IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

IMPERIAL COUNTY BEHAVIORAL HEALTH SERVICES ACT INTEGRATED PLAN DRAFT

March 19, 2026

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Introduction

The Behavioral Health Services Act (BHSA) (Senate Bill (SB) 326, Chapter 90, Statutes of 2023) requires all county Behavioral Health Departments to submit a three-year Integrated Plan for Behavioral Health Services and Outcomes outlining intended use of funds and a budget for behavioral health programs administered, beginning with Fiscal Years (FY) 2026-2029 (July 1, 2026 – June 30, 2029). The Department of Health Care Services (DHCS) is developing a portal where counties will enter their Integrated Plans and updates (herein referred to as the "county portal").

This document is the template for the Three-Year Integrated Plan. The final release of the Integrated Plan will be available on the county portal and questions will be formatted to collect information in a streamlined manner. The county portal will include web form elements such as dropdown menus and text fields. **Throughout this template, bracketed text represents planned user interface elements for the county portal.** Additional information on standards for completing and submitting the Integrated Plan is provided in the Behavioral Health Services Act County Policy Manual (herein referred to as the "Policy Manual") Chapter 3.

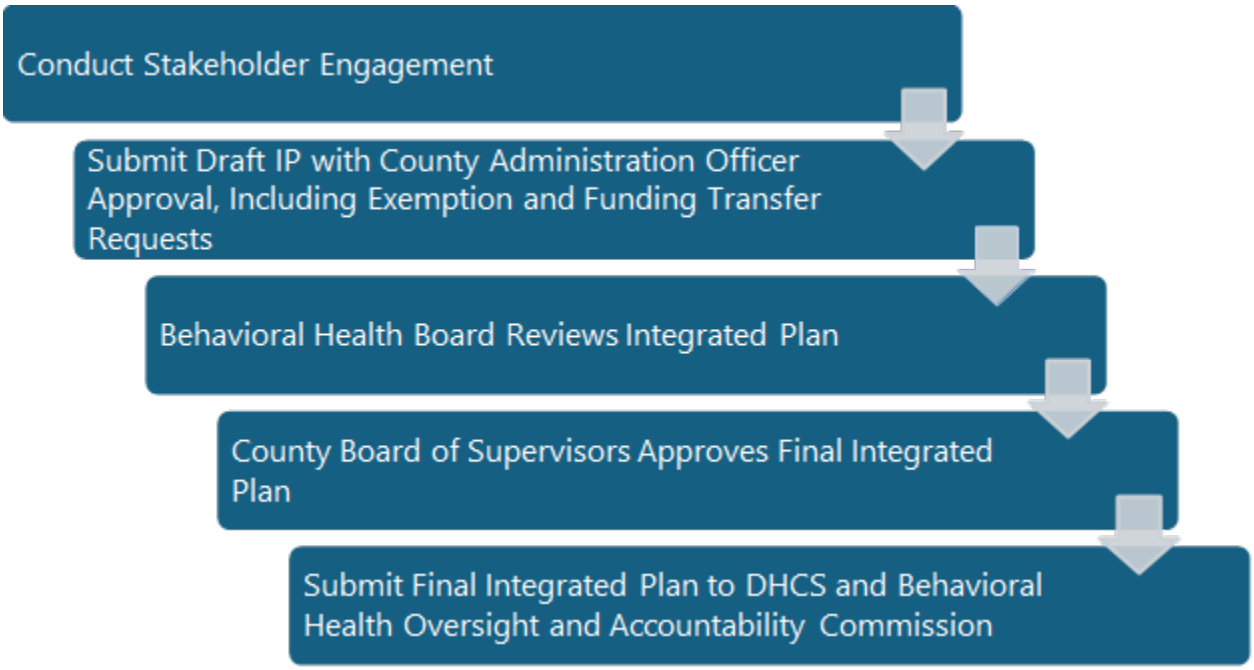

Figure 1. Integrated Plan Submission Workflow

*Recommended sequence. See details on the exemption submission process in the Integrated Plan Submission section (Policy Manual Chapter 3, Section E.4).

2026 - 2029 Integrated Plan

Imperial County

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan .

General Information

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

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
Imperial County

Behavioral Health Agency Name
Imperial County Behavioral Health Services

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Behavioral Health Services Act (BHSA) Coordinator

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Jose Lepe	Joselepe@co.imperial.ca.us

Quality Assurance or Quality Improvement (QA/QI) lead

Name	**Email address**
Sarah Moore	Sarahmoore@co.imperial.ca.us

Medical Director

Name	**Email address**
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County Behavioral Health System Overview

Please provide the city/county behavioral health system (inclusive of mental health and substance use disorder) information listed throughout this section. The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins (i.e., for 2026-2029 IP, data from FY 2023-2024 should be used).

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

Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook. For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan.

Children and Youth

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.

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	4254

Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	20
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	326
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	162
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	90
Were chronically homeless or experiencing homelessness or at risk of homelessness	11
Were in the juvenile justice system	133
Have reentered the community from a youth correctional facility	73
Were served by the Mental Health Plan and had an open child welfare case	192
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	30

Have received acute psychiatric care	83

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.

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	430
Received Medi-Cal SMHS	5347
Received DMC or DMC-ODS services	832
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	512
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	379
Experienced unsheltered homelessness	309
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	138
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	80

Were in the justice system (on parole or probation and not currently incarcerated)	143
Were incarcerated (including state prison and jail)	474
Reentered the community from state prison or county jail	132
Received acute psychiatric services	675

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

   a) **Admitted or detained for 72-hour evaluation and treatment rate**
   441
   b) **Admitted for 14-day and 30-day periods of intensive treatment**
   0
   c) **Admitted for 180-day post certification intensive treatment**
   0

3. **Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs**
   89

4. **Please report the 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

5a) Please describe the local data used during the planning process

Imperial County Behavioral Health Services (ICBHS) utilized different sources of data to inform the planning and development of the BHSA Integrated Plan. Primary data sources included SmartCare Electronic Health Record (EHR) reports, which provided client-level and program-level data on service utilization, diagnoses, demographics, access to care, service outcomes, and trends over time. These reports helped to determine service demand, identify gaps in care, and evaluate program performance across the behavioral health continuum.

In addition, ICBHS relied on internal program logs and tracking systems maintained by county-operated providers. These logs captured information related to referrals, wait times, service capacity, and engagement levels, particularly for priority populations such as children and youth, adults with serious mental illness, individuals with substance use disorders, and justice-involved individuals.

As part of the planning process, ICBHS also drew from state provided resources, including but not limited to the County Population Behavioral Health Workbook. In some instances, ICBHS sought more additional proxy population health data alongside those identified in the workbook. Additional data was drawn from the Imperial County Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP), which were reviewed better understand local population-level data on health outcomes, behavioral health needs, social determinants of health, and disparities affecting priority populations. ICBHS also drew from local housing and homelessness data, including Point-in-Time (PIT) count data and Continuum of Care (CoC) reports, were used to understand trends related to homelessness, housing instability, and housing needs among individuals with behavioral health conditions. As further described in the community planning process, ICBHS also gathered qualitative data from surveys, focus groups and interviews to inform and discuss data findings.

6. If desired, provide documentation on the local data used during the planning process (Optional)
N/A

County Behavioral Health Technical Infrastructure

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

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

2. Please select which of the following EHRs the county uses
SmartCare

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

4. Please select which QHIO the county participates in
Connex

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with

Behavioral Health Information Notice (BHIN) 22-068 and federal law.

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

Provider Directory: https://fhir-calmhsa-provider.ehn-prod.net/fhir/swagger-ui/
Patient Access: https://ihe-calmhsa.ehn-prod.net/SpiritHSB/REST/forward_qedm/r4/

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?**

Yes

3a) Please describe these challenges and concerns

Imperial County Behavioral Health Services (ICBHS) is supportive of the intent and goals of the admission, discharge, and transfer (ADT) data sharing requirements outlined in BHINs 23-056, 23-057, and 24-016 and recognizes the importance of timely data exchange to support care coordination and continuity of care; however, the County would like to note several implementation challenges, including interoperability limitations and variability in technical readiness among external partners, resource and capacity constraints due to the simultaneous implementation of multiple major initiatives (e.g., CalAIM, BHSA, EHR modernization, CARE Act, interoperability mandates), ongoing data quality and standardization issues that require validation and workflow redesign, and the need to carefully balance data sharing with federal and state confidentiality requirements such as HIPAA and 42 CFR Part 2. Additionally, county compliance is inherently dependent on the participation and performance of external entities such as hospitals, managed care plans, HIEs, and vendors, which can impact implementation timelines and completeness of data exchange, and the County encourages DHCS to continue to promote and require robust participation by Managed Care Plans in the exchange of ADT information to ensure bidirectional visibility and effective care coordination across systems. ICBHS remains committed to continued progress toward full compliance and appreciates DHCS's ongoing efforts to advance statewide interoperability, noting that clear technical standards, implementation guidance, technical assistance, and sustainable funding support will be critical to successful and sustainable implementation.

County Behavioral Health System Service Delivery Landscape

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

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

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

Yes

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

a) Alcohol or Drug Treatment Services
b) Case Management Services
Community Mental Health Services Habilitation and Rehabilitation Services
c) Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services
Screening and Diagnostic Treatment Services
d) Outreach services
e) 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

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

1a) Please select all set asides that the county behavioral health system plans to participate in under the MHBG

Children's System of Care Set-Aside
Dual Diagnosis Set-Aside
First Episode Psychosis Set-Aside

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

No

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

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

Yes

1a) Please select all set-asides that the county behavioral health system participates in under SUBG

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

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

No

Opioid Settlement Funds (OSF)

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

Yes

1a) Please check all set asides the county behavioral health system participates in under OSF Exhibit E

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

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

No

Bronzan-McCorquodale Act

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

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

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

Community Health Worker Services (CHW)

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

No

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)

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

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

No

Medi-Cal Specialty Mental Health Services (SMHS)

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

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

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?**

    a) ACT
    b) Clubhouse Services
    c) CSC for FEP
    d) Enhanced CHW Services

e) FACT
f) IPS Supported Employment
g) Peer Support Services

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

No

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

1. Select which of the following services the county behavioral health system participates in DMC-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 Employement

Peer Support Services
Recovery Incentives Program (Contingency Management)

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs

Program or service
Mobile Triage Response Team (MTRT) SAMHSA
Brawley Vista Sands
El Centro Vista Sands
Calexico Vista Sands
Department of Health Care Access and Information
Alcohol and Drug Primary Prevention
SUBG Adolescent and Youth Treatment Set-Aside
Projects for Assistance in Transition from Homelessness

Care Transitions

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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

Statewide Behavioral Health Goals

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

Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C.

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories.
For related policy information, refer to E.6.1 Population-level Behavioral Health Measures.

Priority statewide behavioral health goals for improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County. For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Access to care: Primary measures

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

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

a. **For adults/older adults**
Above
b. **For children/youth**
Above

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

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**
Above

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

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?**
None Identified

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
Below
b. For children/youth
Above

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?
Below

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

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

Imperial County shows strong access to specialty mental health services (SMHS) compared to the state overall, but gaps remain in lower-level mental health care and substance use treatment. Adult SMHS penetration is high (5.9%), meaning more Medi-Cal adults receive specialty mental health care than the state average, but seniors 65+ utilize services at lower rates than younger adults. Youth SMHS access is also strong (8.1%) with no major disparities across groups. In contrast, non-specialty mental health services (NSMHS) for adults are underused (8.2% vs. higher state rates), again with lower access among older adults, suggesting a service gap for mild-to-moderate conditions. Youth NSMHS access is slightly above the state average and fairly even across groups.

For substance use disorder (SUD) care, adult DMC-ODS treatment penetration is slightly below the state average (1.3%), with notably low engagement among Native American adults, while youth SUD access is comparatively higher than statewide, though overall numbers are small. A key concern is treatment initiation: only 34.4% of adults who need SUD treatment begin it promptly, below the state average. Lower initiation rates

are especially seen among young adults (21–25), adults (46–55), and Native American beneficiaries.

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

ICBHS will ensure the transition of care tool is used as intended and refer clients to the Managed Care Plan when appropriate for non-specialty mental health services. Staff will be re-trained on proper use of the transition of care tool, along with cultural competence training focused on Native American communities and traditional healing practices. ICBHS will hold quarterly meetings with the Managed Care Plan to monitor improvements and re-establish regular collaboration to strengthen care coordination through culturally appropriate engagement strategies. The department will also conduct outreach within the Native American community by participating in local cultural events and will work to strengthen relationships by identifying tribal leaders as key partners.

Overall, Imperial performs well in specialty mental health access, especially for youth. ICHBS will focus efforts in engaging the older adult population (65+) as they utilize SMHS at a lower rate than younger adults. DMC-ODS programs will implement Assertive Field-Based SUD services to improve access to care and engagement in treatment particularly for the adult and older adult and Native American populations.

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

a) BHSA Housing Interventions
b) 1991 Realignment
c) 2011 Realignment
d) Substance Abuse and Mental Health Services Administration(SAMHSA) Projects for Assistance in Transition from Homelessness(PATH)
e) BHSA Behavioral Health Services and Supports (BHSS) BHSA Full Services Partnership (FSP)
f) State General Fund
g) Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
h) Community Mental Health Block Grant (MHBG)

Substance Use Block Grant (SUBG)

i) Other

Please describe other

ICBHS will utilize the awarded Behavioral Health Continuum Infrastructure Program (BHCIP) funding by expanding its behavioral health infrastructure to increase access to care across Imperial County, particularly in unserved and underserved communities. Other funding sources such as the Opioid Settlement Funds, Youth Opioid Response grant, Prop 36, AB 109, Cooperative Agreement for Innovative Community Crisis Response Partnerships (CCRP) grant, Behavioral Health Bridge Housing (BHBH), Cal-MED Force – Physician for a Healthy California, and Health Care Access and Information Workforce grants will be utilized for improved access to care.

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

Race or Ethnicity

Sex

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?**

None Identified

Homelessness: Supplemental Measures

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

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

Below

2. What disparities did you identify across demographic groups or special populations?
None Identified

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

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

2. What disparities did you identify across demographic groups or special populations?
None Identified

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?
Above

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

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

Imperial County experiences a higher overall rate of homelessness than the state average, with 84.2 people per 10,000 experiencing homelessness, driven largely by middle-aged adults (ages 35–64). Men are disproportionately affected, and Hispanic/Latino residents are overrepresented in the homeless population compared to their share of the general population. In contrast, student homelessness in K–12 is slightly lower than the state average (5.0%), with marginally higher rates among high school students, often reflecting unaccompanied youth, and no major racial disparities beyond overall enrollment patterns.

Imperial County performs better than the state in terms of homelessness among people with serious mental

illness (SMI) and substance use disorders (SUD), with rates far below statewide levels, though these populations are small and primarily consist of middle-aged adults. Importantly, access to homelessness services is relatively strong, with service utilization exceeding the state average, indicating that many unhoused residents engage with Continuum of Care programs; however, older adults are less likely to access services, highlighting an ongoing gap despite otherwise robust service reach.

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)

The HUD PIT reflects and above average rate of homelessness with a disproportionate number of middle-aged adults 35-64 and Hispanic Latinos individuals being overrepresented. Data also demonstrates that homelessness affect men more than women, reflecting statewide trends. ICBHS will expand housing availability across Imperial County by implementing interim housing options, increasing the number of beds within recovery residences, and partnering with housing developers to broaden the range of housing opportunities. Through these efforts, ICBHS will provide a full continuum of housing-related services designed to meet clients' diverse needs in a culturally responsive and client-centered manner. In addition, ICBHS will strengthen cross-system collaboration with local, regional, community partners, and MCPs to maximize existing housing resources and strategically leverage additional funding sources, ensuring sustainable and coordinated housing solutions for individuals and families served.

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

BHSA Housing Interventions
1991 Realignment
SAMHSA PATH
Other
SUBG

Please describe other

Behavioral Health Bridge Housing

Institutionalization

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

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

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

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

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

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

a. 14-day involuntary detention rates per 10,000

Not Applicable

b. 30-day involuntary detention rates per 10,000

Not Applicable

c. 180-day post-certification involuntary detention rates per 10,000
Not Applicable

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

Conservatorships, FY 2021 - 2022

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

a. Temporary Conservatorships
Above

b. Permanent Conservatorships
Not Applicable

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

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023
[Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities]

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

a. Crisis Intervention

i. For adults/older adults
Above
ii. For children/youth
Above

b. Crisis Residential Treatment Services

i.For adults/older adults
Above

ii. For children/youth
Not Applicable

c. Crisis Stabilization

i.For adults/older adults
Below
ii. For children/youth
Not Applicable

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

No Disparities Data Available

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

No disparities identified.

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)

ICBHS maintains internal departmental data on involuntary detention admissions, temporary and permanent conservatorships established under the LPS Act, mobile crisis interventions, psychiatric hospitalizations, the adult crisis residential facility placements, CARE Act petitions, ASAM Levels 3.7 and 4.0, and step-down services for individuals discharged from higher levels of care.

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)

ICBHS will continue to strengthen preventive interventions across all services and age groups to ensure individuals receive care in the least restrictive environment, thereby reducing the need for institutionalization. This includes the ongoing provision of mobile crisis services, the implementation of Assertive Field-Based Community Services for SUD, and the adoption of required EBPs. ICBHS will also expand access to supportive services such as EI, Peer Support Services, and Housing, while enhancing Casa Serena (Behavioral Health Urgent Care Services) to ensure timely, low-barrier access to care. In parallel, ICBHS will reinforce strong partnerships with local hospitals, courts, schools, correctional facilities, primary care providers, MCPs, Public Health, and the Department of Social Services to collaboratively address the social determinants of health (SDOH) and improve overall outcomes.

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

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

Please describe other

ICBHS will utilize the awarded Behavioral Health Continuum Infrastructure Program (BHCIP) funding by expanding its behavioral health infrastructure to increase access to care across Imperial County, particularly in unserved and underserved communities. Other funding sources such as the Opioid Settlement Funds, Youth Opioid Response grant, Prop 36, AB 109, Cooperative Agreement for Innovative Community Crisis Response Partnerships (CCRP) grant, Behavioral Health Bridge Housing (BHBH), Cal-MED Force – Physician for a Healthy California, and Health Care Access and Information Workforce grants will be utilized for improved access to care.

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?**

i.For adults/older adults
Below
ii. For juveniles
Below

2. **What disparities did you identify across demographic groups or special populations?**
Gender
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?**
None Identified

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

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

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

2. **What disparities did you identify across demographic groups or special populations?**
Age
Gender
Sex

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

Imperial County shows lower overall justice involvement than the state average, with both adult and juvenile arrest rates well below California levels (about 2,059 per 100,000 adults and 131 per 100,000 youth). However, men are disproportionately impacted, making up the vast majority of arrests across age groups, reflecting a strong gender disparity. Racial patterns in arrests generally mirror the county's population, with most individuals arrested being Hispanic/Latino, and no major racial disproportionality noted. The county's recidivism rate is slightly better than the state average (37.5% vs. 39.6%), though detailed local demographic breakdowns are not available; statewide trends suggest higher recidivism among younger men. One area of concern is the Incompetent to Stand Trial (IST) commitment rate, which is slightly above the state average, indicating more individuals primarily adult men with serious mental illness are entering the forensic mental health system through the courts. Overall, Imperial performs comparatively well on arrests and reoffending but faces challenges at the intersection of the justice and behavioral health systems.

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)

ICBHS maintains strong collaboration with the local justice system, including the county jail, courts, law enforcement, public defenders, and the district attorney's office, and will continue these partnerships to further strengthen care coordination and improve access to services. The department will also provide community training on the importance of early identification and recognition of symptoms related to psychotic disorders and active psychosis. In addition, ICBHS will continue delivering services under the CARE Act, Prop 36, CalAIM Justice-Involved Reentry Initiative, to support individuals with significant behavioral health needs.

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

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

Please describe other

ICBHS will utilize the awarded Behavioral Health Continuum Infrastructure Program (BHCIP) funding by expanding its behavioral health infrastructure to increase access to care across Imperial County, particularly in unserved and underserved communities. Other funding sources such as the Opioid Settlement Funds, Youth Opioid Response grant, Prop 36, AB 109, Cooperative Agreement for Innovative Community Crisis Response Partnerships (CCRP) grant, Behavioral Health Bridge Housing (BHBH), Cal-MED Force – Physician for a Healthy California, and Health Care Access and Information Workforce grants will be utilized for improved access to care.

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?
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?
None Identified

Child Maltreatment Substantiations (CWIP), 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?
None Identified

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

The UC Berkley CWIP data demonstrates that slightly more boys than girls are in foster care in Imperial County consistent with national trends. Although foster youth are overwhelmingly Hispanic, no disproportionate racial disparities are identifies as this is reflective of Imperial County's population.

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)

ICBHS will enhance collaboration with the Department of Social Services, Probation, MCPs, Public Health Department, primary healthcare providers, and local community organizations to strengthen cross-system partnerships that support children and families. The department will strengthen its EI programs and implement Housing interventions, High-Fidelity Wraparound, and other EBPs within its children and youth behavioral health programs to provide intensive, coordinated, and family-centered services. ICBHS will continue to screen all children involved in the child welfare system to identify behavioral health needs early. These efforts will be supported through ongoing cross-system coordination and collaboration in alignment with AB 2083 to

ensure integrated comprehensive care.

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

BHSA BHSS
BHSA FSP
2011 RealignmentState General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
BHSA Housing Interventions
1991 Realignment
MHBG
SUBG
Other

Please describe other

Youth Opioid Response grant, Opioid Settlement Funds

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?

a) For the full population measured

Above

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

Age
Race or Ethnicity

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

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

a) For the full population measured

Below

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

None Identified

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?

a) For the full population measured
Below

2. What disparities did you identify across demographic groups or special populations?
None Identified

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

Imperial County shows mixed but generally favorable patterns in addressing untreated behavioral health (BH) needs. Follow-up after emergency department visits for substance use disorder (SUD) is stronger than the state average (41.4%), indicating effective linkage to care, though young adults (ages 21–25) and Black/African American patients have notably lower follow-up rates, pointing to engagement gaps. In contrast, mental health follow-up after emergency visits is slightly below the state average (34.6% vs. ~38%), with no clear disparities identified, suggesting system-wide room for improvement rather than subgroup-specific issues. Encouragingly, self-reported data show fewer adults in Imperial report not receiving behavioral health care when needed (33.7%) compared to the state overall, implying relatively strong safety-net access and fewer barriers across demographic groups. Overall, the county performs well in SUD care transitions and perceived access but needs to strengthen mental health follow-up and targeted outreach to young adults and Black/African American residents.

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 informnew 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)

ICBHS is establishing a Performance Improvement Project (PIP) protocol in partnership with local emergency departments to ensure referrals are made effectively and clients are successfully linked to timely follow-up services, including the exchange of timely data to support continuity of care. The department will work with local hospitals to explore contracting for dedicated staff to facilitate referrals and ensure immediate follow-up for individuals in need of behavioral health services. Additionally, ICBHS will develop formal agreements with hospitals to identify individuals requiring 30-day mental health follow-up and to establish clear processes for information sharing to strengthen care coordination. ICBHS will implement targeted outreach services to engage the young adult and Black/African American populations.

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

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

Please describe other

ICBHS will utilize the awarded Behavioral Health Continuum Infrastructure Program (BHCIP) funding by expanding its behavioral health infrastructure to increase access to care across Imperial County, particularly in unserved and underserved communities. Other funding sources such as the Opioid Settlement Funds, Youth Opioid Response grant, Prop 36, AB 109, Cooperative Agreement for Innovative Community Crisis Response Partnerships (CCRP) grant, Behavioral Health Bridge Housing (BHBH), Cal-MED Force – Physician for a Healthy California, and Health Care Access and Information Workforce grants will be utilized for improved access to care.

Additional statewide behavioral health goals for improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals. In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.
For related policy information, refer to E.6.2 Primary and Supplemental Measures .

Care Experience: Primary Measures

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

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

a) For adults/older adults
Above

b) For children/youth
Below

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

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

a) For adults/older adults
Above

b) For children/youth
Below

Engagement In School: Primary Measures

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

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

Engagement In School: Supplemental Measures

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

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

Student Chronic Absenteeism Rate (Data Quest), 2022

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

Engagement In Work: Primary Measures

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

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

Engagement In Work: Supplemental Measures

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

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

Overdoses: Primary Measures

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

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

a) For the full population measured
Below

b) For adults/older adults
Not Applicable

c) For children/youth
Not Applicable

Overdoses: Supplemental Measures

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

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

a) For the full population measured
Below

b) For adults/older adults
Not Applicable

c) For children/youth
Not Applicable

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

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

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

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

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

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

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

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

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

Above

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

Above

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

a. **For the full population measured**

Not Applicable

b. **For adults/older adults**

Below

c. **For children/youth**

Above

Quality Of Life: Supplemental Measures

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

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

a. **For the full population measured**

Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

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

a. For the full population measured
Above

b. For adults/older adults
Above

c. 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?
Below

Suicides: Primary Measures

Suicide Deaths, 2022

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

a. For the full population measured
Not Applicable

Suicides: Supplemental Measures

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

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

a. For the full population measured
Above

b. For adults/older adults
Below

c. For children/youth
Above

County-selected statewide population behavioral health goals

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

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

Care experience

1. Please describe why this goal was selected

ICBHS selected Care Experience CPS Satisfaction (Youth) Mean Score as an additional Goal under the Additional Statewide Behavioral Health Goals to prioritize youth and their families' voice, enhance service quality, and promote equitable care experience within the behavioral health system.

Youth ages 13–17 represent a critical population within the Imperial County's behavioral health continuum. Early positive engagement and positive service experiences during adolescence are strongly associated with improved treatment adherence, improved clinical outcomes, and long-term wellness. By prioritizing youth and families of youth satisfaction metrics, Imperial County reaffirms its commitment to delivering accessible, culturally responsive, and youth-centered behavioral health services that support early intervention and sustained recovery leading to overall improved outcomes.

2. What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis

Based on the CPS Youth Satisfaction data for Imperial County, families of youth report lower satisfaction than other Imperial County groups, suggesting caregivers feel less culturally respected or informed, indicating a local disparity in engagement with families. ICBHS recognizes the importance of caregiver satisfaction to

ensure youth engagement in services. By improving the care experience of the youth and their families, ICBHS aims to improve timely access to care and prevent acute behavioral health conditions, unnecessary ED visits, institutionalization, justice-involvement, and removal of children from home.
Additionally, improved satisfaction will improve engagement and adherence to treatment, leading to improved outcomes.

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

ICBHS will enhance its service delivery system to remove barriers to access and better support youth and families through culturally responsive strategies and early intervention evidence-based practices. These efforts will strengthen school-based services, promote meaningful family engagement, and expand youth-friendly, stigma-free spaces that encourage timely access to care.

ICBHS is implementing system-level and work-flow changes within its service delivery model to ensure seamless transitions from urgent and crisis services to outpatient care. This coordinated approach promotes continuity of services, reduces gaps in care, and eliminates barriers to access, resulting in more responsive and integrated behavioral health services.

ICBHS will provide training to staff that focuses on trauma-informed, culturally responsive, and developmentally appropriate equitable services to enhance youth and their families' care experience.

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

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

4a. Please describe other

ICBHS will utilize the awarded Behavioral Health Continuum Infrastructure Program (BHCIP) funding by expanding its behavioral health infrastructure to increase access to care across Imperial County, particularly in unserved and underserved communities. Other funding sources such as the Opioid Settlement Funds, Youth Opioid Response grant, Prop 36, AB 109, Cooperative Agreement for Innovative Community Crisis Response Partnerships (CCRP) grant, Behavioral Health Bridge Housing (BHBH), Cal-MED Force Physician for a Healthy California, and Health Care Access and Information Workforce grants will be utilized for improved access to care.

Community Planning Process

All fields must be completed unless marked as optional. You don't need to finish everything at once– your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.B Community Planning Process.

Stakeholder Engagement

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

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

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

Type of engagement
Key informant interviews with subject matter experts

Date
10/24/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/13/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/13/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/14/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/13/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/9/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/2/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/6/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/30/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/28/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/9/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/21/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/13/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/17/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/13/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/27/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/20/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/25/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/8/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/9/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/20/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/17/2025

Type of engagement
Key informant interviews with subject matter experts

Date
10/29/2025

Type of engagement
Key informant interviews with subject matter experts

Date
9/19/2025

Type of engagement
Focus group discussions

Date
10/15/2025

Type of engagement
Focus group discussions

Date
10/15/2025

Type of engagement
Focus group discussions

Date
10/14/2025

Type of engagement
Focus group discussions

Date
10/14/2025
Type of engagement
Focus group discussions

Date
10/15/2025

Type of engagement
Focus group discussions

Date
10/13/2025

Type of engagement
Focus group discussions

Date
10/13/2025

Type of engagement
Focus group discussions

Date
10/13/2025

Type of engagement
Focus group discussions

Date
10/15/2025

Type of engagement
Focus group discussions

Date
10/15/2025

Type of engagement
Workgroups and committee meetings
Date
10/20/2025

Type of engagement
Workgroups and committee meetings

Date
11/17/2025

Type of engagement
Workgroups and committee meetings

Date
2/9/2026

Type of engagement
Workgroups and committee meetings

Date
7/31/2025

Type of engagement
Workgroups and committee meetings

Date
8/26/2025

Type of engagement
Workgroups and committee meetings

Date
10/15/2025

Type of engagement

Workgroups and committee meetings

Date
11/4/2025
Type of engagement
Meeting(s) with county

Date
10/14/2025

Type of engagement
Meeting(s) with county

Date
10/27/2025

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

Catholic Charities
Center for Family Solutions /Womenhaven
Donnelly Center (LGBTQ+ Center)
El Centro Regional Medical Center
Foundations in Recovery
HealthNet
Imperial County Department of Social Services
Imperial County Office ofEducation
Imperial County Sheriff's Office
Imperial County Community College
Imperial Valley Medical Clinic
(OTP)Imperial Valley Regional
Occupational Program InnerCare
Jackson House Crisis Residential
Kaiser Permanente
NAMI
Open Door Ministry
Imperial County Public Health
Pioneers Memorial Hospital
Imperial County Probation Department
Reps4Vets
RiteTrack
Sure Helpline

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

3a. If not, which required stakeholder/groups were you unable to engage in the planning process?
Disability insurers
Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes

a. Disability insurers
Attempted but did not receive a response

b. Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
Attempted but did not receive a response

4. 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

Please see attachments.

ICBH_Focus Groups_Thematic Ar
CPP Report Final 1.30.26.pdf
ICBH_KIIs_Thematic Analysis.10.29.25.pd

Local Health Jurisdiction (LHJ)

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

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

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

   Through active participation in workgroup discussions, ICBHS has ensured that behavioral health priorities including mental health and substance use are fully integrated into broader county health planning efforts. The Behavioral Health Workgroup has provided strategic direction on prevention, early intervention, treatment access, and system coordination, consistent with BHSA's emphasis on equitable access, accountability, and improved outcomes.

   The inclusion of mental health and substance use as a CHIP priority area developed jointly with county partners directly supports BHSA goals of expanding access to care, improving coordination across systems, and addressing disparities in behavioral health outcomes.

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

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

2. **Was data shared?**
   Yes

Data-Sharing from MCPS and LHJs to Support IP development

1. **Select Statewide Behavioral Health Goals that were identified for data sharing to inform IP development**
   Access to Care
   Homelessness
   Untreated Behavioral Health (BH) Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)

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

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

Imperial County considered the Local Health Jurisdiction's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) 2024–2027 in the development of its Behavioral Health Services Act (BHSA) Integrated Plan by aligning priorities, data indicators, and strategies identified in the CHIP with behavioral health planning efforts. Key CHIP focus areas such as improving access to care, addressing substance use, reducing health disparities, supporting youth and families, and strengthening cross-sector collaboration were used to inform BHSA IP goals, target populations, and proposed interventions. Data from the CHA, including behavioral health trends, social determinants of health, and community-identified needs, helped guide resource allocation and coordination between behavioral health, public health, and community partners. This alignment ensures the BHSA IP supports shared countywide objectives, promotes prevention and early intervention, and advances health equity for Imperial County residents.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

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

   ICBHS collaborated with Community Health Plan of Imperial Valley (CHPIV) and its subcontractor Health Net and Kaiser Permanente, Imperial County's Medi-Cal MCPs, as part of the community reinvestment and decision-making process. ICBHS has maintained ongoing communication and coordination with MCP
   partners to ensure alignment between Community Reinvestment planning, CalAIM initiatives, and identified local behavioral health priorities.

   Pursuant to DHCS All Plan Letter (APL) 25-004, MCPs that are in their first year of operation in a county during Calendar Year (CY) 2024 are not required to initiate Community Reinvestment activities until the following year. CHPIV began operations in Imperial County in CY 2024 and, therefore, is not subject to Community Reinvestment requirements until CY 2027.

   CHPIV is utilizing this initial operational period to conduct stakeholder engagement, assess community needs, and review relevant financial and quality performance data. This planning effort is intended to support the development of a comprehensive Community Reinvestment Plan that aligns with DHCS priorities, CalAIM objectives, and locally identified service gaps. Implementation of Community Reinvestment activities is anticipated to begin in CY 2027, informed by CY 2025 financial performance and quality outcomes.

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?**

Although the MCPs do not yet have a formal Community Reinvestment Plan submission, they have expressed their commitment to ongoing collaboration with ICBHS and other stakeholders. As part of this collaboration, ICBHS attended two in-person planning meetings with CHPIV/Health Net in December 2025 and January 2026.

During CY 2026, the MCPs remain open to exploring funding opportunities that advance priorities identified through the Local Health Jurisdiction's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP), consistent with its Population Health Management (PHM) Strategy commitments and obligations in Imperial County.

Through continued collaboration between ICBHS, MCPs, and community stakeholders, future Community Reinvestment activities will be informed by needs identified in the BHSA community planning process, including behavioral health access, untreated behavioral health conditions, homelessness, overdoses, and suicides. ICBHS will continue to engage MCP partners to ensure alignment between Community Reinvestment planning and the County's Integrated Plan priorities.

Comment Period and Public Hearing

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

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1. **Date the draft Integrated Plan (IP) was released for stakeholder comment**
   03/19/2026

2. **Date the stakeholder comment period closed**
   04/18/2026

3. **Date of behavioral health board public hearing on draft IP**
   03/18/2026

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

Link:

5. **Please provide the link to the public posting**

https://bhs.imperialcounty.org/

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

N/A

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

- Public Posting
- Email Outreach

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

Stakeholder group that provided feedback	Summarize the substantive revisions recommended this stakeholder during the comment period
Forthcoming	**Forthcoming**

9. **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.**

Forthcoming

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.

County Provider Monitoring and Oversight

All fields must be completed unless marked as optional. You don't need to finish everything at once– your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 6.C.2 Securing Medi-Cal Payment.

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

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**

   FY 25-26 QIWP.pdf

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

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

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	3
Substance Use Disorder (SUD) services only	3
Both MH and SUD services	1

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

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	2
DMC/DMC-ODS only	3
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

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

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?**
   0

a. 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

ICBHS will conduct targeted outreach with BHSA providers to support Medi-Cal MCP contracting for the delivery of NSMHS. ICBHS will collaborate with MCPs operating in the county to support provider engagement and address administrative and contracting barriers.

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

2a. 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:

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

Behavioral Health Services Act/Fund Programs

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

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

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

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

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**

ICBHS will allocate BHSS funds to reduce barriers to care and expand timely access to SMHS and SUD treatment services, particularly for unserved, underserved, and historically marginalized populations. Consistent with BHSA priorities, services will be delivered through strengthened collaboration with community-based organizations, healthcare providers, and other system partners to promote a coordinated and integrated continuum of care. These partnerships will advance equitable access, address disparities in service utilization and outcomes. Through these efforts, ICBHS aims to improve early identification, linkage to care, service retention, and overall health and wellness outcomes across the county. Additionally, ICBHS will provide consumer support for children and youth receiving behavioral health outpatient services. These funds are intended to address recovery-oriented and functional needs that are not otherwise covered by Medi-Cal or other funding sources.

Consumers' support services may include individualized goods and services that directly support a client's behavioral health recovery, emotional stability, and community functioning. The purpose of these supports is to reduce functional barriers to treatment engagement, promote resilience and pro-social skill

development, strengthen community integration, and support overall mental health and substance use recovery. By addressing social and environmental factors that impact behavioral health outcomes, these BHSS-funded consumer support services enhance the effectiveness of outpatient clinical services and reinforce Imperial County's Children's System of Care framework.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2300
FY 2027 – 2028	2400
FY 2028 – 2029	2500

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

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

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

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

1. **Please select the service types provided under Program**

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

2. **Please describe the specific services provided**

Imperial County's BHSS Non-FSP programs provide comprehensive, person-centered services to adults and older adults with serious mental illness and/or substance use disorders. Core services include wellness and recovery services: Evidence-based practices to support mental health recovery and overall wellness through

individual and group interventions. Peer Support Services: Peer-led support promoting recovery, skill-building, and social connection. Education support: Assistance with higher education enrollment, access to technology (e.g., laptops), and academic guidance. Employment and vocational services: Job readiness training, vocational assessments, life skills development, and provision of tools or resources for employment or vocational programs. Resource navigation: Guidance to access community resources, benefits, and supportive services. Housing linkage: Assistance connecting participants to housing resources and supports to promote housing stability. Consumer support funds will assist with purchases needed for education or (laptop) employment tools (barber tools) for successful completion and employment. These services are designed to provide integrated support that helps individuals achieve personal recovery goals, improve independent living skills, and enhance community participation.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1500
FY 2027 – 2028	1750
FY 2028 – 2029	2000

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**

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

Early Intervention (EI) Programs #1

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

1. **Program or service name**

   Casa Serena

2. **Please select which of the three EI components are included as part of the**

program or service

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

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**

Yes

4. **Please select the EBPs and CDEPs that apply**

CBT for PTSD
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Psychosis
Drug counseling (individual and group)
Mobile Crisis, including use of tools such as the Columbia Suicide Severity Rating Scale or the Stanley-Brown Safety Plan
Motivational Enhancement Therapy (MET) / Motivational Interviewing
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

5. **Please provide the name of the EBPs and CDEPs that apply**

EBPs and CDEPs
Cognitive Behavioral Therapy (CBT) for Anxiety
CBT for PTSD
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Psychosis
Drug Counseling (individual and group)

Mobile Crisis, Including use of tools such as the Columbia Suicide Severity Rating Scale or the Stanley-Brown Safety Plan
Motivational Enhancement Therapy (MET)/Motivational Interviewing
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

6. Please describe intended outcomes of the program or service

Casa Serena is ICBHS' urgent care center where individuals experiencing a behavioral health urgent condition or crisis can access immediate care on a walk-in basis, from Monday to Friday with extended hours up to 10 p.m. Services include crisis assessment and stabilization, psychiatric evaluations and short-term prescribing, brief therapy or counseling, substance use assessment and withdrawal support when appropriate, safety planning, and care coordination to ongoing outpatient treatment or higher levels of care. Casa Serena is designed to reduce unnecessary emergency room visits, involuntary 5150 holds, and decrease the impacts of suicide.

7. 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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	600
FY 2027 – 2028	650
FY 2028 – 2029	700

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

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

Early Intervention (EI) Programs #2

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

1. Program or service name

Crisis Care Mobile Unit

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

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

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**

Yes

4. Please select the EBPs and CDEPs that apply

Brief Risk Reduction Interview and Intervention Model (BRRIIM)
CBT for PTSD
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Psychosis
Drug counseling (individual and group)
Mobile Crisis, including use of tools such as the Columbia Suicide Severity Rating Scale or the Stanley-Brown Safety Plan
Mobile Response and Stabilization Services (MRSS)
Motivational Enhancement Therapy (MET) / Motivational Interviewing
Portland Identification Early Referral Model (PIER)Screening, Brief

Intervention, Referral to Treatment (SBIRT) Seeking Safety (SS)

5. Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Brief Risk Reduction Interview and Intervention Model (BRRIIM)
CBT for PTSD
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Psychosis
Drug Counseling (individual and group)
Mobile Crisis, Including use of tools such as the Columbia Suicide Severity Rating Scale or the Stanley-Brown Safety Plan
Mobile Response and Stabilization Services (MRSS)
Motivational Enhancement Therapy (MET)/Motivational Interviewing
Portland Identification Early Referral Model (PIER)
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)

6. Please describe intended outcomes of the program or service

The CCMU provides in-person, field-based response to individuals experiencing a mental health or substance use crisis wherever they are, which could be their home, school, behavioral health outpatient clinics, workplace, shelter, or street. The CCMU is designed to provide rapid, trauma-informed, community-based intervention and reduce unnecessary ER visits or law enforcement involvement.

