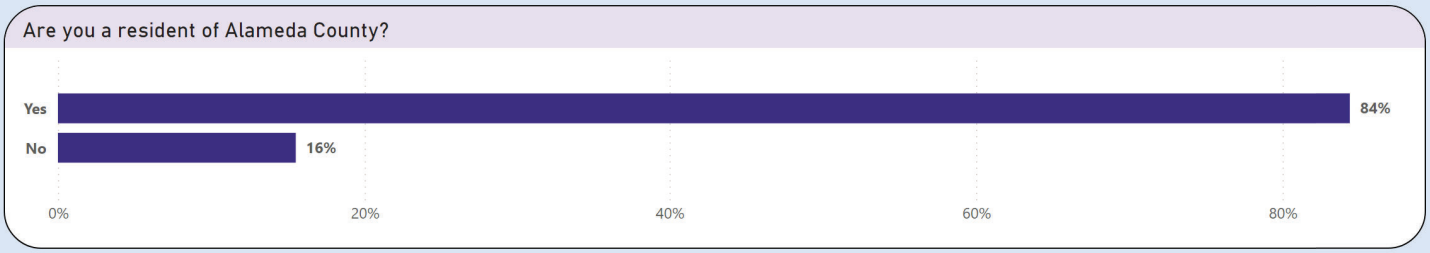
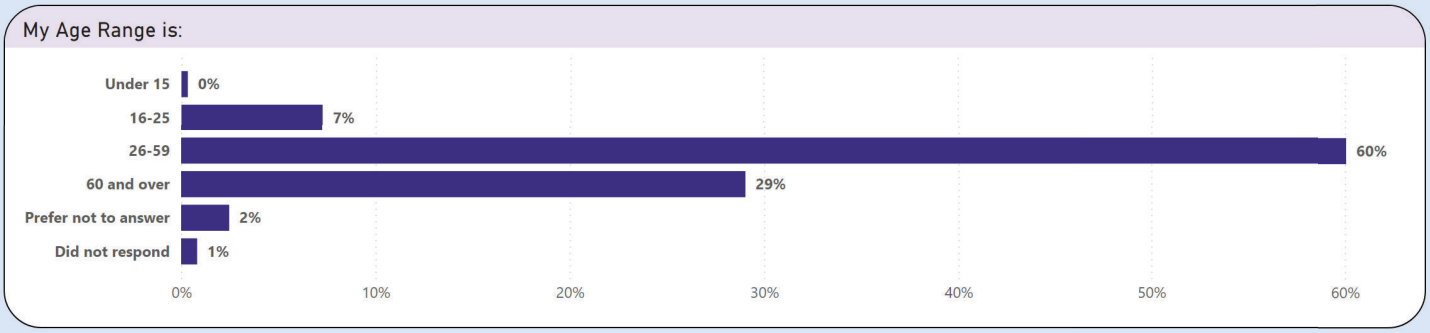
Distinct Survey Respondents	Survey Langauges	Distinct Zip Codes
613	5	101





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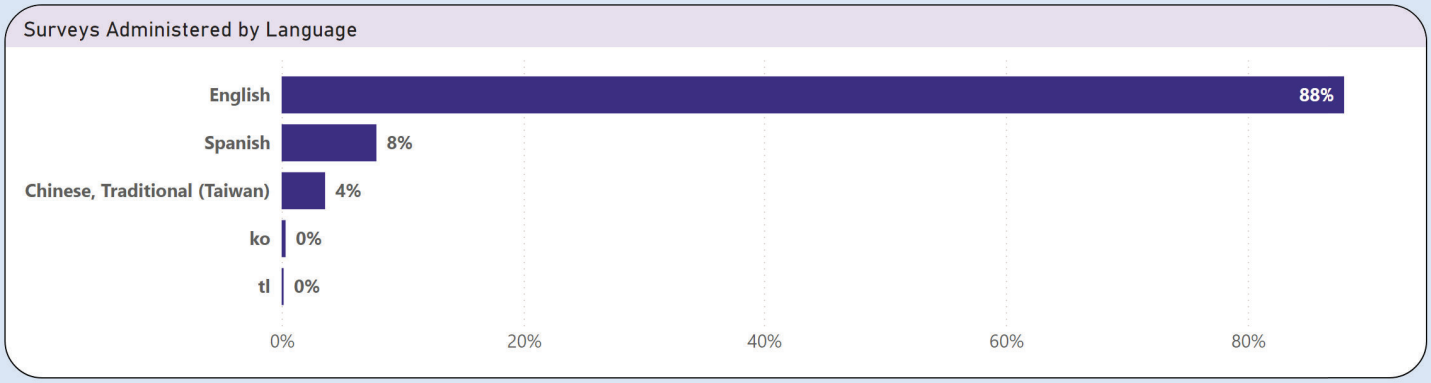

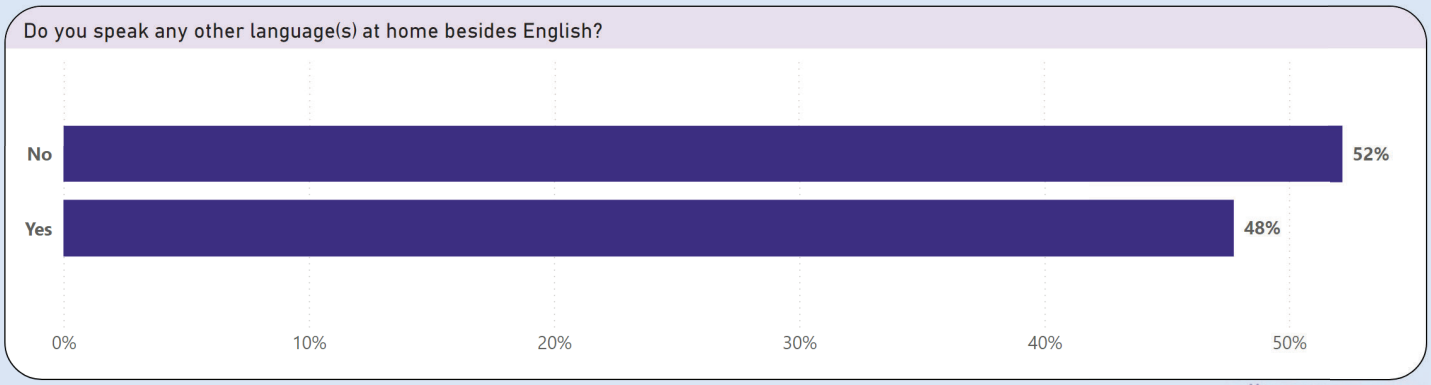

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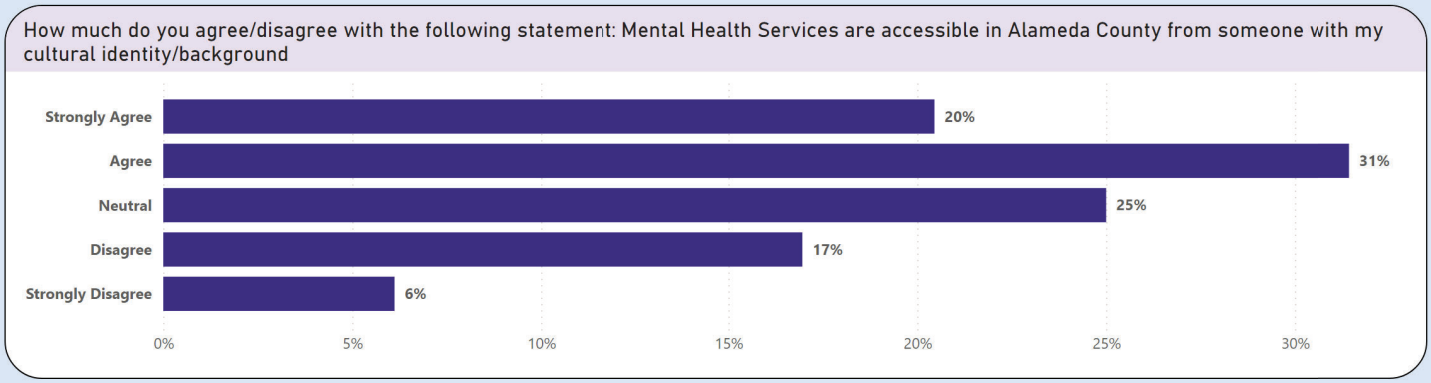