7. 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

8. Please provide the total projected number of individuals served for EI during the plan

period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	125
FY 2027 – 2028	150
FY 2028 – 2029	175

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

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

Early Intervention (EI) Programs #3

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

1. Program or service name

Children and Youth Early Intervention Outpatient Services

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

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

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**

Yes

4. Please select the EBPs and CDEPs that apply

Brief Risk Reduction Interview and Intervention Model (BRRIIM)
CBT for PTSD
Cognitive-Behavioral Interventions for Substance Use Adult (CBI-SUA)
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Psychosis
Contingency Management (CM)
Dialectical Behavior Therapy
Drug counseling (individual and group)
Eye Movement Desensitization and Reprocessing
(EMDR) Functional Family Therapy (FFT)
Incredible Years
Interpersonal Therapy
(IPT) Marijuana Brief
Intervention The Matrix
Model
Motivational Enhancement Therapy (MET) / Motivational Interviewing
Parent Child Interaction Therapy (PCIT)
Portland Identification Early Referral Model (PIER)
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

5. Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Brief Risk Reduction Interview and Intervention Model (BRRIIM)
CBT for PTSD
Cognitive-Behavioral Interventions for Substance Use Adult (CBI-SUA)
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Psychosis

Contingency Management (CM)
Dialectal Behavior Therapy
Eye Movement Desensitization and Reprocessing (EMDR)
Functional Family Therapy (FFT)
Incredible Years
Interpersonal Therapy (IPT)
Marijuana Brief Intervention
The Matrix Model
Motivational Enhancement Therapy (MET)/Motivational Interviewing
Parent Child Interaction Therapy (PCIT)
Portland Identification Early Referral Model (PIER)
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

6. Please describe intended outcomes of the program or service

ICBHS will provide mental health and substance use disorder early treatment services and supports to children and youth ages 25 years or younger. Services will focus on reducing the duration of untreated serious mental health illness and substance use disorders. Early intervention mental health and substance use disorder treatment services and supports to those eligible children and youth will include:

- Mental health treatment services to address first episode psychosis.
- Mental health and substance use disorder services that prevent, respond, or treat a behavioral health
- crisis or activities that decrease the impacts of suicide, return to use of illicit substances or misuse of prescription drugs, and/or accidental overdose/poisoning.
- Early intervention services designed to address co-occurring mental health and substance use issues.

In addition, early intervention mental health and substance use disorder services will be provided to the

following eligible children and youth:

- Individual children and youth at high risk for a behavioral health disorder due to experiencing trauma, as evidenced by scoring in the high-risk range under a trauma screening tool such as an ACEs screening tool, involvement in the child welfare system or juvenile justice system or experiencing homelessness.
- Individual children and youth in populations with identified disparities in behavioral health outcomes.

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

Yes

8. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program

Additional priority name	Description
First Step Next Model	During the CPP process children's mental health emerged as a consistent priority. Stakeholders emphasized the need for early identification and family engagement to ensure clear pathways to more intensive behavioral health services when needed. Based on feedback from the CPP, ICBHS will be implementing the First Step Next model, an evidenced-based practice, to identify, engage, and address behavioral health needs in young children. The First Step Next model employs a systematic screening and referral process to detect early signs of behavioral health conditions, enabling timely and preventative interventions. The model emphasizes teaching pro-social skills, emotional regulation, and adaptive behaviors early on to reduce long-term behavioral health risks through developmentally appropriate supports. First Step Next prioritizes direct, strength-based communication with caregivers and engages families early in the process to foster collaborative planning. This approach reflects the principle that families are primary partners in behavioral health support. Additionally, the model includes ongoing monitoring and linkage to additional behavioral health services as needed.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	300
FY 2027 – 2028	350

FY 2028 – 2029	400

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

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

Early Intervention (EI) Programs #4

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

Program or service name

Adult and Older Adults Early Intervention Outpatient Services

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

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
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
Treatment Services and Supports: Services to address first episode psychosis (FEP)

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

Yes

Please select the EBPs and CDEPs that apply

Brief Risk Reduction Interview and Intervention Model (BRRIIM) CBT for PTSD

Cognitive-Behavioral Interventions for Substance Use Adult (CBI-SUA)
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Psychosis
Contingency Management (CM)
Dialectical Behavior Therapy
Drug counseling (individual and group)
Eye Movement Desensitization and Reprocessing (EMDR) Interpersonal Therapy (IPT)
Marijuana Brief Intervention
The Matrix Model
Motivational Enhancement Therapy (MET) / Motivational Interviewing Portland Identification Early Referral Model (PIER)
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Brief Risk Reduction Interview and Intervention Model (BRRIIM)
CBT for PTSD
Cognitive-Behavioral Interventions for Substance Use Adult (CBI-SUA)
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Cognitive Behavioral Therapy (CBT) for Psychosis
Contingency Management (CM)
Dialectal Behavior Therapy
Drug Counseling (individual and group)
Eye Movement Desensitization and Reprocessing (EMDR)
Interpersonal Therapy (IPT)

Marijuana Brief Intervention
The Matrix Model
Motivational Enhancement Therapy (MET)/Motivational Interviewing
Portland Identification Early Referral Model (PIER)
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)

Please describe intended outcomes of the program or service

ICBHS will provide mental health and substance use disorder early treatment services and supports to adults and older adults 26 years and older. Services will focus on reducing the duration of untreated serious mental health illness and substance use disorders. Early intervention mental health and substance use disorder treatment services and supports to those eligible adults and older adults will include:

- Mental health treatment services to address first episode psychosis.
- Mental health and substance use disorder services that prevent, respond, or treat a behavioral health crisis or activities that decrease the impacts of suicide, return to use of illicit substances or misuse of prescription drugs, and/or accidental overdose/poisoning.
- Early intervention services designed to address co-occurring mental health and substance use issues.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	400
FY 2027 – 2028	450

FY 2028 – 2029	500

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

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

Early Intervention (EI) Programs #5

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

1. **Program or service name**

   County Jail Early Intervention Services

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

   Access and Linkage: Screenings
   Access and Linkage: Assessments
   Access and Linkage: Referrals
   Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

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**

   Yes

4. **Please select the EBPs and CDEPs that apply**

   Cognitive-Behavioral Interventions for Substance Use Adult (CBI-SUA)
   Dialectical Behavior Therapy
   Motivational Enhancement Therapy (MET) / Motivational Interviewing
   Screening, Brief Intervention, Referral to Treatment (SBIRT)
   Seeking Safety (SS)

5. **Please provide the name of the EBPs and CDEPs that apply**

EBPs and CDEPs
Cognitive-Behavioral Interventions for Substance Use Adult (CBI-SUA)
Dialectal Behavior Therapy
Motivational Enhancement Therapy (MET)/Motivational Interviewing
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)
Moral Reconation Therapy (MRT)

6. Please describe intended outcomes of the program or service

ICBHS provides Early Intervention services for youth, adults and older adults who are 18 years of age and older at the local county jail that include screening and assessment, brief interventions, access and linkage to care. Care coordination services are provided to ensure that those individuals who are identified to meet criteria for mental health or substance use disorder services access immediate care upon their release from county jail. If an individual is assessed to meet criteria for residential SUD treatment, ICBHS coordinates admission to a contracted residential facility, provides supportive services to meet the individual's needs such as purchasing clothing and hygiene products, and provides transportation to the facility. Medication for addiction treatment and psychiatric services are provided immediately after release from jail to ensure continuity of care. Services focus on coordinating needed behavioral health services to ensure that individuals do not experience delays or a pause in their treatment, preventing incidences of overdose or suicide after incarceration, reducing risk of recidivism, and promote community reintegration, recovery support, and engagement in treatment.

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

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

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

FY 2027 – 2028	100
FY 2028 – 2029	125

8. **Please describe any data or assumptions the county used to project the number of individuals served through EI programs**
   ICBHS projections for service demand are based on historical data, assessment data, and referral trends, with assumptions that utilization will increase slightly due to population growth and expanded outreach efforts.

Early Intervention (EI) Programs #6

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

1. **Program or service name**
   Juvenile Hall Early Intervention Services

2. **Please select which of the three EI components are included as part of the program or service**
   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
   Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

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**
   Yes

4. **Please select the EBPs and CDEPs that apply**
   CBT for PTSD
   Cognitive Behavioral Therapy (CBT) for Anxiety
   Cognitive Behavioral Therapy (CBT) for Depression

Drug counseling (individual and group)
Functional Family Therapy (FFT)
Marijuana Brief Intervention
The Matrix Model
Motivational Enhancement Therapy (MET) / Motivational Interviewing
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

5. Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Brief Risk Reduction Interview and Intervention Model (BRRIIM)
CBT for PTSD
Cognitive Behavioral Therapy (CBT) for Anxiety
Cognitive Behavioral Therapy (CBT) for Depression
Drug Counseling (individual and group)
Functional Family Therapy (FFT)
Marijuana Brief Intervention
The Matrix Model
Motivational Enhancement Therapy (MET)/Motivational Interviewing
Screening, Brief Intervention, Referral to Treatment (SBIRT)
Seeking Safety (SS)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

6. Please describe intended outcomes of the program or service

ICBHS provides mental health and substance use disorder services to justice-involved youth up to the age of 25 who are detained at the juvenile hall facility. Services provided include screening and assessment, psychiatric treatment, group and individual counseling, medication for addiction treatment, crisis

intervention and stabilization, safety planning, and care coordination. ICBHS focuses on engaging youth who are identified to meet criteria for behavioral health treatment and ensuring that linkage to services after incarceration is effectively coordinated for ongoing care.
Mental health and substance use disorder early intervention services provided at the juvenile hall facility focus on preventing, responding, or treating a behavioral health crisis and/or decreasing the impacts of suicide, return to use of illicit substances or misuse of prescription drugs, and/or accidental overdose/poisoning. Early intervention services are also designed to address co-occurring mental health and substance use issues.

7. **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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	65
FY 2027 – 2028	75
FY 2028 – 2029	85

9. **Please describe any data or assumptions the county used to project the number of individuals served through EI programs**
   ICBHS projections for service demand are based on historical data, assessment data, and referral trends, with assumptions that utilization will increase slightly due to population growth and expanded outreach efforts

Early Intervention (EI) Programs #7

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

1. **Program or service name**

Community Connections and Learning Center (CCLC)

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: Referrals

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

   No

4. **Please describe intended outcomes of the program or service**

The CCLC program will conduct outreach and engagement activities throughout Imperial County that focus on engaging, encouraging, educating, training, and learning about ways to recognize and respond effectively to early signs of potentially severe and disabling mental health and substance use disorders.
Early intervention activities funded through BHSS will meet the following BHSA requirements:

- Be directed towards eligible high-risk individuals within BHSA priority populations, including older adults and youth.
- Have the goal of identifying individuals for access and linkage to services and supports.
- Connect eligible individuals directly to access and linkage programs or to mental health and substance use disorder treatment services and supports, should an individual wish to be connected to services.

Outreach strategies will be tailored to address the specific needs of priority populations such as youth, older adults, justice-involved, LGBTQ+, and veterans. Activities will focus on addressing racial disparities and enhancing equity and equality. Early intervention services provided by the CCLC will also focus on access and linkage to care as early in the onset of behavioral health conditions as practicable, and that referrals for medical and social services are provided as needed. Access and linkage to care will include screening and referral to behavioral health services, mobile response teams, and supportive services such as housing.

Outreach activities will be conducted by participating in community presentations and events, targeting unserved or underserved areas, visiting encampments, conducting community forums, placing informational booths at schools, medical offices, malls, and other community agencies, and participating in other community events where children, youth, adults, and older adults can be reached and engaged in services.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1000
FY 2027 – 2028	1250
FY 2028 – 2029	1500

7. **Please describe any data or assumptions the county used to project the number of individuals served through EI programs**
   ICBHS projections for service demand are based on historical data, assessment data, and referral trends, with assumptions that utilization will increase slightly due to population growth and expanded outreach efforts.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

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

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

1a. CSC program name
PIER for First Episode Psychosis (CSC) program

1b. CSC program description

ICBHS currently has the Portland Identification and Early Referral (PIER) program for First Episode Psychosis (FEP) as its CSC program for individuals experiencing a FEP or early signs of a psychotic disorder. The program serves youth and young adults ages 12 to 25.

The program is designed to provide early identification, rapid access to care, and comprehensive, evidence-based treatment consistent with BHSA and BH-CONNECT requirements. The PIER CSC program utilizes a multidisciplinary team model that includes psychiatry, therapy, case management, supported employment and education services, peer support, and family services.

The program conducts targeted outreach and education activities to increase awareness of early psychosis, reduce the duration of untreated psychosis, and promote equitable access to care across communities within Imperial County. Outreach efforts include community presentations, collaboration with schools and community-based organizations, and educational initiatives to improve early detection and referral pathways.

A core component of the program is the implementation of Multifamily Groups (MFG), which provide structured psychoeducation and skill-building opportunities for individuals and their families. MFG services promote shared decision-making, strengthen natural supports, and reinforce vocational and educational goals as central elements of recovery.

All services are delivered using a person-centered, culturally responsive, trauma-informed, and recovery-oriented approach. The program emphasizes hope, resilience, empowerment, and meaningful participation in work, school, and community life.

The goals of the PIER CSC program are to:

- Reduce psychiatric hospitalizations and emergency department utilization
  Improve educational and employment outcomes
- Decrease involvement with the criminal justice
  system Reduce co-occurring substance use
- Prevent homelessness and housing instability
- Promote long-term recovery and community integration

2. DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population. These projections are not binding and are for planning purposes. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements.

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

Chapter 7, Section A.7.5). **Please input the estimates provided to the county in the table below.**

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	37
Number of Uninsured Individuals	4

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	9
Number of Teams Needed to Serve Total Eligible Population	2

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	9	9	9
Total Number of Teams	1	2	2

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

Yes

5a. Please list the other funding source(s)

In addition to BHSA, ICBHS will supplement its PIER for FEP CSC program with federal MHBG funds. MHBG funding will be used in alignment with federal and state requirements to support early intervention and

treatment services for individuals experiencing FEP. These funds will enhance the county's capacity to deliver evidence-based CSC services, including outreach and early identification activities, multidisciplinary team staffing, care coordination, psychoeducation, supported employment and education, and family engagement through Multifamily Groups (MFG).

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

1. Program or activity name

Community Connections and Learning Center (CCLC)

2. Please describe the program or activity

The CCLC will conduct BHSS O&E activities intended to reach, identify, and engage individuals, families, and communities in the behavioral health system and reduce disparities. To meet requirements of the BHSA, O&E activities will involve broad engagement of unserved and underserved populations in the behavioral health system distinct to those activities provided under the EI, Housing, or FSP programs.

ICBHS through the CCLC will implement a comprehensive outreach and engagement strategy designed to increase awareness, reduce stigma, and connect residents to timely behavioral health care. Recognizing the unique cultural, geographic, and linguistic characteristics of Imperial County, outreach efforts will prioritize accessibility, community trust, and culturally responsive communication.

To ensure broad and equitable dissemination of information, ICBHS will contract with:

- Radio stations serving Imperial County, including English- and Spanish-language programming, to air public service announcements (PSAs), interviews with behavioral health professionals, and educational segments on available services, crisis resources, prevention programs, and specialty care.

- Local newspapers (print and digital editions) to publish informational ads, service directories, wellness campaign messaging, and feature articles highlighting behavioral health topics, early intervention resources, and recovery stories to normalize help-seeking behavior.

- Local television and cable media outlets to broadcast community-focused messaging and promote special initiatives such as wellness events, mobile outreach clinics, and crisis support services.

- Digital and social media platforms, including targeted online advertising, to reach youth, young adults,

families, and underserved populations. Digital campaigns will include links to direct service access points, appointment scheduling information, and crisis resources.

- Outdoor and community-based advertising and flyers/brochures distributed through schools, healthcare providers, faith-based organizations, and community centers.

These contracted outreach and engagement efforts will:

- Increase awareness of available behavioral health services, including outpatient care, crisis services, prevention and early intervention programs, substance use disorder treatment, and specialty services.
- Promote timely access to care, especially for priority populations including children and youth, individuals experiencing homelessness, justice-involved individuals, uninsured, and Spanish-speaking residents.
- Reduce stigma associated with mental health and substance use conditions through culturally relevant messaging.
- Improve equity in service utilization by ensuring materials are linguistically appropriate and culturally responsive.
- Strengthen community partnerships by coordinating media messaging with schools, healthcare providers, law enforcement, and community-based organizations.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2000
FY 2027 – 2028	2500
FY 2028 – 2029	3000

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

ICBHS projected the number of individuals served based on data gathered from O&E activities conducted in previous fiscal years. Data reflects the number of children, youth, adults, and older adults that have been

reached through community presentations, community events, visits to homeless encampments, targeted outreach to priority populations, and informational booths established at schools, medical offices, community agencies, and other community locations.

ICBHS has the English radio show "Let's Talk About It" and Spanish radio show "Expresate," which broadcasts weekly on Wednesday and Thursday. Additionally, ICBHS has a contract with the local Department of Motor Vehicles (DMV) agencies where short videos are shown on their lobbies' televisions in English and Spanish for individuals waiting for DMV services. ICBHS also has a contract at the local mall to place an information booth from Monday to Friday, 8 a.m. to 5 p.m., where staff are assigned to provide information on behavioral health services to shoppers, employees, and mall visitors.

ICBHS has gathered data on the number of individuals that tune in to listen to the radio shows, visit the DMV, or receive information through the mall's booth, and has used this data as part of the projected number of individuals to be served under O&E for the next three fiscal years.

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 each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

1. Program or activity name
ICBHS Workforce, Education and Training (WET)

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

3. 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

ICBHS continues to implement multiple strategies to address workforce shortages, improve retention, and

support professional development across service areas. ICBHS is exploring the use of WET funds and other funding sources to support workforce incentives that reduce barriers to recruitment and career advancement. These include supporting licensing costs, testing fees, study materials, and professional certification processing fees for therapists and counselors to assist staff in completing licensure requirements and advancing within the behavioral health workforce.

ICBHS has also invested in employee engagement and professional development opportunities, including training programs and conference participation to strengthen clinical competencies, support evidence-based practice implementation, and improve workforce satisfaction. Moving forward, the ICBHS will review historical WET expenditures to identify strategies that most effectively address workforce gaps and will continue prioritizing investments based on system needs and available budget resources.

ICBHS is planning to implement several incentive-based retention strategies to support hard-to-fill and high-demand positions. These include after-hours and on-call incentive programs utilizing stipend or gift card supports for staff providing extended coverage. Additional incentives have been provided for transportation staff and shift workers through quarterly recognition and retention incentives. ICBHS is considering providing annual productivity bonuses to eligible staff to encourage performance, retention, and service continuity, with approximately 250 staff receiving annual incentive recognition.

Promotional and recognition efforts have also been expanded through provision of branded work attire, including jackets, shirts, and uniforms for after-hours staff to promote program identity, staff engagement, and workforce cohesion.

Going forward, ICBHS will continue evaluating workforce investments by reviewing prior WET spending patterns, identifying high-priority workforce needs, and aligning future workforce strategies with BHSA, Behavioral Health Transformation (BHT), and system sustainability goals. Continued cross-departmental and budget planning discussions will guide future workforce investment decisions and help prioritize initiatives that strengthen recruitment, retention, and service delivery capacity.

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 each program or activity that is part of the county's overall WET program, provide the

following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

1. Program or activity name
ICBHS Workforce, Education and Training (WET)

2. Please select which of the following categories the activity falls under
Internship and Apprenticeship Programs

3. 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
N/A

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 each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

1. Program or activity name
ICBHS Workforce, Education and Training (WET)

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

3. 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
N/A

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 each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training.

1. Program or activity name
ICBHS Workforce, Education and Training (WET)

2. Please select which of the following categories the activity falls under
Retention Incentives and Stipends

3. 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
N/A

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 Workstation and Network Infrastructure Lifecycle Replacement

2. Please select the type of project
Technological needs project

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

Data security and privacy
System maintenance costs

4. Please describe the project

ICBHS will implement a structured lifecycle replacement program for workstations and network infrastructure that support the County's behavioral health electronic health record (EHR) system and related clinical applications.

The project will replace aging laptops and desktop workstations used by clinical, administrative, and support staff to ensure continued secure access to the SmartCare EHR and other behavioral health technology systems. In addition, limited network equipment replacement (including switches and firewalls) will occur as existing devices reach end-of-life status.

Maintaining current technology infrastructure is critical to ensuring reliable EHR access, protecting protected health information (PHI), and supporting compliance with federal and state data security requirements. This project will improve system stability, enhance cybersecurity protections, and ensure staff are able to effectively document and coordinate care within the County's behavioral health information systems.

The lifecycle replacement strategy allows the County to proactively modernize technology infrastructure while reducing the risk of service interruptions caused by aging hardware.

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

Behavioral Health Patient Portal Implementation

2. Please select the type of project

Technological needs project

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

Online information resources for individuals/families
Personal health record system
System maintenance costs

4. Please describe the project

Imperial County Behavioral Health Services will implement a patient portal integrated with the County's electronic health record (EHR) system to expand digital access to behavioral health services and information.

The patient portal will allow individuals and families receiving services to securely access their behavioral health information, communicate with providers, review appointments, and receive important care-related updates through an online platform. This capability will improve access to care, enhance client engagement, and provide additional tools for individuals to actively participate in their behavioral health treatment.

The project will also support compliance with evolving federal and state requirements related to patient access to health information and digital health services. Implementation of the patient portal represents a significant expansion of the County's behavioral health technology infrastructure and will improve accessibility for individuals receiving services.

Full Service Partnership Programs

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

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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

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	724
Number of Uninsured Individuals	102
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	253

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

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	95
Number of Uninsured Individuals	14

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	48
Number of Uninsured Individuals	7

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

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	12	16	20
Total Number of Teams	2	2	2

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

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

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	581
Number of Uninsured Individuals	81

FSP ICM Practitioners and Teams Needed	Estimates

Number of Practitioners Needed to Serve Total Eligible Population	30
Number of Teams Needed to Serve Total Eligible Population	6

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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	30	30	30
Total Number of Teams	6	6	6

High Fidelity Wraparound (HFW) Eligible Population

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	610
Number of Uninsured Individuals	35

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	229

Number of Teams Needed to Serve Total Eligible Population	5

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	12	15	20
Total Number of Teams	3	4	5

Individual Placement and Support (IPS) Eligible Population

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

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	1415
Numbe of Uninsured Individuals	201

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	103
Number of Teams Needed to Serve Total Eligible Population	41

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	5	8	11
Total Number of Teams	1	1	1

Full Service Partnership (FSP) Program Overview

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

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

   ICBHS operationalizes a trauma-informed, whole-person framework by partnering with individuals, families, and natural supports in service planning, implementation, and evaluation so individuals and families can be connected to community resources. Through community partnerships, culturally responsive grievance processes, and transparent communication of progress, ICBHS fosters trust, accountability, and shared decision-making. These efforts ensure that services address not only behavioral health needs, but also the broader social, cultural, and environmental factors that influence wellness and recovery. In an effort to provide staff with better clinical professional active skills to work effectively with trauma exposed clients, staff are required to participate in a variety of trauma-informed trainings to provide them with a better understanding of how trauma affects behavior and to ensure services are culturally sensitive and responsive to diverse populations.

   Additionally, ICBHS advances a whole-person, trauma-informed approach by embedding the National Standards for Culturally and Linguistically Appropriate Services (CLAS) into its cultural competence plan. Guided by the CLAS principle standard, ICBHS strives to provide care that is effective, equitable, understandable, and respectful of diverse cultural health beliefs, preferred languages, health literacy levels, and communication needs. Through governance and leadership commitments, workforce development, and ongoing staff training, the Department promotes policies and practices that advance health equity and ensure services are responsive to the cultural and linguistic diversity of the community. Language assistance services are offered at no cost, individuals are informed of their rights in their preferred

language, and easy-to-understand materials are made available to support meaningful participation in care.

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

ICBHS is committed to reducing disparities among FSP participants in alignment with BHSA by prioritizing equitable access, culturally responsive services, and outcomes for underserved populations. FSP programs are designed to serve individuals with the highest level of need, including those experiencing homelessness, justice involvement, serious mental illness, substance use disorders, and co-occurring conditions.

To address disparities, ICBHS implements targeted outreach and engagement strategies focused on rural communities, Spanish-speaking individuals, and populations that have traditionally faced barriers to accessing behavioral health care. Services are delivered using a "no wrong door" approach, emphasizing timely access, flexible service delivery, and individualized care planning that reflects each participant's cultural, linguistic, and social needs.

ICBHS promotes cultural approach and workforce diversity by ensuring bilingual and bicultural staff are available across FSP programs. Programs utilize field-based services, telehealth, and community partnerships to reduce transportation and geographic barriers common in Imperial County.

ICBHS uses data-driven monitoring to identify disparities in access, retention, and outcomes among FSP participants. This information is used to inform continuous quality improvement efforts, guide resource allocation, and strengthen coordination with housing, physical health, and social service systems. Through these efforts, ICBHS strives to improve equity, reduce disparities, and achieve meaningful recovery-oriented outcomes for all FSP participants.

Additionally, ICBHS will use FSP funding to cover the cost of treatment for individuals with commercial insurance that does not fully cover the cost of medically necessary behavioral health treatment after making reasonable attempts to obtain payment. FSP funding will also be used to cover the cost of treatment for those who are uninsured. Treatment services will include SMHS, DMC-ODS services, and higher levels of care, such as residential SUD and mental health treatment, including room and board. ICBHS will ensure that FSP funding for residential facilities is used to ensure treatment in the least restrictive environment and when medically necessary. By using FSP funding for the underinsured or uninsured, ICBHS will eliminate barriers to accessing care and will reduce disparities.

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

Access to care
Homelessness
Institutionalization

Justice
involvement
Removal of children from home
Untreated behavioral health
conditions Care experience
Prevention of co-occurring physical health conditions
Engagement in work

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

ICBHS provides ongoing engagement services to individuals receiving FSP ICM that are recovery-oriented, community-based, and supports the individualized needs of clients.

ICBHS provides assertive, field-based outreach and services to maintain consistent engagement with FSP participants. Services are delivered at the clients' homes, shelters, hospitals, and community settings to reduce barriers to care and ensure low-barrier access. ICBHS also works closely with correctional facilities to ensure that individuals being released have immediate access to behavioral health care. Treatment providers maintain close contact with clients based on their needs and risk levels, which can be more than once a week if medically necessary. Targeted case management (TCM) services are provided to ensure proper coordination of care between mental health and SUD services, physical health, vocational/educational, and other community resources.

Treatment providers conduct ongoing assessments to ensure that services address the clients' immediate needs to ensure stability and prevent higher levels of care. ICBHS ensures that services focus on recovery and that these are provided in the least restrictive environment while preventing hospitalization, incarceration, or other forms of institutionalization. ICBHS has also implemented a transportation unit to provide transportation services to clients to and from behavioral health appointments when they don't have their own transportation, when using public transportation is not feasible, or when transportation through their Medi-Cal or MCP cannot be arranged. Transportation services are also provided by the TCM service provider when necessary to ensure linkages to other community resources.

Engagement strategies incorporate motivational interviewing, trauma-informed practices, and culturally responsive approaches to enhance participation and treatment adherence. Peer support specialists play a key role in sustaining engagement by providing recovery coaching, system navigation, and promoting self-advocacy and community integration.

Services are delivered through a multidisciplinary team (MDT) model that includes licensed therapists, psychiatrists, mental health rehabilitation technicians, SUD counselors, nursing staff, and peer support

specialists. Regular MDT meetings are held to ensure coordinated care, ongoing risk monitoring, shared accountability, and continuous adjustment of interventions to support sustained recovery.

Through frequent contact, field-based services, crisis responsiveness, peer involvement, and coordinated multidisciplinary care, ICBHS ensures ongoing engagement and continuity of care for individuals receiving FSP ICM services.

6. 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

Beyond the engagement standards embedded within these evidence-based practices, ICBHS implements enhanced strategies to improve retention, reduce service drop-off, and promote long-term community stability. ICBHS provides expanded field-based outreach for individuals at risk of disengagement, hospitalization, homelessness, or justice involvement. This includes proactive in-person outreach, collateral coordination with family and community partners, flexible scheduling, and enhanced follow-up after missed appointments or crisis events. MDT case reviews are conducted to identify early warning signs of disengagement and implement individualized re-engagement plans.

In addition, to enhanced engagement, ICBHS will incorporate ACT informed strategies by maintaining small caseloads to allow for intensive, individualized support, and ensure team members can respond quickly to client needs. ICBHS will provide round-the-clock case management and crisis support, and deliver comprehensive, integrated services across behavioral health, physical health, housing, and social supports.

ICBHS also offers transportation assistance, benefits advocacy, and flexible support services to address social determinants of health that impact treatment participation. Peer support specialists provide additional recovery coaching and mentorship beyond minimum EBP requirements to strengthen motivation, self-advocacy, and community integration. Structured relapse prevention planning and enhanced monitoring during transitions between levels of care further support continuity of services. Engagement approaches incorporate motivational interviewing, culturally responsive practices, and trauma-informed care to improve adherence and satisfaction with services. Through these enhanced engagement efforts, ICBHS aims to increase service retention, reduce psychiatric hospitalizations and crisis utilization, decrease justice involvement, and improve successful step-down to lower levels of care, consistent with BHSA's goals of improving outcomes and expanding access to community-based behavioral health services and supports.

7. **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.)

ICBHS will comply with the required FSP levels of care by implementing a structured, tiered service delivery model that aligns service intensity with individual clinical need and evidence-based practices. ACT will he high-intensity level of care for individuals with the most complex needs, including those with significant functional impairment, frequent hospitalizations, justice involvement, homelessness, and co-occurring mental health and substance use disorders. FSP ICM will serve as the moderate to lower-intensity level of care for individuals who require ongoing support but demonstrate greater stability.

ICBHS will establish clear criteria for placement, transition, and step-down between levels of care using standardized assessment and reassessment tools to determine medical necessity and functional need. Individuals whose acuity increases will transition from ICM to ACT through a structured review and warm handoff process to ensure continuity of care. Similarly, individuals demonstrating sustained stability and progress in recovery will step down from high-intensity (Level 2) to moderate-intensity (Level 1) services based on defined graduation criteria. Clients will be re-evaluated regularly to ensure appropriate level of care and prevent service gaps.

Regardless of service intensity, all FSP programs will prioritize recovery-oriented, client-centered practices, housing stability, mental health stabilization, and integrated treatment for co-occurring substance use disorders. Peer support services and assertive outreach will be embedded across levels of care to promote engagement and long-term recovery.

ICBHS will use data analytics to identify individuals currently enrolled in FSP services who meet criteria for high- or moderate-intensity services and realign them accordingly. Implementation will include training existing teams, targeted recruitment of specialized staff, use of technical assistance, and fidelity monitoring to ensure adherence to ACT and ICM models. ICBHS will also pilot an ACT team to operationalize the tiered structure, refine transition protocols, and inform broader system implementation through continuous quality improvement.

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

ICBHS will include allowable services such as primary substance use disorder (SUD) FSPs, outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP, and recovery-oriented services.

9. **Primary substance use disorder (SUD) FSPs**
   Yes

9a. If Yes, please describe

ICBHS will provide primary SUD FSP services to individuals whose primary condition is a substance use disorder. The SUD FSP program will be designed to provide comprehensive, individualized, "whatever it takes" community-based care. The program will be intended for people with serious behavioral health needs whose conditions are associated with homelessness, frequent crisis episodes, justice involvement, or high use of emergency services.

Primary SUD FSP services will include assessment, crisis intervention, intensive outpatient services, care coordination, linkage to higher levels of care, Medication for Addiction Treatment (MAT), assertive field-based SUD treatment, intensive case management, harm reduction, and targeted FSP outreach and engagement. SUD FSP services will be co-occurring capable and will assess all individuals for mental health conditions and ensure access to care.

10. 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

11. 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

ICBHS will conduct targeted outreach activities specifically to enroll individuals with significant behavioral health needs who meet FSP eligibility criteria. This FSP outreach to enroll focuses on identifying individuals with serious mental illness (SMI) and co-occurring conditions, particularly those at risk of hospitalization, homelessness, conservatorship, or justice involvement, as well as those who are unserved or disengaged from ongoing treatment.

ICBHS uses data-informed strategies to identify FSP-eligible individuals, including psychiatric inpatient and emergency department utilization, crisis service and high-utilizer reports, CARE Act and LPS referral pathways, county jail behavioral health screening and reentry data, the Homeless Management Information System (HMIS), and internal behavioral health service utilization records. In addition, ICBHS collaborates with cross-system and community partners to identify and refer eligible individuals, including emergency departments, primary care providers, law enforcement agencies, homeless service providers, social services, and residential programs.

Designated FSP staff conduct field-based outreach for enrollment purposes, including in-person eligibility screening, assessments, verification of medical necessity, and development of initial service plans upon acceptance. Engagement strategies are culturally responsive, trauma-informed, and incorporate Motivational Interviewing to support voluntary participation. Referrals are facilitated through formal

submission, warm hand-offs, and cross-agency coordination to ensure timely screening and enrollment by FSP teams.

These outreach activities are distinct from general engagement or crisis response services (e.g., Mobile Crisis Teams, Triage Unit, CARE Act, jail-based services) and focus exclusively on identifying and enrolling FSP-eligible individuals. Through targeted, data-driven outreach and collaboration with specialized partners, ICBHS ensures timely enrollment of high-need individuals into FSP programs, supporting continuity of care and alignment with BHSA goals.

11a. Other recovery-oriented services

Yes

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

ICBHS' FSP programs will integrate recovery-oriented services with a "whatever it takes" approach. Focusing on behavioral health treatment, peer support services, housing, employment, education assistance and life skills to promote independence and long-term wellness. The recovery-oriented services will include integrated treatment and support and linkage to substance use treatment, Casa Serena and Wellness Centers.

13. 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

14. 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:

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

To ensure the FSP program reflects the unique needs of children and youth involved in, or at risk of involvement in, the juvenile justice system, ICBHS conducted a CPP. This included key informant interviews with cross-system partners such as juvenile probation, behavioral health providers, education representatives, social services, and community-based organizations. ICBHS also facilitated focus groups and administered provider and community surveys to identify service gaps and barriers to engagement.

ICBHS reviewed local data related to juvenile justice referrals, behavioral health screening results, service utilization patterns, and transition outcomes to better understand trends impacting justice-involved youth.

Data and stakeholder feedback highlighted challenges including fragmented cross-system coordination, service disruptions during detention and reentry transitions, workforce shortages, and limited access to intensive community-based supports.

Findings from the CPP directly informed FSP program design, emphasizing intensive wraparound services, multidisciplinary care coordination, trauma-informed practices, and structured transition planning to improve continuity of care and reduce further system involvement.

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

To address the unique needs of LGBTQ+ children and youth, ICBHS incorporated targeted outreach and engagement strategies within the CPP to elevate the voices of LGBTQ+ individuals and advocacy partners. This included focus groups inclusive of LGBTQ+ youth participants, stakeholder interviews with community-based organizations, and survey outreach to identify disparities and access barriers.
Qualitative and quantitative data were analyzed to assess themes related to stigma, discrimination, family rejection, housing instability, suicide risk, and the need for affirming behavioral health services. Feedback consistently emphasized the importance of culturally responsive care, safe service environments, and providers trained in gender-affirming and inclusive practices.

As a result, FSP priorities incorporate youth-centered, affirming service approaches, family engagement strategies when appropriate, and ongoing workforce development to strengthen cultural humility and responsiveness. These efforts aim to reduce disparities and improve engagement, retention, and outcomes for LGBTQ+ youth within the FSP program.

c) In the child welfare system

ICBHS engaged Child Welfare Services (CWS), behavioral health providers, caregivers, and other child-serving partners through the CPP to inform FSP development for youth in the child welfare system. The County reviewed available child welfare and behavioral health data, including service access trends, placement transitions, and indicators of behavioral health needs among foster youth.

Stakeholder feedback identified significant challenges related to placement instability, gaps in continuity of care during placement changes, cross-system communication barriers, and the high prevalence of trauma exposure. Data analysis further reinforced the need for coordinated, trauma-informed, and intensive community-based services.

In response, the FSP model prioritizes wraparound and team-based care coordination, caregiver involvement, collaboration with CWS staff, and structured transition planning to ensure continuity of behavioral health services. These strategies are designed to improve stability, reduce service fragmentation, and support positive long-term outcomes for youth involved in the child welfare system.

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

a) Older adults

To ensure the FSP program reflects the unique needs of older adults, ICBHS conducted a comprehensive CPP. This included key informant interviews with cross-system partners such as aging and adult services, primary care providers, behavioral health providers, long-term care representatives, social services, and community-based organizations serving older adults. ICBHS also facilitated focus groups with older adults and caregivers and administered provider and community surveys to identify service gaps, barriers to engagement, and unmet needs related to aging, mobility, and social isolation.

ICBHS reviewed local data related to older adult referrals, behavioral health screening results, service utilization patterns, co-occurring medical conditions, housing stability, crisis response, and care transitions (including hospital and skilled nursing facility discharges). Data and stakeholder feedback highlighted challenges including fragmented care coordination across physical health, behavioral health, and long-term services; service disruptions during hospitalizations or changes in level of care; transportation barriers; caregiver strain; and limited access to intensive, home- and community-based supports.

Findings from the CPP directly informed FSP program design, emphasizing person-centered and culturally responsive services; multidisciplinary care coordination integrating physical and behavioral health; trauma-informed and age-friendly practices; caregiver engagement and support; benefits and entitlement navigation; and structured transition planning to improve continuity of care, promote aging in place, and reduce avoidable institutionalization or crisis system involvement.

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

To address the unique needs of adult LGBTQ+ individuals, ICBHS incorporated targeted outreach and engagement strategies within the CPP to ensure meaningful input from LGBTQ+ adults and advocacy partners. This included focus groups inclusive of LGBTQ+ adult participants, stakeholder interviews with community-based organizations serving LGBTQ+ communities, and survey outreach to identify disparities, service gaps, and access barriers across behavioral health, housing, employment, and healthcare systems.

Analytics were used to assess themes related to stigma and discrimination, family estrangement, housing and employment instability, elevated risk for depression and suicide, and the need for affirming and culturally responsive behavioral health services. Feedback indicated the importance of safe and welcoming service environments, confidentiality protections, providers trained in gender-affirming and inclusive practices, and integrated care that addresses co-occurring physical health and substance use needs.

As a result, FSP priorities incorporate affirming, trauma-informed, and person-centered service approaches tailored to LGBTQ+ adults, peer support opportunities, linkage to LGBTQ+-specific community resources, and ongoing workforce development to strengthen cultural humility and responsiveness. These efforts aim to reduce disparities, increase trust and engagement in services, and improve retention and long-term behavioral health outcomes for LGBTQ+ adults within the FSP program.

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

ICBHS engaged adult probation, sheriff and jail health services, behavioral health providers, reentry partners, public defenders, courts, housing agencies, and community-based organizations through the CPP to inform FSP development for adults who are in, or at risk of involvement in, the justice system. The County reviewed available criminal justice and behavioral health data, including arrest and booking trends, jail length of stay, diversion participation, service access patterns, crisis utilization, and indicators of behavioral health and substance use treatment needs.

Stakeholder feedback identified significant challenges related to disruptions in care during incarceration and reentry, limited coordination across justice and health systems, housing instability upon release, barriers to employment, transportation challenges, and the high prevalence of trauma and co-occurring disorders. Data analysis further reinforced the need for coordinated, trauma-informed, and intensive community-based services that begin pre-release and continue post-release to reduce recidivism and crisis system involvement.

In response, the FSP model prioritizes multidisciplinary, team-based care coordination; close collaboration with probation, courts, and jail health staff; pre-release engagement and structured reentry planning; linkage to housing and employment supports; and integrated treatment for co-occurring mental health and substance use conditions. These strategies are designed to improve continuity of care, reduce service fragmentation, enhance community stability, and support positive long-term outcomes for adults involved in or at risk of involvement in the justice system.

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
N/A

Program descriptions
N/A

Current funding source
N/A

BHSA changes to existing programs to meet BHSA requirements
N/A

Expected timeline of operation
N/A

Mobile-field based programs

Existing programs
N/A

Program descriptions
N/A

Current funding source
N/A

BHSA changes to existing programs to meet BHSA requirements
N/A

Expected timeline of operation
N/A

Open-access clinics

Existing programs
Adult Substance Use Disorder Treatment Program: El Centro and Calexico Clinic

Program descriptions

The Adult SUD Treatment Program provides comprehensive, evidence-based services in an outpatient setting for adults experiencing substance use and co-occurring conditions. Based on clinical need and medical necessity, individuals may receive services at the outpatient or intensive outpatient level of care. The program emphasizes a recovery-oriented, person-centered approach designed to reduce barriers to treatment and promote sustained recovery.

Available DMC-ODS services include:

- Screening and assessment
- Care coordination and treatment planning
- Individual and group counseling
- Medication services
- Medication-Addiction Treatment (MAT)
- Recovery services
- SUD crisis intervention
- Ambulatory withdrawal management

Current funding source
DMC-ODS

BHSA changes to existing programs to meet BHSA requirements
N/A

Expected timeline of operation
Currently in operation

New Programs for Assertive Field-Based SUD Treatment Services
Targeted outreach

New programs
Adult Substance Use Disorder Treatment Program: El Cento and Calexico clinic

Program descriptions
Targeted outreach for Assertive Field-Based SUD Treatment Services in Imperial County will focus on clearly defined high-need populations using data-informed strategies to engage individuals in community settings.

Planned funding
BHSA Funding

Planned operations

ICBHS will acquire Peer Support Specialist (PSS) position to enhance outreach through lived-experienced, build trust and reduce stigma. In field-based interactions, PSS will help initiate connections, provide recovery-oriented education, support service navigation, and reinforce engagement through follow-up, appointment reminders, and warm handoffs to clinical teams. PSS will strengthen credibility, cultural responsiveness, and sustained participation in SUD treatment and recovery services.

Expected timeline of implementation
July 1, 2026

Mobile-field based programs

New programs
N/A

Program descriptions
N/A

Planned funding
N/A

Planned operations
N/A

Expected timeline of implementation
N/A

Open-access clinics

New programs

Adult Substance Use Disorder Treatment Program: El Centro and Calexico clinic

Program descriptions
ICBHS will strengthen access to Assertive Field-Based SUD Treatment Services by maintaining an open-access clinic model while expanding medical capacity through additional physicians leveraged via telehealth.

Planned funding
BHSA Funding

Planned operations
Telehealth-enabled MD will increase timely evaluations, initiate same-day treatment and strengthen continuity of care by allowing individuals engaged through field-based outreach to connect with prescribing providers without traditional scheduling barriers. This model supports flexible, demand-based service delivery, reduces wait times, and improves responsiveness to urgent clinical needs, including MAT. ICBHS will enhance clinic workflows to prioritize same-day service availability, including designated walk-in assessment slots. Individuals presenting without prior appointments will be evaluated for immediate treatment based on clinical need and staffing capacity, ensuring low-barrier and timely access to SUD treatment services.

Expected timeline of implementation
July 1, 2026

Medications for Addiction Treatment (MAT) Details

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

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

   ICBHS will expand MAT capacity to meet community needs by increasing provider participation, optimizing clinic workflows for same day medication initiation, and strengthening integration of field-based referrals from outreach. Barriers to access, including transportation, eligibility, and cultural or linguistic challenges, will be addressed, with priority given to high-risk populations such as individuals with OUD, justice-involved or unhoused persons, and pregnant/postpartum individuals. ICBHS will assess effectiveness by monitoring provider capacity, same-day initiation rates, referral to treatment timeliness, engagement and retention outcomes, and disparities in access. This data will inform and guide continuous quality improvement efforts and ensure alignment with BHSA requirements.

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

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

3. **What forms of MAT will the county provide utilizing the strategies selected above?**
Buprenorphin
e Methadone
Naltrexone

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
Large gap

Single and multi-family homes

Large gap

Housing in mobile home communities
Large gap

(Permanent) Single room occupancy units
Large gap

(Interim) Single room occupancy units
Large gap

Accessory dwelling units, including junior accessory dwelling units
Large gap

(Permanent) Tiny homes
Large gap

Shared housing
Medium gap

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

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

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

License-exempt room and board
Large gap

Hotel and Motel stays
Small gap

Non-congregate interim housing models
Large gap

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

Small gap

Recuperative Care
Small gap

Short-Term Post-Hospitalization housing
Small gap

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

Peer Respite
Large 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?**

   To expand housing supply and improve access for BHSA eligible individuals, ICBHS will strategically leverage a combination of state, local, and federal housing partnerships and funding sources, including Behavioral Health Bridge Housing (BHBH), Transitional Rent provided by the MCP and the Continuum of Care (CoC).

   With BHBH, ICBHS will expand interim and bridge housing capacity to increase short term housing beds, provide operating subsidies, fund housing navigation, tenancy supports and strengthen discharge to housing pathways (e.g. CARE Act, Justice involved, and or hospital). This approach reduces system bottlenecks and prevents unnecessary institutional stays by ensuring individuals have safe, supported placements while permanent housing is secured.

   Through Transitional Rent (TR), ICBHS will maximize benefits under CalAIM housing supports through MCP partnerships by coordinating referrals, align behavioral health case management with housing navigation, use TR as bridge to longer-term subsidies and reduce return to homelessness during stabilization periods.

ICBHS will work closely with the local public housing authority to prioritize BHSA eligible individuals for federal housing assistance, such as housing choice vouchers, mainstream vouchers for persons with disabilities and project-based vouchers aligned with behavioral health-designated units. This partnership will include data-sharing agreements and coordinated entry prioritization to assist in matching individuals with serious behavioral health conditions to available subsidies.

To expand permanent supporting housing supply, ICBHS will braid BHSA resources with other funding such as No Place Like Home, local housing trust funds and CoC for supportive housing and rapid rehousing. By braiding BHBH, TR, federal housing vouchers, state capital programs, and local partnerships, the county will create a coordinated housing continuum from crisis stabilization to permanent supportive housing thereby expanding supply, accelerating placements, and improving long-term housing stability for BHSA eligible individuals.

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?

BHSA housing interventions will intersect with existing housing resources and supportive services to strengthen and expand the continuum of housing supports available to BHSA eligible individuals in Imperial County. ICBHS will coordinate BHSA housing efforts with local, state, and federal housing programs to ensure individuals experiencing homelessness or housing instability who have behavioral health needs are connected to appropriate levels of housing and supportive services.

BHSA housing interventions will complement and leverage existing resources such as permanent supportive housing, rapid rehousing, and emergency shelter programs administered through partnerships with the Imperial CoC, local housing authorities, and community-based organizations. In addition, ICBHS will align housing interventions with Medi-Cal funded services through the MCPs, including enhanced care management and community supports, to provide individuals with both stable housing and ongoing behavioral health support.

BHSA funding will also coordinate with housing developments created through California behavioral health infrastructure initiatives, including peer respite and supportive housing developed through Behavioral Health Continuum Infrastructure Program grants. These resources will expand housing capacity while ensuring that residents have access to integrated mental health and substance use disorder treatment, targeted case management, and recovery supports.

Through cross-system collaboration, coordinated entry processes, and shared case conferencing with homelessness service providers, ICBHS will ensure BHSA housing resources are strategically targeted to individuals with the highest behavioral health needs. This coordinated approach will reduce fragmentation, improve housing stability, and create a more comprehensive continuum that ranges from

outreach and interim housing to permanent supportive housing with ongoing behavioral health services.

Together, these efforts will strengthen Imperial County's ability to provide stable housing paired with behavioral health treatment, promoting recovery, reducing homelessness, and improving long-term outcomes for BHSA eligible individuals.

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

ICBHS overall strategy to promote permanent housing placement and long-term housing retention for individuals receiving BHSA Housing Interventions is centered on a housing first, recovery-oriented, and integrated service approach. This strategy prioritizes rapid access to permanent housing paired with flexible behavioral health services and ongoing tenancy supports to ensure individuals with serious behavioral health conditions can successfully obtain and maintain stable housing.

ICBHS will coordinate closely with the county's homelessness response system, including the local CoC, housing authorities, and community-based housing providers, to ensure BHSA eligible individuals are connected to appropriate housing resources through coordinated entry and referral processes. Individuals experiencing homelessness or housing instability who have significant behavioral health needs will be prioritized for housing opportunities that include supportive services.

To support successful housing placement, ICBHS will utilize housing navigation and transition services to assist individuals with locating housing units, completing applications, securing necessary documentation, and addressing barriers to tenancy. These efforts will be coordinated with the MCPs to maximize available resources and reduce duplication of services.

To promote housing stability and retention, individuals receiving BHSA Housing Interventions will have access to ongoing behavioral health treatment and supportive services, including targeted case management, FSP programs, substance use disorder treatment, peer support services, and linkage to medical and social services. Tenancy sustaining supports will focus on strengthening independent living skills, addressing behavioral health needs that may impact housing stability, and providing crisis response when needed.

ICBHS will also work collaboratively with landlords and housing providers to build partnerships that increase housing opportunities for individuals with behavioral health conditions. This may include landlord engagement, education about supportive services, and coordinated problem-solving to prevent evictions and support successful tenancies.

ICBHS will implement master leasing as a possible strategy to promote permanent housing placement and retention. ICBHS will expand potential housing options such as license exempt board and care,

assisted living facilities, other recovery supportive housing options, and landlord engagement to facilitate placement and provide rental assistance. Through these combined efforts, rapid connection to housing, integrated behavioral health services, coordinated system partnerships, and proactive tenancy supports, ICBHS aims to increase permanent housing placements, reduce returns to homelessness, and promote long-term stability and recovery for individuals receiving BHSA housing interventions.

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)?**

ICBHS is implementing activities that engage local developers to enhance the County's current housing options for BHSA eligible individuals. Activities include planning for increased infrastructure through capital development, developing relationships to engage landlords to participate in master leasing, rental and operational subsidies, and providing supportive services in other permanent housing settings. ICBHS is also in the process of increasing recovery housing beds for individuals in SUD treatment.

ICBHS is also implementing a range of coordinated actions and activities to connect BHSA eligible individuals to PSH and ensure they receive the supportive services necessary to maintain long-term housing stability. These efforts are designed to expand access to PSH while leveraging existing housing resources and behavioral health services across the county.

ICBHS collaborates with the Imperial County CoC, local housing authorities, and community-based housing providers to identify individuals with significant behavioral health needs who would benefit from PSH. Through coordinated entry and interagency collaboration, BHSA eligible individuals experiencing homelessness or housing instability are prioritized for PSH placements.

To facilitate housing access, the county supports housing navigation and transition services that assist individuals with locating available units, completing housing applications, securing documentation, and addressing barriers to tenancy. These services are coordinated with the MCPs and include housing transition navigation, housing deposits, and tenancy sustaining services.

ICBHS also provides ongoing supportive services to individuals residing in PSH and other permanent housing settings. These services may include targeted case management, FSP services, substance use disorder treatment, mental health services, peer support, and connections to other community resources such as medical care, vocational/educational, and socials services. These supports are designed to help residents maintain housing stability, manage behavioral health conditions, and improve overall well-being.

ICBHS also engages with housing providers and landlords to strengthen partnerships that increase the availability of PSH opportunities for individuals with behavioral health conditions. These partnerships support housing placement, provide education about supportive services available to tenants, and promote collaborative problem-solving to help prevent evictions and sustain housing placements.

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**

ICBHS will ensure that all housing intervention settings supported through the BHSA provide access to appropriate clinical and supportive behavioral health care and housing-related services through coordinated service delivery, standardized program expectations, and strong partnerships with housing providers and community-based organizations.

ICBHS will integrate behavioral health services into housing settings by connecting residents to a comprehensive range of mental health and substance use disorder treatment services, including outpatient treatment, targeted case management, medication support, peer support services, and recovery-oriented programs. Individuals residing in housing supported through BHSA Housing Interventions will be assessed for behavioral health needs and linked to appropriate levels of care within ICBHS.

Supportive services will be delivered through programs such as FSP, outpatient mental health programs, substance use disorder treatment services, and care coordination models designed to provide individualized support. These services may include ongoing case management, crisis intervention, life skills development, connection to medical and social services, and assistance with activities that promote recovery and housing stability.

ICBHS will also ensure access to housing-related supports such as housing navigation, tenancy sustaining services, and benefits advocacy to help individuals maintain stable housing. These services will assist residents with lease compliance, conflict resolution with landlords or neighbors, budgeting, and maintaining independent living skills.

To strengthen coordination between housing and service providers, ICBHS will establish collaborative partnerships with housing developers, property managers, and community-based organizations that operate or manage housing units. These partnerships will include clearly defined service expectations, referral processes, and communication protocols to ensure residents can easily access behavioral health services when needed.

Eligible Populations

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

   ICBHS will implement a coordinated, equitable, and data-informed process to identify, screen, and refer individuals who are eligible for BHSA housing interventions. ICBHS' approach will prioritize individuals with significant behavioral health needs who are experiencing homelessness or housing instability, consistent with BHSA requirements and local needs.

   ICBHS will identify potential BHSA housing intervention candidates through multiple entry points within the behavioral health system and partner networks. These may include mental health and substance use disorder programs, crisis services, FSP programs, jail and justice system partners, hospital and emergency department referrals, outreach teams, and community-based providers. Coordination with the local CoC will also support identification of individuals experiencing housing instability who have behavioral health needs.

   Individuals identified as potential candidates will undergo standardized screening and clinical assessment to determine behavioral health eligibility, housing need, and level of care. Screening processes will assess mental health and/or substance use disorder conditions, functional impairment, risk factors, housing status, and service needs. Assessments will be conducted by qualified behavioral health staff using established clinical tools and documentation processes to ensure consistency and compliance with BHSA requirements.

   Once determined eligible, individuals will be connected to appropriate housing interventions, including housing navigation, rental assistance (when applicable), supportive services, or placement into permanent supportive housing settings. Assigned care coordinators will support the individual through enrollment, housing search, lease-up, and transition into housing. Ongoing coordination will ensure that housing placements are aligned with clinical service plans.

   ICBHS will ensure that identification and referral processes are accessible, culturally responsive, and trauma-informed. Efforts will include outreach to underserved communities, collaboration with community-based organizations, and strategies to reduce barriers to access for individuals with
   co-occurring disorders, justice involvement, or limited engagement in services.

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:**

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

To ensure housing interventions services reflect the unique needs of eligible children and youth including those in, or at risk of involvement with the juvenile justice system ICBHS conducted a focused CPP. Activities included review of local housing, behavioral health, child welfare, and juvenile justice data; engagement with cross-system partners such as behavioral health, education, child welfare, probation, housing providers, and the CoC; youth and family focus groups; and provider and community surveys.

ICBHS analyzed youth homelessness trends, system transition points (e.g., foster care exit, hospital discharge, juvenile detention release), crisis utilization, justice involvement, and service access patterns, alongside stakeholder feedback and best-practice research. Key themes included family conflict, placement instability, limited youth-appropriate housing options, service fragmentation during transitions, stigma, and the need for culturally responsive, developmentally appropriate supports.

These findings informed Housing Interventions priorities emphasizing family-centered and youth-specific housing models, coordinated cross-system transition planning, integrated housing navigation and tenancy supports, and strengthened collaboration among behavioral health, child-serving systems, and juvenile justice partners to promote housing stability and positive youth outcomes.

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

To ensure housing interventions services address the unique needs of LGBTQ+ children and youth, ICBHS conducted a targeted CPP. Activities included review of local housing, behavioral health, and juvenile justice data; engagement with cross-system partners such as behavioral health, education, child welfare, probation, housing providers, LGBTQ+ advocacy groups, and the CoC; focus groups with LGBTQ+ youth and families; and provider and community surveys.

ICBHS analyzed trends in youth homelessness, system transitions (e.g., foster care, hospital discharge, juvenile detention release), crisis utilization, justice involvement, and service access, combined with stakeholder feedback and research on LGBTQ+ youth needs. Key themes included family rejection, placement instability, lack of safe and affirming housing, service fragmentation during transitions, discrimination and stigma, and the need for culturally responsive, gender-affirming supports.

These findings guided housing interventions priorities emphasizing safe, affirming, and youth-centered housing; integrated housing navigation and tenancy support; coordinated cross-system transition planning; and strengthened collaboration among behavioral health, child-serving systems, juvenile justice, and LGBTQ+ organizations to promote housing stability, safety, and well-being for LGBTQ+ youth.

c) In the child welfare system

To ensure housing interventions services meet the unique needs of children and youth involved in the child welfare system, ICBHS conducted a focused CPP. Activities included review of local housing, behavioral health, and child welfare data; engagement with cross-system partners such as behavioral health, child welfare, probation, housing providers, and the CoC; focus groups with youth and families involved in child welfare; and provider and community surveys.

ICBHS analyzed trends in youth homelessness, system transitions (e.g., foster care exit, hospital discharge, juvenile justice involvement), crisis service use, and service access patterns, alongside stakeholder feedback and research on best practices for child welfare-involved youth. Key themes included placement instability, limited availability of family- and youth-appropriate housing, gaps in transition planning, service fragmentation across systems, stigma, and the need for culturally responsive, trauma-informed supports.

These findings shaped housing interventions priorities emphasizing family- and youth-centered housing models, coordinated cross-system transition planning, integrated housing navigation and tenancy supports, and strengthened collaboration among behavioral health, child welfare, juvenile justice, and housing partners to improve housing stability, safety, and positive outcomes for child welfare-involved youth.

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

a) Older adults

To ensure housing interventions services reflect the unique needs of eligible older adults, ICBHS conducted a comprehensive CPP. Activities included review of local housing and behavioral health data; engagement with cross-sector partners such as behavioral health, healthcare, social services, housing providers, and the CoC; focus groups with adults and older adults with lived experience; and provider and community surveys.

ICBHS analyzed homelessness trends, crisis and hospitalization data, justice involvement, and service access patterns, along with stakeholder feedback and best-practice research. Key themes included limited affordable and supportive housing, long waitlists, fragmented coordination during system transitions (e.g., hospital, crisis, and justice settings), housing instability, stigma and discrimination, and the need for culturally responsive and accessible housing supports.

These findings informed housing interventions priorities emphasizing coordinated, housing-first approaches; integrated housing navigation and tenancy-sustaining services; strengthened cross-system collaboration; and structured transition planning to improve housing stability and recovery outcomes for eligible older adults.

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

To ensure housing interventions services address the unique needs of adults who are in, or at risk of involvement in, the justice system, ICBHS incorporated targeted outreach and data review as part of its CPP. This included engagement with probation, sheriff and jail health services, courts, public defenders, reentry providers, housing agencies, and the local CoC, as well as focus groups and surveys that included individuals with lived experience of incarceration and homelessness.

ICBHS reviewed data related to jail bookings and releases, length of stay, reentry trends, homelessness and coordinated entry system data, crisis and hospitalization utilization, and service access patterns. Stakeholder feedback highlighted significant barriers, including housing instability upon release, limited access to affordable housing for individuals with criminal justice histories, fragmented coordination between justice and housing systems, stigma and discrimination, and service disruptions during incarceration and reentry transitions.

These findings informed Housing Interventions priorities that emphasize pre-release housing planning, strong collaboration with justice partners, housing navigation and tenancy-sustaining services, and coordinated, wraparound supports to reduce homelessness, promote stability, and decrease recidivism among justice-involved adults.

c) In underserved communities

To ensure housing interventions services address the unique needs of adults in underserved communities, ICBHS incorporated targeted outreach and equity-focused analysis within its CPP. This included engagement with community-based organizations, culturally specific service providers, faith-based partners, healthcare providers, housing agencies, and the local CoC, as well as focus groups and surveys inclusive of individuals from historically underserved racial, ethnic, rural, and low-income communities.

ICBHS reviewed disaggregated data on homelessness, service access, crisis utilization, geographic disparities, and social determinants of health to identify inequities in housing stability and behavioral health outcomes. Stakeholder feedback highlighted barriers including limited affordable housing in rural areas, transportation challenges, language access gaps, digital divide issues, stigma, and lack of culturally responsive services.

These findings informed Housing Interventions priorities that emphasize equitable access, culturally and linguistically responsive housing navigation, strengthened partnerships with trusted community providers, targeted outreach in high-need areas, and integrated supports designed to reduce disparities and improve housing stability among adults in underserved communities.

Local Housing System Engagement

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

   ICBHS will coordinate closely with the local CoC to ensure streamlined referrals, shared prioritization, and effective linkage of BHSA eligible individuals to Housing Interventions services. This coordination will support alignment between the behavioral health system and the county's homelessness response system to maximize housing stability outcomes.

   ICBHS will participate in collaborative planning efforts with the CoC, including joint meetings and ongoing communication to align policies, eligibility criteria, and prioritization processes. Through these partnerships, the county will ensure that individuals with significant behavioral health needs are appropriately prioritized within coordinated entry processes for housing resources, including permanent supportive housing and other housing interventions.

   Clear referral pathways will be established between the ICBHS, the CoC, and the MCPs. CoC and MCP partners, including homeless outreach teams, shelters, housing navigators, and other service providers, will be able to refer individuals directly to ICBHS for behavioral health screening, assessment, and enrollment in Housing Intervention services when appropriate. Similarly, ICBHS programs will refer BHSA eligible individuals to the CoC and MCPs for housing placement consideration and connection to available housing resources.

   To support effective coordination, ICBHS will designate staff responsible for housing system collaboration to serve as liaisons with the CoC. These staff will facilitate communication, participate in case conferencing when appropriate, and ensure timely responses to referrals. Shared processes will support data-informed decision-making while maintaining confidentiality requirements. This integration will help ensure that individuals referred through the CoC receive both housing placement and ongoing behavioral health supports necessary for long-term stability.

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

a) Local CoC

ICBHS actively participates in CoC governance, coordinated planning, and case conferencing to align housing interventions with the community's homeless response system. ICBHS will work closely with the local CoC to

align priorities, coordinate referrals, and participate in shared planning processes. ICBHS will engage in coordinated entry discussions and case conferencing, as appropriate, to ensure individuals with significant behavioral health conditions are prioritized for housing resources, including PSH. Ongoing communication will support streamlined referrals between systems and reduce duplication of services.

b) Public Housing Agency

ICBHS will partner with local public housing agencies to support access to housing vouchers and other rental assistance programs for BHSA eligible individuals. This collaboration may include sharing information on supportive services available to tenants, coordinating documentation needed for eligibility, and working together to promote successful lease-ups and long-term housing retention.

c) MCPs

ICBHS maintains a formal partnership with MCP's and have ongoing collaboration meetings with Healthnet and their provider to develop a seamless system. MCP and ICBHS leadership discuss and monitor partnership goals through monthly and quarterly meetings. Through cross-system collaboration, coordinated entry processes, and shared case conferencing, ICBHS will ensure BHSA housing resources are strategically targeted to individuals with the highest behavioral health needs. This coordinated approach will reduce fragmentation, improve housing stability, and create a more comprehensive continuum that ranges from outreach and interim housing to permanent supportive housing with ongoing behavioral health services.

d) ECM and Community Supports Providers

ICBHS will align housing interventions with ECM and community supports provided by the MCP. Regular care coordination meetings will ensure shared care plans, defined roles, and braided funding strategies. Community supports such as housing navigation, transitional rent, housing deposits, and tenancy-sustaining services are leveraged alongside behavioral health services. This integration prevents duplication, maximizes available funding, and ensures individuals receive both clinical and housing-related supports. Collaboration between the MCP providers and ICBHS will continue through referral process and monthly check-in meetings.

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

Through integrated planning, formal referral pathways ICBHS will collaborate with other existing housing programs to ensure housing interventions are implemented as a coordinated system of care that expands access and promotes sustained housing stability for BHSA eligible individuals.

ICBHS will actively collaborate with existing and prospective PSH developers and operators to expand

housing capacity for individuals with behavioral health needs. This may include participation in planning discussions for new developments, alignment of supportive service models with housing site requirements, and coordination of referrals to ensure units are filled with eligible individuals who can benefit fromintegrated supports. ICBHS will also work with providers to define clear expectations for service integration within PSH settings.

Through a collaborative approach ICBHS will ensure that BHSA Housing Interventions are not implemented in isolation, but rather as part of a coordinated housing and behavioral health continuum. By leveraging federal, state, and local housing resources alongside behavioral health services, Imperial County aims to expand permanent housing opportunities, strengthen tenancy supports, and improve long-term outcomes for individuals with complex behavioral health needs.

3. 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?

ICBHS will collaborate closely with Homekey+ projects and supportive housing sites to ensure BHSA eligible individuals are effectively referred, housed, and supported with integrated clinical and tenancy services. The county's approach will align housing development efforts with behavioral health service capacity to promote long-term stability and recovery.

ICBHS will establish structured referral pathways in partnership with housing developers, operators, and local CoC partners. Individuals identified as BHSA eligible, particularly those experiencing homelessness, frequent crisis utilization, justice involvement, or high behavioral health needs, will be prioritized for referral. ICBHS staff will collaborate with housing providers to ensure timely documentation, eligibility verification, and coordinated lease-up processes.

Once individuals are housed in Homekey+ or supportive housing sites, ICBHS will ensure access to ongoing clinical and recovery-oriented services. These may include outpatient mental health and substance use disorder treatment, FSP services, targeted case management, peer support, crisis intervention, and care coordination. Services will be delivered through a combination of on-site supports where feasible, community-based services, and telehealth to ensure continuity of care.

4. 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

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?**
   20

4. **How many of these individuals will receive rental subsidies for permanent housing on an annual basis?**
   5

5. **How many of these individuals will receive rental subsidies for interim housing on an annual basis?**
   5

6. **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?**

   ICBHS uses a data-driven forecasting methodology that integrates historical utilization trends, housing market data and program design to estimate total rent subsidies that may be needed and the projected number of individuals served annually in interim and permanent housing settings. The method was based on BHBH numbers for interim housing and MHSA capital investment permanent housing statistics. ICBHS will examine statistics from TR eligible individuals and the need for continued BHSA Housing Interventions after TR is exhausted for ongoing projections.

6a. For which setting types will the county provide rental subsidies?

Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Housing in mobile home communities
Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
Time Limited Interim Settings: Hotel and motel stays
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Non-Time-Limited Permanent Settings: Single room occupancy units

7. **Will this Housing Intervention accommodate family housing?**
   Yes

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

   BHSA housing interventions funding will be used to support time-limited and ongoing rental subsidies in both interim and permanent supportive housing settings. Funds may cover rental gap assistance, master leasing costs, operating support for dedicated behavioral health units, and flexible housing assistance to facilitate rapid placement. In interim settings, funding will support short-term bridge housing placements that stabilize individuals' exiting crisis, inpatient, residential, or justice settings while permanent housing is secured.

   In permanent settings, BHSA funds will primarily support rental subsidies not covered by other sources, as well as tenancy-sustaining services aligned with SMHS and TCM. This includes housing navigation, landlord engagement, move-in coordination, and lease compliance support to promote long-term stability.

   Overall, the intervention leverages BHSA resources to reduce homelessness among high-acuity individuals, accelerate housing placements, and ensure access to integrated behavioral health services that support recovery and housing retention.

   BHSA Housing eligible individuals will be assessed for housing needs and available options post TR. The focus will be to maintain stability and advance to permanent housing with rental assistance interventions including deposits and rent.

9. **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

10. 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

ICBHS will establish and maintain a diversified portfolio of housing options that includes a mix of permanent supportive housing, interim housing, scattered-site units, and flexible leasing options through partnerships across county departments and community-based organizations. This will help identify available housing resources and future unit opportunities including master leasing arrangements with private landlords, nonprofit housing providers, and property management firms. As well as partner with housing developers, and supportive housing providers to identify both existing and new housing opportunities.

11. Total number of units funded with BHSA Housing Interventions per year

20

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

N/A

Operating Subsidies (Chapter 7, Section C.9.2)

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**

   20

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

ICBHS will fund the ongoing operational costs of permanent supportive housing and other eligible housing models serving BHSA qualified populations. Operating subsidy funds will be used for:

- Utilities (electricity, water, gas, trash, internet)
- Routine maintenance and repairs
- Property management and administrative costs Insurance and property taxes (as applicable)
- Furnishings and essential household items for common areas
- Housing incidentals (Appliance, heater, etc.)
- Vacancy costs necessary to maintain unit availability
- Other reasonable and allowable housing operating expenses

5. For which setting types will the county provide operating subsidies?

Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Single room occupancy units
Non-Time-Limited Permanent Settings: Other settings identified under the Transitional Rent benefit

6. Will this be a scattered site initiative?
Yes

7. Will this Housing Intervention accommodate family housing?
Yes

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

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

Landlord Outreach and Mitigation Funds (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
20

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

ICBHS will incorporate the following interventions with the intention to strengthen partnerships with private property owners and reduce barriers that may prevent landlords from renting to BHSA-eligible tenants.

- Reimbursement for excessive unit damage beyond the security deposit

- Holding fees -Vacancy loss payments during unit turnover when tied to program participation Landlord incentives (signing bonus, one-time incentive)
- Unpaid rent not covered by rental subsidies (within allowable limits) Eviction prevention costs (back-rent)
- Cleaning and repair costs necessary to restore units to rentable condition
- Limited risk-sharing incentives to encourage participation

It is anticipated that these activities will help expand the pool of available rental units and promote landlord confidence in working with tenants receiving behavioral health services. Thus, increasing access to housing opportunities for individuals with serious behavioral health conditions.

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

6. Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Participant Assistance Funds (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
20

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

ICBHS will provide participant assistance interventions to assist in removing barriers to housing and support individuals with severe mental illness who are chronically homeless with immediate housing needs through the following interventions:

- Costs associated with obtaining government-issued identification and other vital documents
- Housing application fees
- Fees for credit reports
- Security deposits
- Utility deposits
- Storage fees
- Pet deposits and other pet fees
- Move-in costs
- Rent and utility arrears

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**

20

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

ICBHS will use BHSA housing interventions funding to support individuals with significant behavioral health

needs who are experiencing homelessness or housing instability and who are not eligible to receive housing-related services through Medi-Cal MCPs. This ensures that critical housing supports are available to uninsured individuals, individuals who are not enrolled in MCP housing benefits, or individuals whose needs exceed available MCP-funded services. BHSA funds will ensure access to comparable housing navigation, rental assistance, and tenancy sustaining services within the county's Behavioral Health System. Services will be coordinated with existing housing partners, the CoC, Public Housing Agencies, and other community stakeholders to avoid duplication and maximize resource alignment.

Through this intervention, ICBHS will expand equitable access to housing supports, ensure service continuity for uninsured or ineligible individuals, and strengthen the overall continuum of housing and behavioral health services in the community.

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
500

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

ICBHS will use BHSA housing interventions funding to support outreach and engagement activities designed to connect individuals experiencing homelessness or housing instability with significant behavioral health needs to housing and supportive services. The outreach and engagement component will focus on proactive, community-based efforts to identify, engage, assess, and connect BHSA-eligible individuals to Housing Interventions services, behavioral health treatment, and appropriate housing resources. Services will be trauma-informed, culturally responsive, and delivered in collaboration with local housing and homeless service partners.

Outreach and Engagement services may include the following:

- Street outreach and field-based engagement to individuals experiencing unsheltered homelessness, including those with serious mental illness and/or substance use disorders.
- Engagement and relationship-building activities to support individuals who are reluctant or historically disconnected from services.

- Initial housing-focused screening and assessment to determine eligibility for BHSA Housing Interventions and related supports.
- Linkage and referral coordination to PSH, interim housing, rental assistance programs, and other housing resources.
- Targeted case management and navigation services to assist with documentation, benefits enrollment, and preparation for housing placement.
- Collaboration with the CoC, emergency shelters, hospitals, crisis response teams, and justice partners to identify high-need individuals and coordinate referrals.
- Transportation assistance to support engagement, housing searches, and connection to services, when appropriate.
- Crisis stabilization linkage to ensure individuals engaged through outreach can access appropriate behavioral health care and avoid unnecessary institutionalization.

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?
Yes

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

3. How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?
1

Capital Development Project

Capital Development Project Specific Information

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

1. Name of Project
Sunrise Housing

2. **What setting types will the capital development project include?**

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

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

20

4. **Will this project braid funding with non-BHSA funding source(s)?**

No

5. **Total number of units in project, inclusive of BHSA and non-BHSA funding sources**

0

6. **Total number of units funded with Housing Interventions funds only**

14

7. **Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units**

N/A

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

9/1/2028

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

450000

10. **Have you utilized the "by right" provisions of state law in your project?**

Yes

Other Housing Interventions (Optional)

1. **If the county is providing another type of Housing Interventions not listed above, please describe the intervention**

N/A

2. **Is the county providing this intervention to chronically homeless individuals? Anticipated number of individuals served per year**
   N/A

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)**

ICBHS will use BHSA housing interventions funding to support the continuation and sustainability of the BHBH program ending June 30, 2027 by maintaining interim housing capacity, strengthening service integration, and ensuring smooth transitions to permanent housing for individuals with significant behavioral health needs.

BHSA Housing Interventions funding will support BHBH program operations by providing resources for:

- Interim housing subsidies to maintain short-term housing stability for individuals experiencing homelessness while they await placement into PSH or other permanent housing.
- Operating support for bridge housing sites, including costs associated with maintaining safe and structured interim settings that serve individuals with serious mental illness and/or substance use disorders.
- Integrated behavioral health services, including targeted case management, outpatient mental health and substance use treatment, crisis intervention, peer support, and other recovery services.
- Housing navigation and transition services to move individuals from bridge housing into permanent housing as quickly as possible.
- Tenancy readiness and sustaining supports to prepare individuals for successful lease-up and long-term housing retention.
- Coordination with the CoC, public housing agencies, landlords, and PSH providers to create streamlined pathways from bridge housing to permanent housing resources.

By aligning BHSA Housing Interventions funding with the BHBH program model, the county will ensure that bridge housing continues to function as a critical stabilization and transition platform rather than a long-term housing solution. The focus will remain on rapid engagement, behavioral health treatment integration, and expedited movement into permanent housing whenever feasible.

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?

None of the Above

2. For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

a) Housing Transition Navigation Services
No

b) Housing Deposits
No

c) Housing Tenancy and Sustaining Services
No

d) Short-Term Post-Hospitalization Housing
No

e) Recuperative Care
No

f) Day Habilitation
No

g) Transitional Rent
No

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

ICBHS has implemented a structured, collaborative process to identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports, including Transitional Rent, offered through Medi-Cal MCPs. This approach ensures that eligible members receive timely access to housing supports while coordinating with behavioral health services and broader housing resources.

ICBHS will identify potential candidates for housing-related community supports through multiple entry points within the behavioral health system, including:

- ICBHS outpatient behavioral health clinics, including FSP programs.
- Crisis services, including mobile crisis teams, crisis residential programs, and emergency departments.
- Outreach and engagement activities targeting individuals experiencing homelessness or housing instability.
- Coordination with justice system partners, shelters, and the CoC.

ICBHS will confirm eligibility in compliance with DHCS guidelines and BHSA Policy Manual program requirements and will conduct a behavioral health assessment that will include screening for homelessness or risk of homelessness, functional impairment, and level of clinical need. Identification will prioritize Medi-Cal members with significant mental health and/or substance use disorder needs who are experiencing housing instability or at risk of homelessness.

Once eligibility for services is confirmed, ICBHS will submit a formal referral to the MCP for housing-related Community Supports, including Transitional Rent services. ICBHS will continue to provide targeted case management, behavioral health services, and housing navigation support while the member is enrolled in MCP housing-related Community Supports. ICBHS will maintain communication with MCP providers to track housing outcomes, address barriers, and ensure service integration.

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

ICBHS has implemented structured coordination and communication processes to ensure that the county's contracted provider network for housing interventions is fully known to and accessible by MCPs serving the county. This ensures seamless referral pathways, service integration, and alignment of housing and behavioral health supports. ICBHS has contracted with interim, recovery, and permanent housing providers and will ensure that an up-to-date directory is maintained and shared with the MCPs as more contracts are developed.

ICBHS will actively share the provider network information with MCPs through participation in joint planning meetings and ongoing cross-system coordination. Through these coordinated efforts, ICBHS will ensure MCPs have full visibility into the Housing Interventions provider network, enabling timely referrals, seamless service delivery, and enhanced support for BHSA-eligible individuals navigating both housing and behavioral health systems.

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

6. Please describe the county behavioral health system's coordination efforts to align network development

ICBHS' coordination efforts with the MCPs directly align with and advance network development by ensuring that housing interventions are delivered through a structured, integrated, and adequately resourced provider network capable of meeting the needs of BHSA eligible individuals. These efforts are intentionally designed to build capacity, fill service gaps, and strengthen cross-system partnerships. It ensures that the Housing Interventions network is not developed in isolation. Instead, it is integrated within the broader housing and behavioral health care infrastructure. This alignment reduces duplication, leverages braided funding streams, and strengthens referral pathways.

ICBHS will maintain ongoing communication with the MCPs and housing partners to support continuous refinement of the network. Regular updates on capacity, unit availability, referral flow, and outcomes will allow ICBHS to adjust contracts and partnerships to ensure adequate geographic coverage and service accessibility.

7. 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?

ICBHS has established coordinated processes with the MCPs and contracted housing provider to ensure that Medi-Cal members living with significant behavioral health conditions do not experience gaps in services when MCP housing-related services, including transitional rent or other community supports, are exhausted.

ICBHS works with MCPs and housing provider partners to identify members receiving housing assistance well in advance of service end dates. ICBHS engages in shared care coordination and case conferencing to ensure proactive transition planning to prevent service interruptions. This allows behavioral health staff to reassess housing stability, update service plans, and coordinate next steps prior to benefit exhaustion.

Regardless of the status of MCP housing benefits, members remain eligible for county behavioral health services based on medical necessity. ICBHS ensures ongoing access to mental health and SUD services to help stabilize members while alternative housing resources are identified. If an individual remains housing insecure after MCP housing supports end, and meets eligibility criteria, ICBHS will utilize BHSA Housing Interventions funding to bridge gaps, including rental subsidies, tenancy sustaining services, or housing navigation supports.

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)?

No

a) Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?

No

ai) 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

ICBHS will not participate in the Flex Pool at this time due to limited administrative capacity to manage leasing arrangements, track subsidy allocations, and coordinate with multiple landlords and tenants. ICBHS plans to implement BHSA housing interventions through direct partnership with housing providers, PSH developers, or other housing providers that can provide stable units with supportive services. ICBHS also plans to implement Master Leasing as a more effective strategy for securing units for BHSA eligible individuals.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides more than one program, use the "Add additional program" button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects.

Does the county's plan include the development of innovative programs or pilots?
No

Workforce Strategy

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

a) Does the county intend to adopt this recommended approach for BHSA-funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

b) Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Build Workforce to Address Statewide Behavioral Health Goals

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)?**
   27%

2. **Upload any data source(s) used to determine vacancy rate**
   FY 25-26 Total Allocations, Vacant and Fill Rates.pdf

3. **For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates**
   Licensed Clinical Social Worker
   Licensed Marriage and Family Therapist Licensed Professional
   Clinical Counselor Psychiatrist
   Substance Use Disorder Counselor

4. **Please describe any other key workforce gaps in the county**

ICBHS continues to experience significant workforce gaps affecting recruitment, retention, and service sustainability. High turnover remains a concern, particularly among crisis staff and shift-lead classifications required to work evenings, nights, weekends, and on-call schedules. Despite offering shift differentials, extended and nontraditional work hours contribute to burnout and staff transfers to other positions.

Compensation challenges further impact recruitment and retention across classifications. A recent salary study indicates that several positions may fall approximately 20–30% below market rate, with limited differentiation based on years of experience. Administrative and clerical roles are particularly difficult to fill due to lower salary ranges. Compensation disparities also affect SUD counselors, whose responsibilities are comparable to behavioral health therapists but are often compensated at lower rates.

In addition to salary considerations, after-hours requirements and the state mandate for 24/7 mobile crisis

coverage place additional strain on staffing resources. These requirements can create barriers for staff with caregiving responsibilities and contribute to workforce shortages.

To mitigate these gaps, ICBHS has implemented strategies including expanded telehealth services, continuous recruitment through rolling postings, step advancements for new hires, reduced after-hours frequency, and redistribution of certain responsibilities to broaden the staffing pool. However, workforce challenges persist due to ongoing structural factors related to compensation competitiveness, shift work demands, and mandated service obligations. Continued system-level attention will be necessary to strengthen and stabilize the behavioral health workforce.

5. How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

Over the next three fiscal years, ICBHS anticipates a significant shift in workforce needs driven by new and forthcoming requirements under Behavioral Health Transformation (BHT) and BH-CONNECT. Implementation of new EBPs, fidelity monitoring standards, and expanded reporting requirements will require both expansion of staffing capacity and enhancement of existing staff competencies.

ICBHS expects to establish new positions associated with new and restructured programs, including expansion of clinical classifications to accommodate lower caseload requirements tied to certain EBPs and FSP levels of care. Existing staff will require training in newly adopted EBPs, and some modalities will require formal certification and ongoing continuing education to maintain fidelity standards. Workforce planning efforts will include identifying EBPs not currently offered, determining the number of clinical and non-clinical staff requiring training, and assessing whether additional recruitment is necessary to meet service delivery expectations.

In addition to staffing growth, ICBHS anticipates the need for increased clinical supervision capacity to support expanded EBP implementation and quality oversight. Administrative and data infrastructure staffing will also need to grow to meet enhanced documentation, reporting, and performance monitoring requirements under BHT and BH-CONNECT. This includes building systems for data collection, tracking, and fidelity monitoring for FSP levels of care.

Programmatic transitions such as the planned evolution of the Wellness Center into a Clubhouse model will further influence workforce composition and training needs in later fiscal years. ICBHS anticipates both quantitative growth in staffing and qualitative shifts in workforce competencies, requiring significant organizational investment to build sustainable service delivery capacity while maintaining ongoing operations

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

1a) Please explain any actions or activities the county is engaging in to leverage the program

ICBHS intends to leverage the BH-CONNECT Workforce Initiative by pursuing participation in the Behavioral Health Scholarship Program administered through the California Department of Health Care Access and Information (HCAI).

ICBHS is actively monitoring program guidance and application timelines and has identified the Scholarship Program as a key strategy to address workforce shortages impacting FSP and CSC for FEP services. Efforts include outreach to current staff, interns, and community-based provider partners to increase awareness of scholarship opportunities tied to service commitments in public behavioral health.

ICBHS is also coordinating with regional educational institutions and training programs to promote scholarship participation among students pursuing degrees in social work, marriage and family therapy, psychology, psychiatric nursing, and substance use disorder counseling. challenges, with the goal of strengthening local workforce pipelines an Workforce planning efforts are prioritizing classifications with the greatest recruitment and retention improving long-term staffing sustainability in alignment with BH-CONNECT requirements.

2. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?

Yes

2a) Please explain any actions or activities the county is engaging in to leverage the program

ICBHS plans to leverage the BH-CONNECT Workforce Initiative by supporting participation in the behavioral health student loan payment program.Currently, several therapists have independently applied for the program to obtain student loan repayment assistance. ICBHS supports these efforts by sharing program information, application timelines, and eligibility requirements with eligible staff to encourage participation.

Promoting the student loan payment Program serves as a key retention strategy, particularly for licensed eligible therapists who carry significant educational debt.

ICBHS will continue to disseminate information about the program to current and prospective staff as part of broader workforce stabilization efforts, with the goal of improving retention in critical service areas, including FSP, CSC for FEP.

3. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?

Yes

3a) Please explain any actions or activities the county is engaging in to leverage the program

ICBHS plans to leverage the BH-CONNECT workforce Initiative by pursuing opportunities under the behavioral health recruitment and retention program to address persistent workforce shortages impacting FSP, CSC for FEP, crisis services, and implementation of new EBPs.

Consistent with BHSA implementation plan priorities, ICBHS is assessing hard-to-fill classifications, including licensed eligible therapists, crisis staff, substance use disorder counselors, and clinical supervisors. The recruitment and retention program will be utilized to strengthen hiring incentives, improve retention of qualified staff, and enhance workforce stability in rural and high-need service areas.

ICBHS is integrating this strategy into its broader workforce development framework, which includes continuous recruitment efforts, step advancements for new hires, expanded telehealth flexibility, and support for professional development and certification required for EBP implementation. Participation in the recruitment and retention program will further support competitive hiring practices, reduce turnover, and build sustainable staffing capacity necessary to meet BHSA, BHT, and BH-CONNECT service delivery and reporting requirements.

4. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?

Yes

4a) Please explain any actions or activities the county is engaging in to leverage the program

ICBHS is exploring participation in the BH-CONNECT behavioral health community-based provider training program as part of its broader workforce development and capacity-building efforts. ICBHS is currently reviewing program eligibility requirements and participation criteria to determine which community-based providers and organizational partners may qualify for training supports under this program.

ICBHS plans to use this opportunity to strengthen workforce competencies related to evidence-based

practices, FSP service delivery, and CSC for FEP. Efforts will focus on identifying training gaps among contracted community-based providers and aligning training opportunities with service priorities established in the BHSA IP, BHT initiatives, and local service needs.

ICBHS will continue coordinating with provider partners to assess eligibility, encourage participation in available training opportunities, and support workforce skill development to improve service quality, fidelity to EBPs, and long-term system capacity.

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

No

5a) 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

ICBHS applied to the HCAI to support the implementation of a Psychiatry Residency Program. ICBHS was successfully accredited as both a Sponsoring Institution and a Psychiatric Residency Program, with its first cohort scheduled to begin in July 2026. This milestone represents a significant effort to expand the number of psychiatric providers serving Imperial County and address critical workforce shortages in behavioral health.

In addition, ICBHS maintains affiliation agreements with 20 educational institutions to provide internship and training opportunities for clinical graduate students, nursing staff, and Substance Use Disorder (SUD) counselors. These partnerships have strengthened the local workforce pipeline and increased interest in careers within the behavioral health field, contributing to long-term strategies aimed at reducing workforce gaps and improving access to care.

Budget and Prudent Reserve

All fields must be completed unless marked as optional. You don't need to finish everything at once– your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve.

Download and complete the budget template using the button below before starting this section

1. Please upload the completed budget template

Imperial County IP Plan Budget.pdf

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

a) Behavioral Health Services and Supports (BHSS)
No excess prudent reserve.

b) Full Service Partnership (FSP)
No excess prudent reserve.

c) Housing Interventions
No excess prudent reserve.

3. **Enter date of last prudent reserve assessment**
   5/20/2025

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

a) BHSS
No excess prudent reserve.

b) FSP
No excess prudent reserve.

c) Housing Interventions
No excess prudent reserve.

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once– your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

Behavioral health director certification

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

1. **Please upload the completed Behavioral health director certification template**

Behavioral Health Director Certificatio

County administrator or designee certification

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

1. **Please upload the completed County administrator or designee certification template**

County Administrator or De

Board of supervisor certification

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

1. **Please upload the completed Board of supervisor certification template**

   Forthcoming

Requests

Funding Transfer Request

1. **Please enter the proposed allocation adjustments to the tables below**

	Plan year one	Plan year two	Plan year three
Behavioral Health Services and Supports (Base 35%)	35	35	35
Full Service Partnership (Base 35%)	42	35	35
Housing Intervention (Base 30%)	23	23	23
Housing Interventions for Outreach and Engagement	0	7	7

Behavioral Health Services and Supports Transfers

2. Enter the proposed dollars transferred into/from Behavioral Health Services and Supports (Base 35 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Full Service Partnerships	0	0	0
Dollars transferred from Housing Intervention	0	0	0
Dollars transferred into Full Service Partnerships	0	0	0

Dollars transferred into Housing Intervention	0	0	0

3. For Behavioral Health Services and Supports, please include a rationale for the funding allocation transfer request

N/A

Full Service Partnership Transfers

4. Enter the proposed dollars transferred into/from Full Service Partnerships (Base 35 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Behavioral Health Services and Supports	0	0	0
Dollars transferred from Housing Intervention	$1, 146, 600	0	0
Dollars transferred into Behavioral Health Services and Supports	0	0	0
Dollars transferred into Housing Intervention	0	0	0

5. For Full Service Partnership, please include a rationale for the funding allocation transfer request

The BHSA transition reduced FSP funding for counties to support and sustain the current programs. Based

on these changes, ICBHS requires transferring 7% from Housing to FSP for continued sustainability and continuity of care during the first year of the BHSA transition. ICBHS will continue to assess the FSP program needs to determine future funding.Housing Interventions Transfers

Housing Interventions Transfers

6. Enter the proposed dollars transferred into/from Housing Interventions (Base 30 percent)

	Plan year one	Plan year two	Plan year three
Dollars transferred from Behavioral Health Services and Supports	0	0	0
Dollars transferred from Full Service Partnerships	0	0	0
Dollars transferred into Behavioral Health Services and Support	0	0	0
Dollars transferred into Full Service Partnerships	$1, 146, 600	0	0

6. For Housing Intervention, please include a rationale for the funding allocation transfer request

The BHSA transition reduced FSP funding for counties to support and sustain the current programs. Based on these changes, ICBHS requires to transfer 7% from Housing to FSP for continued sustainability and continuity of care during the first year of the BHSA transition. ICBHS will continue to assess the FSP program needs to determine future funding.

Supporting Information and Data

1. How does the funding transfer request respond to community needs and input?

ICBHS will benefit from stronger support to meet the needs of individuals with serious mental illness, co-occurring disorders, frequent hospitalizations, justice-involvement, and experiencing homelessness or at risk of homelessness. The transfer of 7% from Housing to FSP will assist ICBHS in responding to urgent service gaps, especially for high-acuity clients. ICBHS will also focus on providing FSP services to children under the age of 12 and primary SUD FSP, which are services not provided in the past, requiring additional funding.

2. Please include local data supporting the funding transfer request

PDF Transfer 7% justification.pdf

APPENDIX A

Imperial County Behavioral Health

Behavioral Health Services Act

Community Planning Process Report
Fall/Winter 2025

HMA

Table of Contents

Overview and Background

Imperial County Behavioral Health (ICBH) conducted a Community Planning Process (CPP) to support implementation of Proposition 1, the Behavioral Health Services Act (BHSA), and to inform future behavioral health planning in the county. To support this effort, ICBH contracted Health Management Associates (HMA), a national healthcare consulting firm, to provide technical assistance and facilitate the CPP in alignment with state requirements.

ICBH, in partnership with HMA, led a countywide engagement effort to ensure that local planning is informed by stakeholders closest to the work, including community members, peers, families, individuals with lived experience, front-line providers, and representatives from county and partner public agencies serving Imperial County residents. Through this process, stakeholders shared experiences navigating the behavioral health system, identified service gaps and structural challenges, and described opportunities for improving access, coordination, and outcomes across the continuum of care.

The findings summarized in this report reflect perspectives across the behavioral health spectrum and are intended to inform ICBH planning efforts as well as broader system collaboration with community partners.

Summary of the CPP Engagement Process

Stakeholder Engagement and Data Collection

The 2025 CPP was conducted over a five-month period, from July through November, and employed multiple, complementary engagement and data collection methods to gather input from across Imperial County's behavioral health system. ICBH and HMA designed the CPP to capture perspectives from both system partners and community members with lived experience, with particular attention to individuals and populations that are often underrepresented in formal planning efforts.

Engagement activities included:

- **Key Informant Interviews (KIIs):** HMA conducted individual interviews with 25 organizations and leaders representing a range of sectors, including behavioral health, healthcare, education, housing, social services, advocacy, and peer-led organizations. Interview participants reflected a cross-section of Imperial County's behavioral health ecosystem, including public agencies, community-based providers, and organizations serving priority populations. Interviews focused on system strengths, service gaps, workforce capacity, coordination challenges, and opportunities to improve access, quality, and equity across the continuum of care. Interviews were facilitated by external consultants to encourage candid feedback and independent analysis.
- **Focus Groups:** Ten focus groups were conducted with targeted populations, including youth, peers, providers, housing and social service representatives, individuals with substance use disorder, and LGBTQ+ community members. These discussions centered on lived experiences navigating behavioral health services, barriers to access and engagement, cultural responsiveness, and community-identified priorities for

improvement. Focus groups provided space for participants to share experiences in their own words and to build on one another's perspectives.

- **Surveys:** The CPP included two surveys designed to broaden participation beyond facilitated sessions. A provider survey gathered input from 133 behavioral health and related service providers across the county, while a community member survey captured 75 perspectives from residents regarding service access, needs, and priorities. Surveys included both closed-ended and open-ended questions to allow for quantitative analysis and narrative input.
- **Steering Committee Engagement:** Preliminary CPP findings were presented to the BHSA Steering Committee to gather feedback, validate emerging themes, and solicit input on priorities for the first year of the Integrated Plan. Steering Committee discussions focused on resonance with lived and professional experience, areas of alignment, and considerations for implementation.
- **Opioid Settlement Community Conversations:** 139 Community members were invited to participate in four facilitated meetings to share lived experience, discuss substance use–related challenges, and identify priorities for the use of Opioid Settlement funds. These conversations helped inform community-driven priorities across prevention, treatment, harm reduction, and recovery supports.

Qualitative data from interviews, focus groups, and open-ended survey responses were coded thematically and analyzed using an iterative approach. Themes were triangulated across engagement methods to identify issues that were consistently raised by multiple stakeholder groups. Quantitative survey results were used to contextualize and reinforce qualitative findings. Steering Committee review served as an additional validation step to ensure that findings accurately reflected community experience and system realities.

Collectively, these engagement activities were designed to move beyond a single moment of input and instead capture a range of voices, experiences, and perspectives across Imperial County. By engaging participants through multiple formats and settings, the CPP created opportunities for dialogue that reflected how people interact with the behavioral health system in their daily lives. The insights gathered through this process provide a community-informed foundation for thoughtful, responsive BHSA implementation.

Findings and Community Feedback

The following section summarizes the cross-cutting themes that emerged from Imperial County's BHSA Community Planning Process. These themes reflect a synthesis of input gathered through focus groups, key informant interviews, provider and community surveys, and Steering Committee discussions. Collectively, they represent shared concerns, priorities, and recommendations voiced by community members, providers, and system partners regarding the behavioral health continuum in Imperial County.

Participants provided feedback on the broader behavioral health ecosystem, including services and systems that extend beyond the direct authority or scope of Imperial County Behavioral Health. Some input reflects varying levels of awareness regarding program eligibility, funding constraints, and agency roles. While not all suggestions raised through the CPP can be implemented within the parameters of BHSA regulations or available resources, the themes summarized below offer critical guidance for Integrated Plan development and future system improvements.

Cross-Cutting Themes

1. **Workforce Shortages and System Capacity Constraints**
   Across all engagement activities, workforce shortages emerged as the most pervasive and urgent challenge. Participants consistently cited difficulty recruiting and retaining clinicians, case managers, psychiatrists, and bilingual staff. High turnover, burnout, and pay disparities between county and contracted providers limit service capacity, increase wait times, and disrupt continuity of care.

2. **Barriers to Access and Timely Care**
   Community members and providers described significant barriers to accessing behavioral health services, including long waitlists, limited after-hours availability, transportation challenges, and complex intake processes. These barriers are especially pronounced in rural areas and among working families, youth, and individuals with limited resources.

3. **Fragmented Continuum of Care and Weak Transitions**
   Stakeholders noted that while crisis services are relatively strong, the broader continuum of care is fragmented. Transitions between crisis stabilization, outpatient services, substance use treatment, and long-term recovery lack consistency and follow-up. The absence of closed-loop referrals and shared tracking systems contributes to clients falling through gaps in care.

4. **Housing Instability as a Barrier to Recovery**
   Housing instability was repeatedly identified as a critical barrier to behavioral health stabilization and recovery. Participants emphasized the lack of supportive and transitional housing options, particularly for families, women, and individuals exiting treatment or crisis settings. Without stable housing, progress made in treatment is often short-lived.

5. **Crisis Response Gaps and Overreliance on Law Enforcement**
   While mobile crisis services were widely valued, stakeholders described limited coverage during evenings and weekends and an overreliance on law enforcement during behavioral health crises. Participants expressed a strong desire for expanded, non-law-enforcement crisis response options and more seamless coordination with emergency departments.

6. **Youth Behavioral Health and Early Intervention Needs**
   Youth mental health emerged as a consistent priority. Schools, families, and providers reported rising anxiety, depression, self-harm, and substance use among children and adolescents. Participants emphasized the need for earlier identification, school-based services, family engagement, and youth-friendly, stigma-free spaces for support.

7. **Substance Use Disorder (SUD) Continuum Gaps**
   Community input highlighted significant gaps in the local SUD continuum, including the absence of in-county detox services, limited residential treatment options, and insufficient aftercare supports. Stigma related to substance use and medication-assisted treatment (MAT) continues to hinder engagement, particularly among youth and rural populations.

8. **Cultural Responsiveness, Equity, and Trust**
   Participants underscored the importance of culturally responsive and linguistically appropriate services. While Spanish-language access is a strength, gaps remain for LGBTQ+ residents, veterans, men, and smaller cultural groups. Stigma, confidentiality concerns, and distrust of systems continue to deter help-seeking, reinforcing the need for peer-led and community-rooted approaches.

9. **Outreach, Communication, and System Navigation**
   Many community members reported difficulty understanding what services are available, how to access them, and what to expect once connected. Effective outreach was described as consistent, localized, and relational, with strong support for peer messengers, school-based outreach, and age-appropriate communication channels such as social media for youth.

10. **Strong Relationships and Opportunities for Collaboration**
    Despite system challenges, participants consistently identified Imperial County's strong relationships and collaborative culture as a key asset. The county's size allows for personal connections across agencies, and Behavioral Health leadership was described as accessible and responsive. Stakeholders expressed optimism that these strengths can support more integrated planning, shared accountability, and system transformation moving forward.

Summary Recommendations

Community input gathered through the Community Planning Process indicates that Imperial County's behavioral health system is navigating a period of significant transition and opportunity. Stakeholders consistently describe a system anchored by strong relationships and commitment, yet constrained by workforce shortages, fragmented coordination, housing instability, and access barriers that limit timely and equitable care. At the same time, participants expressed optimism that BHSA implementation can serve as a catalyst for strengthening integration, advancing equity, and shifting the system toward prevention, continuity, and whole-person care.

The recommendations below synthesize cross-cutting themes from community members, providers, and system partners and are intended to inform the development and implementation of Imperial County Behavioral Health's Integrated Plan.

Strengthening System Integration and Coordination

1. **Advance coordinated referral and navigation across systems.**
   Prioritize the development or enhancement of cross-system referral, tracking, and follow-up processes that connect behavioral health, managed care, hospitals, schools, housing providers, and community-based organizations. Improved coordination should focus on reducing duplication, minimizing handoff failures, and ensuring individuals successfully connect to ongoing care.
2. **Improve continuity across levels of care.**
   Address gaps at transition points by strengthening step-down supports, warm handoffs, and follow-up services as individuals move between crisis response, outpatient care, substance use treatment, housing interventions, and community-based supports.

Improving Access, Equity, and Quality

3. **Reduce barriers to timely access.**
   Streamline intake and eligibility processes, expand same-day or rapid-access options, and increase evening, weekend, and mobile or field-based services to better reach rural communities, working families, and individuals with transportation challenges.
4. **Embed culturally responsive and affirming practices systemwide.**
   Continue to strengthen language access, cultural humility, and affirming care across programs, with focused strategies to meet the needs of Latino communities, LGBTQ+ residents, veterans, farmworkers, youth, and other populations experiencing disproportionate behavioral health impacts.

Building a Sustainable Workforce

5. **Stabilize and support the behavioral health workforce.**
   Address workforce shortages by investing in recruitment, retention, and career advancement, including competitive compensation, reduced administrative burden, supervision support, and targeted strategies to grow bilingual and bicultural staffing capacity across county and contracted providers.
6. **Expand peer and lived-experience roles.**
   Increase the integration of peers and community health workers across outreach, navigation, crisis response, and ongoing care. Formalize training, supervision, and team-based models to strengthen engagement, trust, and continuity.

Prioritizing Youth, Prevention, and Early Intervention

7. **Strengthen prevention and early-intervention pathways for youth.**
   Expand school-linked and community-based early-intervention efforts for children, youth, and transition-age youth, including trauma-informed supports, family engagement, and clear pathways to more intensive behavioral health services when needed.

Addressing Substance Use and Crisis Needs

8. **Close gaps in the substance use disorder continuum.**
   Invest in a more complete SUD continuum by expanding access to detoxification, residential treatment, medication for addiction treatment, harm-reduction strategies, and coordinated transitions between treatment, recovery housing, and long-term supports.
9. **Enhance crisis response capacity beyond law enforcement.**
   Strengthen 24/7 crisis response by expanding mobile crisis services, improving after-hours coverage, and deepening coordination with emergency departments to reduce reliance on law enforcement and emergency room boarding.

Expanding Housing and Supportive Interventions

10. **Align housing investments with behavioral health supports.**
    Prioritize supportive, transitional, and recovery-oriented housing models that are integrated with behavioral health services, case management, and peer support, including options responsive to the needs of families, women, youth, and individuals exiting crisis or residential care.

APPENDIX B

Imperial County Behavioral Health CPP Focus Groups: Thematic Analysis (n=10)

Theme 1. Persistent Barriers to Access and Engagement

Summary:
Across populations, participants described multiple obstacles preventing timely or consistent access to behavioral health services. Transportation barriers and long wait times were nearly universal, particularly affecting residents in rural and northern parts of Imperial County. Workforce shortages contribute to delays and rushed appointments, while stigma and fear of judgment continue to discourage youth, LGBTQ+, and small-town residents from seeking help. Participants also cited confusion about available services and limited guidance navigating care systems.

Key Insights:

- Transportation, geography, and system navigation remain the top barriers.
- Wait times and staff shortages create discouragement and disengagement.
- Cultural stigma and confidentiality fears limit help-seeking, particularly among youth and marginalized groups.

"If you want help but can't get there, how are you supposed to go to therapy?" — Youth participant

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Theme 2. Fragmented Continuum of Care

Summary:
While Imperial County has strong crisis response programs and well-regarded facilities like Casa Serena and the Wellness Center, participants emphasized that the broader continuum of care remains disjointed. Transitions between crisis stabilization, outpatient, and long-term recovery are inconsistent, with little follow-up once immediate needs are met. The absence of in-county residential or inpatient facilities forces residents to travel outside the region, disrupting recovery and family support systems. Prevention and early-intervention services are also underdeveloped, especially in schools.

Key Insights:

- The system performs well at crisis response but falters in long-term continuity.
- Gaps in local residential and inpatient care undermine recovery stability.
- Prevention and early education, especially for youth, need expansion.

“They stabilize you, but then you’re on your own — there’s no next step.” — Social Services participant

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Theme 3. Inconsistent Quality of Care and Workforce Strain

Summary:
The quality of behavioral health services varies across programs and providers. Many participants praised compassionate staff and specific programs (e.g., SUD treatment and the Wellness Center), but frequent staff turnover, high caseloads, and administrative barriers weaken consistency. Medication management often dominates treatment, with clients desiring more holistic, person-centered approaches that address root causes and social context.

Key Insights:

- Workforce shortages and burnout compromise quality and continuity.
- Clients desire more counseling and relational care rather than medication-only approaches.
- In some areas, the same clients cycle through care repeatedly due to systemic strain.

“They’re caring people, but they’re stretched too thin.” — Peer participant

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Theme 4. Cultural Responsiveness and Representation

Summary:
Most participants reported feeling respected by behavioral health staff, especially in terms of language accessibility and general courtesy. However, they emphasized the need for deeper cultural humility, greater diversity among providers, and services that reflect the lived realities of Imperial County residents. Spanish-language access is strong, but smaller ethnic and cultural groups remain underserved. LGBTQ+ participants noted positive progress in inclusivity but called for ongoing training and broader community acceptance.

Key Insights:

- Cultural responsiveness is improving but uneven across programs.
- Representation and relatability are essential for trust-building, particularly for youth and marginalized groups.

- Continuous staff training and community education are needed to strengthen inclusivity.

"It helps when your provider understands where you come from." — Education focus group participant

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Theme 5. Community Awareness, Outreach, and Trust-Building

Summary:
Effective engagement occurs when outreach is consistent, local, and peer-led. Social media platforms (TikTok, Instagram) are highly effective among youth, while word of mouth and community events resonate with older adults. Participants emphasized that trust builds through repeated contact and familiarity with outreach staff — "showing up consistently" matters more than large-scale campaigns. However, stigma and misinformation persist, particularly around mental health and LGBTQ+ issues.

Key Insights:

- Outreach must be tailored by age, language, and cultural group.
- Peer and lived-experience messengers are the most trusted communicators.
- Consistency and relational trust are vital for long-term engagement.

"If you keep showing up, people start believing you care." — Outreach worker (Social Services)

Theme 6. Vision for an Integrated, Person-Centered System

Summary:
Across all focus groups, participants expressed a shared vision for an integrated behavioral health system that meets people where they are. They called for co-located facilities combining mental health, SUD, medical, and housing services; expanded transportation; a bilingual and culturally aligned workforce; and investment in prevention and education. The ideal future system would employ peers, provide trauma-informed and affirming care, and prioritize youth, family, and community partnerships.

Key Insights:

- Integration and co-location are top priorities for improving coordination and access.
- Workforce development — including peer integration — is critical for sustainability.

- Participants want holistic, whole-person care that addresses behavioral, physical, and social needs.

"All the departments should be in one building — it should feel like one system, not a maze." — SUD provider

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Refined Thematic Framework Summary Table

Theme	Core Focus	Key System Implications
1. Barriers to Access and Engagement	Structural and social barriers limiting service entry	Expand transportation, reduce stigma, improve navigation
2. Fragmented Continuum of Care	Gaps in follow-up, prevention, and residential care	Develop local inpatient/residential options and improve transition support
3. Inconsistent Quality and Workforce Strain	Uneven service quality and provider burnout	Increase workforce capacity, retention, and supervision
4. Cultural Responsiveness and Representation	Need for culturally aligned, relatable, empathetic staff	Expand diversity and cultural humility training
5. Community Awareness and Trust-Building	Outreach effectiveness and engagement	Strengthen peer-based, tailored outreach and education
6. Vision for an Integrated, Person-Centered System	Countywide aspiration for coordinated, holistic care	Build integrated care hubs and invest in prevention and workforce

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Summary

The themes together depict a behavioral health system that is **compassionate yet capacity-limited**, **respectful yet unevenly inclusive**, and **innovative yet fragmented**. Participants across all groups — youth, peers, providers, clients, and system partners — collectively envision a **stronger, integrated, community-rooted system** that removes

logistical barriers, normalizes behavioral health care, and delivers equitable, person-centered services to all Imperial County residents.

Findings: Thematic Analysis of Imperial County Behavioral Health Focus Groups

Ten focus groups were conducted across Imperial County with diverse participant groups including youth, peers, providers, social services representatives, housing providers, SUD clients, and LGBTQ+ community members. Using thematic analysis, six major themes emerged that describe participants' experiences with the behavioral health system and their vision for improvement. These themes reflect the interconnected challenges and opportunities facing behavioral health care access, quality, and coordination in the county.

Theme 1. Barriers to Access and Engagement

Across nearly all groups, participants identified substantial logistical, structural, and social barriers that impede access to behavioral health (BH) care.
Transportation challenges were the most consistent barrier, particularly in rural areas where bus routes are infrequent and Medi-Cal rides are unreliable. Many residents described long wait times between intake and treatment, often caused by workforce shortages and high staff turnover.
Social stigma and confidentiality concerns further deter engagement, especially among youth, LGBTQ+ individuals, and residents in smaller or more conservative communities.

Several participants also noted difficulty understanding where or how to obtain services. Youth frequently reported that behavioral health resources were not well advertised in schools, while adults described complex or confusing referral pathways. Collectively, these barriers contribute to delays in care, disengagement, and unmet mental health and substance-use needs.

"Some clients won't go to the mobile unit because everyone can see them." — Social Services staff
"If you want help but can't get there, how are you supposed to go to therapy?" — Youth participant

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Theme 2. Fragmented Continuum of Care

Participants widely agreed that while Imperial County offers strong crisis-response programs such as Casa Serena and the Wellness Center, the broader continuum of care remains fragmented. Clients receive immediate crisis stabilization but often experience

limited follow-up or difficulty transitioning to ongoing services.
The absence of in-county residential or inpatient treatment options forces many to travel to other regions, disrupting family support and continuity of care. Prevention and early-intervention programs — particularly those embedded in schools — were viewed as insufficient or inconsistently delivered.

Overall, participants described a system that is effective in emergencies but weak in sustained engagement and recovery support. They emphasized the need for warm hand-offs, long-term case management, and stronger linkages across programs and departments.

"They stabilize you, but then you're on your own — there's no next step." — Social Services participant

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Theme 3. Workforce Strain and Inconsistent Quality of Care

Although many residents praised the compassion and commitment of individual providers, the quality of behavioral health services was described as uneven. High caseloads, limited supervision, and frequent turnover create inconsistency in care and weaken client–provider relationships.
Some participants reported that care was overly focused on medication management rather than counseling, peer support, or root-cause treatment. Others noted that differences between mental health and substance-use services create confusion and hinder coordination.

These workforce and structural challenges not only affect service quality but also limit retention and contribute to cyclical client engagement patterns — with individuals frequently re-entering services due to interrupted progress.

"They're caring people, but they're stretched too thin." — Peer participant

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Theme 4. Cultural Responsiveness and Representation

Cultural respect and inclusivity were recurring priorities across groups. Participants generally felt treated with dignity and noted strong bilingual capacity throughout the county, but they emphasized that true cultural responsiveness requires more than language access.
Residents called for providers who reflect the community's diversity and understand the lived experiences of local families, agricultural workers, LGBTQ+ residents, and people

experiencing homelessness.
Youth and peers highlighted the need for relatable staff who can communicate in accessible, non-clinical ways.

Although LGBTQ+ participants described positive experiences with affirming providers, they also encountered resistance when promoting outreach in conservative spaces. Participants stressed the importance of continued cultural-competence training and trauma-informed practices for all staff.

"It helps when your provider understands where you come from." — Education group participant

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Theme 5. Community Awareness and Trust-Building

Effective engagement, according to participants, depends on authenticity, consistency, and trusted messengers.
Younger residents identified social media platforms like TikTok and Instagram as the most effective outreach tools, while older adults relied on word-of-mouth, referrals, and community events. Across age groups, participants valued outreach that was personal and consistent rather than promotional.

Peer and lived-experience messengers — people who "speak from experience" — were viewed as the most credible communicators. Participants also recommended population-specific outreach approaches: for instance, text-based outreach for younger adults, phone calls for older adults, and bilingual materials for Spanish-speaking families.
However, stigma, misinformation, and institutional mistrust continue to limit the reach of behavioral-health education campaigns, underscoring the need for ongoing visibility and presence across neighborhoods, schools, and faith communities.

"If you keep showing up, people start believing you care." — Outreach worker

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Theme 6. Vision for an Integrated, Person-Centered System

Across all focus groups, participants articulated a shared vision for a behavioral health system that is **integrated, compassionate, and community-rooted**.
They envision co-located service hubs that combine mental health, substance-use, housing, and medical supports in one accessible location.
Participants called for a larger and more stable bilingual workforce, transportation vouchers, after-hours services, and sustained investment in prevention and education.

Youth and parents emphasized the importance of school-based programs and family mental-health literacy, while providers and peers championed hiring more people with lived experience to strengthen engagement.
The ideal future system would address not only behavioral health needs but also the social determinants that shape them — housing, employment, and social connection — creating a truly whole-person model of care.

"All the departments should be in one building — it should feel like one system, not a maze." — SUD provider

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Summary

Collectively, these themes illustrate a behavioral health system that is **deeply valued but stretched to its limits**. Imperial County residents see evidence of compassion, resilience, and progress within the system — yet they continue to experience access barriers, workforce strain, and disjointed care.

Participants' vision for the future emphasizes integration, prevention, and cultural responsiveness: a system that is **accessible, coordinated, and reflective of the community it serves.**

APPENDIX C

Imperial County Behavioral Health: Thematic Analysis (Key Informant Interviews) [n=24]

1. Workforce Shortages and Retention Challenges

Widespread theme across nearly all organizations.

- Providers report difficulty recruiting and retaining clinicians, case managers, and psychiatrists.
- Contracted CBOs cannot match county pay scales, leading to turnover after staff complete licensure hours.
- Burnout, documentation burden, and lack of career advancement contribute to attrition.
- Limited bilingual and bicultural workforce capacity, especially for male and rural-area staff.

Illustrative Input:

"We train clinicians and lose them as soon as they're licensed." – CFS/Womanhaven
"The same handful of clinicians are stretched across multiple programs." – Innercare

Implication: Workforce instability disrupts continuity of care, creates long waitlists, and erodes trust among clients.

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2. Fragmented Care Coordination and Data Systems

Repeated concern across FQHCs, hospitals, public agencies, and CBOs.

- Absence of shared data or referral tracking between Imperial County Behavioral Health (ICBHS) and partner agencies (e.g., Innercare, Health Net, ECRMC).
- Reliance on fax, paper referrals, or client self-report to confirm service engagement.
- No closed-loop referral mechanism to verify whether clients connect to next-level care.
- Managed care plans and county programs struggle to integrate records due to privacy and technical barriers.

Illustrative Input:

“We fax a referral and never know what happens.” – FQHC leader
“Care coordination depends on whether the client is a good historian.” – Innercare

Implication: Clients with co-occurring or chronic conditions fall through the cracks, especially during transitions between systems (hospital, probation, SUD programs, etc.).

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3. Housing Instability and Lack of Transitional Options

Most consistent and urgent theme.

- Nearly every interview described housing as a barrier to recovery.
- Few supportive or transitional housing units; families, women, and SUD clients most affected.
- Shelter contracts often reimburse for one client, not dependents (forcing agencies to absorb family costs).
- After-care housing for people exiting crisis or recovery programs is severely limited.

Illustrative Input:

“We have nowhere to send a mom with her kids after she finishes treatment.” – WomanHaven
“Clients leave Jackson House and end up homeless again.” – Crisis residential provider

Implication: Behavioral stabilization is undermined by unstable housing; relapse and hospital recidivism are common.

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4. Access Barriers and Long Wait Times

Clients face lengthy delays to start services.

- Waitlists for therapy or psychiatry commonly exceed 4–6 weeks.
- Intake steps (nurse → case manager → psychiatrist) discourage follow-through.
- Transportation barriers compound delays, particularly in rural towns (Calipatria, Westmorland, Ocotillo).
- Limited after-hours or weekend options.

Illustrative Input:

“By the time the therapist calls, the crisis has passed — or gotten worse.” – Sure Helpline
“Rural areas never see the mobile unit anymore.” – Open Door Ministry

Implication: Delays and rigid hours create inequities in access, especially for farmworkers, youth, and working parents.

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5. Crisis Response Gaps and Reliance on Law Enforcement

Systemic tension between behavioral health, hospitals, and police.

- Crisis calls after hours default to law enforcement; families fear calling 911.
- County mobile crisis teams (MERT/CCRT) praised but understaffed and slow to deploy.
- Hospitals report long wait times for 5150 evaluations; ERs hold patients overnight due to lack of psychiatric beds.
- No specialized non-law-enforcement crisis option currently available.

Illustrative Input:

“Calling the police retraumatizes survivors.” – WomanHaven
“After midnight, the ER becomes the psych unit.” – ECRMC
“Weekend coverage is nonexistent.” – ICSO

Implication: Families and providers lack safe, timely crisis interventions, leading to ER boarding and avoidable incarceration.

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6. Youth and School-Linked Needs

Youth behavioral health and early intervention repeatedly identified as a gap.

- Rising anxiety, depression, self-harm, and substance use reported by schools and CBOs.
- Long waits for youth therapy; referrals often lost between systems.
- Schools want trauma-informed supports and family engagement.
- Youth need safe, stigma-free spaces (drop-in centers, peer programs).

Illustrative Input:

“Kids are cutting, using, and waiting three months for help.” – RiteTrack
“We need a TAY one-stop where youth can access everything without shame.” – IVROP
“Teachers see the issues but don’t have the tools.” – ICOE

Implication: Prevention and early intervention infrastructure remain underdeveloped; most investment goes toward crisis response instead of upstream supports.

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7. Substance Use Disorder (SUD) and Continuum Gaps

Substance use is a countywide concern, intersecting with housing, justice, and youth systems.

- No in-county detox facility; clients must go to San Diego or Riverside.
- MAT programs exist (methadone, buprenorphine), but stigma remains strong.
- Transition points between SUD treatment, probation, and sober living lack coordination.
- Providers call for more harm reduction and contingency management approaches.

Illustrative Input:

“People go to sober living before they’re ready for detox — and relapse.” – Foundation in Recovery
“Methadone still carries stigma; cities don’t want mobile units.” – IV Medical Clinic
“Youth as young as 11 are using.” – RiteTrack

Implication: Without detox and after-care housing, recovery efforts are fragile. Stigma and jurisdictional silos prevent effective coordination.

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8. Stigma, Cultural Barriers, and Distrust

Behavioral health stigma deeply embedded in community culture.

- Fear of being labeled or losing confidentiality deters people from seeking help.
- Latino cultural norms discourage open discussion of mental illness (“no estamos locos”).
- Veterans, law enforcement, and men experience unique stigma tied to job and masculinity.

- LGBTQ+ residents face discrimination and lack of culturally affirming care.

Illustrative Input:

"Veterans won't talk about trauma if it risks their gun rights." – Reps for Vets
"We need more providers who truly understand LGBTQ+ clients." – Donnelly Center

Implication: Stigma undermines outreach and retention; building trust through peers, community education, and culturally responsive practice is essential.

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9. System Strengths and Emerging Collaboration

Despite challenges, respondents consistently praised the county's openness and relationships.

- Small size fosters personal connections between departments (Probation, BH, Education, PH).
- BH leadership viewed as responsive and approachable.
- Monthly meetings with hospitals and public health improving coordination.
- Grants like BHSSA and CHIP have encouraged cross-sector planning.

Illustrative Input:

"Because we're small, collaboration is easier here." – Probation
"Behavioral Health listens — they just need more resources." – Catholic Charities

Implication: Strong relational infrastructure provides a foundation for system transformation once capacity issues are addressed.

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10. Community Priorities for the Next 3 Years

Across interviews, success was envisioned as:

- **Adequate staffing** and equitable pay for contracted providers.
- **24/7 crisis coverage** and reduced ER boarding.
- **Expanded housing** linked with behavioral health and employment supports.
- **Shared referral and data systems** to close care loops.

- **Trauma-informed and culturally competent workforce** serving youth, LGBTQ+, veterans, and farmworkers.
- **Prevention-focused approach** rather than crisis-driven response.

Summary

Thematic Domain	Key Insights
Workforce	Shortages, turnover, wage disparities, burnout
Coordination	Fragmented data and referrals, lack of feedback loops
Housing	Insufficient capacity, family shelter gaps
Access	Wait times, transportation, limited after-hours services
Crisis	Overreliance on law enforcement, 5150 delays
Youth	Early intervention, school partnerships, prevention
SUD	Detox gap, stigma, coordination issues
Stigma & Culture	Fear, cultural taboos, lack of affirming care
System Strengths	Collaboration, leadership responsiveness
Vision for Success	Unified, person-centered, well-staffed system

KII's Thematic Analysis: Community Perspectives on Behavioral Health in Imperial County

Across interviews, participants described a system marked by **commitment and compassion** — but also **limited capacity, fragmented coordination, and chronic workforce shortages**. Stakeholders consistently expressed respect for the dedication of county staff while acknowledging that structural barriers continue to limit progress.

The overarching narrative from the interviews is clear: Imperial County's behavioral health system is staffed by people who care deeply about their community, but it operates within significant constraints — especially workforce, housing, and infrastructure. Despite these

barriers, the small size and strong relationships across agencies give Imperial County a unique opportunity to create a more cohesive, person-centered system.

Workforce Challenges and Service Capacity

Every organization emphasized that workforce shortages remain the county's most urgent and systemic problem. Providers across sectors — from health centers to social services and housing programs — struggle to recruit and retain qualified clinicians, case managers, and peer specialists. Contracted agencies, in particular, are unable to match county pay scales, leading to high turnover.

"Once our staff get licensed, they leave for better pay," one provider shared. "We're constantly training new people."

This revolving door disrupts continuity of care and adds strain on remaining staff. Smaller agencies reported losing bilingual clinicians faster than they can be replaced. High caseloads, limited supervision, and heavy documentation requirements further contribute to burnout.

Stakeholders linked workforce instability directly to service access and quality. "Even when we have funding," one director said, "we don't have the people to do the work."

Fragmented Coordination and Disconnected Systems

Across the system, interviewees described **fragmentation between providers and sectors** as a major barrier to effective care. Behavioral health, primary care, managed care plans, and hospitals often operate in parallel rather than as an integrated network.

Innercare and other FQHCs noted that referrals to county behavioral health are typically faxed, with no confirmation that a patient engaged in services. Hospitals and CBOs reported similar experiences. As one participant explained, "We don't know if clients actually make it to their next appointment — there's no feedback loop."

Stakeholders repeatedly called for shared data infrastructure, formal memoranda of understanding (MOUs), and joint case conferencing. Managed care plans expressed readiness to support data-sharing pilots, but technical and privacy challenges have slowed progress. Without integrated systems, clients with complex needs — especially those with co-occurring disorders or housing instability — are easily lost between agencies.

Housing Instability and Limited Transitional Options

The housing crisis was described as **the single most significant barrier** to behavioral health recovery and stability in Imperial County. Every provider interviewed — from crisis

centers to sober living programs — cited the lack of affordable and supportive housing as a major challenge.

Programs serving women and families, like CFS/Womanhaven and Open Door Ministry, described turning people away or keeping them longer because there was nowhere else to send them. Foundation in Recovery and Jackson House emphasized that many clients relapse or return to homelessness immediately after discharge due to the absence of transitional housing.

Systemic barriers, such as contracts that only reimburse for a single client instead of family units, further limit access. Stakeholders repeatedly called for housing models that integrate behavioral health support, case management, and peer navigation. As one participant summarized, “Housing and treatment have to go hand in hand — otherwise we’re setting people up to fail.”

Barriers to Access and Timely Care

Even where services exist, access remains inconsistent and delayed. Long wait times for therapy and psychiatry — often four weeks or more — were common across all organizations. Multiple intake steps discourage clients from following through, particularly those in crisis or without transportation.

In rural communities, distance and limited transit options further compound the problem. “People in Calipatria or Ocotillo have to choose between work and care,” one provider said. Several participants also called for evening or weekend hours to accommodate working families.

While telehealth has improved accessibility for some, others — particularly older adults and those with limited technology access — find it impersonal or confusing. Stakeholders agreed that the first point of contact matters deeply. As one crisis line worker noted, “When people reach out for help, that first conversation determines whether they stay.”

Crisis Response Gaps and Reliance on Law Enforcement

Crisis response emerged as one of the most fragile parts of the system. The county’s mobile crisis team (MERT/CCRT) was widely praised but described as understaffed and inconsistently available, especially after hours and on weekends.

Law enforcement, hospitals, and behavioral health providers all acknowledged that emergency response currently depends too heavily on police intervention. Domestic

violence and trauma organizations stressed that police involvement can retraumatize survivors and discourage future help-seeking.

At El Centro Regional Medical Center, behavioral health evaluations are often delayed overnight due to limited after-hours clinician availability, forcing patients to remain in the ER for extended periods. The Sheriff's Office similarly reported limited in-jail behavioral health coverage outside weekday hours.

Stakeholders consistently called for a 24/7 crisis continuum with non-law-enforcement options, faster response times, and improved coordination between emergency departments and behavioral health teams.

Youth Behavioral Health and Early Intervention

Schools, youth facilities, and education partners described a rising behavioral health crisis among youth. Increasing anxiety, depression, and substance use among students were universal concerns.

Educators and program staff emphasized the need for early identification, trauma-informed supports, and expanded school-based services. Wait times for therapy — sometimes up to three months — lead to disengagement, especially for adolescents in crisis. "Kids are cutting, using, and waiting months for help," one youth provider said.

The Imperial County Office of Education, IVROP, and RiteTrack highlighted progress under the Behavioral Health Student Services Act (BHSSA), which has improved collaboration between educators and mental health staff. However, participants stressed that schools still need dedicated counselors, family navigators, and safe, stigma-free spaces for youth.

Many stakeholders envisioned a transitional-age youth (TAY) center or "one-stop" hub combining behavioral health, housing, education, and job readiness services to better engage young people.

Substance Use Disorder (SUD) and Recovery Continuum Gaps

Substance use — particularly opioids, methamphetamine, and fentanyl — remains a major community concern. Stakeholders described a fragmented and incomplete SUD continuum, with no detox center in the county and limited residential treatment options.

Clients are often placed in sober living before detox is complete, increasing relapse risk. Providers like Imperial Valley Medical Clinic and Foundation in Recovery noted that stigma

toward MAT and methadone programs continues to be a major barrier — both from the public and local jurisdictions hesitant to host treatment sites.

Participants emphasized the need for harm reduction, contingency management, and integrated dual-diagnosis treatment, as many clients present with co-occurring mental health and substance use disorders. As one provider put it, “If we can meet people where they are — without judgment — we can keep them alive long enough to recover.”

Stigma, Culture, and Trust

Cultural stigma around mental health and substance use was a recurring theme across interviews. Many residents, particularly within Latino communities, still view behavioral health issues as personal weakness rather than medical conditions.

Providers described the hesitation among men, veterans, and first responders to seek help due to fear of job consequences or community gossip. LGBTQ+ residents also experience barriers to care, especially in rural areas lacking affirming providers.

Leaders from the Imperial Valley LGBTQ Resource Center and Reps for Vets emphasized that peer-led, culturally competent outreach is critical. “Veterans open up to veterans,” one participant said. Others stressed that care must begin with empathy and understanding: “People won’t accept services from someone who doesn’t see them first as human.”