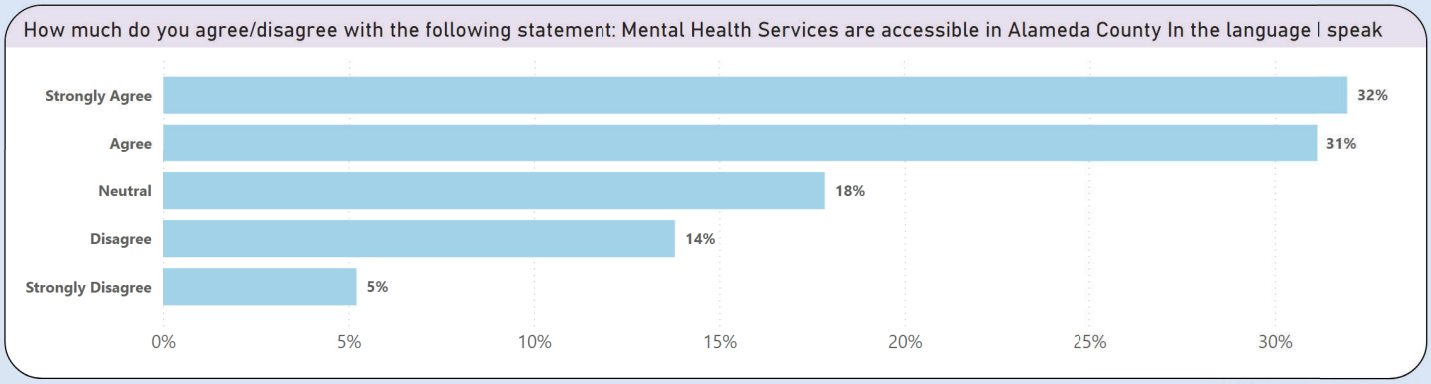

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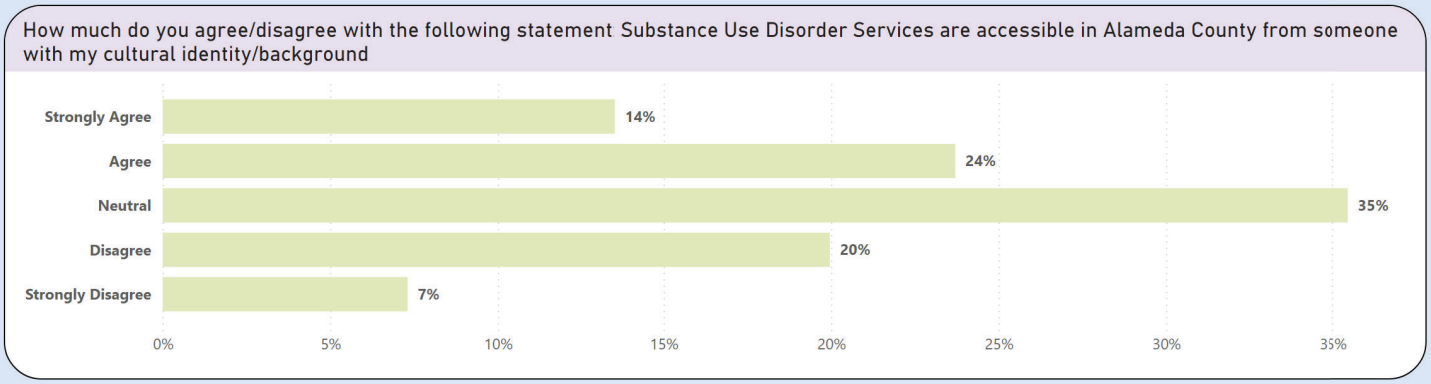

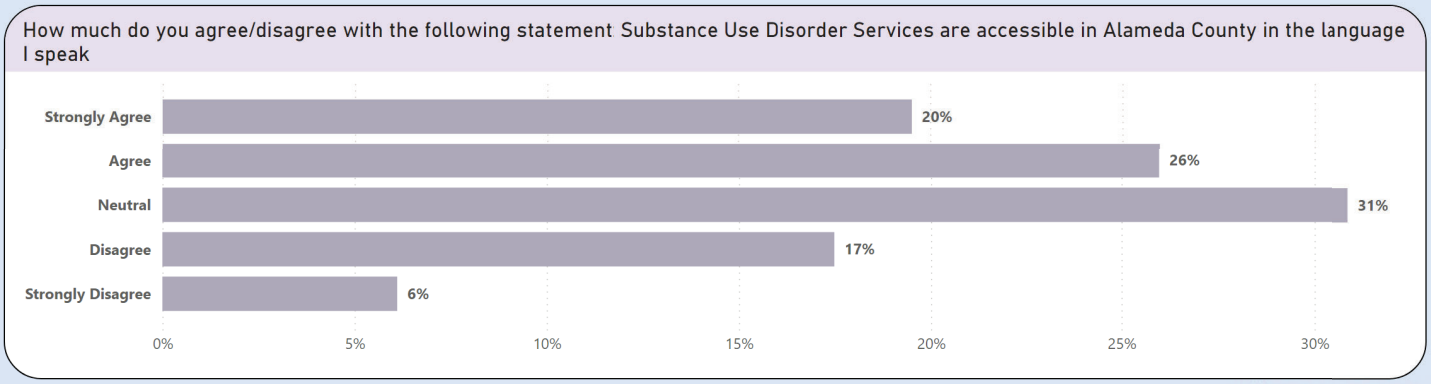

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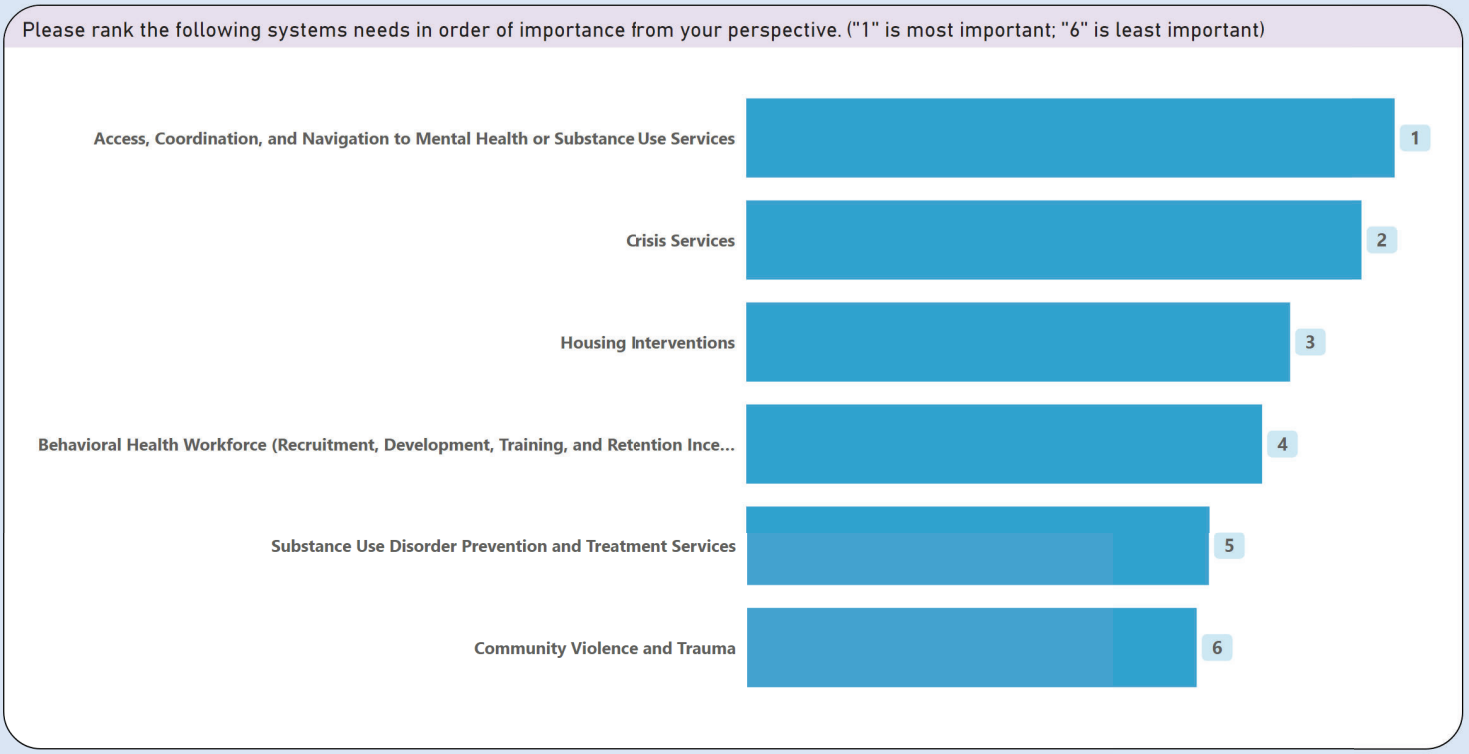

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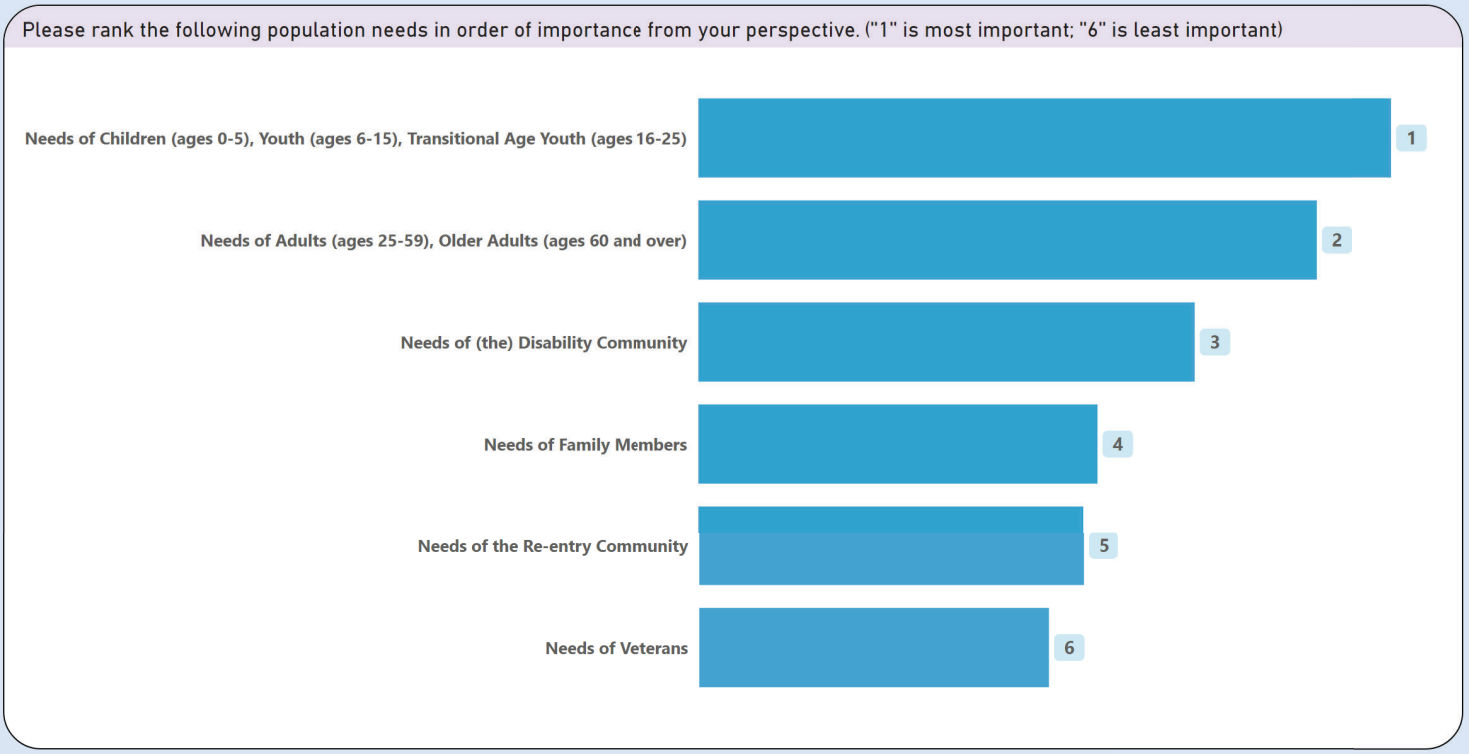