Collaboration and System Strengths

Despite the challenges, Imperial County’s small size and close relationships were described as key strengths. Providers praised the accessibility and responsiveness of Behavioral Health leadership, noting a culture of partnership rather than competition.

Joint efforts through the Community Health Improvement Plan (CHIP), BHSSA, and multi-agency task forces were cited as positive models for collaboration. Several participants expressed pride in how local agencies “step up for one another” and described ICBHS as open to feedback and innovation.

Stakeholders see an opportunity to build on this collaborative foundation to develop shared goals, integrated data systems, and coordinated planning across sectors.

Vision for the Future

Across all interviews, participants articulated a shared vision for Imperial County's behavioral health system: a compassionate, connected network of care that meets people where they are and addresses both behavioral and social needs.

In three years, stakeholders hope to see:

- Adequate staffing and equitable pay for contracted providers;
- 24/7 crisis coverage with non-law-enforcement options;
- Expanded housing linked with supportive services;
- Integrated data and referral systems connecting all providers;
- Trauma-informed and culturally responsive care; and
- A prevention-focused system that emphasizes early intervention and community education.

As one participant concluded, "We already have the relationships. What we need now are the resources and coordination to make them work."

Conclusion

The key informant interviews provide a rich, community-driven snapshot of Imperial County's behavioral health landscape. They reveal a system with strong relationships, dedicated staff, and clear alignment on priorities — but one constrained by limited capacity, housing shortages, and structural fragmentation.

The insights captured here underscore that community voice in Imperial County is not abstract — it is deeply practical, focused on fixing what is known to be broken, and rooted in compassion for the people served. As Imperial County Behavioral Health continues to plan for the next phase of transformation, these perspectives offer both a roadmap and a reminder: system change begins with listening, and sustainable progress depends on the partnerships already forming across the county.

APPENDIX D

QUALITY IMPROVEMENT WORK PLAN

FY 2025 2026

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

Table of Contents

QUALITY IMPROVEMENT (QI) PROGRAM OVERVIEW

IMPERIAL COUNTY
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Quality Improvement (QI) Work Plan Overview

I. Introduction

Quality Improvement (QI) is an essential component of any successful organization. At its core is the belief that every client has the right to quality care - a belief that must be shared by all staff, from leadership to frontline workers. When this belief is embedded throughout an agency, resources can be focused on meaningful improvements. Doing things right the first time not only improves outcomes but also reduces costs. Outdated and inefficient processes are major barriers to delivering high-quality services.

Quality Management (QM) and QI are shared responsibilities across all units and staff. Think of the QM Program as an umbrella: the canopy represents the program itself, the ribs holding it open are staff and QI activities, and the handle is the QM Unit and leadership supporting it.

Imperial County Behavioral Health Services (ICBHS), including Specialty Mental Health Services (SMHS) and Substance Use Disorder Services (SUDS), are jointly committed to maintaining and improving service quality. The QM Unit leads this effort by identifying improvement opportunities, recommending QI activities like Performance Improvement Projects (PIPs), and ensuring follow-through. It also reviews service documentation for compliance and supports continuous improvement processes.

The Quality Improvement Committee (QIC) reviews QI outcomes, recommends policy changes, and ensures implementation. The QI Work Plan outlines all QI activities, evaluates their effectiveness in improving care, and is updated annually to reflect progress, results, and new objectives for FY 24–25 based on input from stakeholders (e.g. SMHS, SUDS, fee-for service providers, consumers, and family members).

II. Quality Improvement Program

The goal of the QI Program is to improve access to and delivery of both SMHS and SUDS, while assuring that services are community-based, client directed, age appropriate, culturally competent, and process and outcome focused. The QI Program approach is an integrative process that links knowledge, structure, and process together to assess and improve quality. This approach is designed to coordinate performance monitoring activities throughout the organization including, but not limited to, client and system outcomes, utilization management, clinical records review, monitoring of client and provider satisfaction, and resolution of grievances and appeals.

1) QI Program Description

It is the responsibility of ICBHS as a provider of both Medi-Cal SMHS and SUDS to develop a written QI Program description, in which structure and processes are clearly defined with responsibility assigned to appropriate individuals. ICBHS' QI Program description includes the following elements:

1. The QI Program description shall be evaluated annually and updated as necessary.
2. The QI Program shall be accountable to the ICBHS Director.
3. A licensed behavioral health staff person shall have substantial involvement in QI Program implementation.
4. SMHS and SUDS staff, fee-for-service (FFS) providers, consumers, and family members shall actively participate in the planning, design, and execution of the QI Program.
5. The role, structure, function, and frequency of meetings of the Quality Improvement Committee (QIC), and other relevant committees, shall be specified.
6. The QIC shall oversee and be involved in QI activities, including performance improvement projects.
7. The QIC shall recommend policy decisions; review and evaluate the results of QI activities including performance improvement projects; institute needed QI actions; and ensure follow up of QI processes.
8. Dated and approved minutes shall reflect all QIC decisions and actions.
9. The QI Program shall coordinate performance monitoring activities throughout ICBHS including, but not limited to, client and system outcomes, utilization management, credentialing, monitoring and resolution of grievances, appeals, fair hearings, providers' appeals, assessment of client and provider satisfaction, and clinical records review.
10. Contracts with hospitals and with individual, group, and organizational providers shall require cooperation with the ICBHS QI Program, and access to relevant clinical records to the extent permitted by State and Federal laws by ICBHS and other relevant parties.

2) Quality Improvement Committee

a) Membership Composition of the QIC

Members of the QIC are key stakeholders in both the SMHS and SUDS and shall include a licensed mental health and substance use disorder professional. Each member is appointed by the ICBHS Director and serves a minimum of one-year term. The QIC consists of the following stakeholders:

Leadership

- Director
- Assistant Director
- Deputy Director – Children Services
- Deputy Director – Youth and Young Adult Services
- Deputy Director – Adult Services
- Deputy Director – Mental Health Triage & Engagement Services
- Deputy Director – Substance Use Disorder Services
- Deputy Director – Administration

Management and QM Staff

- Behavioral Health Manager – Managed Care
- Behavioral Health Manager – Access Unit
- Program Supervisor – Quality Management
- Administrative Analyst(s) – Quality Management

Providers

- Licensed Mental Health Professional
- Licensed SUD Provider

ICBHS & Consumer Representation

- Ethnic Services Representative
- Patient's Rights Advocate
- Clients of both SMHS and SUD services
- Consumer/Family Member Quality Improvement Subcommittee Chair(s)
- Family members

b) QIC Meeting

For Fiscal Year (FY) 2024–2025, QIC meetings were held on the second Thursday of each month from 1:00 p.m. to 2:30 p.m., except for August, during which no meeting is scheduled.

Beginning in FY 2025–2026, QIC meetings will be held on a bi-monthly basis. If a need arises before a scheduled meeting, an emergency meeting will be convened.

c) QIC Agenda

All departmental personnel, providers, and committee members may contribute to the agenda items. All agenda items and materials shall be submitted to the QM program clerical support prior to the first Thursday of each month by 5:00 p.m. All agenda items and materials shall be reviewed by the chairperson and the QM Unit before being saved to the QIC meeting shared file. The goal of the QM Unit is to ensure that the meeting agenda and materials are saved in the department's QIC meeting shared file at least one week prior to the scheduled meeting.

d) Meeting Minutes

The QM Unit is responsible for the QIC meeting minutes. The minutes are available to each QIC member and to ICBHS members of management. The minutes will contain, at a minimum, the following:

a. The name and location of where the meeting was held.
b. The date and time of the meeting.
c. The members present, listed by name and title.
d. The members absent, listed by name and title.
e. Issues discussed.
f. Review and evaluation of the results of QI activities, including performance improvement projects.
g. Decisions and/or recommendations made.
h. Action(s) taken.
i. Implementation of needed QI activities.
j. Ensure the follow up of QI processes.

e) Voting

The QIC shall follow these guidelines:

a. A quorum (the presence of more than half of the appointed members) is required for any decisions and/or actions taken by QIC.
b. The chairperson (or designee) is not a voting member, except in the event of a tie-vote in which case the chairperson (or designee) vote will prevail.

f) Officers

The Managed Care Behavioral Health Manager will be the chairperson for the QIC. The vice-chairperson for the QIC will be the QM Unit Program Supervisor.

g) Duties of Officers

The QIC chairperson shall preside at all meetings. The QIC chairperson is responsible for the review of agenda items and materials with the QM Unit prior to distribution. In the QIC chairperson's absence, the chairperson will arrange with the vice-chairperson to handle his or her responsibilities.

h) QIC Role and Responsibilities

The QIC plays an active role in the planning, design, implementation, and ~~execution~~ versight of the QM program. The QIC is actively involved in reviewing the annual QI Work Plan development and implementation, as appropriate.

The QIC oversees the required components of the QI Work Plan including the PIPs. It is responsible for recommending policy decisions, evaluating the results of QI activities, initiating necessary QI actions, and ensuring appropriate follow up.

As part of its oversight function, the QIC coordinates performance monitoring efforts by reviewing and evaluating reports produced by the QM Unit. These address state-mandated areas including, but not limited to:

State Mandated Areas:

1. Service delivery capacity
2. Accessibility of services
3. Client/family satisfaction
4. Service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices
5. Continuity and coordination of care with physical health care providers (PCP) and other human services agencies
6. Provider Complaints and Appeals
7. Strategies to Reduce Avoidable Hospitalizations
8. Timeliness of Services
9. No Show Rates
10. Performance Improvement Projects

3) Consumer/Family Member Quality Improvement Subcommittee

The Consumer/Family Member Quality Improvement Subcommittee (CFQIS) consists of ICBHS consumers and family members who assist in the planning, design, and execution of the QI Program. CFQIS was developed to improve access and delivery of services and assure that services are based on the needs of the community and are consumer-directed, age-appropriate, and culturally competent.

CFQIS is responsible for reviewing QI activities, identifying opportunities for improvement, planning and implementing County services, and making recommendations to the QIC. The CFQIS meets monthly, with the meeting location alternating each month between El Centro and Brawley. The chairpersons for each subcommittee are voted on by the members of each respective CFQIS and attend the QIC to address opportunities for improvement and make recommendations on behalf of the CFQIS.

4) Quality Improvement Work Plan

The Quality Improvement (QI) Program shall have a QI Work Plan that includes the required elements set forth by the Department of Health Care Services (DHCS) which include: (a) an annual evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and client service, and describing completed and in-process QI activities, including performance improvement projects; (b) monitoring of previously identified issues, including tracking of issues over time; (c) planning and initiation of activities for sustaining improvement; and (d) objectives and planned activities for the coming year.

5) Quality Management Unit

The QM Unit oversees the coordination of QI Program activities. The Managed Care Behavioral Health Manager, under the direction of the Director, is responsible for the implementation of QI activities and provision of leadership for the QI Program. The QM Unit is responsible to the QIC for conducting, monitoring, and evaluating QI Program activities.

The QM Unit is responsible for the development of the QI Work Plan that is consistent with the DHCS contract and attachments. The QM Unit will ensure that relevant cultural competence and linguistic standards are incorporated in the QI Work Plan.

III. CalAIM Behavioral Health Initiative – FY 2024-25 Activities

ICBHS remains committed to the successful implementation of CalAIM behavioral health reforms. The FY 2024–25 QI Work Plan includes specific monitoring activities and objectives aligned with the following CalAIM initiatives:

1. Specialty Mental Health Services (SMHS) Access Criteria

ICBHS continues to implement the revised SMHS access criteria for both adults and youth (under age 21), in alignment with CalAIM policy changes. This includes broadening service eligibility and realigning "medical necessity" definitions per WIC §14184.402 to improve access and service coordination across the care continuum.

2. SUDS Policy Improvements I Health Services (SMHS) Access Criteria

Building on early implementation experience, ICBHS has adopted SUDS policy refinements to improve clinical care and reduce administrative burden. FY 24–25 QI efforts include monitoring service delivery enhancements and measuring client outcomes resulting from these improvements.

3. Documentation Redesign – SMHS and SUDS

As part of CalAIM's documentation reform, ICBHS has implemented streamlined clinical documentation practices to enhance efficiency, promote person-centered care, and ensure compliance with quality standards. The QM Unit continues to evaluate documentation outcomes, support staff training, and track system-level changes during FY 24–25.

4. No Wrong Door Policy

ICBHS upholds the "No Wrong Door" approach, ensuring beneficiaries receive timely mental health and/or substance use disorder services regardless of where they initially seek care (ICBHS or MCP). The QI Work Plan includes objectives to monitor timely access, assess coordination during service transitions, and ensure appropriate reimbursement pathways are in place.

5. Standardized Screening and Transition Tools

ICBHS has adopted DHCS-mandated standardized tools to:

- Appropriately screen and refer beneficiaries to the correct delivery system (ICBHS or MCP).
- Support transitions between delivery systems and services with continuity of care.

The QM unit continues to monitor tool usage, implementation fidelity, and coordination of care as part of FY 24-25 quality assurance activities.

6. Behavioral Health Payment Reform

ICBHS is transitioning from cost-based reimbursement toward value-based payment models that promote quality, efficiency, and better health outcomes. The FY 24–25 QI Work Plan includes performance monitoring activities tied to emerging payment structures and client-centered outcomes.

While SmartCare has enhanced ICBHS ability to deliver aligned CalAIM services, some functionalities remain in development and will be introduced in phases. The QM Unit continues to evaluate the system's effectiveness, track gaps, and provide recommendations for improvement.

The ICBHS FY 24-25 QI Work Plan incorporates monitoring, evaluation, and continue quality improvement efforts directly related to CalAIM. The QM Unit and QIC remain actively involved in assessing CalAIM related performance indicators, compliance with policy updates, and the overall impact on client care.

SERVICE DELIVERY CAPACITY

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

Service Delivery Capacity

I. Service Delivery Capacity

As the SMHS and SUDS provider for the County of Imperial, ICBHS provides services in a rural area that extends 4,482 square miles. Described below are the current number, types, and geographical distribution of Imperial County Behavioral Health Services within SMHS and SUDS delivery system and Federal Network Adequacy Standards for FY 24-25.

A. Update on the objectives and activities for FY 24-25:

The QM Unit compiled information on the current number, type, and geographical distribution of SMHS and SUDS services provided by ICBHS through staff providers and contract providers. The information provided includes the geographic distribution of services, the target population, the type of service, client demographics, the number of beneficiaries served, and the number of services claimed in FY 24-25.

ICBHS is responsible for providing or arranging medically necessary SMHS and SUDS services. Imperial County residents may access services in person by walking into one of ICBHS outpatient clinics (during hours) or by calling the toll-free telephone number (during and after hours). Access staff assigned to the 24-hour toll-free telephone line will provide information on how to access services, including services needed for urgent requests. For SMHS requests the access staff will proceed and administer a screening tool and if it is determined that the individual meets the criteria for SMHS, the access staff will coordinate an appointment within 10 business days from the date of request for an initial assessment at any of the SMHS outpatient clinics near the client's city of residence. For SUDS requests the access staff will coordinate an appointment within 10 business days from the date of requests for a screening at any of the SUDS clinics near the client's city of residence.

ICBHS is also responsible for authorizing client requests for SUDS residential treatment. Beneficiaries who are determined to need residential treatment are referred to one of ICBHS' out-of-county contracted residential treatment facilities. ICBHS provides transportation and care coordination services to beneficiaries receiving residential treatment services to ease the transition to a facility located outside the county.

Requests for NTP services are made directly to ICBHS' contracted NTP provider. Beneficiaries requesting NTP services are offered an intake appointment within 3 business days from the date of the request.

ICBHS and contracted providers provide accommodation to serve people with physical disabilities, including vision and hearing impairments, if needed. In addition, services are made available to all

individuals with mobility, communication, or cognitive impairments as required by federal and state laws and regulations.

1) SMHS Direct Service Providers

a) Geographic Location of Programs and Population Served

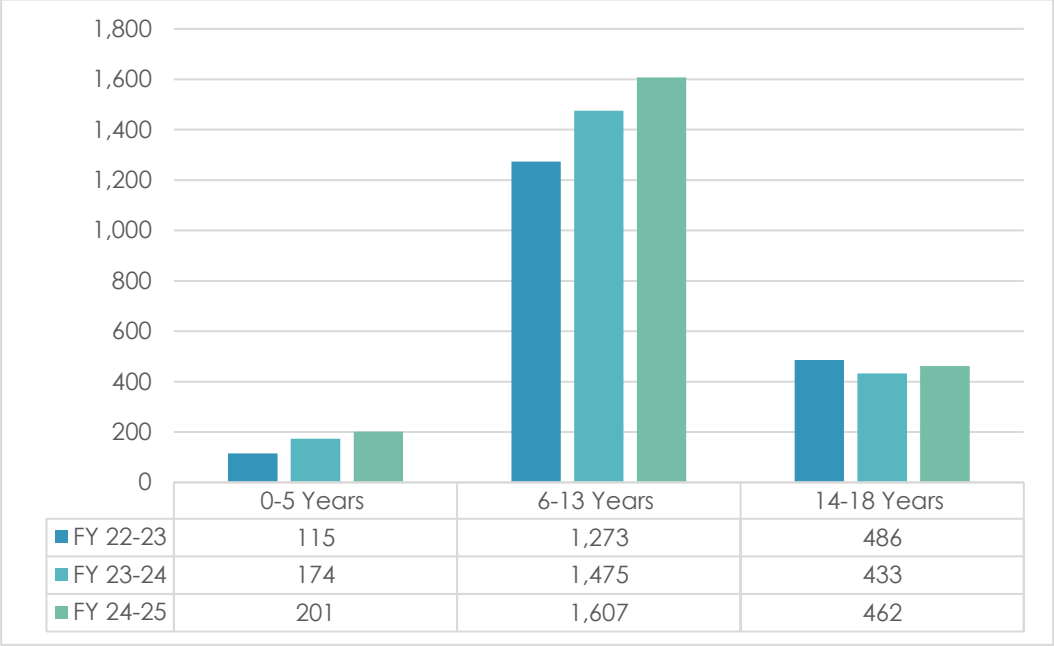
During FY 24-25, ICBHS provided SMHS at 25 Medi-Cal Sites. Each site provides services according to the client's age group and residence.

Region	Sites	Address	Provider No.
Northern Region	Team 6: Child. & Adol. Outpatient	195 S. 9th St., Brawley, CA 92227	1384
	Brawley Vista Sands	1401 "B" St. Brawley, CA 92227	1334
Central Region	Team 5: Child. & Adol. Outpatient	120 N. Eighth St., El Centro, CA 92243	1301
	Team 12: Child. & Adol. Outpatient	651 Wake Ave., El Centro, CA 92243	1398
	El Centro Vista Sands	1530 Waterman Ave., El Centro, CA 92243	1332
	Prevention and Early Intervention - TF-CBT	313 Waterman Ave., El Centro, CA 92243	1382
	First Step to Success	801 Broadway St., El Centro, CA 92243	1364
	Middle School Behavioral Modification Program	1052 Heber Ave, Room 105-106	13A9
Southern Region	Team 4: Child. & Adol. Outpatient	101 Hacienda, Ste. C., Calexico, CA 92231	1350
	Calexico Vista Sands	2300 Rockwood Ave. Rm. 30 Calexico, CA 92231	1335
Eastern Region	San Pascual FRC - Children	676 Baseline Rd., Winterhaven, CA 9	1364

Children's Division

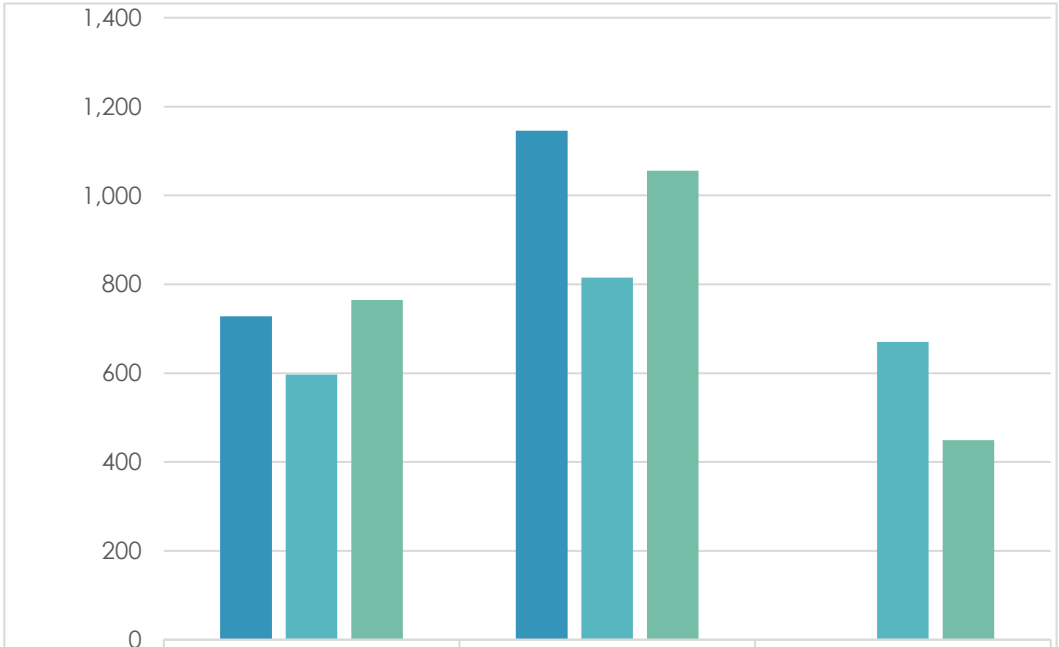
Charts 1.1-1.6 indicate the demographic information for beneficiaries served by Children Services.

Chart 1.1 Children Served by Age Group



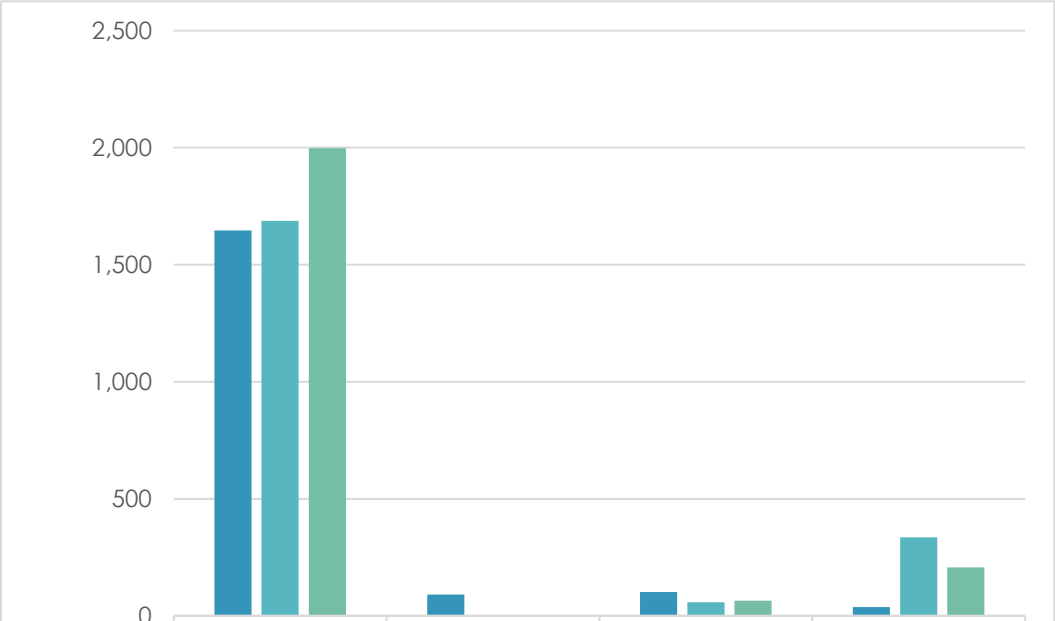
	0-5 Years	6-13 Years	14-18 Years
FY 22-23	115	1,273	486
FY 23-24	174	1,475	433
FY 24-25	201	1,607	462

Chart 1.2 Children Served by Gender



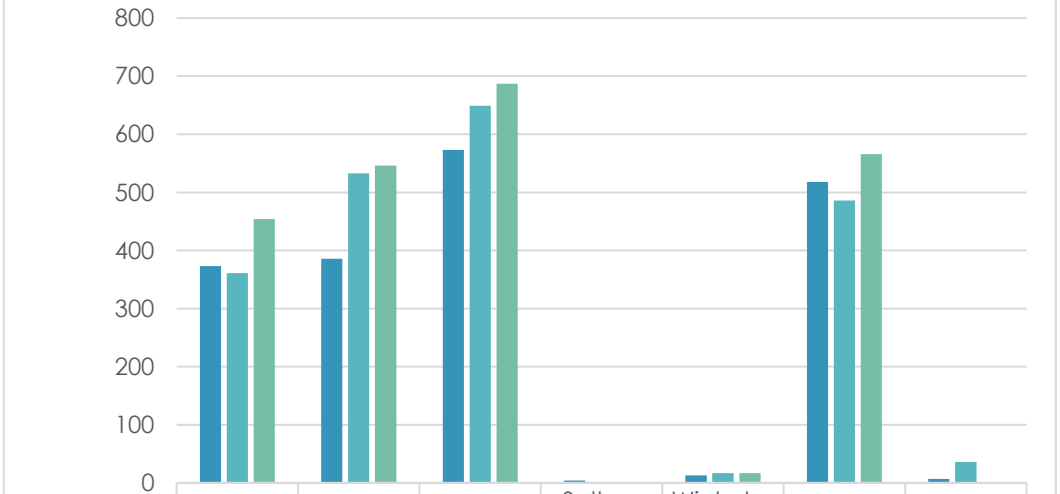
	Female	Male	Other/Unknown
FY 22-23	728	1,146	0
FY 23-24	597	815	670
FY 24-25	765	1,056	449

Chart 1.3 Children Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 22-23	1,646	90	101	37
FY 23-24	1,688	0	58	336
FY 24-25	1,998	0	65	207

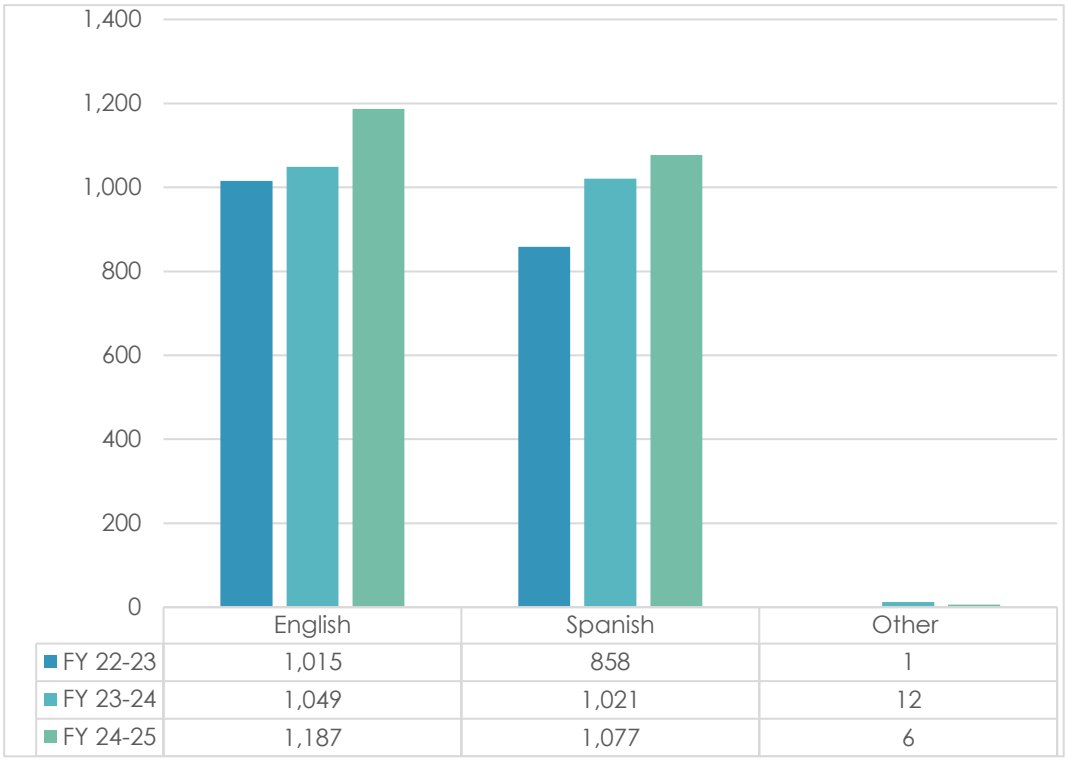
Chart 1.4 Children Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknown
FY 22-23	373	386	573	4	13	518	7
FY 23-24	361	533	649	0	17	486	36
FY 24-25	454	546	687	0	17	566	0

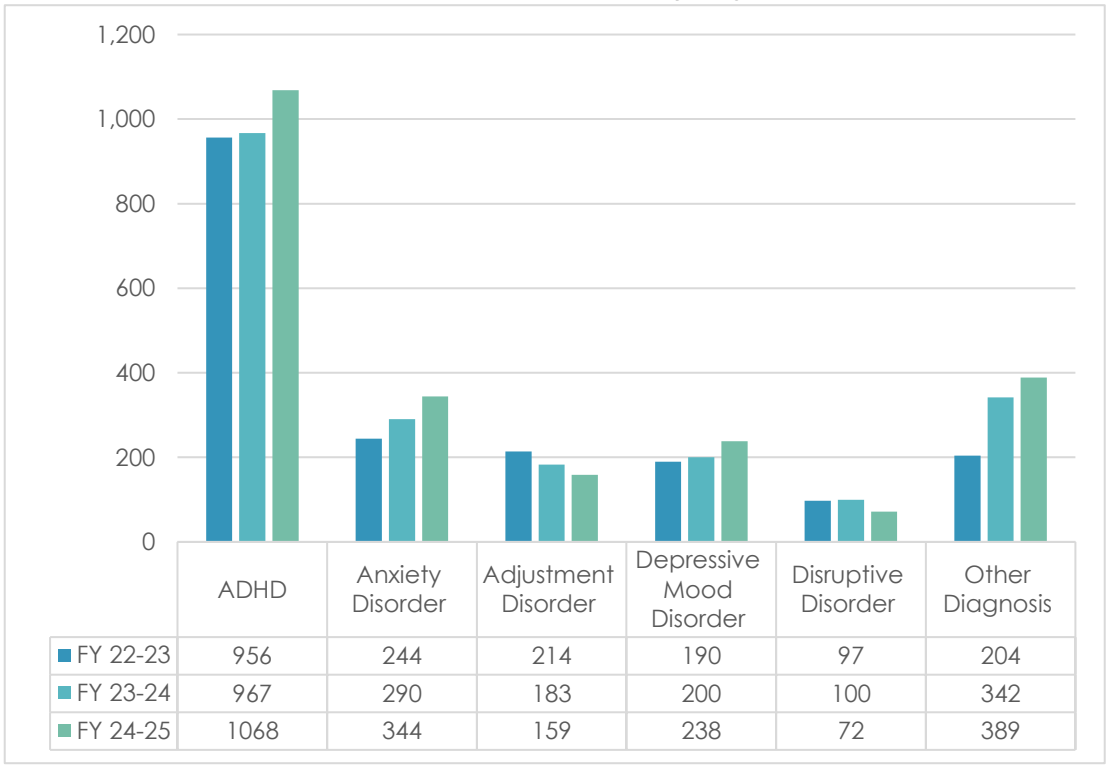
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart 1.5 Children Served by Language



	English	Spanish	Other
FY 22-23	1,015	858	1
FY 23-24	1,049	1,021	12
FY 24-25	1,187	1,077	6

Chart M1.6 Children Served by Diagnosis



	ADHD	Anxiety Disorder	Adjustment Disorder	Depressive Mood Disorder	Disruptive Disorder	Other Diagnosis
FY 22-23	956	244	214	190	97	204
FY 23-24	967	290	183	200	100	342
FY 24-25	1068	344	159	238	72	389

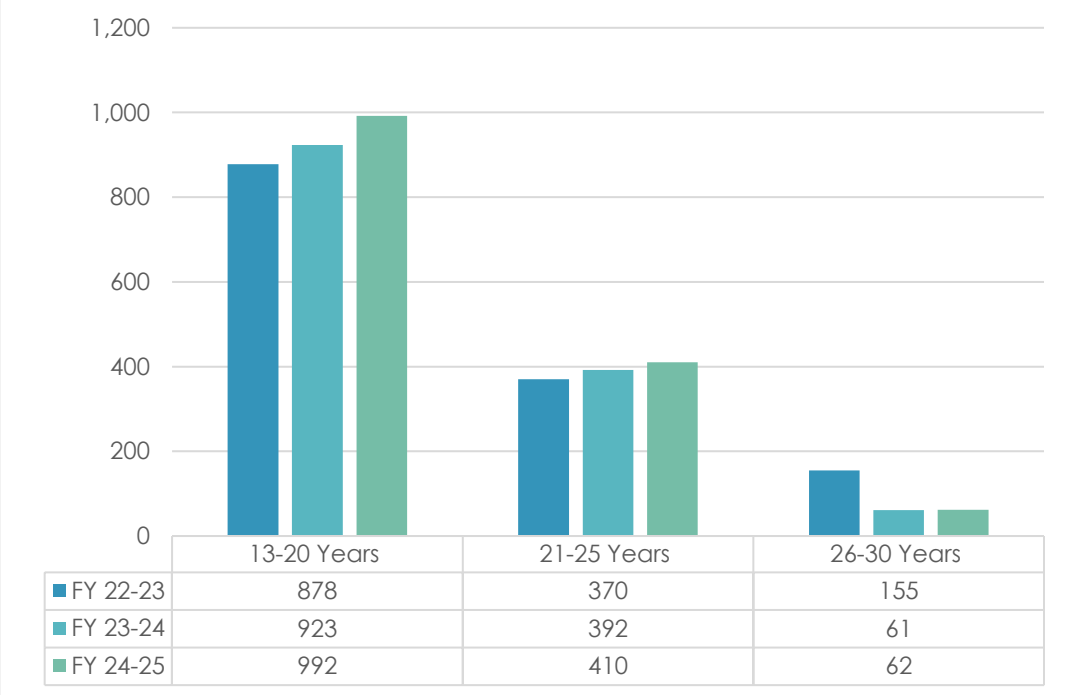
**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

Youth & Young Adults Division

Region	Sites	Address	Provider No.
Northern Region	Youth and Young Adult Brawley Family Resource Center	480 N. Imperial Ave., Rm 95 Brawley, CA 92227	1392
	Youth and Young Adult Brawley Anxiety and Depression Clinic and FSP	1535 Main Street Rm 22, Brawley, CA 92227	1381
Central Region	Adolescent Habilitative Learning Program (AHLP)	1001 W. Brighton Ave., El Centro, CA 92243	1390
	Youth and Young Adult El Centro Family Resource Center	1014 W. Brighton Ave., El Centro, CA 92243	1393
	Youth and Young Adult El Centro Anxiety and Depression Clinic and FSP	1295 State Street, El Centro, CA 92243	1329
Southern Region	Youth and Young Adult Calexico Anxiety and Depression and FSP	101 Hacienda, Calexico, CA 92231, Ste. A	1395

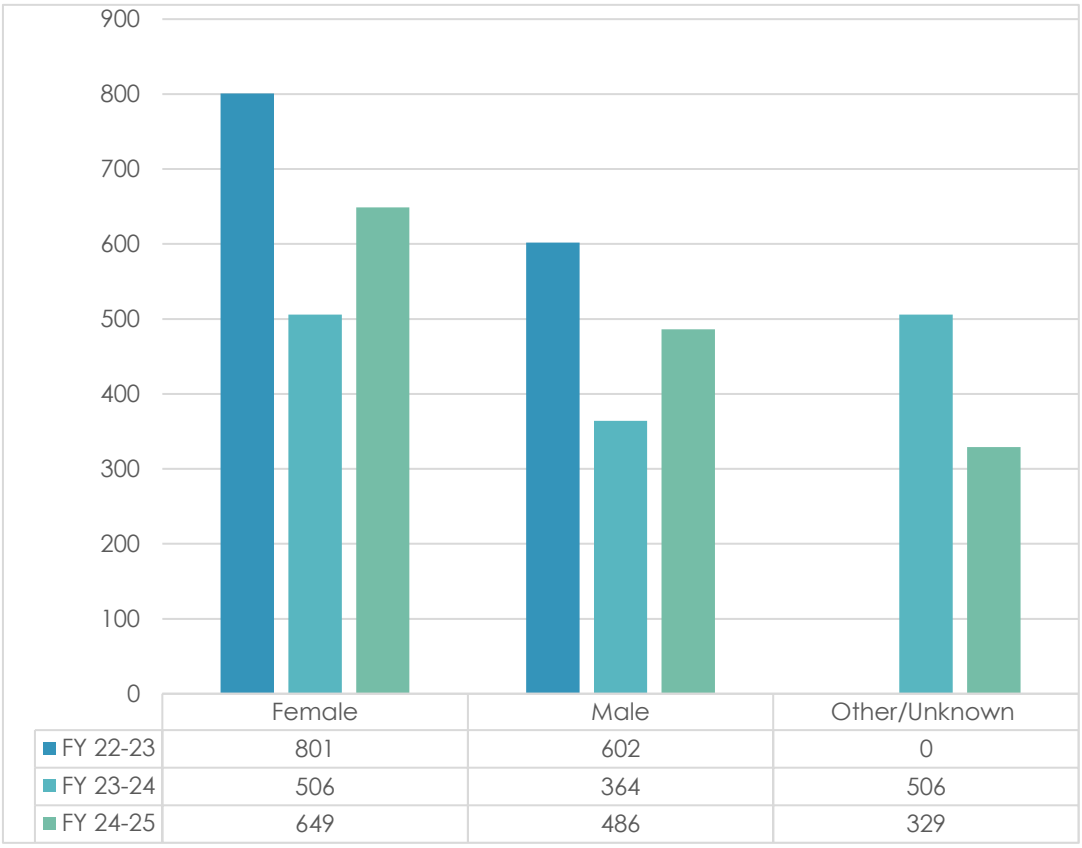
Charts M1.7-M1.12 indicate demographic information for beneficiaries served by YAYA Services.