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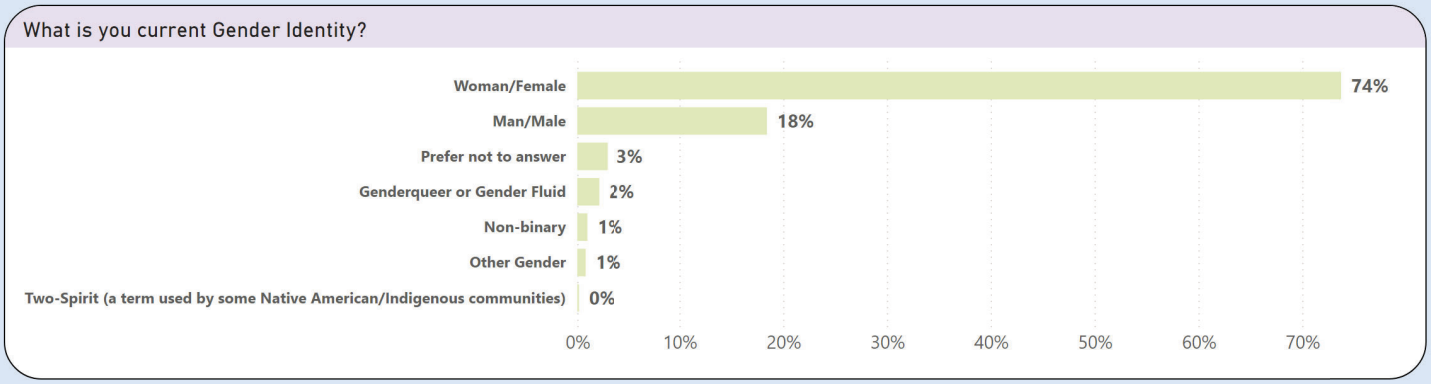

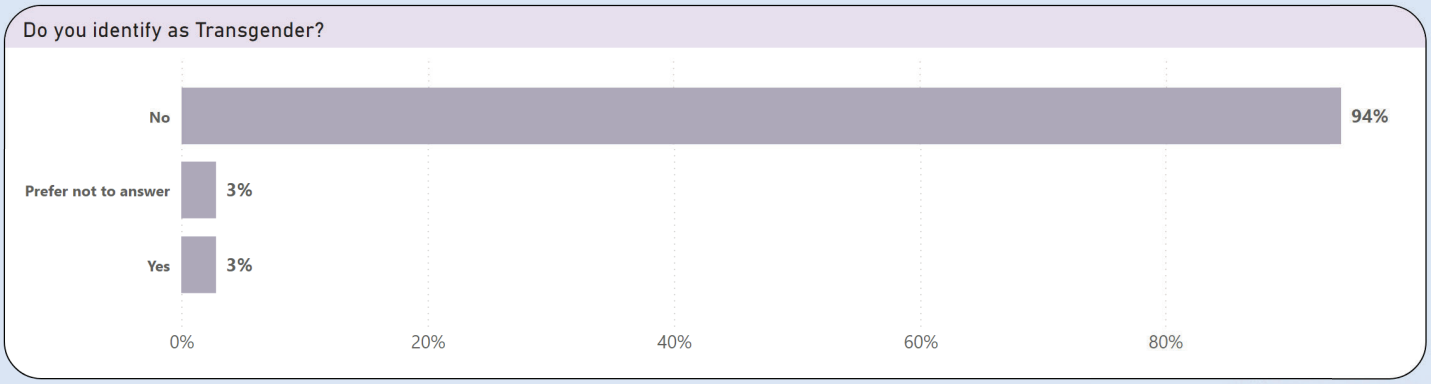

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What is your current Gender Identity? ‘Other’ written responses

agneder	1
genderqueer/androgyne/female/male/non-binary/transgender	1
Non-binary transfem	1
Not important for this stupidncategory	1
Trans man	1
Total	**5**

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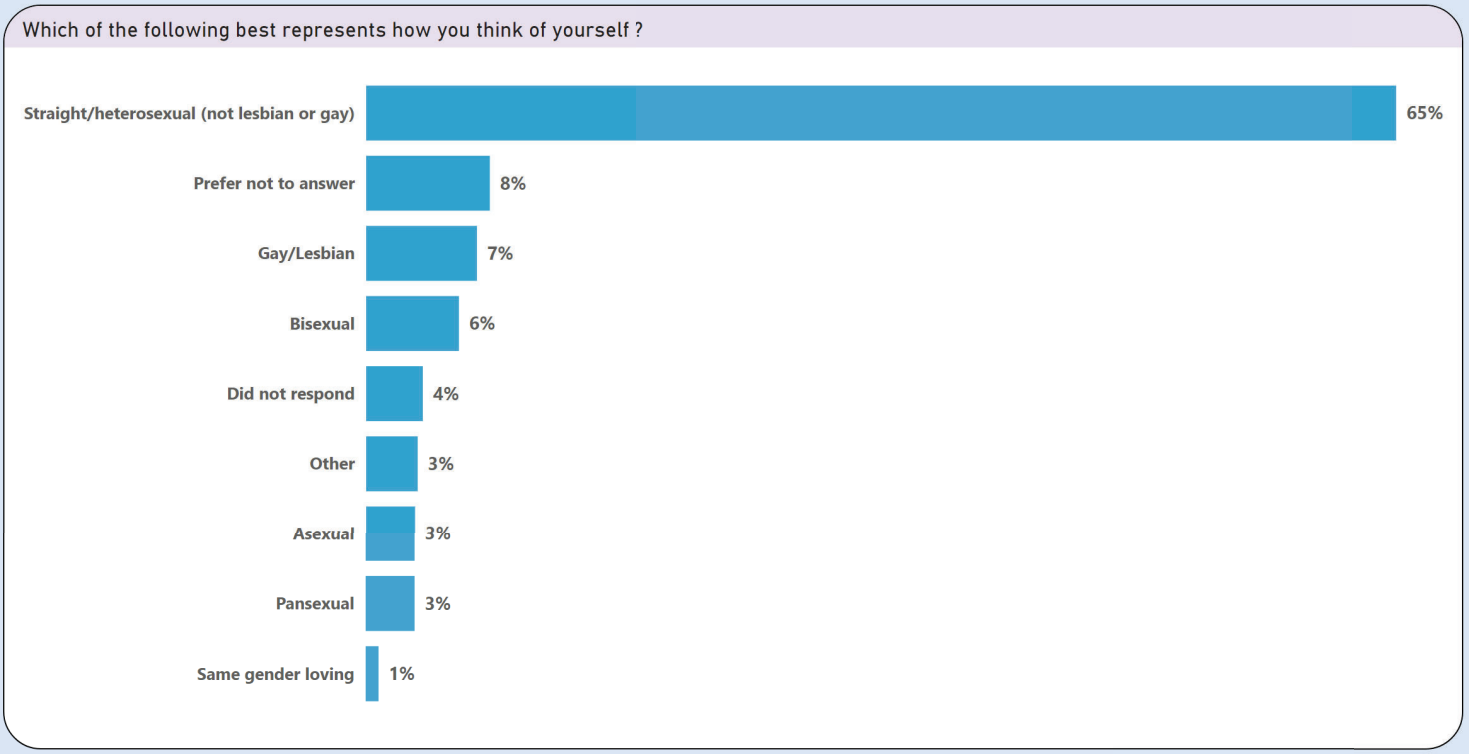

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Which of the following Best Represents how you think of yourself? 'Other' written responses

Queer	9
Another stupid question	1
bisexual/lesbian/gay/straight/homosexual/heterosexual/omnisexual	1
confused	1
Cranky old lady, post-sexual	1
Na	1
non sexual	1
none that apply	1
Not sure. Probably Bi.	1
Sapio Demi sensual/Romantic	1
Striaght	1
Why are you asking this question	1
Total	**20**

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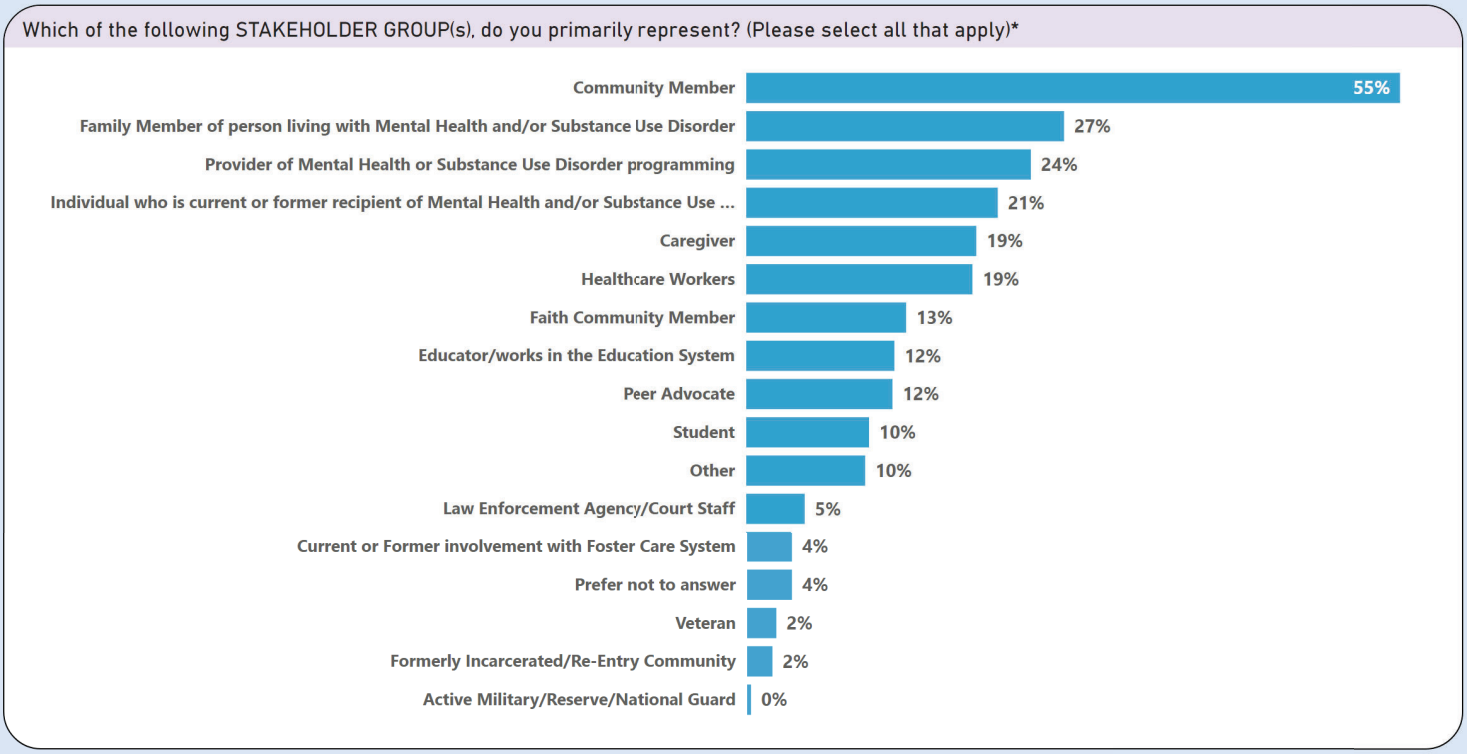

Note: the values show the percentage of the total number of respondents taking the survey, not the percentage of stakeholder response values.

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Which of the STAKEHOLDER GROUP(S), do you primarily represent? 'OTHER' written responses

OTHER Response	# Respondent Stakeholder
court	2
-	1
ACBH Employee	1
Afghan	1
Agency Partner	1
Alameda County Healthy Schools and Communities	1
Case manager/outreach worker	1
City Human Services	1
City staff	1
Clinical Supervisor of Regional Center of the East Bay (RCEB). Receive many inquiries regarding clients with substance abuse and/or other mental health needs.	1
Community volunteer	1
Crisis worker	1
Director of Elder Services	1
Disability Service Provider	1
Disabled	1
Disabled person	1
Elder	1
elderly	1
Encampment community	1
Former city commissioner (many of the above are long-term prior situations)	1
Former inmate slave/involuntary servitude as a wildland Firefighter; Person who gave birth to a child while incarcerated; Hx of trauma, Black Native American both quantum and Freedman in lineage.	1
Formerly Homeless Individuals	1
Gospel musician/Christian mother of Churches and Christian organization, Missionary worker	1
Health care professional that works in a law enforcement agency	1
Heppac	1
Housing	1
Housing Service Provider	1
I do not represent the groups, but rather preside over misdemeanor drug court as a judge. rt	1
I just know a few ..	1

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Which of the STAKEHOLDER GROUP(S), do you primarily represent? 'OTHER' RESPONSES

OTHER Response	# Respondent Stakeholder
I do not represent the groups, but rather preside over misdemeanor drug court as a judge. rt	1
I just know a few ..	1
I work in Alameda County, formerly worked in Education.	1
Justice reform advocate	1
Legal Service provider	1
Living w disability	1
Mental Health Clinician	1
mother of adult with IDD and has occasional crisis situations	1
Na	1
NAMI Tri-Valley	1
none	1
Nonprofit health administration (unemployed)	1
Nonprofit Provider - housing, employment, wraparound services	1
Oakland resident	1
Outreach Advocate	1
parent of adult children with anxiety	1
patients rights advocate	1
Patients' Rights Advocate for Behavioral Health Services	1
private attorney practicing in collaborative court	1
retired ACMC RN	1
Sin trabajo	1
Social services and affordable housing and mental health service provider end advocate	1
social worker	1
Someone who utilizes mental health services	1
Substance Use Prevention, Social Emotional Learning	1
Superior court Judge	1
Union representative	1
Violence Prevention Advocate	1
voluntaria en organizaciones sin fines de lucro.	1
Volunteer, advocate	1
Work for nonprofit focusing on homelessness	1
work part time human services for seniors	1
Workforce development professional	1
Total	**61**

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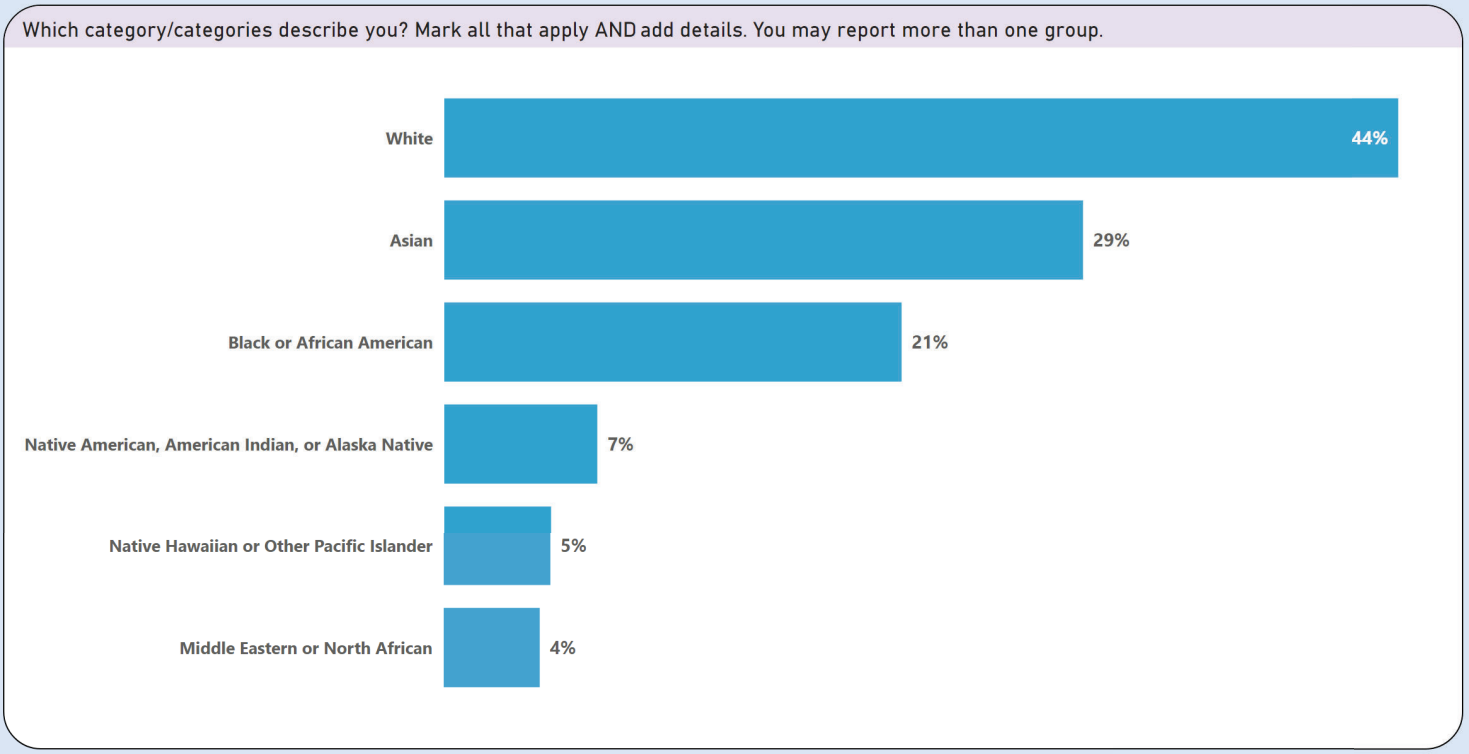

Note: the values show the percentage of the total number of respondents taking the survey, not the percentage of race response values. Multiple responses results in percentages being greater than 100%.

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Race Subcategories

Race	Category	% Race
Asian	Chinese	13%
Asian	Specify	7%
Asian	Asian Indian	2%
Asian	Filipino	2%
Asian	Japanese	2%
Asian	Vietnamese	2%
Asian	Taiwanese	1%
Asian	Korean	1%
Asian	Pakistani	0%
Asian	I am not Asian Indian	0%
Black or African American	African American	17%
Black or African American	Specify	5%
Black or African American	Haitian	0%
Black or African American	Nigerian	0%
Black or African American	Ethiopian	0%
Black or African American	Jamaican	0%
Middle Eastern or North African	Specify	4%
Middle Eastern or North African	Iranian	0%
Middle Eastern or North African	Egyptian	0%
Middle Eastern or North African	I am not Middle Eastern or North African	0%
Middle Eastern or North African	Syrian	0%
Native American, American Indian, or Alaska Native	Specify	5%
Native American, American Indian, or Alaska Native	American Indian	2%
Native American, American Indian, or Alaska Native	Central or South American Indian	0%
Native American, American Indian, or Alaska Native	Alaska Native	0%
Native Hawaiian or Other Pacific Islander	Specify	3%
Native Hawaiian or Other Pacific Islander	Native Hawaiian	1%
Native Hawaiian or Other Pacific Islander	Samoan	1%
Native Hawaiian or Other Pacific Islander	Tongan	0%
Native Hawaiian or Other Pacific Islander	I am not Native Hawaiian or Other Pacific Islander	0%
White	English	22%
White	Specify	17%
White	Irish	12%
White	German	9%
White	Spanish/Spaniard	7%
White	Italian	5%
White	Polish	2%