Chart 1.7 Youth and Young Adults Served by Age Group



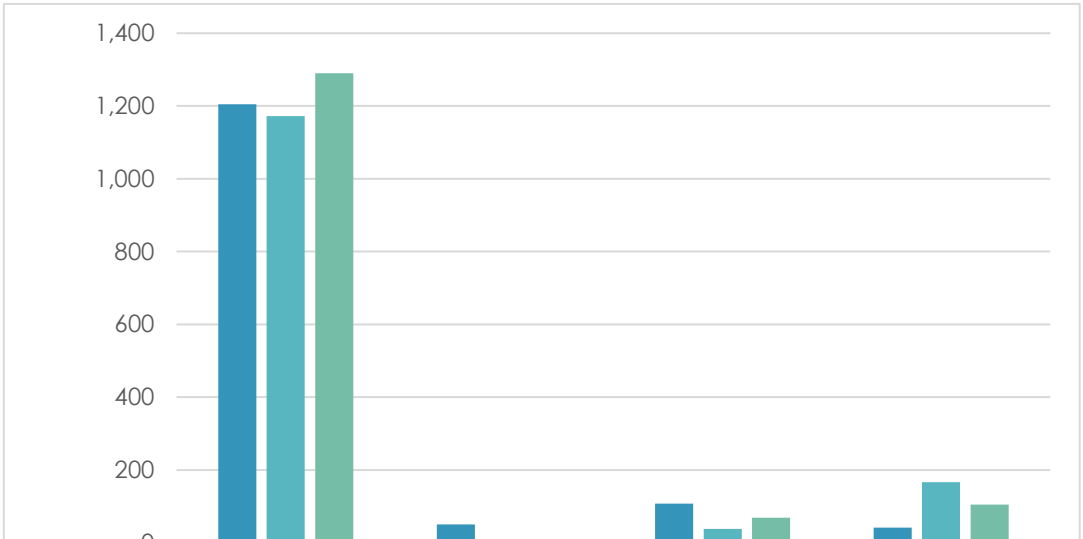
	13-20 Years	21-25 Years	26-30 Years
FY 22-23	878	370	155
FY 23-24	923	392	61
FY 24-25	992	410	62

Chart 1.8 Youth and Young Adults Served by Gender



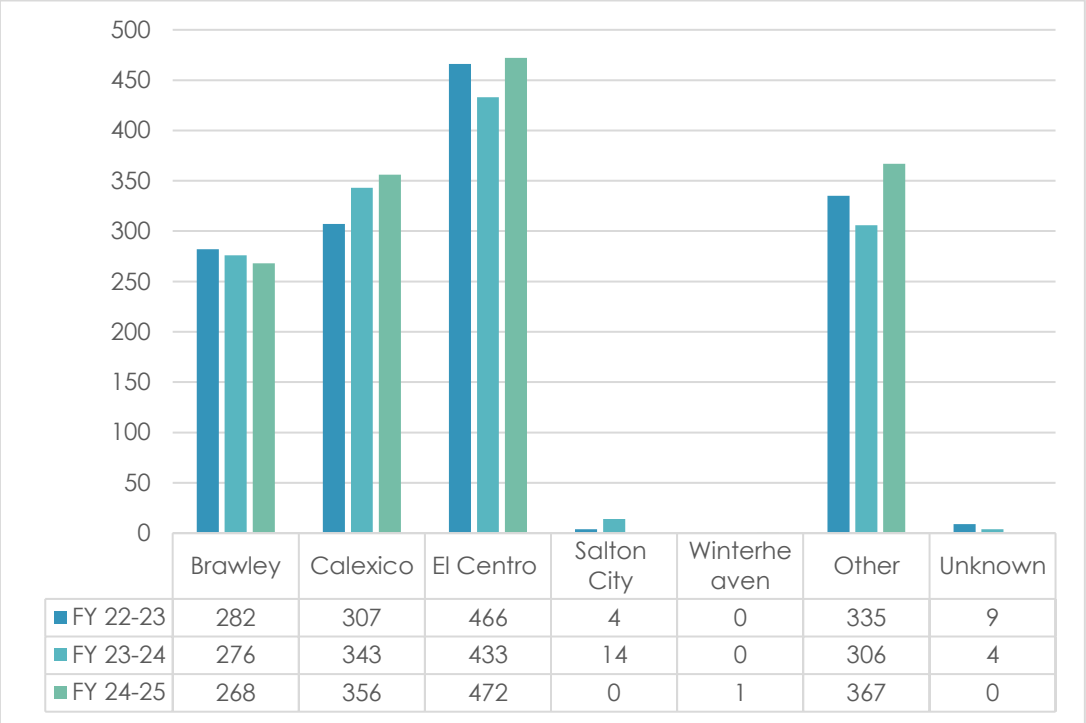
	Female	Male	Other/Unknown
FY 22-23	801	602	0
FY 23-24	506	364	506
FY 24-25	649	486	329

Chart 1.9 Youth and Young Adults Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 22-23	1,205	50	107	41
FY 23-24	1,172	0	38	166
FY 24-25	1,290	0	69	105

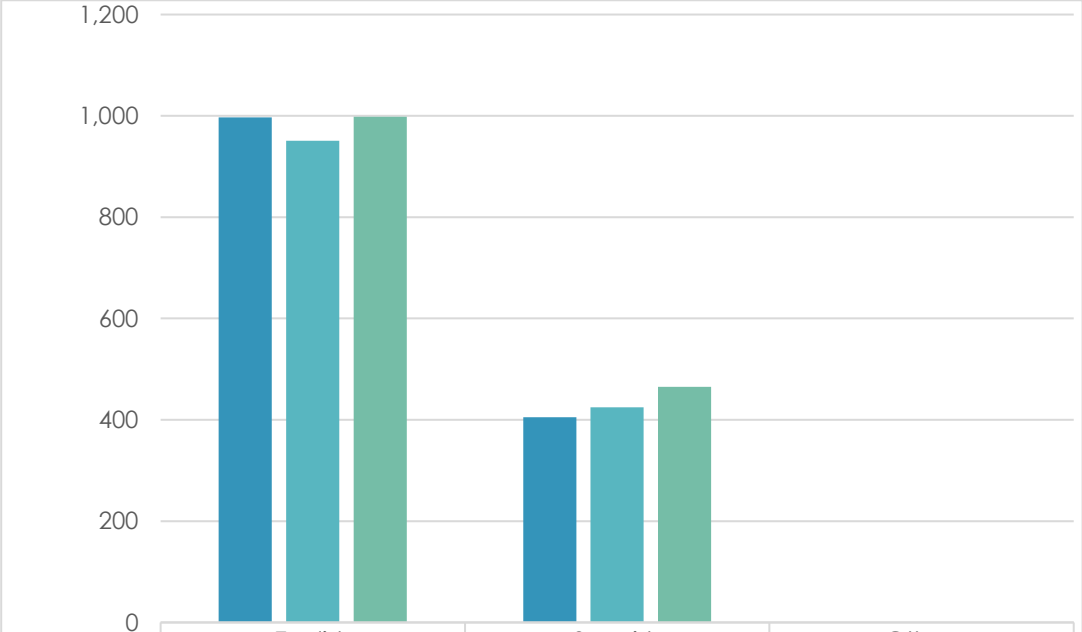
Chart 1.10 Youth and Young Adults Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknown
FY 22-23	282	307	466	4	0	335	9
FY 23-24	276	343	433	14	0	306	4
FY 24-25	268	356	472	0	1	367	0

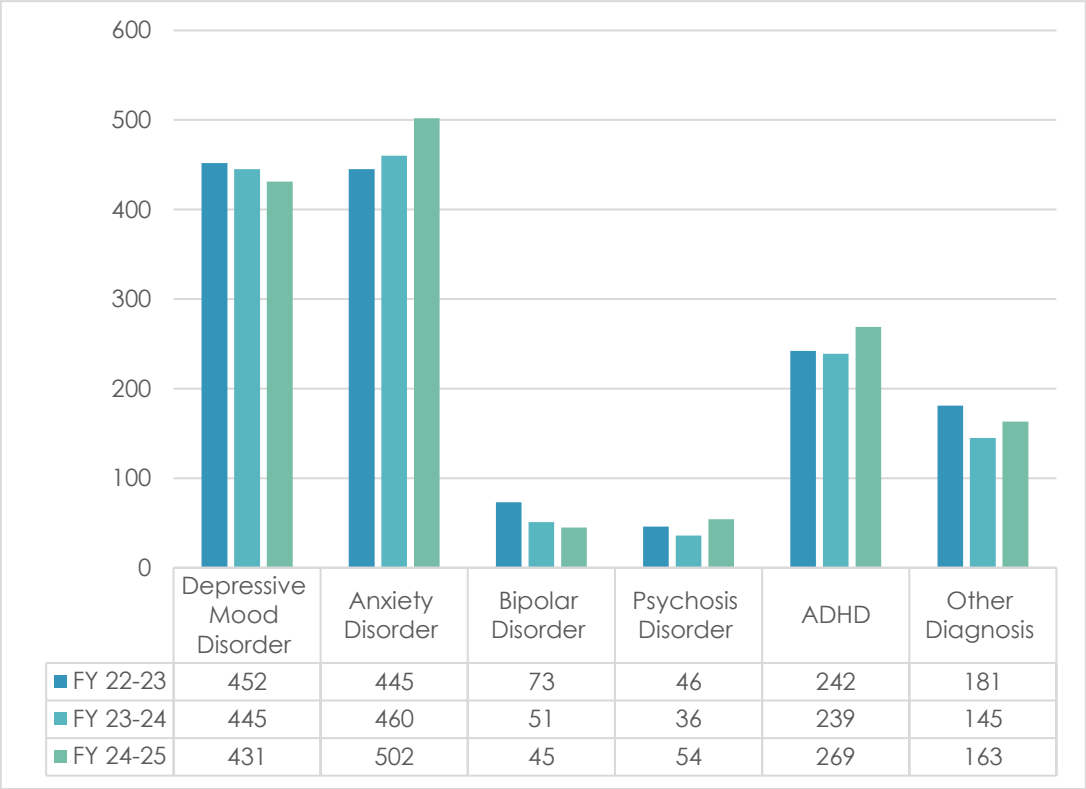
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart 1.11 Youth and Young Adults Served by Language



	English	Spanish	Other
FY 22-23	997	405	1
FY 23-24	951	425	0
FY 24-25	998	465	1

Chart 1.12 Youth and Young Adults Served by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 22-23	452	445	73	46	242	181
FY 23-24	445	460	51	36	239	145
FY 24-25	431	502	45	54	269	163

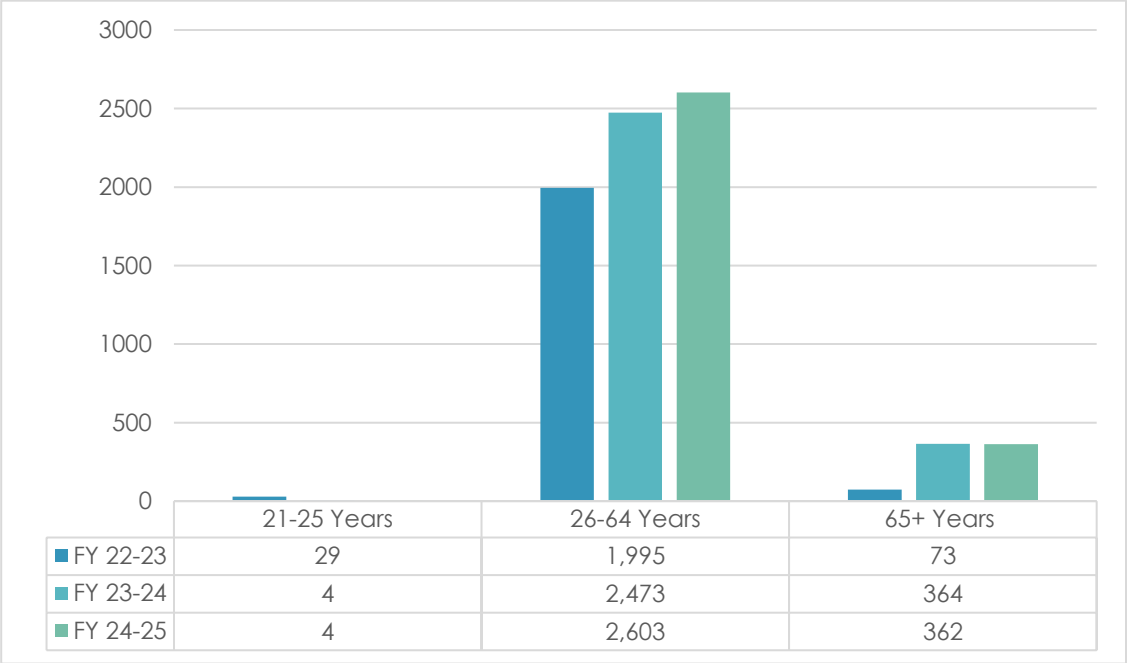
**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

Adults Division

Region	Sites	Address	Provider No.
Northern Region	Adult Brawley Anxiety and Depression	229 Main Street, Brawley, CA 92227	1379
	Adult Brawley MHSA FSP Program		
Central Region	Adult El Centro Anxiety and Depression	313 Waterman Street, El Centro, CA 92243	1382
	Adult El Centro MHSA FSP Program	2695 S. Fourth Street, Ste. B, El Centro, CA 92243	1366
Southern Region	Adult Calexico Anxiety and Depression	1501 W. Imperial Ave., Calexico, CA 92231	1388
	Adult Calexico MHSA FSP		
Eastern Region	San Pascual FRC	676 Baseline Road, Winterhaven, CA 92283	1364

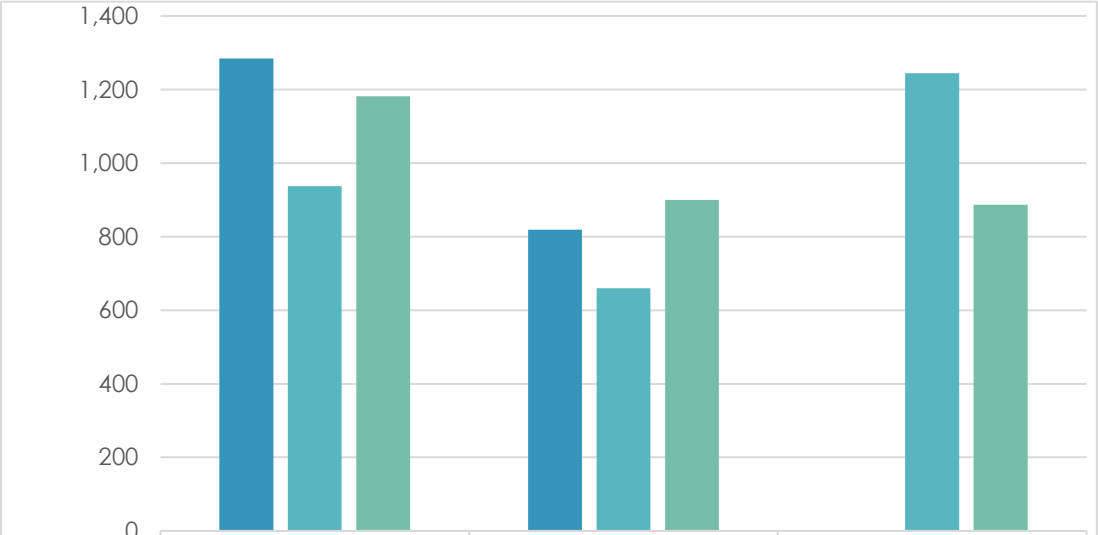
Charts 1.13-1.18 indicate the demographic information for beneficiaries served by Adults Services.

Chart 1.13 Adults Served by Age



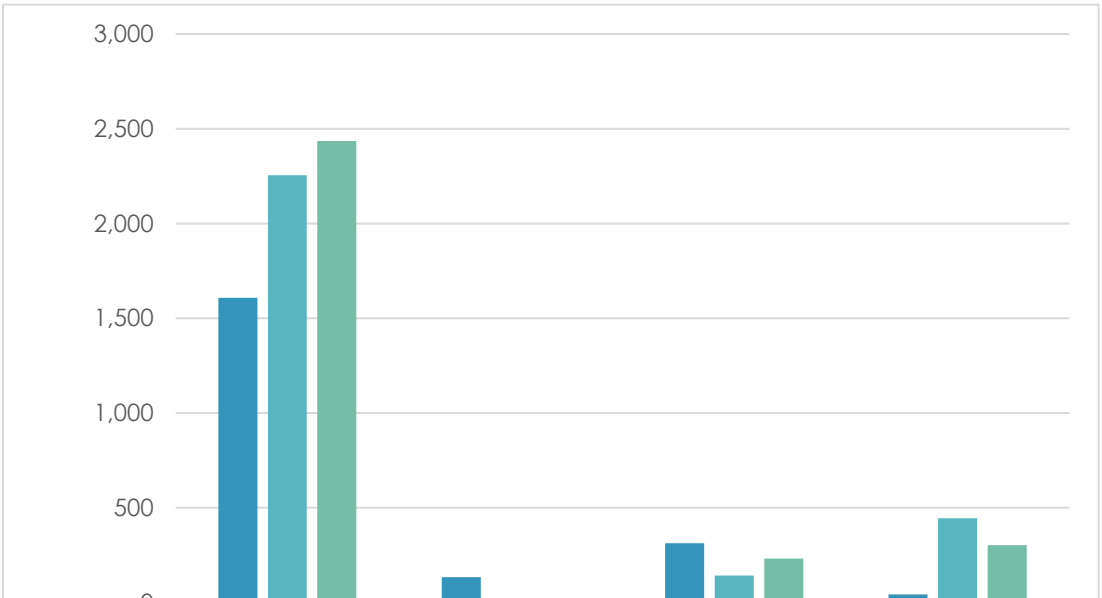
	21-25 Years	26-64 Years	65+ Years
FY 22-23	29	1,995	73
FY 23-24	4	2,473	364
FY 24-25	4	2,603	362

Chart 1.14 Adults Served by Gender



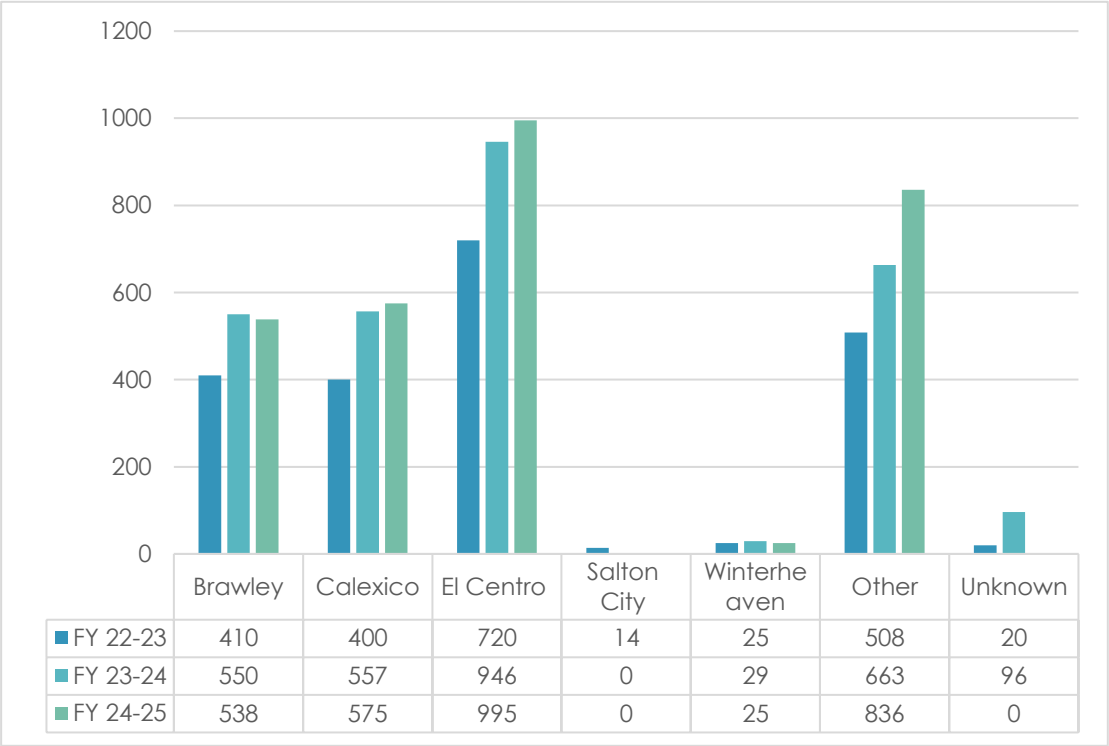
	Female	Male	Other/Unknown
FY 22-23	1,284	819	0
FY 23-24	937	660	1,244
FY 24-25	1,182	900	887

Chart 1.15 Adults Served by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 22-23	1,608	134	313	42
FY 23-24	2,254	0	142	445
FY 24-25	2,435	0	232	302

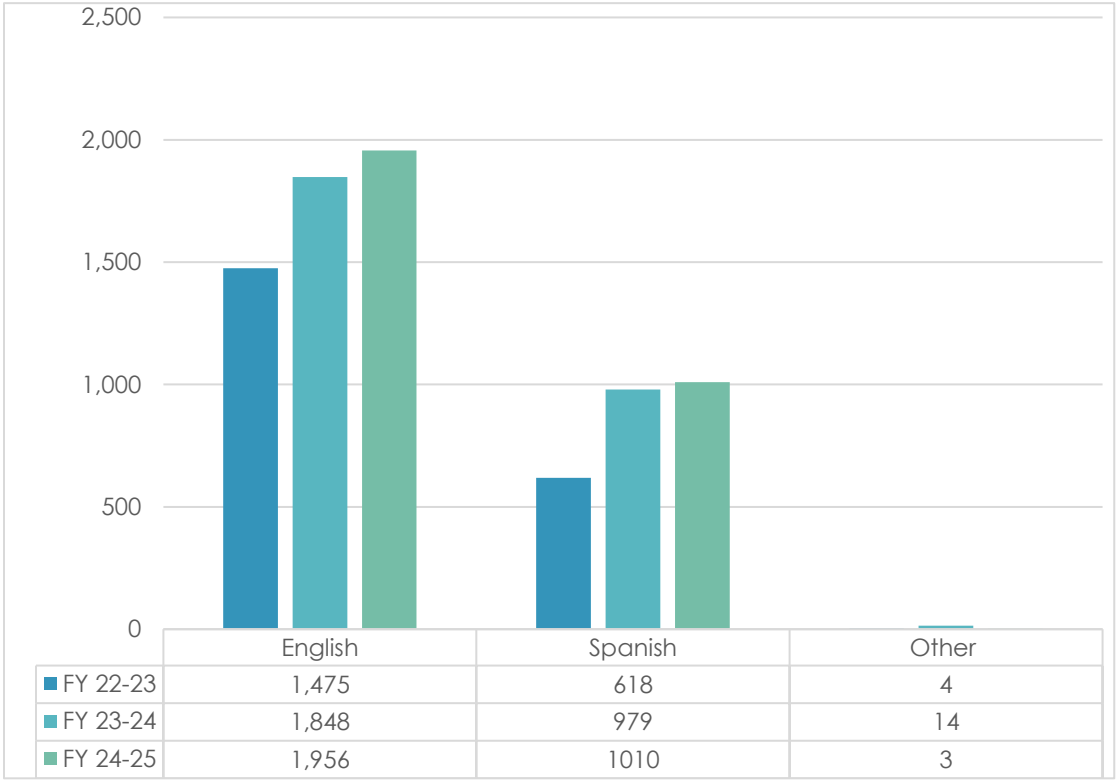
Chart 1.16 Adults Served by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknown
FY 22-23	410	400	720	14	25	508	20
FY 23-24	550	557	946	0	29	663	96
FY 24-25	538	575	995	0	25	836	0

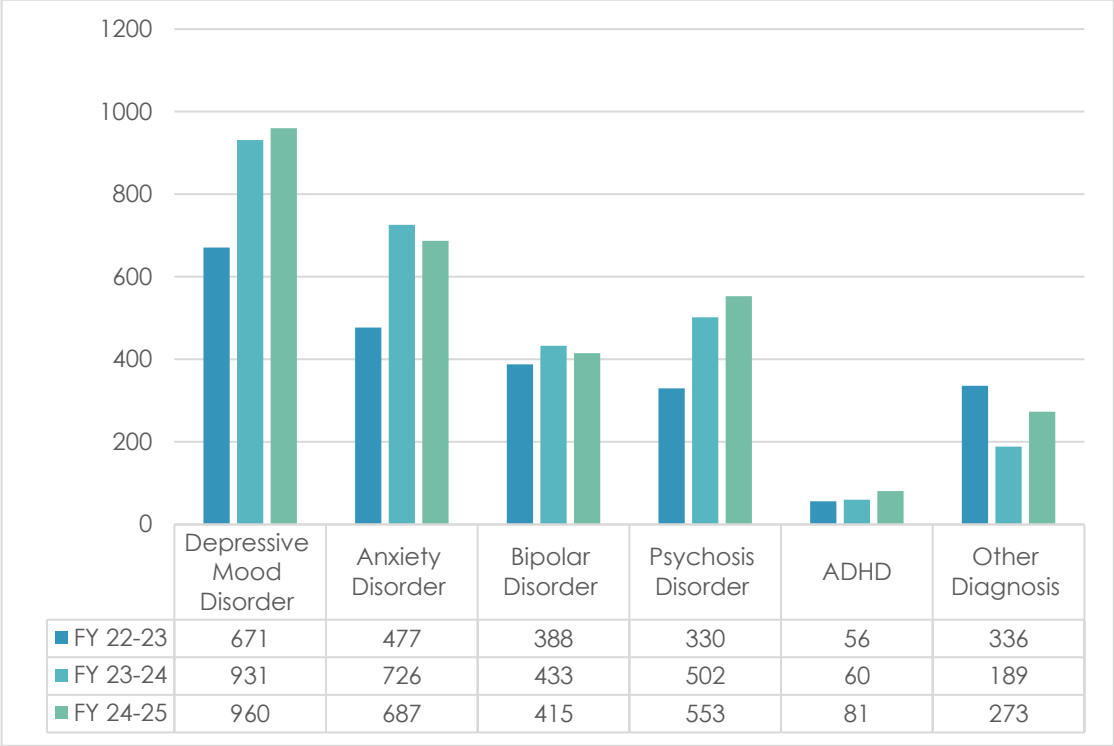
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart 1.17 Adults Served by Language



	English	Spanish	Other
FY 22-23	1,475	618	4
FY 23-24	1,848	979	14
FY 24-25	1,956	1010	3

Chart 1.18 Adults Served by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 22-23	671	477	388	330	56	336
FY 23-24	931	726	433	502	60	189
FY 24-25	960	687	415	553	81	273

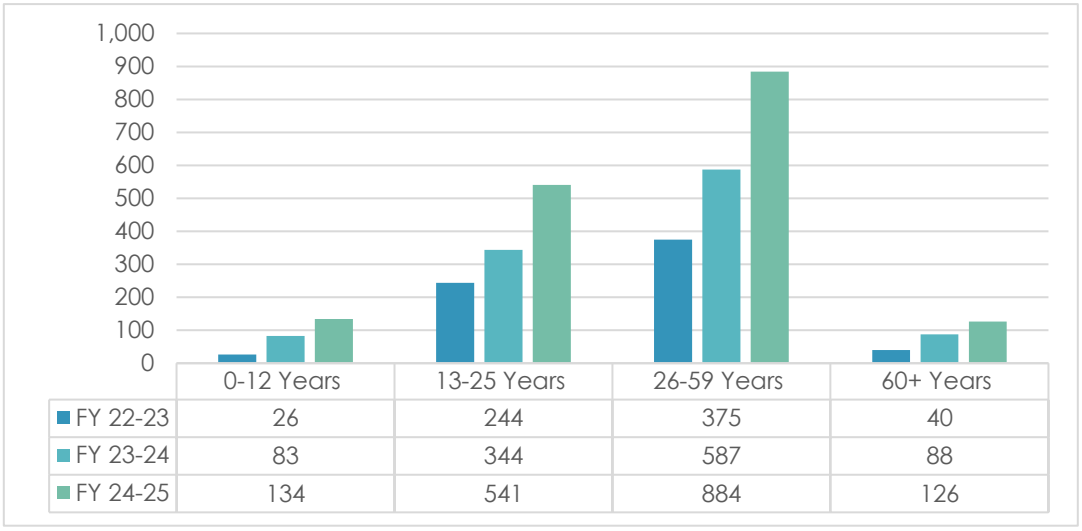
**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

Mental Health Triage Engagement

Region	Sites	Address	Provider No.
Central Region	Community Engagement Supportive Services (CESS)	1699 W. Main Street, Ste. A, El Centro, CA 92243	1394
	Transitional Engagement Supportive Services (TESS)		
	Crisis Care Mobile Unit (CCMU)	801 Broadway, El Centro, CA 92243	1373
	Mental Health Triage Unit (MHTU)	202 N. 8th Street, El Centro, CA 92243	1351

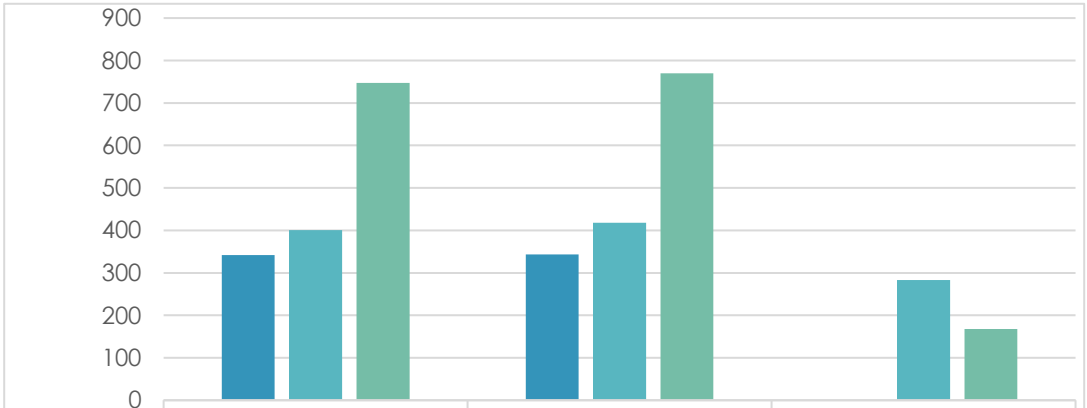
Charts 1.19-1.24 indicate the demographic information for beneficiaries served by MHTES.

Chart 1.19 Emergency Services by Age Group



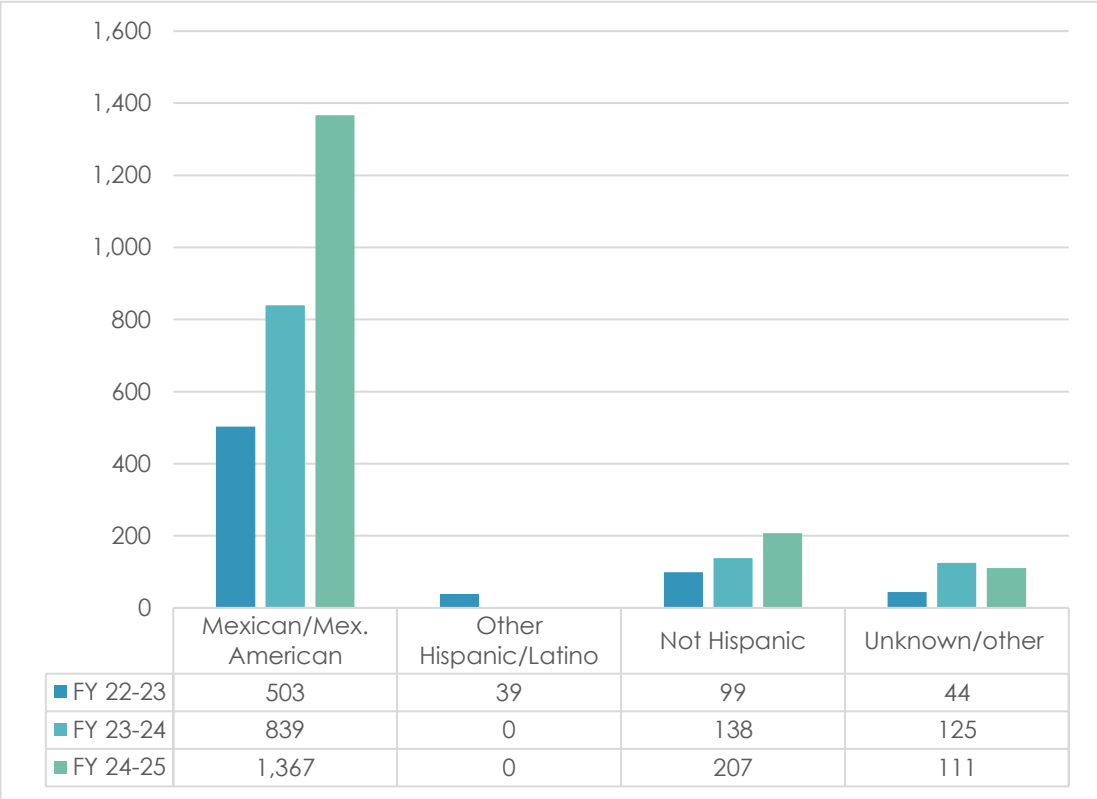
	0-12 Years	13-25 Years	26-59 Years	60+ Years
FY 22-23	26	244	375	40
FY 23-24	83	344	587	88
FY 24-25	134	541	884	126

Chart 1.20 Emergency Services by Gender



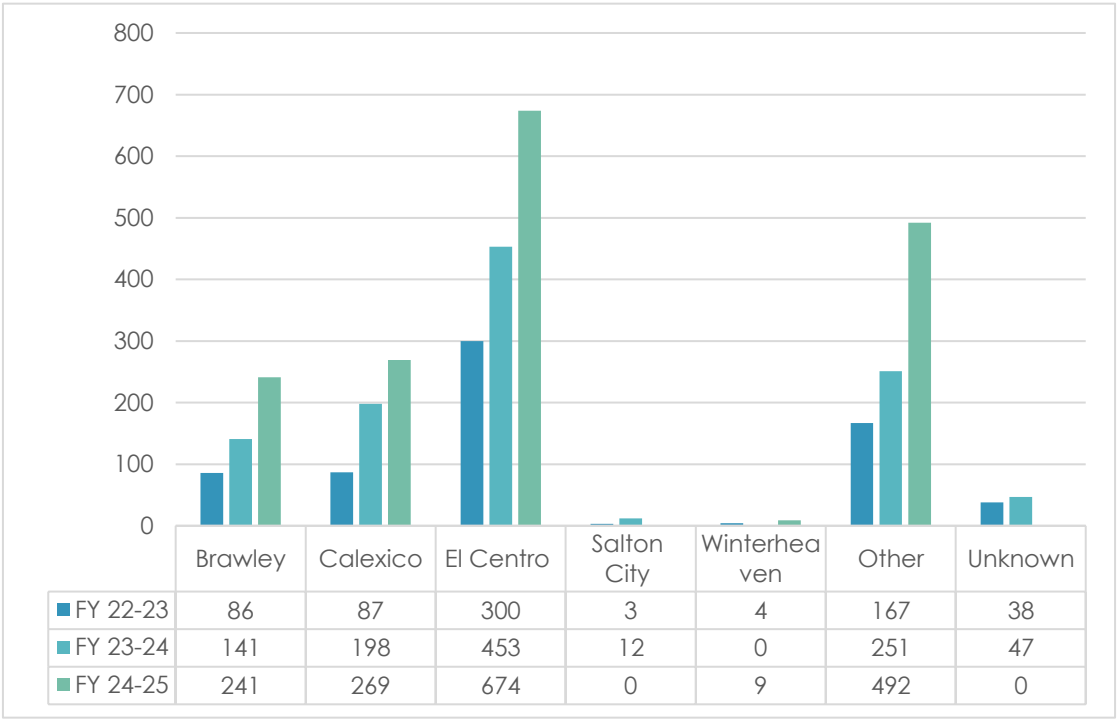
	Female	Male	Other
FY 22-23	342	343	0
FY 23-24	401	418	283
FY 24-25	747	770	168

Chart 1.21 Emergency Services by Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 22-23	503	39	99	44
FY 23-24	839	0	138	125
FY 24-25	1,367	0	207	111

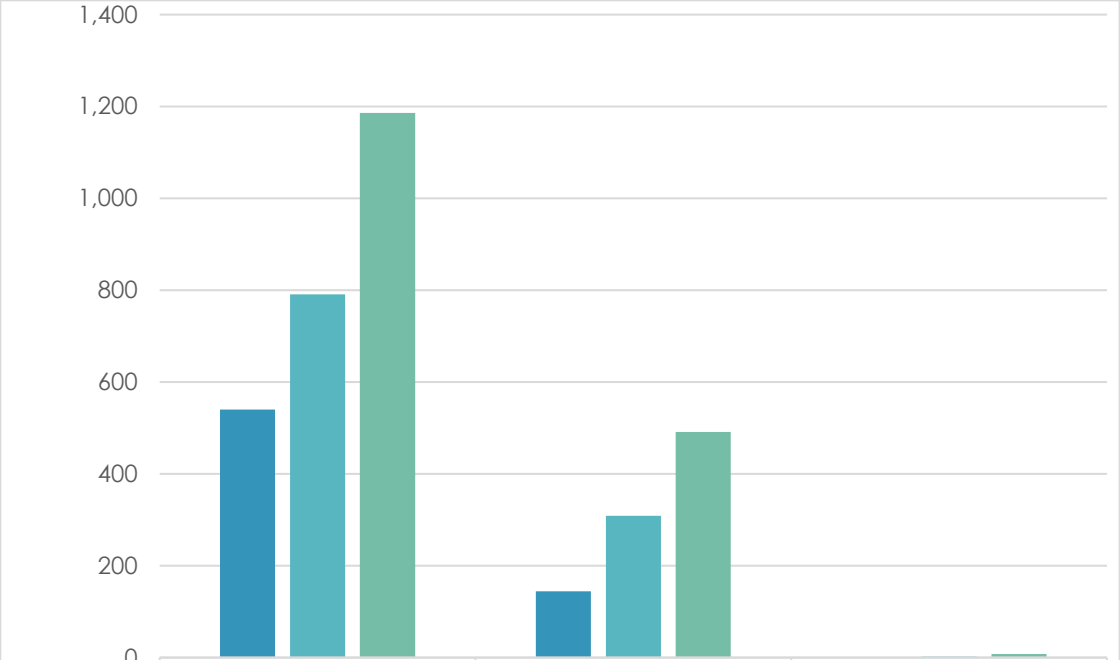
Chart 1.22 Emergency Services by City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhea ven	Other	Unknown
FY 22-23	86	87	300	3	4	167	38
FY 23-24	141	198	453	12	0	251	47
FY 24-25	241	269	674	0	9	492	0

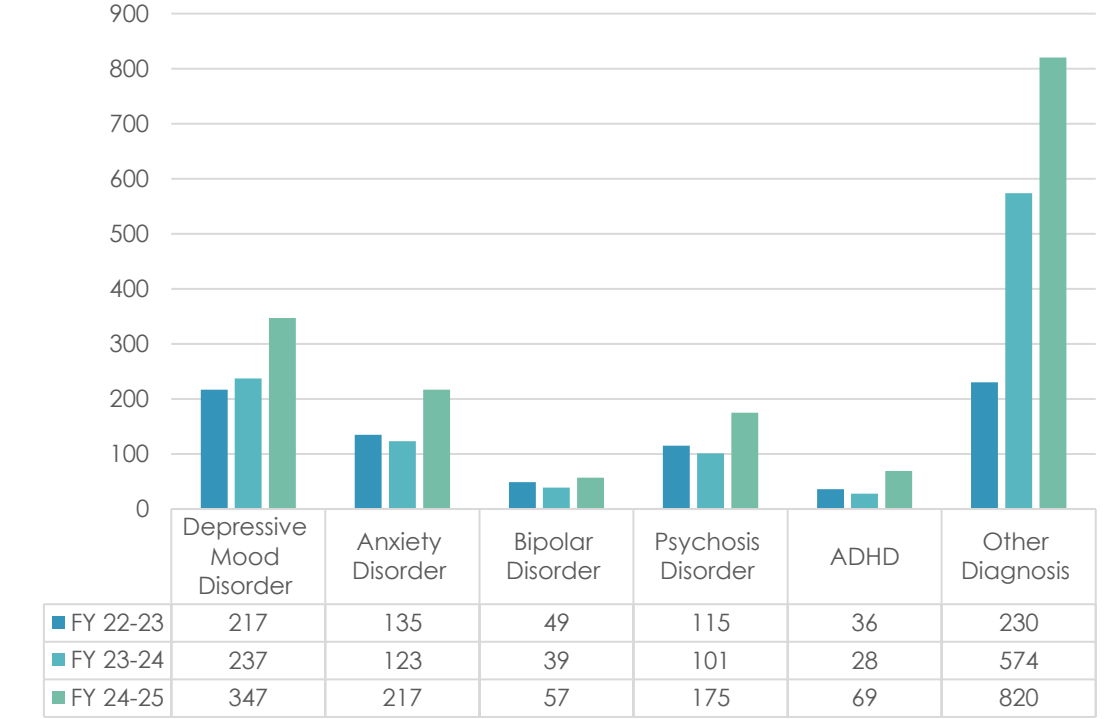
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart 1.23 Emergency Services by Language



	English	Spanish	Other
FY 22-23	540	144	1
FY 23-24	791	309	2
FY 24-25	1,186	491	8

Chart 1.24 Emergency Services by Diagnosis



	Depressive Mood Disorder	Anxiety Disorder	Bipolar Disorder	Psychosis Disorder	ADHD	Other Diagnosis
FY 22-23	217	135	49	115	36	230
FY 23-24	237	123	39	101	28	574
FY 24-25	347	217	57	175	69	820

**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

b) *Services Provided*

SMHS are provided based on an assessment of whether the client meets access and medical necessity criteria.

ICBHS provides an array of SMHS, which are targeted at addressing the needs of the identified population. Clinical services are organized primarily around the structure of SMHS as outlined in Title 9 of the California Code of Regulations. Additional services are provided based on other sources of funding and interagency collaboration.

The number of unduplicated Medi-Cal clients served by division and the total are included in the table below:

Table 1.1 Medi-Cal Clients Served by Division			
Division	**FY 22-23***	**FY 23-24**	**FY 24-25**
Adults Services	2,097	2,841	2,969
YAYA Services	1,403	1,376	1,464
Children Services	1,874	2,082	2,270
MHTES	685	1,102	1,685
ICBHS Total	**6,059**	**7,401**	**7,239**
***July 1, 2022, through December 31, 2022**			

c) *Utilization of Services for FY 24-25*

The utilization of services for FY 24-25 has been obtained from the monthly Units of Service Summary reports completed by the ICBHS Fiscal Unit. The following is a breakdown of the services that are billed under each type of service.

- Assessment: Assessments completed by a LPHA or MD; Assessment contribution by a non-LPHA; Review of hospital records; Psychological testing; Individual therapy, Family therapy with the client present; Report generation for care coordination; TBS; Psychosocial rehab-individual; Nursing evaluation; and add-on services such as interactive complexity, sign language or oral interpretative services, and prolonged office or other outpatient EM service(s) beyond the maximum time.

- Care Coordination: Targeted Case Management (TCM) and Intensive Care Coordination (ICC).

- Crisis Intervention: Crisis intervention/mobile crisis and psychotherapy for crisis.

- Medication Support Services: Medication training and support; Medication support to an existing client; Oral medication administration; Medication support telephone; Medical team conference with participation by Physician and patient and/or family not present; and Interpretation or explanation of results of psychiatric or other medical results.

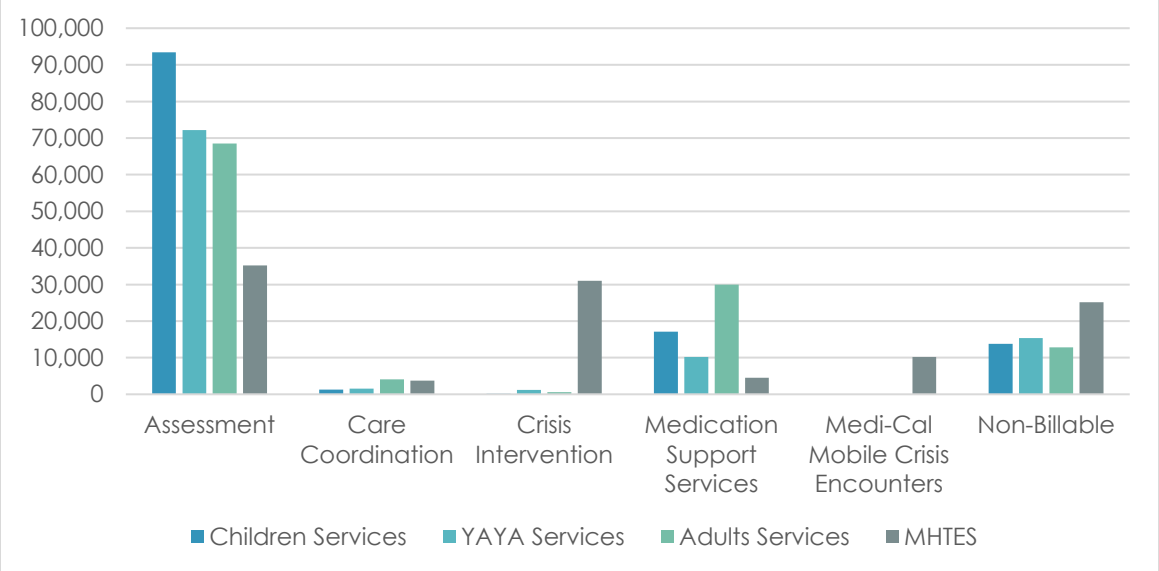
- Medi-Cal Mobile Crisis Encounters: Mobile crisis encounters; Transportation mileage; and Transportation, staff time.