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Race Subcategories written response

Asian
afghani
American/Caucastion
Asian Pacific Islander/Native American
Burmese
Cambodian
Cambodian (khmer)
Guatemalan
Hispano Latino
Hong Kong
Khmer
Lao
Latina
Mexican
Mexican American
Mexican, Puerto Rican
Mexican/American
Mexicana
Mexicano
N.A.
N/A
Na
Native American
Nepalese
Nepali
None
Tibetan

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Race Subcategories written response

Middle Eastern or North African
afghani
Another stupid question
Ashkenazi Jewish
Jordanian
Mexican
Mexican/American
Mexicano
N.A.
N/A
Na
No
None
Turkish

Native Hawaiian or Other Pacific Islander
Mexican
Mexican/American
Mexicanos
N.A.
N/A
Na
No
None
None f

Native American, American Indian, or Alaska Native
Aboriginal
Alice
Aztec
Blackfeet tribe
Cherokee
Lakota
Maya
Maya K'iche'
Mestizo/Moreno
Mexican
Mexicano
Mixed Native Latino ancestry
N.A.
N/A
Na
None
Possibly Cheroke
Puerto Ricans are the descendants of indigenous people who were enslaved alongside their African counterparts and sometimes raped by their white Spanish masters.
Sean

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Race Subcategories written response

White
?
American
Ashkenazi Jewish
Ashkenazi Jewish, Mestizo/Moreno
ASL & Dari
Austrian
Broadly European
Canadian, Pennsylvania Dutch, Swiss
Canadian/Ukranian
Chinese
Dutch, Scottish, French, Scandinavian
dutch/german
Dutch/Irish
Eastern European
eastern european grandparents
Eastern European Jewish
european
european jewish
european mix
Father : German Irish, Mother: Italian
Finnish
French
French, Divine
Greek
human
Human being
I don't understand these categories! I am none of these.
Jewish
Jewish American
Jewish and Portugese
Lithuanian Canadian
Mexican
Mexican/American
Mixed anglo ancestry
Mixed European
Mixture. Above except Polish, Spanish and Italian. Add Norwegian, Swedish and French.
Mulatto grandparents
N.A.
N/A
Na
No
None
Northern european light-skin, English-Irish indigenous continental North American
Norwegian and Czech
Norwegian, Polish
Norwegian, Swedish
Portuguese, too
Russian
Russian Jewish
Russian.
Scots, Dutch
Scottish
Scottish and French
Scottish and Scandinavian, primarily. Married to a Spaniard.
Scottish Swedish english
Scottish, Dutch,
Scottish, french
Scottish, Swedish
Scottish/Greek
Slovenian
Some northern European, Scandinavian
Swedish
Swedish, Danish, Scottish
Swiss
thank you for not lumping us all together!
These ancestors owned, raped, abused, and murdered the others.
Tibetan/Nepali
To many to name!
Ukrainian
White
White/Caucasian
Why?

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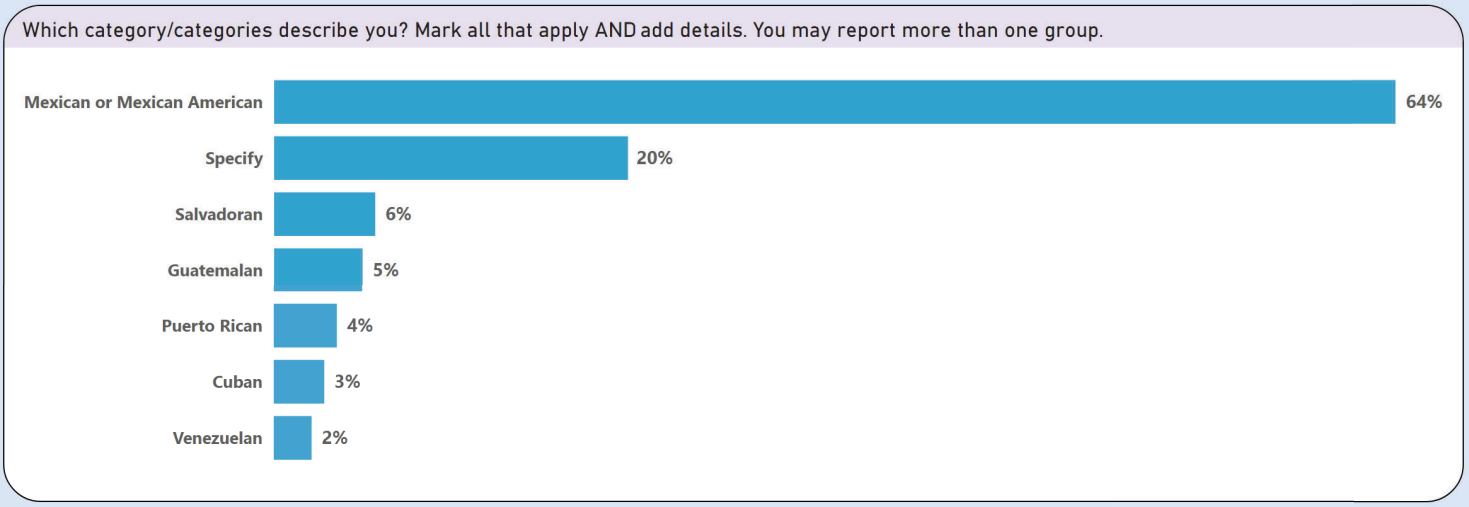
Respondents Reporting Latino/a/x Ethnicity

140

Percent Survey Respondents Reporting Latino/a/x Ethnicity

23%



Note: the values show the percentage of the total number of respondents taking the survey, not the percentage of ethnicity response values.
For "Specify" label, see "Ethnicity-Open-Ended Response" tab.

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Which category/categories describe you? 'Other' written response

Specific Response	# Respondents
N/A	4
None	3
Peruvian	3
Na	2
Afghan	1
Argentinian	1
Chilean	1
Chilena	1
Colombian	1
Hispanic/Latino	1
Hondurean	1
Indigenous	1
Mestizo/Moreno	1
Mixed Latino ancestry (Aruban)	1
N.A.	1
Nicaraguan	1
Nicaraguense	1
Nicaraguense.	1
Peruana	1
Trinidadian	1
Total	**28**

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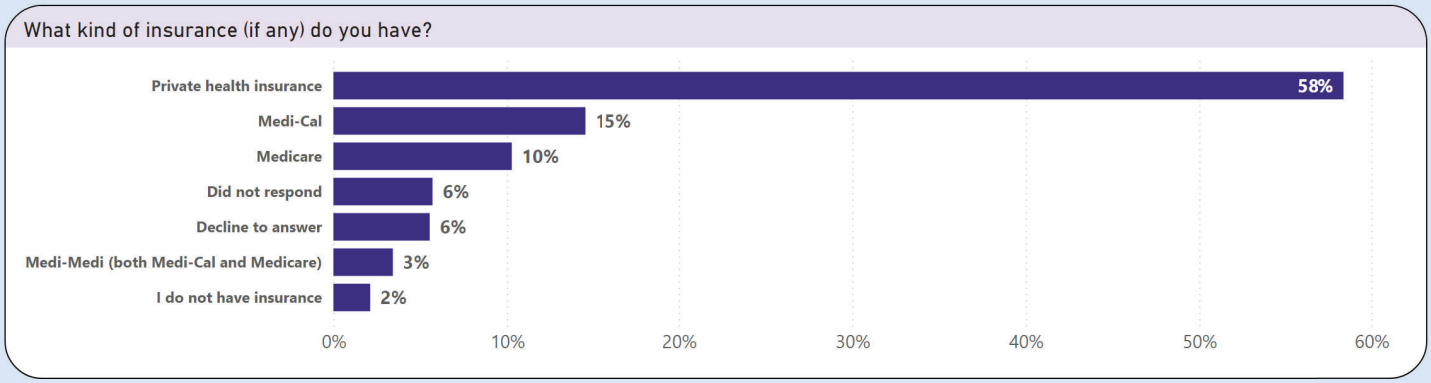

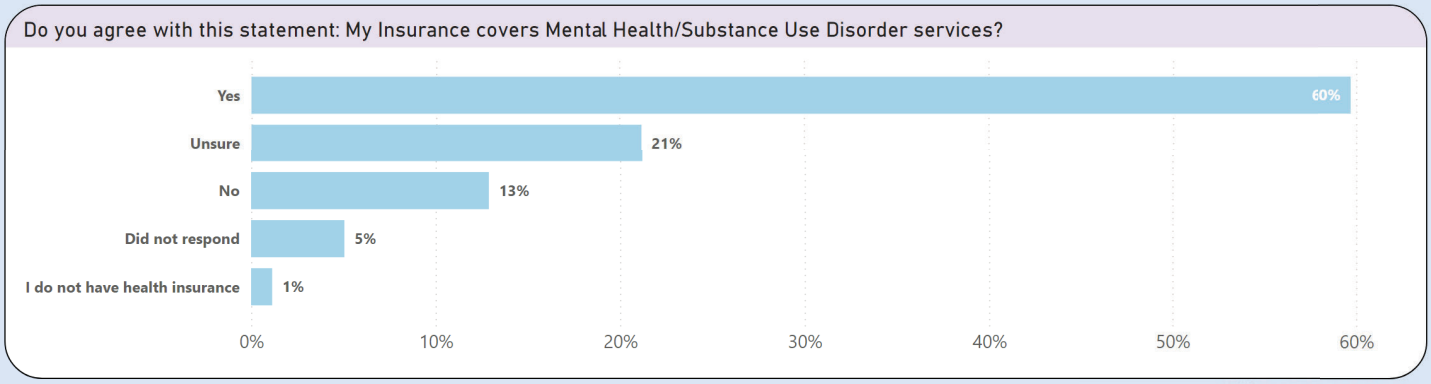

Note: Please see "No Insurance" tab to see open ended responses given to the question "*What kind of insurance (if any) do you have? - I do not have any health insurance. Why?*"

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No insurance. Why?	# Respondent
Aetna/medicaid	1
Cover california	1
I can't access	1
I don't qualify for medical but market place is expensive	1
I left in order to be able to get insurance	1
Kaiser through Covered California	1
Kaiser through my employer	1
Me negaron	1
No	1
No he buscado seguro	1
Not working & not sure how to qualify for healthcare	1
Private & Medicare	1
VA Insurance	1
Total	**13**

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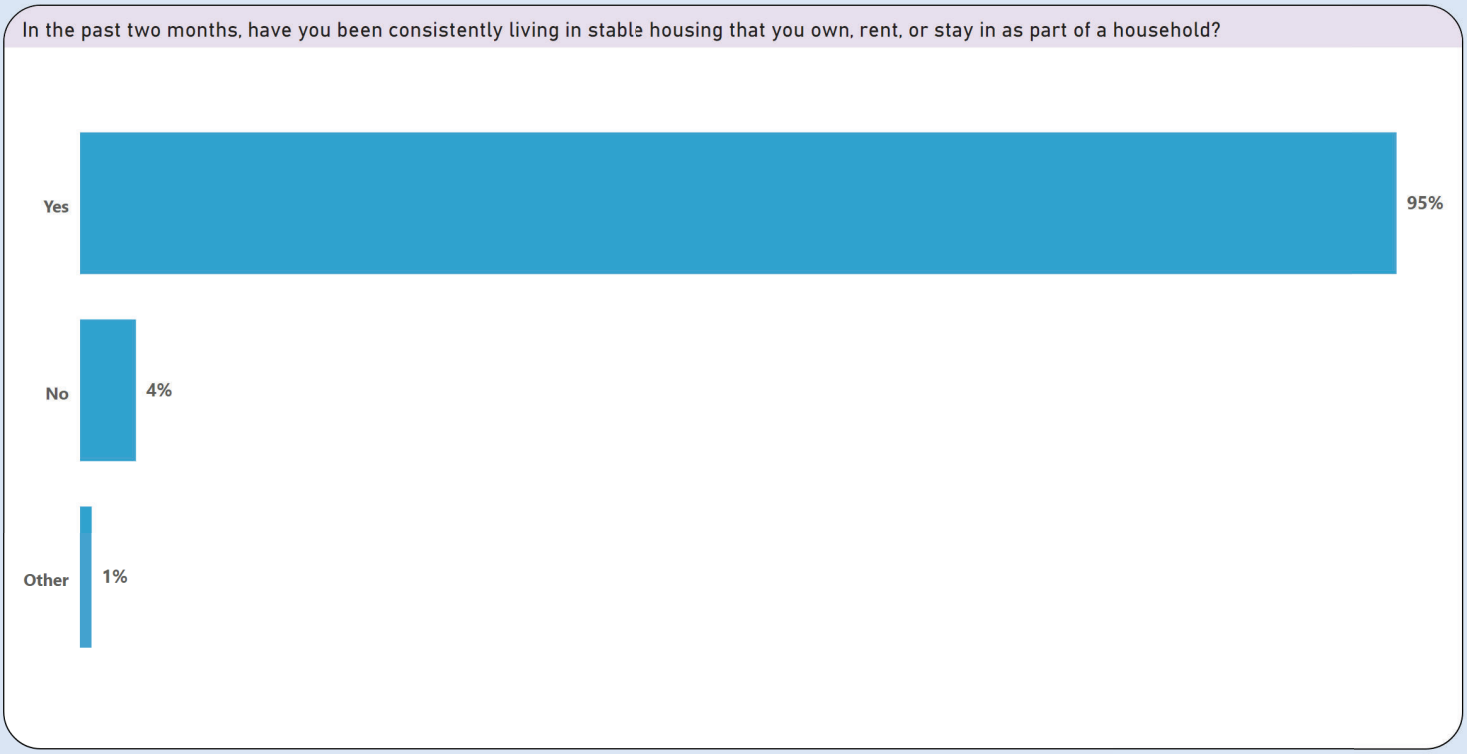

Note: Please see "Stable Housing-Other" tab to see open ended responses given to the question "*In the past two months, have you been consistently living in stable housing that you own, rent, or stay in as part of a household? - Other (please specify)*"

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Other (please specify)	#
En un shelter refugio	
I'm relying on my family I can't afford any rent	
Live with friends and it's not stable... Illegal unit	
N/A	
The move was rough and full of iffy, dangerous places to stay, with insect and rat infestations, and without legal ways to escape in case of a fire. I now have stable housing that I own.	
Total	

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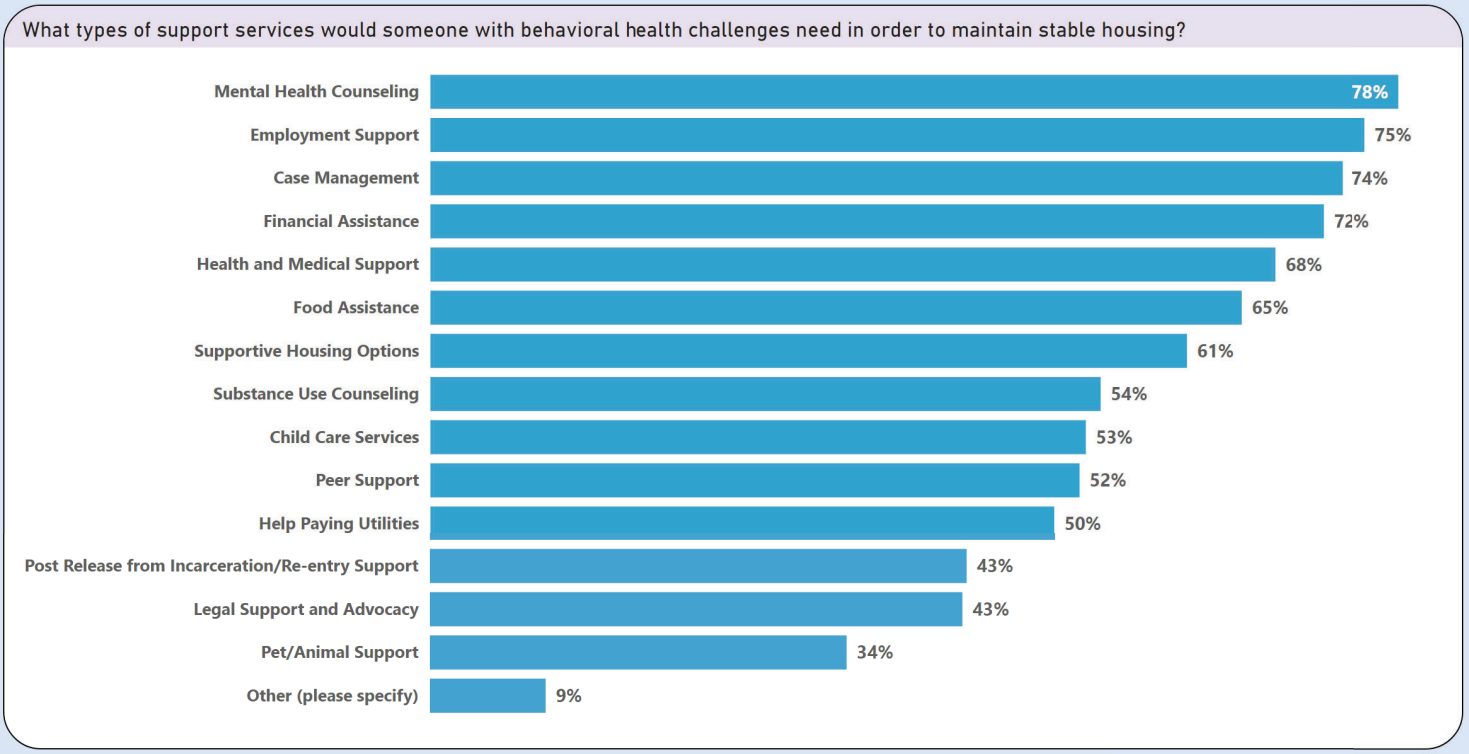

Note: Please see "Stable Housing-Other" tab to see open ended responses given to the question *"In the past two months, have you been consistently living in stable housing that you own, rent, or stay in as part of a household? - Other (please specify)"*

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What types of support services would someone with behavioral health challenges need in order to maintain stable housing? ‘Other’ written response

all above for those with different conditions
All are great, however, many supportive housing services restrict pets, restrict drug use, and have very strict rules about curfew. We have seen that individuals would rather turn away housing than live under constant rules or give up a pet. Something to consider.
All can be required, depending on the individual's needs.
All of it!
All of the above
All of the above!! Wrap around services in all areas!!
All of the above, I imagine depending on their life circumstance.
Any of the above could apply and must be evaluated on a case by case basis
Any possible
Basic skills to re learn how to do basic thing around the house regarding taking care of themselfs
Community support/programming
Connection to supportive community
Connections for employment
Consistency
Crisis response available at all times of day/night
Culturally appropriate group and community based services
Depending on circumstance, any of the above.
Depends on severity and what they say they need
Depends so much on the person!
each person is different. all of the above needs to be accessible,& available and keep freedom of choice in mind.m of choice
Education Support, if parenting- maybe respite care?
Everything contributes to the allostatic load and stressors of mental well being
Everything; housing instability is a systemic and interrelated problem
Find the meaning of life beyond material enjoyment
Harm Reduction Services

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What types of support services would someone with behavioral health challenges need in order to maintain stable housing? ‘Other’ written response

Help to make Kaiser provide competent therapy! And not make patients in crisis wait 3 months for an answer
HOUSING FIRST. HOUSING ALWAYS.
Housing Subsidies
I can't choose all of them. But all of them.
I depends... it's NOT a homogeneous community
I did not choose pet/animal support because it is specific to the person and I think legal support might be SSI or SSDI or not everyone needs it. But maybe I just choose them all.
I worked in behavioral health for 15 years. All supports are needed
It depends on their finances and severity of need
it really depends on what their need is currently, the severity/frequency/duration of their symptoms, their current levels of social support and ability to navigate systems, etc.
Less judgment and a thriving democracy
Mandatory housed treatment facilities
Medication assisted treatment
medication management
N/a
Nonviolent stable community
Ongoing connection to affinity group to support stabilization of behavioral health
potentially all of the above, but I checked the ones I believe to be the most important
probably all of these should be offered
Public benefits assistance/navigation
Social Connections, e.g., Id, Drivers License, Immigration, etc
Support with Transportation
These are all very important and I'm sure there are more areas that I can't even think of at the moment. Possibly, caregiver assistance services for those who care for loved ones. Family planning assistance (free access to sex education, birth control, abortion), we also need safe places where kids can play outside, nice family friendly parks, community services, DEI/culturally sensitive services (despite current politics), more readily-available services in more languages.
This is what professionals should determine
This of course depends on the level of mental health need and diagnosis.
To maintain stable housing it takes mental health wellness and peer support, financial stability, health care stability, child care services if needed, quality safe affordable available housing, a job that allows them to thrive and not run out of money before the next check. There are so many things that goes into being able to have stability.
Weekly sessions with a professional, well trained therapist for as long as it takes. Probably for a lifetime.