- Non-Billable: Any other non-billable service that must be documented and is not accounted for by other available non-billable procedure codes. Services may include those provided in the Wellness Center, homeless services, school-based socialization programs that are grant funded, and/or Conservatorship Services.

ICBHS SMHS units of service provided by the four service divisions during FY 24-25 are shown below:

Table 1.2 Units of Service					
Type of Service	Children Services	YAYA Services	Adults Services	MHTES	ICBHS - SMHS
Assessment	93,413	72,182	68,548	35,233	**269,376**
Care Coordination	1,255	1,528	4,054	3,694	**10,531**
Crisis Intervention	147	1,206	621	30,993	**32,967**
Medication Support Services	17,078	10,206	29,947	4,502	**61,733**
Medi-Cal Mobile Crisis Encounters	0	0	0	10,220	**10,220**
Non-Billable	**13,795**	**15,402**	**12,851**	**25,163**	**67,211**

Chart 1.25 Units of Service by Division



2) *SMHS Contracted Providers*

a) *Geographic Location of Programs & Population Served*

As part of ICBHS efforts to ensure SMHS are available to Imperial County residents, ICBHS contracts with a variety of local and out-of-county providers:

i. *In-County*

During FY 24-25, ICBHS had three SMHS contracted outpatient providers, one contracted adult crisis residential treatment services provider, and one contracted Short-Term Residential Therapeutic Program (STRTP) provider. The contracted outpatient providers are responsible for providing mental health services, targeted case management, medication support services, intensive care coordination, intensive home-based services, and therapeutic behavioral services.

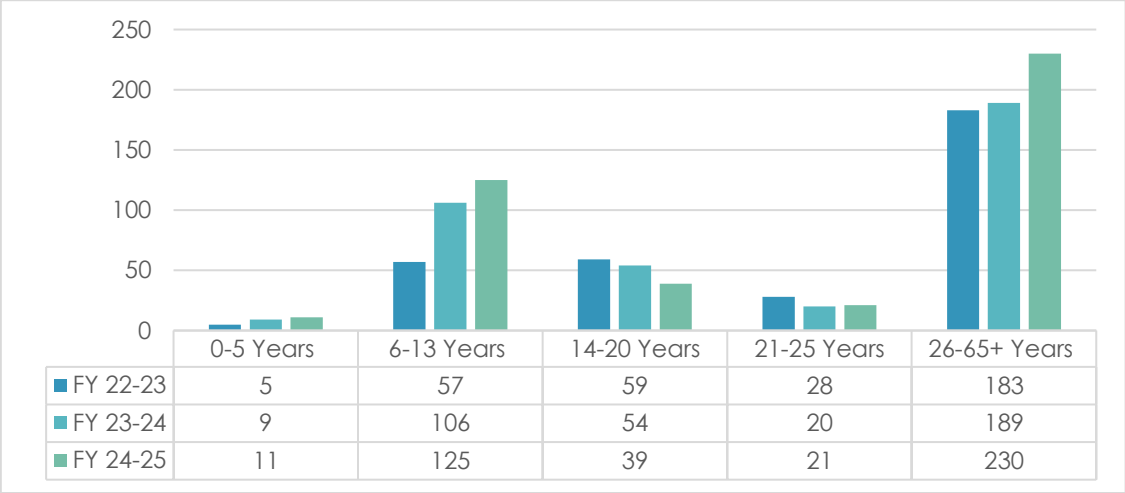
Outpatient services are available to beneficiaries of all ages, while the adult crisis residential treatment services provider only serves adults age 18 and older, and the STRTP provider only serves youth placed in the facility. Contracted SMHS services are available to beneficiaries throughout Imperial County.

ii. *Out-of-County*

During FY 24-25, ICBHS had one contracted provider located outside of the county. This provider provides adult residential treatment services to adult beneficiaries who are referred by ICBHS.

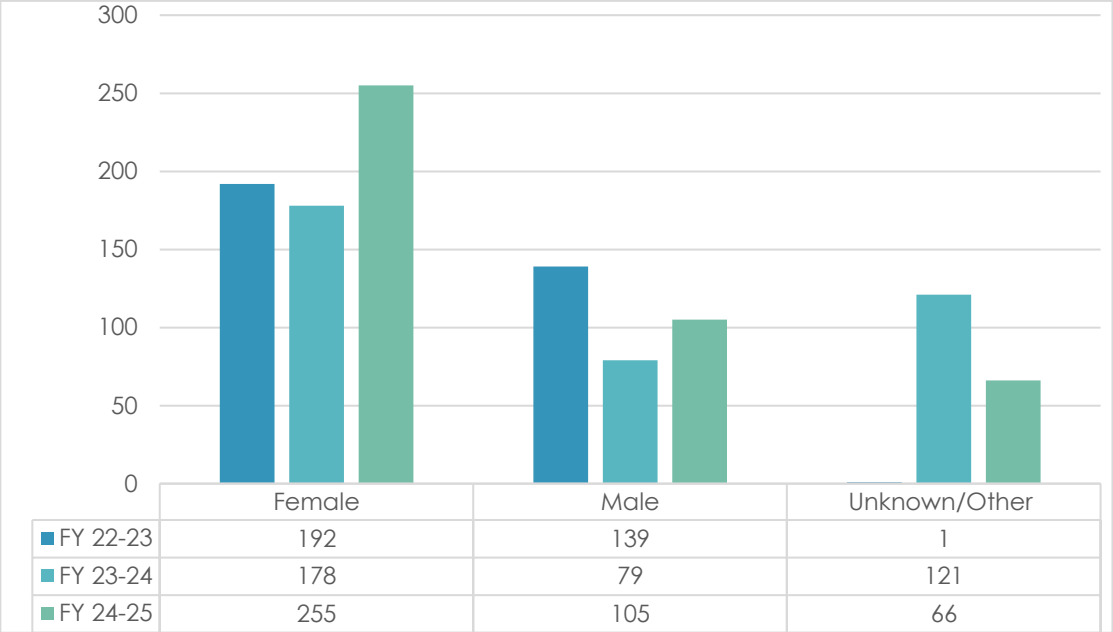
The graphs below indicate demographic information for beneficiaries served by the ICBHS SMHS contracted providers.

Chart 1.26 Beneficiaries Served by Contact Providers - Age Group



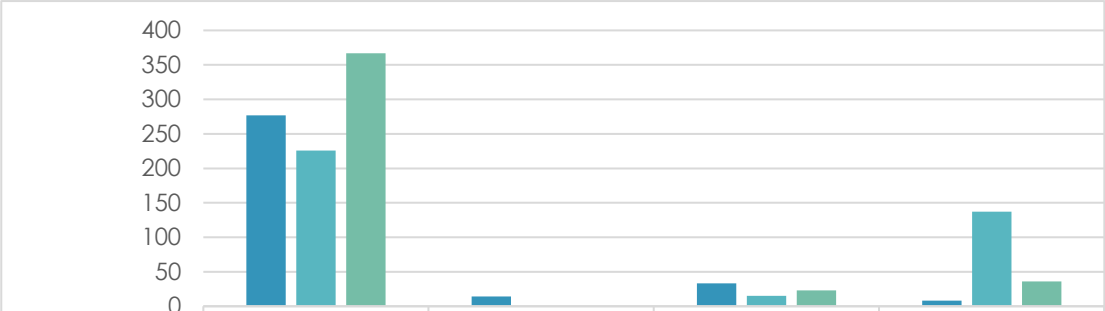
	0-5 Years	6-13 Years	14-20 Years	21-25 Years	26-65+ Years
FY 22-23	5	57	59	28	183
FY 23-24	9	106	54	20	189
FY 24-25	11	125	39	21	230

Chart 1.27 Beneficiaries Served by Contact Providers - Gender



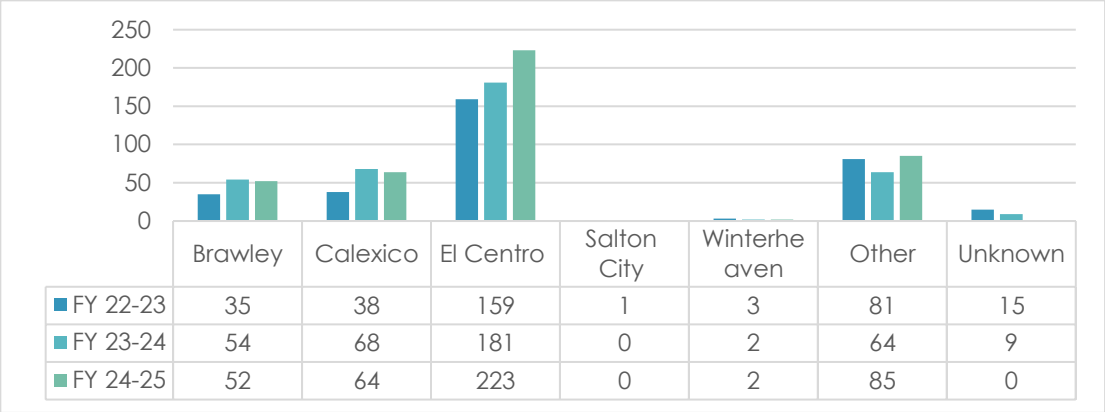
	Female	Male	Unknown/Other
FY 22-23	192	139	1
FY 23-24	178	79	121
FY 24-25	255	105	66

Chart 1.28 Beneficiaries Served by Contact Providers – Ethnicity



	Mexican/Mex. American	Other Hispanic/Latino	Not Hispanic	Unknown/other
FY 22-23	277	14	33	8
FY 23-24	226		15	137
FY 24-25	367		23	36

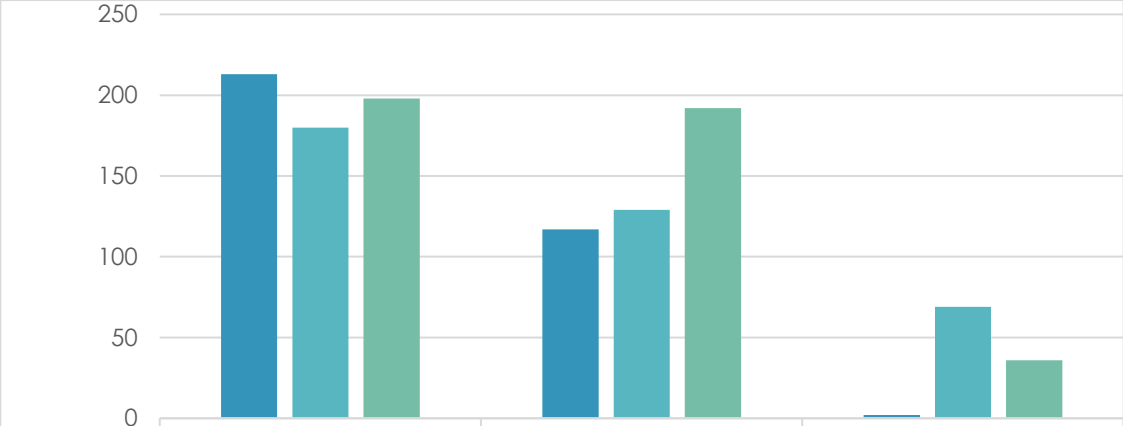
Chart 1.29 Beneficiaries Served by Contact Providers - City of Residence



	Brawley	Calexico	El Centro	Salton City	Winterhe aven	Other	Unknown
FY 22-23	35	38	159	1	3	81	15
FY 23-24	54	68	181	0	2	64	9
FY 24-25	52	64	223	0	2	85	0

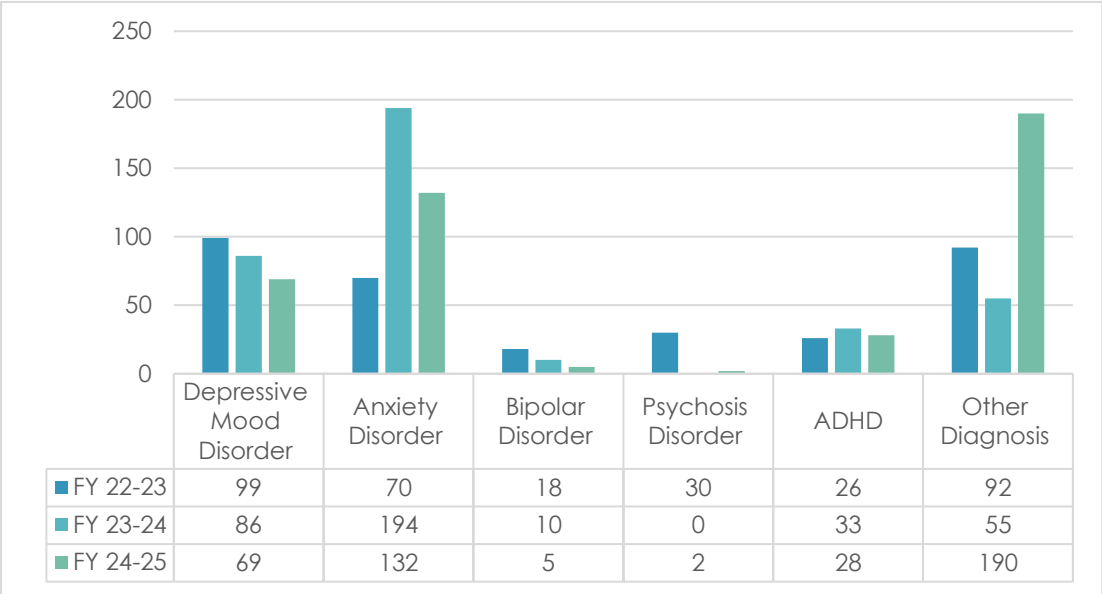
**Other includes county line cities such as, Imperial, Holtville, Heber, Seely, Salton City, Palo Verde, Bombay Beach, etc.*

Chart 1.30 Beneficiaries Served by Contact Providers – Language



	English	Spanish	Other
FY 22-23	213	117	2
FY 23-24	180	129	69
FY 24-25	198	192	36

Chart 1.31 Beneficiaries Served by Contact Providers – Diagnosis



**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

b) Services Provided

The table below indicates the number of beneficiaries served by contracted providers during FY 24-25, in addition to a comparison for the past three years.

Table 1.3 Beneficiaries Served by Contract Providers

Fiscal Year	Number of Beneficiaries
FY 24-25	426
FY 23-24	378
FY 22-23	332

3) SUDS Direct Service Providers

a) Geographic Location of Programs & Population Served

During FY 24-25, ICBHS provided SUDS at 4 county-operated Medi-Cal certified sites. Each site provides services according to the client's age group and residence.

Adolescents Division

Region	Sites	Address	Provider No.
Central Region	El Centro Adolescent SUDS Treatment Program	315 S. Waterman Ave. El Centro, CA 92243	1303
Southern Region	Adolescent Calexico SUDS Treatment Program	101 Hacienda Dr. Suite B. Calexico, CA 92231	13SN

Charts 1.32 - 1.37 indicate the demographic information for beneficiaries served by adolescent SUDS.

Chart 1.32 Adolescents Served by Age Group

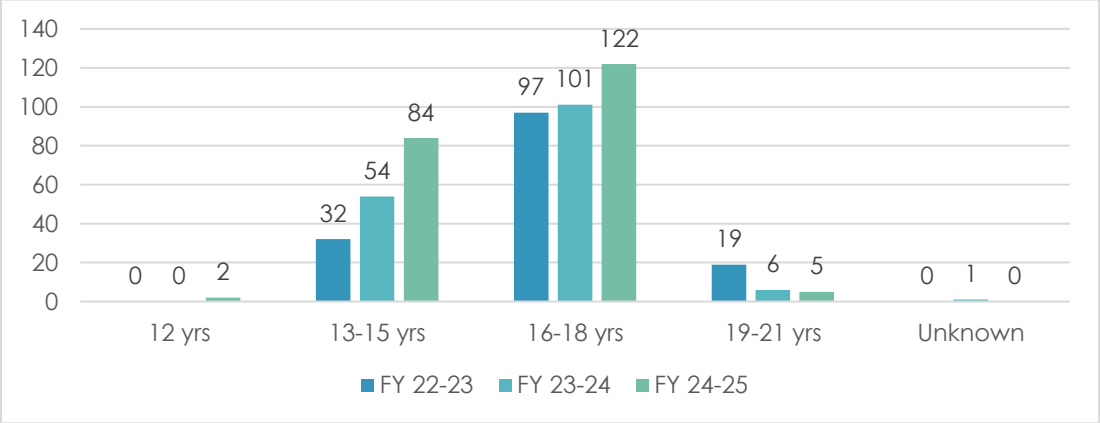


Chart 1.33 Adolescents Served by Gender

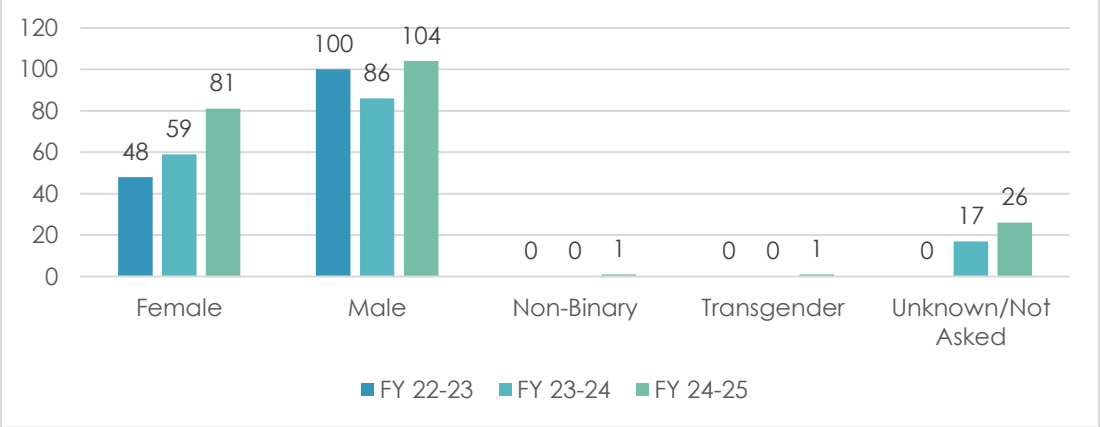


Chart 1.34 Adolescents Served by Ethnicity

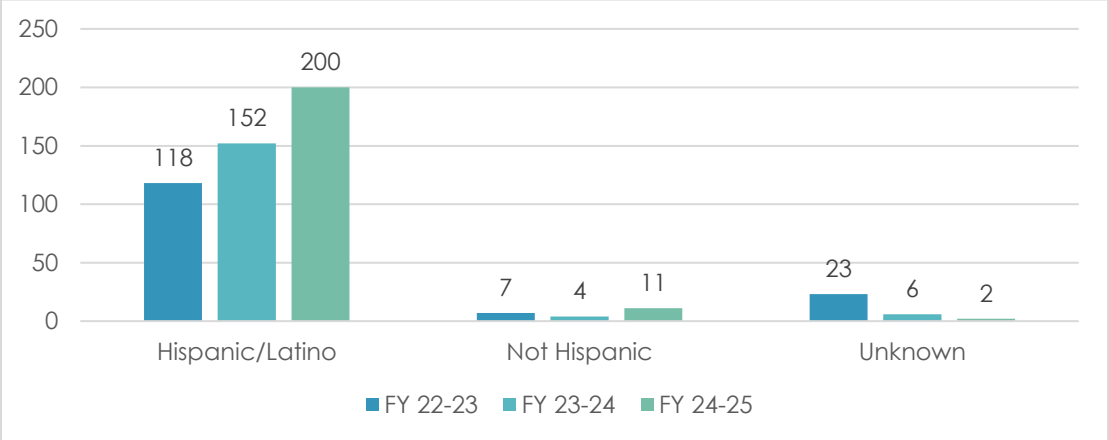


Chart 1.35 Adolescents Served by City of Residence

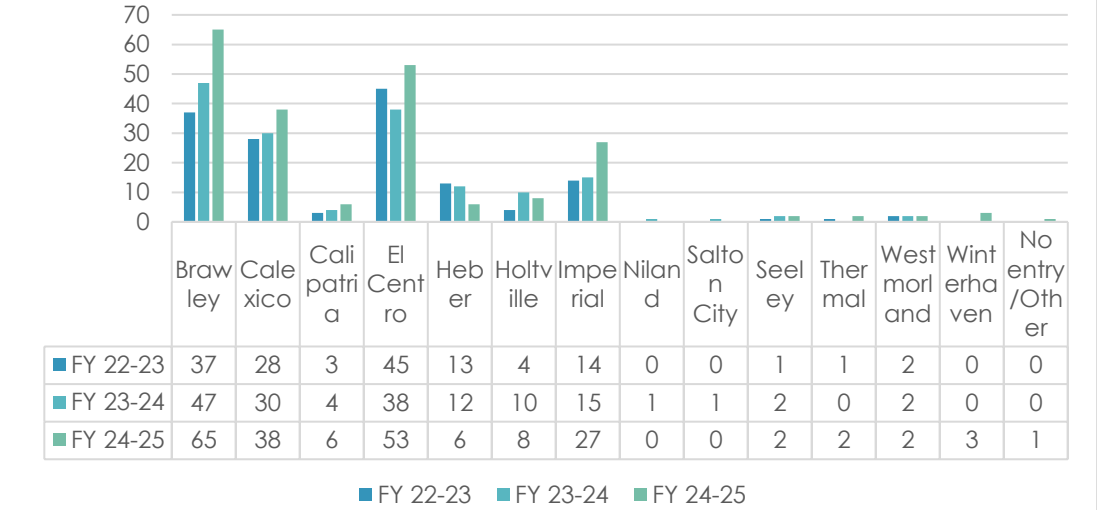


Chart 1.36 Adolescents Served by Language

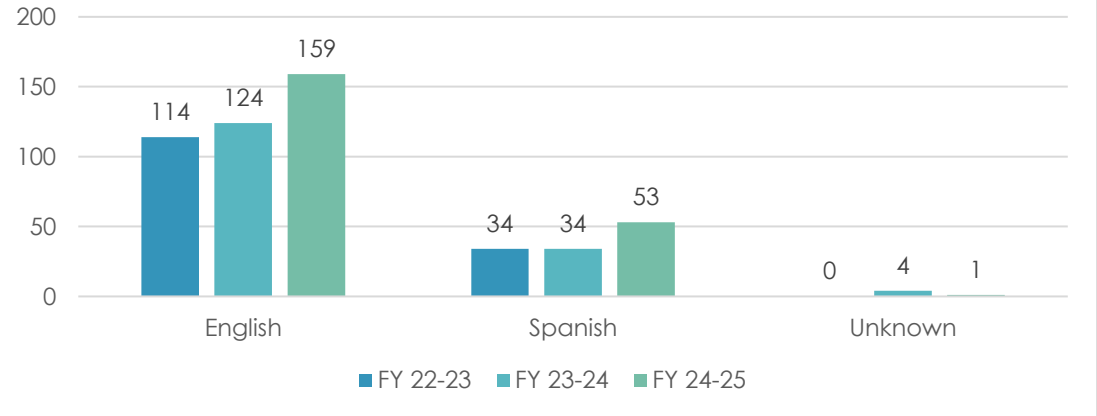
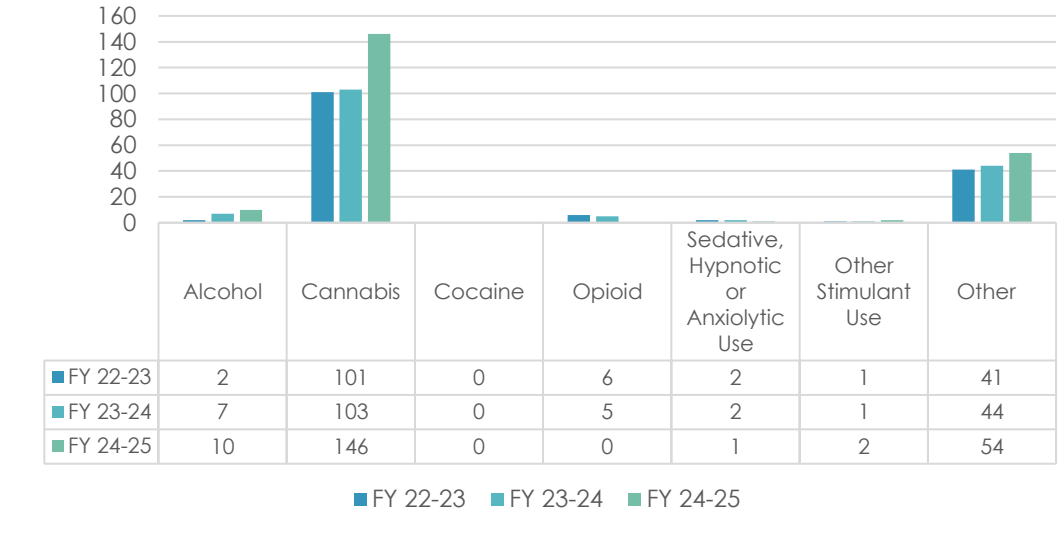


Chart 1.37 Adolescents Served by Diagnosis



**Data may not total the number of beneficiaries served as some have more than one diagnosis.*
**Other- Includes ICD10 Z Codes covering history of other conditions, tobacco, and other social determinants of health.*

Adults Division

Charts 1.38-1.43 indicate the demographic information for beneficiaries served by Adult SUDS.

Region	Sites	Address	Provider No.
Central Region	El Centro Adult SUDS Treatment Program	2695 S. 4th Street El Centro, CA 92243	1309
Southern Region	Calexico Adult SUDS Treatment Program	25 East 3rd Street Calexico, CA 92231	13PH

Chart 1.38 Adults Served by Age Group

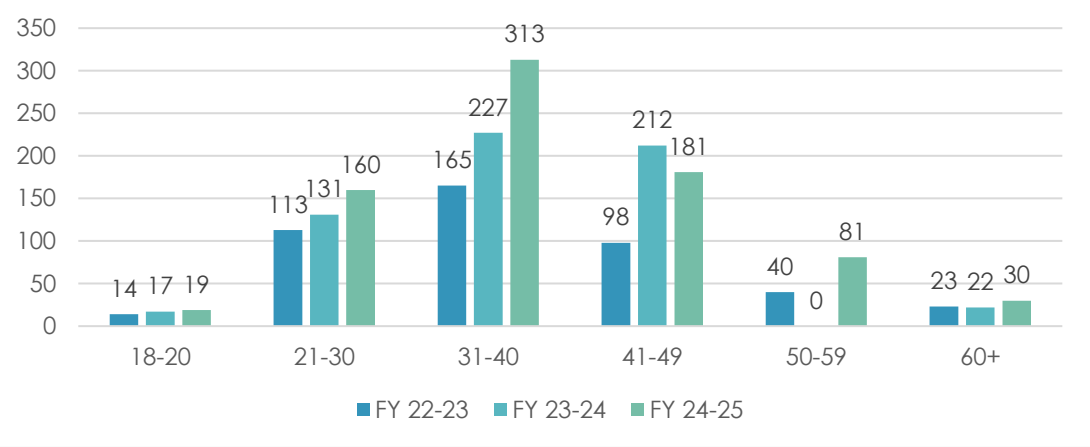


Chart 1.39 Adults Served by Gender

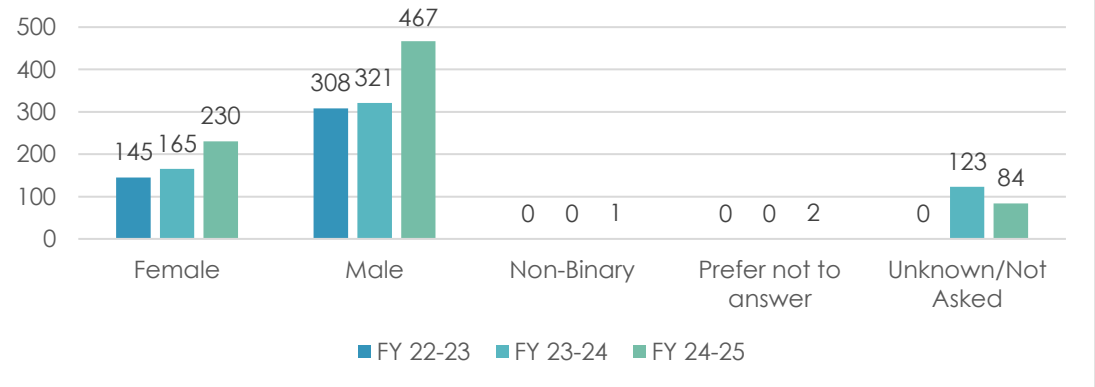


Chart 1.40 Adults Served by Ethnicity

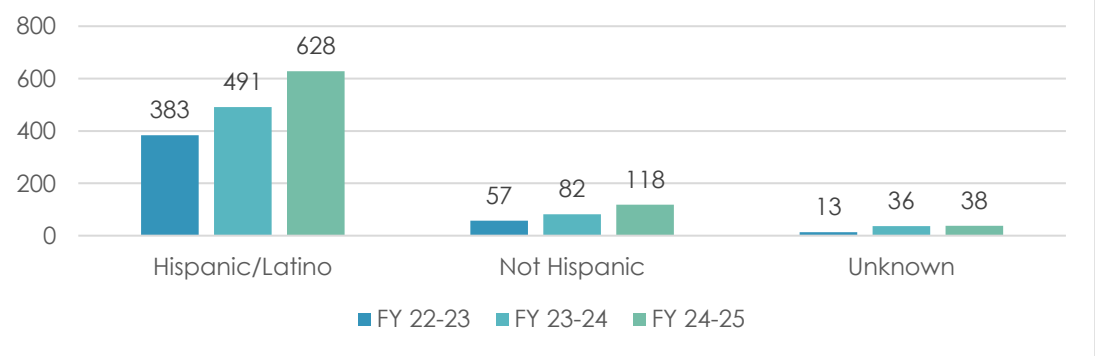


Chart 1.41 Adults Served by City of Residence

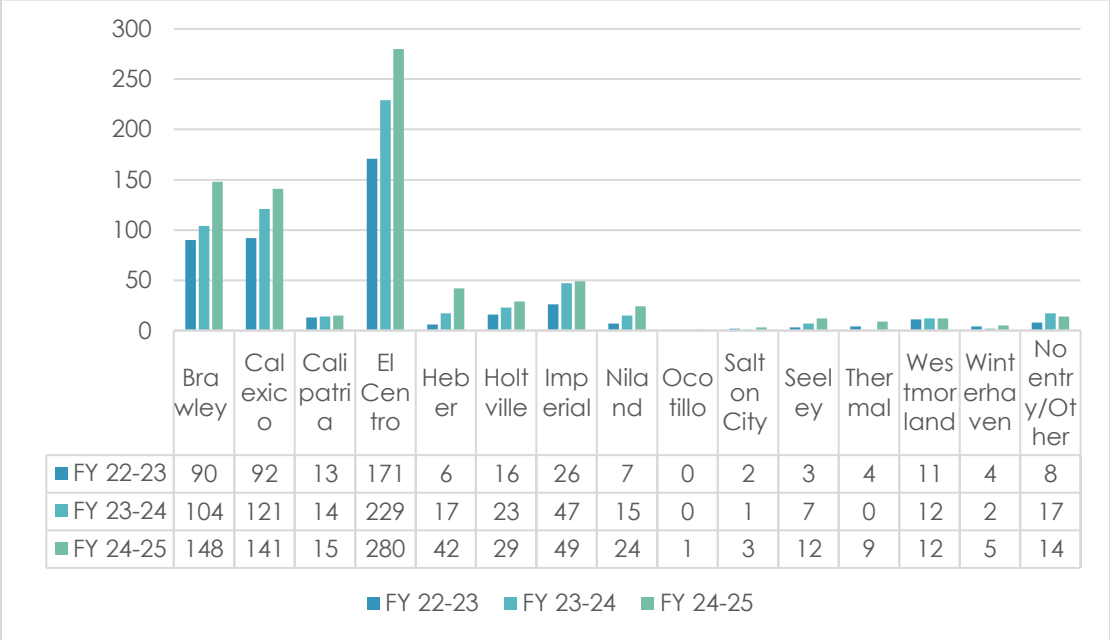


Chart 1.42 Adults Served by Language

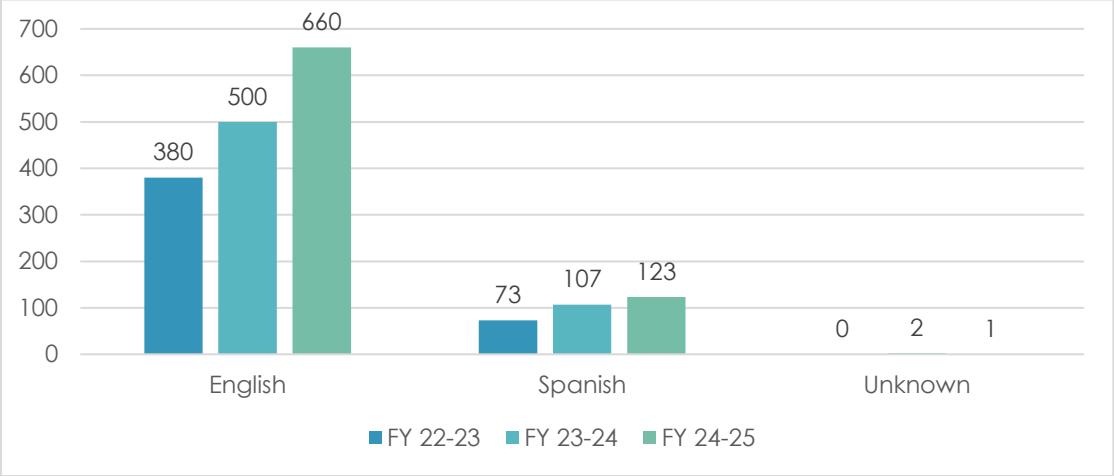
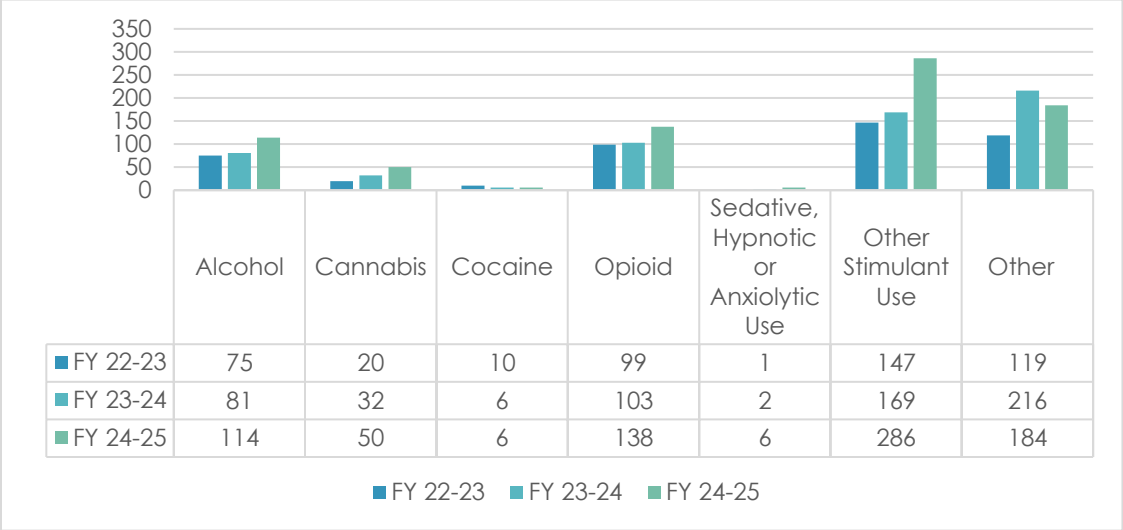


Chart 1.43 Adults Served by Diagnosis



**Data may not total the number of beneficiaries served as some have more than one diagnosis.*

**Other- Includes ICD10 Z Codes covering history of other conditions, tobacco, and other social determinants of health.*

b) Services Provided

ICBHS provides a full continuum of SUDS, including Outpatient Treatment, Intensive Outpatient Treatment, Medications for Addiction Treatment (MAT), Withdrawal Management, Care Coordination, and Recovery Services.

Outpatient Treatment (ASAM Level 1) offers up to nine hours per week for adults and under six hours for adolescents. IOT (ASAM Level 2.1) provides 9–19 hours weekly for adults and 6–19 hours for adolescents, with possible extensions based on medical necessity.

The components of ASAM Level 1 and 2.1 include assessment, care coordination, individual/group counseling, family therapy, medication services, MAT for opioid, alcohol, and other SUDs, recovery education, SUD crisis intervention, and recovery support. Services may be provided in person, via telehealth, or by phone.

MAT is available at the Adult El Centro SUD Clinic and includes a wide range of medications for opioid and alcohol use disorders, overdose prevention, and withdrawal management based on clinical need and client consent. Medications include:

- Opiate overdose prevention- Naloxone (Narcan);
- Opiate use treatment - Buprenorphine- Naloxone (Suboxone) and Naltrexone (oral and extended release);
- Opiate withdrawal management/symptomatic relief-Clonidine for anxiety, Ibuprofen for aches, Dicyclomine for stomach cramping, Loperamide for diarrhea, and Trazodone for insomnia;
- Reduction of alcohol craving - Naltrexone, extended release injectable (Vivitrol), and Acamprosate (Campral);
- Alcohol withdrawal management - Librium (chlordiaxepoxide), Gabapentin, Clonidine (Catapres), Diazepam, Lorazepam, and Trazadone for sleep disturbances; and
- Opioid Use Management - Sublocade (buprenorphine) injection, Brixadi

Ambulatory withdrawal management with extended on-site monitoring is available at the Adult El Centro SUD Clinic, based on clinical need and consent.

Care Coordination supports the integration of SUD, mental health, and medical care to promote whole-person wellness. It is provided alongside all levels of treatment or as a standalone service. Services can be provided in a clinical or non-clinical setting and can be provided in person, by telehealth, or by telephone. Care Coordination includes coordination with medical and mental health providers, discharge planning and transitions between levels of care, and referrals and linkages to community resources (e.g., housing, employment, education, transportation).

Recovery Services support ongoing recovery and relapse prevention, helping clients maintain their highest level of functioning. Services may be provided alone or alongside other DMC-ODS services, including MAT and NTP, and are available post-incarceration for individuals with a prior SUD diagnosis. Eligibility is based on provider or self-assessed relapse risk; a remission diagnosis is not required. Services can be delivered in clinical or community settings, in person, by phone, or via telehealth.

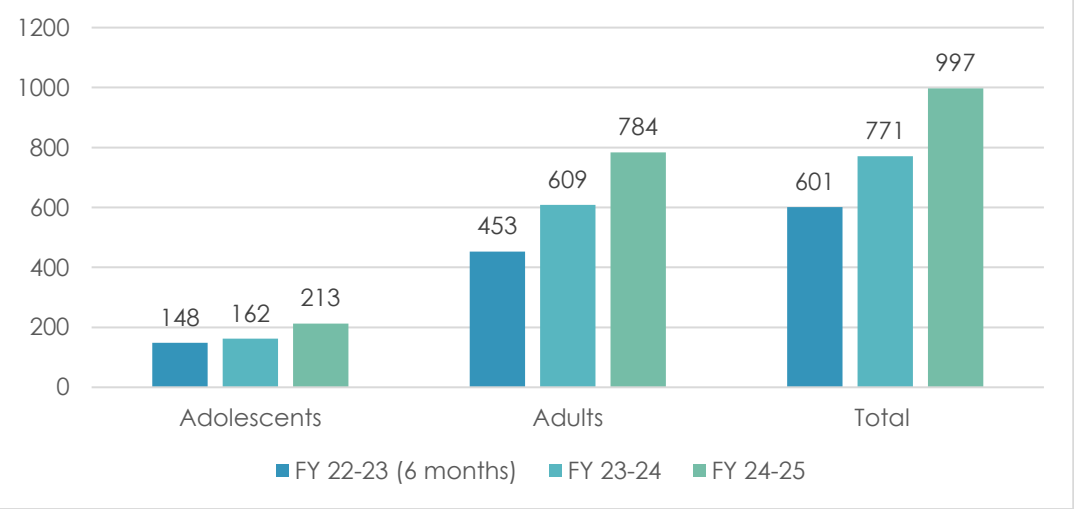
The number of unduplicated beneficiaries is included in the table and chart below:

Table 1.4 Unduplicated Medi-Cal Clients Served

SUD Programs	FY 22-23*	FY 23-24	FY 24-25
Adolescent SUD Services	148	162	213
Adult SUD Services	453	609	784
Total	**601**	**771**	**997**

**July 1, 2022, through December 31, 2022*

Chart 1.44 Beneficiaries Served by SUD Programs



c) Utilization of Services for FY 24-25

The utilization of services for FY 24-25 has been obtained from the monthly Units of Service Summary reports completed by the ICBHS Fiscal Unit. The following is a breakdown of the services that are billed under each type of service.