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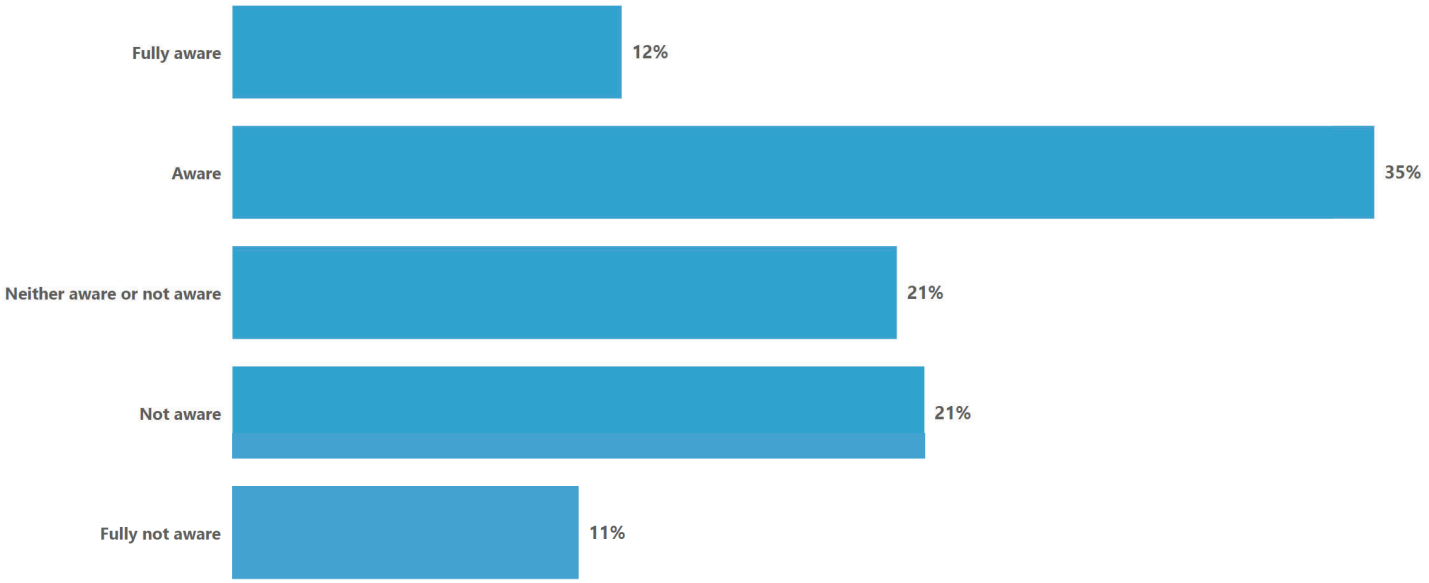
What types of support services would someone with behavioral health challenges need in order to maintain stable housing?



Note: Please see "Stable Housing-Other" tab to see open ended responses given to the question "*In the past two months, have you been consistently living in stable housing that you own, rent, or stay in as part of a household? - Other (please specify)*"

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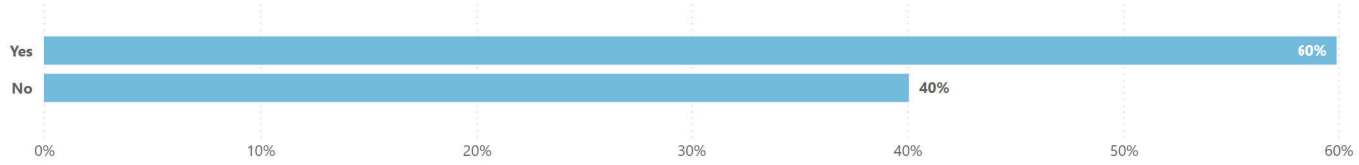
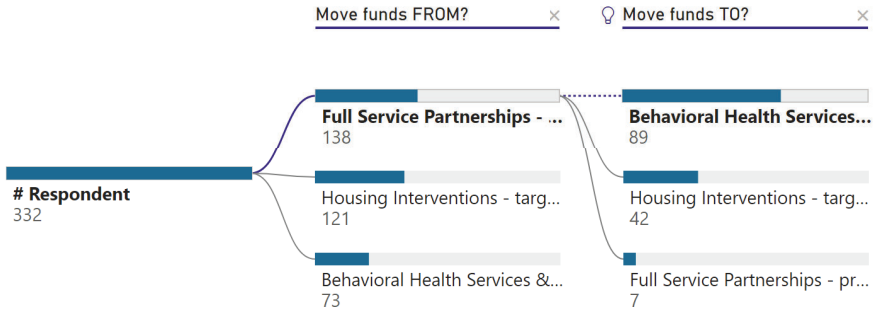
Under BHSA there will be three funding categories: 1) Housing Interventions, 2) Full Service Partnerships and 3) Behavioral Health Services and Supports. The state allows counties to move a percentage of BHSA funds (up to 7% per category) from one category to another.Do you recommend moving a small portion of funding from one category to another?



If you answered "Yes" to the previous question, where would you...



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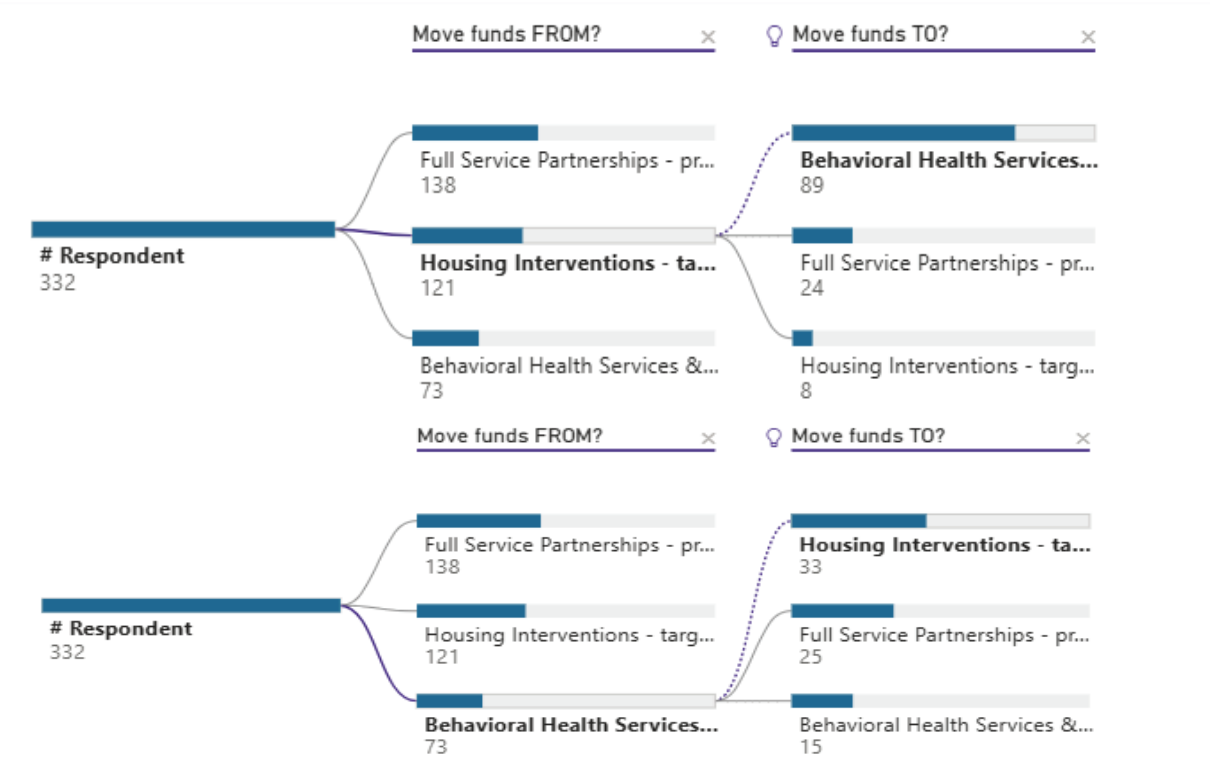
If you answered “Yes” to the previous question, where would you move funds?



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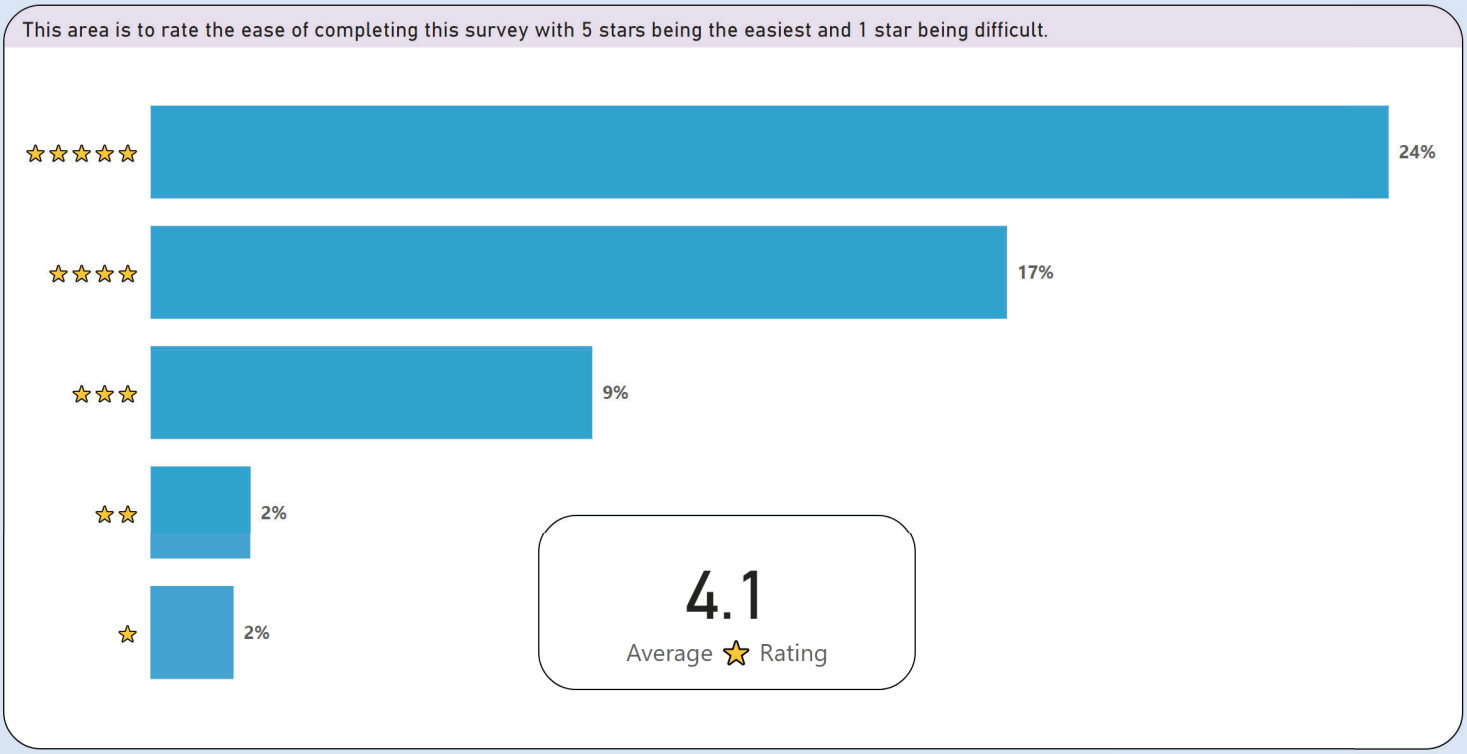

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Community Feedback from the Community Program Planning Process (CPPP)
Top System Needs Analysis - Ranking in Survey, Listening Sessions

Access Coordination and Navigation to Services: ***(#1 – Survey, #1 – Listening Sessions)***

- Expand culturally and linguistically responsive navigation resources to ensure access, services should include individuals with a disability.
- Establish consistent, well publicized access points such as community events, mobile clinics and local community hubs to improve access.
- Invest in peer navigators, community health workers, and school based support teams to ensure warm handoffs for services.
- Increase usage of technology and create policy innovation to simplify access for both online and telephone resource navigation.

Crisis Services: ***(#2 – Survey, #4 – Listening Sessions)***

- Expand around the clock mobile crisis response teams with behavioral health professionals to assist law enforcement.
- Increase crisis stabilization and detox shelter beds.
- Improve post crisis continuity of care to create clear handoffs to long term support services after crisis intervention.
- Invest in workforce development for crisis service professionals to meet growing demand and reduce response times.

Housing Interventions: ***(#3 – Survey, #2 – Listening Sessions)***

- Expand Permanent supportive housing with integrated services paired with onsite case management, peer support and health services.
- Develop and fund more mental health and substance use residential treatment facilities.
- Strengthen housing navigation, retention services and outreach for housing navigation, case management and pre-release planning from jails.
- Create a flexible housing subsidy pool to incentivize development of recovery oriented housing units.

Behavioral Health Workforce: ***(#4 – Survey, #3 – Listening Sessions)***

- Expand and diversify the workforce through accessible training and education pathways.
- Increase compensation, benefits, and career supports to improve recruitment and retention.
- Improve workplace culture and accountability to reduce burnout and turnover.
- Strengthening partnerships with community based organizations to grow local workforce.

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Needs of Substance Use Disorder Prevention and Treatment Services: (#5 Survey, #6 – Listening Sessions)

- Some community feedback spoke of long wait times and lack of programs in South and East County. Recommendations for the county to invest in new treatment centers and increase capacity for existing treatment centers. There were also recommendations to expand residential services focusing on youth, expanding MAT offerings, and increase immediate access to detox and crisis care.
- Coordination and improving warm handoffs between mental health and SUD services. With BHSA county can fund programs that treat co-occurring disorders and ensure equal access to both mental health and SUD services for all residents, including those with SMI and substance use issues.
- Partner with entrusted CBOs and hire locally for lasting program impact. Additional outpatient and education services with staff from target communities can help direct residents to immediate treatment, housing and build trust for recovery.
- Increase funding for prevention, early intervention, and CBOs. Some programs mentioned were trauma informed education, violence prevention and youth focused prevention. Opening up additional community health spaces with peer led staff and staff that reflect the diversity of the county.

Needs of Community Violence and Trauma: (#6 – Survey, #5 – Listening Sessions)

- Community feedback voiced the continued need to invest in community based violence and trauma response teams that are culturally competent, trauma informed, and have non law enforcement clinicians, case managers and peer support workers.
- County should seek partners with CBOs, peer groups, and culturally relevant trauma recover programs especially in neighborhoods impacted by violence. County should find creative ways to partner with grassroots organizations with lived experience and established community trust.
- Resources should prioritize Prevention and Early Intervention programs. There is a need to increase violence prevention programs and crisis intervention services for all populations, in particular the youth and TAY. Trauma reduction services are needed as well.

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Community Feedback from the Community Program Planning Process (CPPP)
Top Population Needs Analysis - Ranking in Survey, Listening Sessions

Needs of Adults (ages 25-59), Older Adults (ages 60 and over): ***(#1 - Survey, #2 – Listening Sessions)***

- Integrate behavioral health services into community and senior settings using evidence based practices to support aging care and family supports for dementia care.
- Expand wraparound services for long term treatment, caregiver resources, financial education, parenting programs to address burnout and intergenerational trauma.
- Increase culturally competent outreach and engagement strategies especially for marginalized populations to prevent and reduce isolation and suicide.
- Enhance housing and placement options for unhoused adults, older adults, and for individuals with pets or complex needs that cannot stay in traditional shelters.

Needs of Children (ages 0-5), Youth (ages 6-15), Transitional Age Youth (ages 16-25):
(#2 – Survey, #1 – Listening Sessions)

- To reduce stigma, ensure that mental health navigators are present in schools or lead training so that children, youth, and TAY populations as well as their parents are connected to resources.
- Expand prevention programs to empower young people to learn and understand mental health and know when to seek help and support peers and family members.
- Develop integrated youth friendly centers that provide wraparound services that include mental health care, housing support, education, and job readiness.
- Invest in programs starting at childbirth through early childhood and continuing the client support through early adulthood.

Needs of Disability Community: ***(#3 – Survey, #3 - Listening Sessions)***

- Create/expand accessible, affordable, integrated health and housing options for the disabled.
- Ensure Regional Center clients have support to connect with behavioral health, housing, and crisis supports.
- Invest in culturally competent and disability informed staff that are fluent in ASL and trained to support individuals with cognitive and invisible disabilities.
- Ensure disability needs are included in behavioral health planning and ensure that services reflect the diverse needs of the disability community.

Needs of Family Members: ***(#4 – Survey, #4 - Listening Sessions)***

- Increase access to family navigation services and crisis supports to ensure families can quickly connect to mental health and substance use resources.
- Create outreach campaigns using various forms of media and signage to increase awareness of behavioral health services and to help reduce stigma.
- Assist family awareness and access to housing, employment, food access and culturally inclusive behavioral health services.
- There is a need to provide early education, early intervention, peer support and advocacy tools for families to help navigate systems and care.

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Needs of the Re-Entry Community: (#5 – Survey, #6 – Listening Sessions)

- Navigation to services and housing for the Reentry population when they are getting out of jail and in their first few months out can be beneficial to prevent recidivism.
- Additional funding for collaborative courts and treatment beds was voiced several times.
- Increased wrap-around services for those being released from prison. Increased funding for prevention strategies.
- Workforce placement programs to help reentry population find employment after being released.

Needs of Veterans: (#6 – Survey, #5 – Listening Sessions)

- Suicide prevention programs and education are strategies that were voiced by community.
- High suicide rates could be the result of mental health stigma, social isolation.
- Housing outreach and navigation services for unhoused veterans.
- Additional veteran facilities, including a hospital, can help veterans get access to services especially in a crisis.

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Population Needs community feedback word cloud

System Needs community feedback word cloud

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30-DAY PUBLIC COMMENT NOTICE

for the Alameda County Behavioral Health Services Act (BHSA) Integrated Plan FY26-29

30-Day Public Comment: March 19, 2026 – April 20, 2026

Community Feedback Session

Meeting Date: April 8, 2026 • **Time:** 6:00PM PST

Click Here to Join the Zoom Meeting

Phone: +1408-961-3927 • Meeting ID: 627 868 1319 • Passcode: 040361

Please visit the ACMHSA website to view the plan: **ACMHSA.org**

Scan or click here
to leave Public Comment

Behavioral Health Department
Alameda County Health

HHREC
HEALTH & HUMAN RESOURCE EDUCATION CENTER

For more Information, contact: **BHSA@ACGOV.ORG**

Thank you!

Behavioral Health Department
Alameda County Health

Many people are not aware of the behavioral health resources available in Alameda County.

If you or someone you know needs support, we encourage you to visit our website at **www.acbhcs.org** or call **1 (800) 491-9099** to learn more about services and how to access care.

For BHSA policy items, please contact BHSA@acgov.org.

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