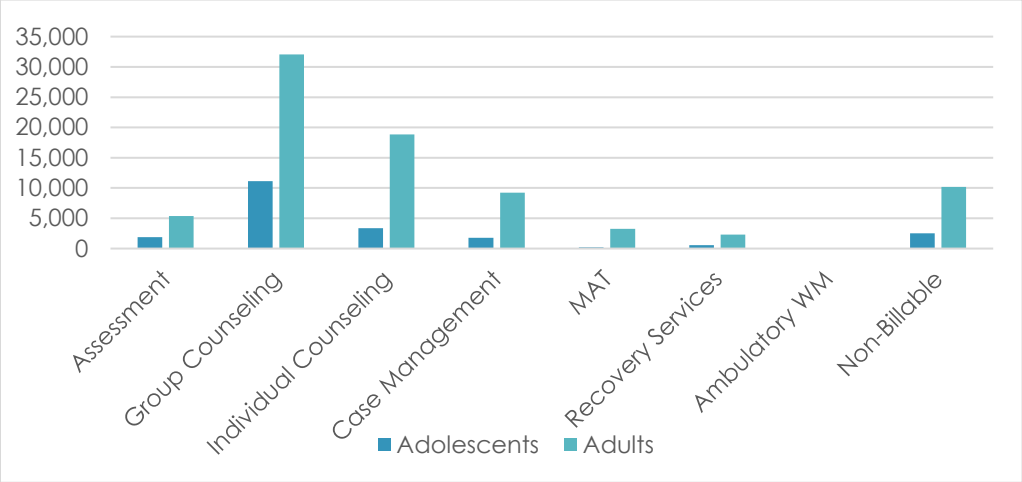
- Assessment: Assessments completed by a LPHA or MD; ASAM assessment or other structured SUD assessment; and SUD screening.
- Group Counseling: Group counseling services.
- Individual Counseling: Individual counseling services; Contingency Management; and any SUD crisis interventions.
- Case Management: Targeted Case Management/Intensive Care Coordination; Medical team conference with participation by the physician, patient and/or family not present.
- Medication Assisted Treatment: Medication training and support and/or oral medication administration.
- Recovery Services: Psychosocial rehabilitation individual; Psychosocial rehabilitation group; and comprehensive community support services.
- Ambulatory Withdrawal Management: Ambulatory withdrawal management services delivered in an office setting with the frequency to be determined by the severity of withdrawal symptoms.
- Non-Billable: Any other non-billable service that must be documented and is not better accounted for by other available non-billable procedure codes.

SUDS units of service provided by the Adolescent SUD Program and the Adult SUD Program during FY 24-25 are shown below:

Table 1.5 SUDS Units of Service

Type of Service	Adolescents	Adults
Assessment	1,871	5,389
Group Counseling	11,151	32,040
Individual Counseling	3,372	18,860
Case Management	1,765	9,250
Medication Assisted Treatment	175	3,271
Recovery Services	544	2,332
Ambulatory Withdrawal Management	0	0
Non-Billable	**2,536**	**10,207**

Chart 1.45 Units of Service by SUD Programs



4) *SUDS Contracted Providers*

a) *Geographic Location of Programs & Population Served*

To ensure the appropriate levels of care are available to Imperial County residents, ICBHS contracts with local and out-of-county providers to SUDS services:

i. *In-County*
During FY 24-25, ICBHS had one contracted provider for NTP services. NTP services were provided in NTP-licensed clinics located in Calexico and in El Centro. This provider has services available for all individuals that reside in all geographic areas of the county; however, it has primarily served the 18+ age group due to beneficiaries between the ages of 0-17 not seeking these services.

ii. *Out-of-County*
During FY 24-25, ICBHS had three DMC certified contracted providers for residential treatment services. The residential programs provided adolescent and adult residential treatment services, which are limited to 14-day detox services. ABC Recovery provided levels of care 3.2 and 3.5; Tarzana Treatment Centers 3.1, 3.2, 3.3, 3.5, 3.7, 4.0 & OTP Level 1; and Clare Matrix 3.1, 3.2, and 3.5. The providers are designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

b) Services Provided

Narcotic treatment and residential treatment services are available, based on medical necessity and the individualized treatment plan, to all beneficiaries residing in Imperial County who meet the established medical necessity criteria and pertinent ASAM level of care designation.

The NTP contracted provider offers narcotic treatment in various forms of services that are based on the individuals' needs and assessment. The components of NTP services include Intake; Individual and Group Counseling; Patient Education; Medication Services; Collateral Services; Crisis Intervention Services; Treatment Planning; Medical Psychotherapy; Recovery Services; and Discharge Services. NTP is also required to provide other non-controlled medications approved by the FDA, such as buprenorphine, disulfiram, and naloxone for providing medication assisted treatment to patients with substance use disorder.

During Fiscal Year 2024-2025, a total of 279 clients received counseling services as a part of NTP services. It is important to note that this total reflects unique individuals and not the number of counseling sessions provided. As such, the count may differ from the number of counseling services provided throughout the year.

From FY 2023-2024 to FY 2024-2025, there was a notable increase in the number of total clients and clients receiving individual counseling, while a slight decrease was observed in the number of clients receiving group counseling.

The residential treatment providers offer residential treatment in a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis. Residential treatment services are provided to both non-perinatal and perinatal beneficiaries. This includes both adults and adolescents. The components of Residential treatment services include: Intake; Individual and Group counseling; Patient Education; Family Therapy; Safeguarding Medications; Collateral Services; Crisis Intervention Services; Treatment Planning; Transportation Services; Case Management; and Discharge Services.

During Fiscal Year 2024-2025, a total of 105 clients received residential treatment admissions. It is important to note that this total reflects unique individuals and not the number of residential admissions completed. As such, the count may differ from the number of residential services throughout the year.

From FY 2023-2024 to FY 2024-2025, there was a notable increase in the number of total clients and clients who received each ASAM level of care. There were no reported admissions to ASAM level 4.0 or OTP level 1 during this reporting period.

The services provided by contracted providers to Imperial County residents on FY 24-25 are displayed below:

Table 1.6 NTP Utilization of Services			
Type of Service	FY 22-23	FY 23-24	FY 24-25
Individual Counseling	217	229	**279**
Group Counseling	203	211	**210**
Total		240	**279**

Table 1.7 Residential Admissions by Level of Care			
Type of Service	FY 22-23 Admissions	FY 23-24 Admissions	FY 24-25 Admissions
ASAM Level 3.1	27	30	**40**
ASAM Level 3.2	12	6	**13**
ASAM Level 3.3	0	0	**2**
ASAM Level 3.5	62	55	**64**
ASAM Level 3.7	0	0	**1**
ASAM Level 4.0	0	0	**0**
OTP – Level 1	0	0	**0**
Total	**88**	**79**	**105**

5) Federal Network Adequacy Standards

Network adequacy standards were developed pursuant to Title 42 of the Code of Federal Regulations. Network adequacy standards include time, distance, and timely access requirements with which ICBHS must comply, taking into consideration the urgency of the need for services and the assurance of adequate capacity of services on the number and type of providers, age groups served by each provider, as well as the language capabilities of each. Imperial County must meet the distances standard of up to 60 miles or 90 minutes from the client's place of residence.

Reporting requirements include accessibility analyses confirming compliance with the time and distance standards for both children/youth and adults. Provider data that includes provider counts by type, licensure, National Provider Identification numbers, site locations, ages served, cultural competence, and language capabilities are also included in the reporting, as is the expected utilization of services, language line utilization, and grievances and appeals regarding access to services.

During FY 2024–25, ICBHS submitted monthly 274 files to DHCS for both SMHS and SUDS. These files included data on provider capacity, mandatory provider types, provider service validation, contract validation, and time/distance standards. Each submission identified which network providers delivered specific covered services and was submitted by the 10th of each month. For the FY 2025–26 Annual Network Adequacy Certification, DHCS used the July 2025 274 file to validate ICBHS's compliance with network capacity and composition requirements, including mandatory provider types and time/distance standards.

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will monitor the number, type, and geographic distribution of SMHS and SUDS in order to verify that timely and appropriate services are available to all Medi-Cal beneficiaries within Imperial County.

- ICBHS will ensure service delivery capacity to meet the needs of beneficiaries.

- ICBHS will monitor its network adequacy and submit data through the monthly submissions of the 274 standard files.

QUALITY IMPROVEMENT MONITORING

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

Quality Improvement Monitoring

I. Timeliness of Services

The QM Unit monitors ICBHS ability to meet the following timeliness standards as established by DHCS:

Table 2.1 Timely Access Standards for SMHS

Service Type	Timely Access
Outpatient Non-Urgent Non-Psychiatric Specialty Mental Health Services	Offered an appointment within 15 business days of request for services.
Non-urgent follow-up appointments	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.
All Urgent SMHS Appointments	Urgent Appointments 48 hours without prior authorization. 96 hours with prior authorization
Psychiatric Services	Offered an appointment within 15 business days of request for services.

Table 2.2 Timely Access Standards for SUDS

Service Type	Timely Access
Outpatient Services – Outpatient Substance Use Disorder Services	Offered an appointment within 10 business days of request for services.
Non-urgent follow-up appointments with a Non-Physician	Offered a follow-up appointment with a non-physician within 10 business days of the prior appointment.
All Urgent SUD Appointments	Urgent Appointments 48 hours without prior authorization. 96 hours with prior authorization
Opioid Treatment Program	Within three business days of request

The QM Unit collects data through the EHR, Timeliness of Services report, monthly to verify that beneficiaries can access services timely without delay. Individual instances of access delays may result in the QM Unit conducting a more in-depth review to identify any potential quality of care issues. A corrective action plan is issued when the SMHS or SUDS overall compliance rate with timeliness standards falls below 80 percent. Timeliness findings are reported to clinical management and/or the QIC, on a quarterly basis.

a. Update on the objectives and activities for FY 24-25:

1) SMHS Outpatient Non-Urgent Non-Psychiatric Specialty Mental Health Services

The DHCS standard for timelines to first non-urgent services is 10 business days. The current intake process for SMHS allows clients to be scheduled an appointment with a mental health professional if at the time of the request the client requests a non-urgent service. The first offered

non-urgent service is an intake assessment scheduled with a licensed/registered clinician. Requests for non-urgent services are recorded by the Access Unit.

The QM Unit evaluates timeliness to first non-urgent services by reviewing the date of the request and determining the length of time to the first offered appointment. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes timeliness to first non-urgent services data for FY 24-25

Table 2.3 Timeliness to First Non-Urgent Services				
Review Period	Medi-Cal Requests	Appointments Offered Within 10 Business Days	Appointments Offered Over 10 Business Days	Compliance Rate
FY 24-25	4,985	4,887	98	98%
FY 23-24	2,728	2,592	136	95%
FY 22-23	2,902	2,761	141	95%

2) *SMHS Non-Urgent Follow-Up Appointments*

The DHCS standard for timeliness to non-urgent follow-up appointments with a non-physician provider is 10 business days from the date of the first non-urgent service rendered. The non-urgent follow-up service is a clinically appropriate outpatient service scheduled with a licensed/registered clinician.

The QM Unit evaluates timeliness to non-urgent follow-up appointments by reviewing the date of the first non-urgent service rendered and determining the length of time to the offered follow-up appointment. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes timeliness to non-urgent follow-up appointment data for FY 24-25:

Table 2.4 Timeliness to Non-Urgent First Followed Up Offered Non-Urgent Services				
Review Period	Non-Urgent Follow-Up Offered Appointments	Appointments Offered Within 10 Business Days	Appointments Offered Over 10 Business Days	Compliance Rate
FY 24-25	3,083	2,674	409	87%

3) *SMHS All Urgent Appointments*

The DHCS standard for timeliness to urgent services not requiring prior authorization is 48 hours. For urgent services requiring prior authorization, the DHCS timeliness standard is 96 hours. Requests for urgent services not requiring prior authorization are recorded by the Access Unit, while requests for urgent services requiring prior authorization are recorded by the Payment Authorization Unit.

ICBHS provides urgent services upon request or when it is determined that a client's "condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for [a non-urgent appointment] … would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function …." (28 CCR § 1300.67.2.2, subd. (b)(7); Health & Safety Code § 1367.01, subd. (h)(2))

The QM Unit evaluates timeliness to urgent services not requiring prior authorization by reviewing the date of the request and determining the length of time to the first offered service. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes the FY 24-25 data related to timeliness to urgent services not requiring prior authorization:

Table 2.5 Timeliness to Urgent Services Not Requiring Authorization				
Review Period	Requests	Services Offered Within 48 Hours	Services Offered Over 48 Hours	Compliance Rate
FY 24-25	352	337	15	96%
FY 23-24	152	134	18	88%
FY 22-23	17	15	2	88%

The QM Unit evaluates timeliness to urgent services requiring prior authorization by reviewing the date of the request and determining the length of time to the first offered service following authorization. The monitoring process involves gathering data from the Payment Authorization Unit's treatment authorization log. The table below summarizes the FY 24-25 data related to timeliness to urgent services requiring prior authorization:

Table 2.6 Timeliness to Urgent Services Requiring Authorization				
Review Period	# of TARs Submitted	Requests for Urgent Services	Services Offered Within 96 Hours	Compliance Rate
FY 24-25	214	0	N/A	N/A
FY 23-24	218	0	N/A	N/A
FY 22-23	196	0	**N/A**	**N/A**

4) SMHS Psychiatric Services

The DHCS standard for timeliness to first non-urgent psychiatry service is 15 business days. The first offered non-urgent psychiatry service is an Initial Psychiatry Assessment (IPA) scheduled with a psychiatrist. Beneficiaries may request non-urgent psychiatry services by calling the ICBHS 24/7 Line and requesting an appointment with a psychiatrist. Requests for non-urgent psychiatry services are recorded by the Access Unit.

The QM Unit evaluates timeliness to first non-urgent psychiatry services by reviewing the date of the request and determining the length of time to the first offered psychiatry appointment. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes timeliness to first non-urgent psychiatry services data for FY 24-25:

Table 2.7 Timeliness to First Non-Urgent Psychiatric Services				
Review Period	Requests	Appointments Offered Within 15 Business Days	Appointments Offered Over 15 Business Days	Compliance Rate
FY 24-25	24	19	5	79%
FY 23-24	0	N/A	N/A	N/A
FY 22-23	8	7	1	88%

5) *SUDS Outpatient Services*

The DHCS standard for timelines to first non-urgent services is 10 business days. The current intake process for SUDS services allows for clients to be scheduled an appointment with a SUD professional if at the time of the request the client requests a non-urgent service. The first offered non-urgent service is a clinically appropriate outpatient service scheduled with a SUD counselor or a licensed/registered clinician, which can include prevention, screening, assessment, individual counseling, group counseling, targeted case management, or recovery service. Requests for non-urgent services are recorded by the Access Unit.

The QM Unit evaluates timeliness to first non-urgent services by reviewing the date of the request and determining the length of time to the first offered appointment. During FY 23-24, the absence of a dedicated tracking mechanism in the EHR prevented reliable reporting of first non-urgent timeliness data. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes timeliness to first non-urgent services data for FY 24-25:

Table 2.8 Timeliness to First Non-Urgent Services

Review Period	Requests	Appointments Offered Within 10 Business Days	Appointments Offered Over 10 Business Days	Compliance Rate
FY 24-25	1,489	1,478	11	99%
FY 23-24	N/A	N/A	N/A	N/A
FY 22-23	525	519	6	99%

6) *SUDS Non-Urgent Follow-Up Appointments with a Non-Physician*

The DHCS standard for timeliness to non-urgent follow-up appointments with a non-physician SUD provider is 10 business days from the date of the first non-urgent service rendered. The non-urgent follow-up service is a clinically appropriate outpatient service scheduled with a counselor or registered/licensed clinician, which can include individual counseling, group counseling, targeted case management, or recovery services. Requests for non-urgent follow-up appointments are recorded by the SUD programs.

The QM Unit evaluates timeliness to non-urgent follow-up appointments by reviewing the date of the first non-urgent service rendered and determining the length of time to the offered follow-up appointment. During FY 23-24, the absence of a dedicated tracking mechanism in the EHR prevented reliable reporting of non-urgent follow-up timeliness data. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes timeliness to non-urgent follow-up appointment data for FY 24-25:

Table 2.9 Timeliness to Non-Urgent Follow-Up Appointments with a Non-Physician

Review Period	Requests	Appointments Offered Within 10 Business Days	Appointments Offered Over 10 Business Days	Compliance Rate
FY 24-25	1,000	985	15	99%
FY 23-24	N/A	N/A	N/A	N/A

7) *SUDS All Urgent Appointments*

The DHCS standard for timeliness to urgent services not requiring prior authorization is 48 hours. For urgent services requiring prior authorization, the DHCS timeliness standard is 96 hours. All requests for urgent services not requiring prior authorization are recorded by the Access Unit.

ICBHS provides urgent SUDS services upon request or when it is determined that a client's "condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for [a non-urgent appointment] … would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function …." (28 CCR § 1300.67.2.2, subd. (b)(7); Health & Safety Code § 1367.01, subd. (h)(2))

The QM Unit evaluates timeliness to urgent services not requiring prior authorization by reviewing the date of the request and determining the length of time to the first offered service. The monitoring process involved gathering data collected through the ICBHS Timeliness of Services report in the EHR. The table below summarizes the FY 24-25 data related to timeliness to urgent services not requiring prior authorization:

Table 2.10 Timeliness to Urgent Services Not Requiring Authorization

Review Period	Requests	Services Offered Within 48 Hours	Services Offered Over 48 Hours	Compliance Rate
FY 24-25	11	11	0	100%
FY 23-24	11	10	1	91%
FY 22-23	4	2	2	50%

The QM Unit also evaluates timeliness to urgent services requiring prior authorization by reviewing the information collected in the EHR Inquiry Log. To date no client requests have been made for urgent services requiring prior authorization.

8) *SUDS Opioid Treatment Program*

The DHCS standard for timeliness to first opioid treatment services is 3 business days. Beneficiaries request services directly from ICBHS' contracted NTP provider, although they may also request opioid treatment services by contacting the 24-hour access line or through a referral from another provider. The first non-urgent opioid treatment service is an initial assessment.

The QM Unit evaluates timeliness to first opioid treatment services by reviewing the date of the request and determining the length of time to the first offered appointment. This data is gathered and reported by the NTP provider monthly using an Excel spreadsheet. The table below summarizes the timeliness to opioid treatment services data for FY 24-25:

Table 2.11 Timeliness to First NTP/OTP Services				
Review Period	Medi-Cal Requests	Appointments Offered Within 3 Business Days	Appointments Offered Over 3 Business Days	Compliance Rate
FY 24-25	190	190	0	100%
FY 23-24	182	182	0	100%
FY 22-23	200	200	0	100%

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will monitor SMHS and SUDS Timely Access Standards monthly to verify beneficiaries can access services without delay.

- The QM Unit will issue corrective action plans to SMHS and SUDS if less than 80 percent of Medi-Cal client requests were not offered a service within the required timeframe.

- SMHS and SUDS divisions will ensure a complete protocol is developed and maintained that outlines the necessary steps for accurately completing the SMHS and SUDS Timeliness Record in SmartCare, supporting consistent processes and timely access to services for beneficiaries.

II. Accessibility of Services

The QM Unit monitors accessibility of SMHS and SUDS by evaluating the responsiveness of the 24/7 Access Line and the Mental Health Triage Unit.

a. Update on the objectives and activities for FY 24-25:

1) Responsiveness of the 24/7 Access Line

The QM Unit monitors the responsiveness of ICBHS 24/7 Access Line monthly by conducting random test calls, during business hours and after hours, in English and Spanish, Imperial County's threshold language. Monitoring is conducted to verify that the 24/7 Access Line is available to beneficiaries 24 hours a day, seven days a week.

Test calls determine the ability of the 24/7 Access Line to provide information related to 1) available SMHS and/or SUDS, 2) referrals for urgent services and medical emergencies, 3) information regarding problem resolution and fair hearing process, and 4) interpreter and translation service information. Test callers also assess whether or not the 24/7 Access Line appropriately determines the urgency of callers' requests; answers call within five rings; provides information related to TTY/TDY services; and providers with written SMHS and/or SUDS materials upon request.

During FY 24-25, the QM Unit conducted 52 test calls, 30 during business hours and 22 after hours. Below are the findings related to the test calls conducted by the QM Unit:

Table 3.1 24/7 Access Line			
Test Call Criteria	Percentage of Test Calls Where Requirement Was Met		
	Business Hours	After Hours	All Calls
Language Capability	100%	100%	100%
SMHS Access Information	100%	87%	93%
Urgency Assessment	100%	85%	92%
Resolution and Fair Hearing Process	95%	100%	97%
Access Log Criteria	Percentage of Test Calls Where Requirement Was Met		
	Business Hours	After Hours	All Calls
Name of the caller	82%	82%	81%
Date of the request	82%	95%	88%
Initial disposition of the request	77%	90%	83%

2) Access to After-Hours Care

ICBHS is responsible for ensuring beneficiaries have access to after-hours care. After-hours care is provided through the 24/7 Access Line, where callers are assessed for safety and urgency of need and referred to the ICBHS Triage Unit for immediate attention. ICBHS has established a one-hour standard from the time of the request to provide after-hours care.

The QM Unit compares the After-Hours Access Log call times from the EHR, which identifies the client's request for after-hours care (requests made after-hours, weekends, and holidays) to the times contacts are made to the client by After-Hours Triage staff, to determine whether after-hours care was provided within one hour.

In review of the data for FY 24-25, the QM Unit determined that access to after-hours care was provided within one hour for only 49 percent of requests. This is a slight increase when compared to last fiscal year; however, the compliance rate continues to be low and could be attributed to staff failing to log their after-hours encounters with beneficiaries.

Table 3.2 SMHS Access to After-Hours Care			
Review Period	Requests	Within Standard	Compliance Rate
FY 24-25	464	225	**49%**
FY 23-24	440	206	**47%**
*FY 22-23	164	161	**98%**

Inclusive of July-December 2022 data only due to EHR transition.

During FY 24-25, the QM Unit determined that access to after-hours care was provided within one hour for 100% of requests for SUDS services.

Table 3.3 SUDS Access to After-Hours Care			
Review Period	Requests	Verified	Compliance Rate
FY 24-25	1	1	100%
FY 23-24	0	0	N/A
FY 22-23	5	2	40%

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will continue to monitor the 24/7 Access Line to verify that SMHS and/or SUDS services and information are available to beneficiaries at all hours through the 24/7 Access Line and the Mental Health Triage Unit.

- The QM Unit will monitor beneficiaries' access to after-hours services through multiple established support channels. After-hours care is provided through telephone-based assistance available 24 hours a day, 7 days a week via the Beneficiary Access Line and the Suicide and Crisis Hotline. In-person after-hours support is provided at Casa Serena, Monday through Friday from 5:00 p.m. to 10:00 p.m. Furthermore, Mobile Crisis Response Teams are deployed to ensure timely access to urgent mental health and substance use services when clinically indicated.

III. Client/Family Satisfaction

The QM Unit monitors client/family satisfaction with the SMHS and SUDS through the consumer/family satisfaction survey; grievances, appeals, and fair-hearings process; and requests to change persons providing services.

a. Update to the objectives and activities for FY 24-25:

1) Consumer/Family Satisfaction Survey

In Calendar Year (CY) 2024, ICBHS administered two statewide satisfaction surveys: the Consumer Perception Survey (CPS) for beneficiaries receiving SMHS and the Treatment Perception Survey (TPS) for those receiving SUDS. Both surveys, developed by the state, were provided in English and Spanish—the threshold languages for the county.

CPS - SMHS

The CPS, conducted annually, uses a point-in-time method to gather input from beneficiaries receiving face-to-face mental health services, case management, or medication support during a designated one-week sampling period. In CY 2024, ICBHS collected a total of 293 CPS surveys, a decrease of 104 compared to the previous year.

Among these, 59 youth clients completed the CPS. Youth survey results showed notable improvement in Cultural Sensitivity and General Satisfaction. There was a slight decline in Perception of Access. Overall, the data reflects a positive trend in satisfaction and culturally responsive care for youth beneficiaries.

In contrast, 104 youth family members completed the CPS and reported mixed results. While there was a slight increase in Outcome of Services and Perception of Functioning, there were

notable decreases in Social Connectedness, Cultural Sensitivity, and Participation in Treatment Planning. These findings indicate areas requiring further attention to strengthen family engagement and support.

Survey findings for youth and youth families are summarized below, including a side-by-side comparison with CY 2023 findings:

Table 4.1 Youth CPS Results				
Survey Area	CY 2022 (n=82)	CY 2023 (n=67)	CY 2024 (n=59)	Difference in % (2023 to 2024)
General Satisfaction	86%	81%	88%	+7
Perception of Access	95%	87%	86%	-1
Participation in Treatment Planning	94%	77%	78%	+1
Outcome of Services	94%	73%	76%	+3
Social Connectedness	69%	80%	86%	+6
Cultural Sensitivity	82%	85%	93%	+8
Perception of Functioning	66%	78%	78%	0

Table 4.2 Youth Families CPS Results				
Survey Area	CY 2022 (n=138)	CY 2023 (n=156)	CY 2024 (n=104)	Difference in % (2023 to 2024)
General Satisfaction	90%	89%	88%	-1
Perception of Access	93%	93%	88%	-5
Participation in Treatment Planning	90%	90%	84%	-6
Outcome of Services	70%	75%	78%	+3
Social Connectedness	87%	96%	84%	-12
Cultural Sensitivity	96%	98%	92%	-6
Perception of Functioning	68%	72%	78%	+6

Adult beneficiaries completed 115 CPS surveys in 2024, continuing a pattern of generally high satisfaction. Significant increases were observed in Perception of Access and Perception of Functioning, with other areas such as General Satisfaction and Quality and Appropriateness also showing improvement. The only area with a slight decline was Participation in Treatment Planning.

Survey findings for adults are summarized below, including a side-by-side comparison with CY 2023 findings:

Table 4.3 Adult CPS Results				
Survey Area	CY 2022 (n=93)	CY 2023 (n=128)	CY 2024 (n=115)	Difference in % (2023 to 2024)
General Satisfaction	81%	90%	93%	+3
Perception of Access	94%	90%	97%	+7
Quality and Appropriateness	90%	88%	93%	+5
Participation in Treatment Planning	95%	92%	91%	-1
Outcome of Services	72%	74%	77%	+3
Social Connectedness	83%	80%	80%	0.0
Perception of Functioning	71%	71%	77%	+6

A smaller group of 15 older adult beneficiaries participated in the CPS. Despite the smaller sample size, results were overwhelmingly positive. General Satisfaction, Perception of Access, *and* Quality and Appropriateness all improved, with Perception of Access showing the most significant gain. Participation in Treatment Planning was the only area that declined. This data highlights continued satisfaction among older adults, alongside a need to better engage them in shared decision-making.

Survey findings for older adults are summarized below, including a side-by-side comparison with CY 2023 findings:

Table 4.4 Older Adult CPS Results

Survey Area	CY 2022 (n=45)	CY 2023 (n=46)	CY 2024 (n=15)	Difference in % (2023 to 2024)
General Satisfaction	92%	96%	100%	+4
Perception of Access	92%	88%	100%	+12
Quality and Appropriateness	83%	88%	93%	+5
Participation in Treatment Planning	91%	96%	87%	-9
Outcome of Services	70%	83%	85%	+2
Social Connectedness	67%	77%	77%	0.0
Perception of Functioning	80%	74%	85%	+11

All CPS results were reviewed by ICBHS management and shared with both internal teams and contract providers to support continuous improvement efforts.

TPS - SUDS

TPS follows a semi-annual, point-in-time methodology and targets all SUDS clients receiving face-to-face services during a two-week sampling window.

In CY 2024, 52 youth clients receiving outpatient services from the county's two adolescent SUD clinics completed the TPS. Participation significantly increased from previous years. However, the data revealed a downward trend in many areas. Notable declines included Staff Sensitivity to Cultural Background, Feel Less Cravings for Drugs and Alcohol, and Good Enrollment Experience. While most areas showed a decrease, a few areas, such as Feeling Better Able to Do Things and Willingness to Recommend Services, showed improvement, indicating positive treatment impact for some participants.

Among adult SUDS clients, 369 surveys were completed—a significant increase of 124 surveys from CY 2023, although participation by beneficiaries receiving outpatient and residential services continues to be low. Most adult respondents reported consistently high satisfaction, particularly in areas such as Treated with Respect, Feeling Welcomed, and Overall Satisfaction with Services. While there were slight declines in Staff Helped Connect with Services, Staff Giving Enough Time, and Coordination with Physical and Mental Health Providers, the overall feedback remained favorable. Encouragingly, 94.1 percent of respondents said they would recommend the program to a friend.

Survey findings for youths and adults are summarized below, including a side-by-side comparison with CY 2023 findings:

Table 4.5 Youth TPS Results				
Survey Area	CY 2022 % (n=21)	CY 2023 % (n=14)	CY 2024 % (n=52)	Difference in % (2023 to 2024)
Convenient location	81.0	92.9	82.4	-10.5
Services available at a convenient time	90.5	92.9	82.0	-10.9
Good enrollment experience	81.0	92.9	68.6	-24.3
Received services right for me	90.5	85.7	80.4	-5.3
Staff treated me with respect	100	92.9	82.0	-10.9
Staff sensitive to cultural background	68.4	85.7	60.0	-25.7
Counselor provided necessary services	80.0	71.4	62.8	-8.6
Worked with counselor on treatment goals	95.2	92.9	79.6	-13.3
Counselor took the time to listen	95.2	92.9	83.7	-9.2
Developed positive trusting relationship with counselor	80.0	85.7	71.4	-14.3
Counselor was sincerely interested	90.5	78.6	79.6	+1.0
Liked my counselor here	90.5	85.7	83.7	-2.0
Counselor is capable of helping me	100	85.7	79.6	-6.1
Staff helped with health and emotional needs	100	92.9	83.3	-9.6
Staff helped with other issues	90.0	92.3	83.3	-9.0
Better able to do things	85.7	71.4	77.6	+6.2
Feel less craving for drugs and alcohol	N/A	64.3	58.3	-27.4
Satisfied with services I received	100	85.7	74.0	+2.6
Would recommend the services to a friend	81.0	71.4	80.4	+16.1

Table 4.6 Adult TPS Results				
Survey Area	CY 2022 % (n=192)	CY 2023 % (n=245)	CY 2024 % (n=369)	Difference in % (2023 to 2024)
Convenient location	85.3%	90.4%	91.4	+1.0
Convenient time	90.5%	95.0%	93.5	-1.5
I chose my treatment goals	88.7%	91.9%	90.9	-1.0
Staff gave me enough time	93.7%	95.8%	90.3	-5.5
Treated with respect	91.0%	95.0%	95.5	+0.5
Understood communication	90.5%	97.1%	96.6	-0.5
Cultural sensitivity	90.5%	95.3%	92.7	-2.6
Work with physical health care providers	88.2%	92.9%	88.5	-7.3
Work with mental health providers	87.2%	91.1%	89.3	-5.3
Staff helped connect with services	N/A	87.3%	86.3	-6.9
Better able to do things	89.9%	93.8%	90.6	-0.5
Feel less cravings for drugs and alcohol	N/A	94.6%	90.2	-3.6
Felt welcomed	92.6%	95.8%	95.7	+2.8
Overall satisfied with services	94.2%	94.6%	93.0	-0.7
Got the help I needed	91.1%	93.2%	90.2	-4.4
Recommend agency	92.3%	93.7%	94.1	+6.8

TPS results were reviewed by SUDS leadership and shared with staff and contracted providers to guide ongoing quality improvement initiatives.

Supplemental Quality Monitoring Activities

In addition to the CPS and TPS, the Quality Management (QM) Unit conducted several follow-up efforts to further assess client experiences and inform system improvements. These included targeted surveys with older adults receiving SMHS, with 50 total responses collected, 20 via phone and 30 through focus groups. Results showed that 84 percent of participants received services in their preferred setting, indicating generally positive perceptions of access.

Similarly, follow-up surveys with youth clients were conducted to evaluate satisfaction with access, treatment planning, and outcomes. Of the 40-youth surveyed (39 by phone and one in a focus group), 92 percent reported satisfaction with services, 98 percent were satisfied with access, 88 percent felt involved in treatment planning, and 92 percent believed they were making progress.

Finally, the QM Unit implemented monthly phone surveys throughout FY 2024–2025. A total of 132 clients, parents, and guardians participated. Over 94 percent reported satisfaction with their services and expressed that treatment had positive impact on their overall quality of life. Notably, no participants receiving SMHS reported dissatisfaction or raised any concerns during the survey process.

These various data collection efforts continue to inform the department's commitment to person-centered, culturally responsive, and outcome-driven care.

2) Grievances and Appeals

The Quality Management (QM) Unit is responsible for monitoring the grievances and appeals system to ensure compliance with federal requirements. This includes oversight of all grievance and appeal logs submitted by both county-operated and contracted providers. The QM Unit ensures that all concerns are reviewed and addressed appropriately and that beneficiaries are fully informed of their rights throughout the process.

During Fiscal Year 2024–2025, ICBHS received a total of 72 grievances, 10 standard appeals, and 11 expedited appeals related to SMHS. While this reflects a decrease in the number of grievances compared to the previous year, the number of appeals—both standard and expedited—increased. In contrast, SUDS received 4 grievances and no appeals during the same reporting period. The numbers include both Medi-Cal and non-Medi-Cal beneficiaries.

The table below summarizes the grievances and appeals by category:

Table 4.7 Grievances & Appeals by Category						
Grievance Category	FY 22-23		FY 23-24		FY 24-25	
	SMHS	SUDS	SMHS	SUDS	SMHS	SUDS
Related to Customer Service	0	0	0	0	4	2
Related to Case Management	0	0	0	0	0	0
Access to Care	20	0	20	1	0	0
Quality of Care	97	7	97	7	38	2
County (Plan) Communication	0	0	0	0	0	0
Confidentiality	0	0	0	0	3	0
Payment/Billing Issues	0	0	0	0	0	0
Suspected Fraud	0	0	0	0	0	0
Abuse, Neglect or Exploitation	0	0	0	0	0	0
Lack of Timely Response	0	0	0	0	2	0
Denial of Expedited Appeal	0	0	0	0	0	0
Filed for other reasons	4	0	5	2	25	0
Appeal Category	FY 22-23		FY 23-24		FY 24-25	
	SMHS	SUDS	SMHS	SUDS	SMHS	SUDS
Denial or Limited Authorized or Service (s)	1	0	0	0	0	0
Reduction, Suspension, or Termination of a Previously Authorized Service	28	0	11	1	21	0
Payment Denial	0	0	0	0	0	0
Service Timeliness	0	0	0	0	0	0
Untimely Response to Appeal or Grievance	0	0	0	0	0	0
Denial of Client Request to Dispute Financial Liability	0	0	0	0	0	0

Among the SMHS grievances filed during FY 24–25, two exempt grievances were not logged within the required one working day. However, all other grievances and appeals were resolved in accordance with federal guidelines and to the satisfaction of the beneficiaries involved. No significant trends or systemic issues were identified from the SMHS grievances and appeals data.

Similarly, all SUDS grievances received during the fiscal year were addressed in compliance with regulatory requirements, and there were no appeals submitted. The issues raised were resolved to beneficiaries' satisfaction, and no recurring patterns or concerns were identified in the grievances filed.

3) Requests to Change Persons Providing Services

The Quality Management (QM) Unit actively monitors all client requests to change their assigned service providers in order to identify potential trends related to specific programs or staff, and to ensure that any concerns related to the therapeutic relationship or treatment approach are addressed appropriately.

SMHS

During Fiscal Year 2024–2025, ICBHS received a total of 238 requests from Medi-Cal beneficiaries seeking to change their SMHS provider—a slight decrease from the 253 requests received in FY 2023–2024. An additional 25 requests were submitted by non-Medi-Cal clients.

Of the total requests received across both Medi-Cal and non-Medi-Cal populations, 253 (96 percent) were approved, 4 (1 percent) were denied, and 4 requests were withdrawn by the client. Each request was reviewed and processed in accordance with established procedures.

The table below outlines the reasons cited for requesting a provider change during the past three fiscal years:

Table 4.8 Reason for Requests for Change of Provider			
Reason	FY 22-23	FY 23-24	FY 24-25
Quality of Care Treatment Concerns	57	70	31
Quality of Care-Staff Behavioral Concerns	20	24	10
Service Not Available	18	21	22
Request Transfer to Another Clinic	2	8	6
Language Barrier	10	15	21
Not Feeling Comfortable with Provider	10	85	78
In-Person Provider	N/A	36	28
No Therapeutic Alliance with Provider	5	8	17
Dissatisfaction with Provider	22	4	29
Disagreement with Course of Treatment	1	3	20
Confidentiality	0	1	1

Notably, the most common reasons in FY 2024–2025 included Not Feeling Comfortable with Provider (78 requests), Dissatisfaction with Provider (29 requests), and Quality of Care – Treatment Concerns (31 requests). While the overall volume of requests decreased slightly, certain categories—such as Disagreement with Course of Treatment and No Therapeutic Alliance—saw notable increases, signaling potential areas for continued provider training and engagement.

SUDS

For SUDS, ICBHS received 26 requests from Medi-Cal beneficiaries and 7 requests from non-Medi-Cal clients seeking a provider change, reflecting a slight decrease from the previous fiscal year's total of 28 Medi-Cal requests.

The table below outlines the reasons cited for requesting a provider change during the past three fiscal years:

Table 4.9 Reason for Requests for Change of Provider			
Reason	FY 22-23	FY 23-24	FY 24-25
Quality of Care Treatment Concerns	N/A	2	12
Prefer a Spanish Speaking Provider	1	0	0
Not feeling comfortable with Male/Female Provider	3	4	12
No therapeutic Alliance with Provider	5	2	3
Dissatisfaction with Provider	N/A	0	4
Disagreement with Course of Treatment	1	0	0
Uncomfortable with Provider	4	20	2

In FY 2024–2025, the most frequently cited reasons included *Quality of Care – Treatment Concerns* and *Not Feeling Comfortable with Male/Female Provider* (12 requests each). These trends suggest an increased sensitivity among clients to provider fit and perceived quality of care.

All requests were reviewed by clinical managers and evaluated in the context of the client's clinical needs and service history. When possible, clinical managers discussed the concerns directly with the client or their authorized representative. In cases where contact could not be established, the request was processed based on the available information.

When appropriate, clinical managers encouraged clients or their authorized representatives to communicate directly with their provider to resolve concerns. Regardless of the outcome, all clients or their representatives were notified of the decision by telephone, mail, or in person within the required 14 business days.

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will continue to conduct monitoring activities to determine client/family satisfaction with SMHS and SUDS.

- The QM Unit will conduct monthly phone surveys on an as-needed basis to assess client satisfaction with ICBHS, their treatment provider and/or care team, and their overall experience with services.

- ICBHS will implement corrective action to ensure the grievance and appeal system requirements are implemented appropriately to ensure the protection of client rights when filing grievances and appeals.

- QM will assume full responsibility for receiving, acknowledging, investigating, and resolving all grievances, appeals, and complaints submitted to ICBHS, ensuring compliance with DHCS requirements and adherence to internal policies and procedures. Patients' Rights advocate and the QM Unit will assist with communication between clients and providers ensuring client's receive quality of care treatment.

IV. Service Delivery System and Meaningful Clinical Issues Affective Beneficiaries, Including the Safety and Effectiveness of Medication Practices

The QM Unit monitors the service delivery system and meaningful clinical issues affecting SMHS and SUDS beneficiaries, including the safety and effectiveness of medication practices. This is accomplished through medication monitoring, chart reviews, oversight of triage services, and evaluation of NTP utilization of Methadone and non-Methadone Medication-Assisted Treatment (MAT), as well as assessing the provision of services at certain levels of care and/or follow-up treatment.

i. Update on the objectives and activities for FY 24-25:

1) Medication Monitoring

The medication monitoring reviews for SMHS are conducted monthly by seven adult and child psychiatrists, a pharmacist, and the Medical Director while the SUDS reviews are conducted quarterly by the Medical Director and two medical doctors focusing on the programs delivering Medication Assisted Treatment (MAT). The Medical Director conducts monthly medication monitoring reviews for the NTP provider.

Utilizing a review tool, the Medication Monitoring Committee monitors the SMHS delivery system, including telepsychiatry, to review the safety and effectiveness of medication practices; identify meaningful clinical issues affecting beneficiaries' system-wide; review medication practices for children, youth and young adults, and adults receiving medication support services; and address any quality-of-care concerns or outliers identified related to medication use. On the other hand, the reviews tools used for monitoring MAT and NTP service delivery are used to review the safety and effectiveness of medication practices; identify meaningful clinical issues affecting beneficiaries' system-wide; medication practices for MAT; and address any quality-of-care concerns or outliers identified related to medication use.

Charts are randomly selected from the EHR or through quality-of-care referrals when an identified concern requires further review. The QM Unit compiles the data, identifying opportunities for improvement and areas of concern. All reports are submitted to the Medical Director, and the QM Unit ensures that management receives copies of the reports and completed tools, as appropriate. Findings from the SMHS report, including areas of concern and improvement opportunities, are discussed with the SMHS psychiatrists, while the SUDS findings are reviewed by the Medical Director with the two medical doctors.

During FY 24-25, the Medication Monitoring Committee reviewed 239 charts: 126 from Adult Services, 32 from Children Services, and 81 from Youth and Young Adult Services. Areas with compliance at 85 percent or below were identified as opportunities for improvement. SMHS was compliant at 86 to 100 percent in all 18 areas evaluated. This represents a decrease from 92 to 100 percent in FY 23-24. No significant findings were identified, suggesting that SMHS prescribers are largely adhering to best practices in the implementation of medication support services.

In FY 24-25, the Medical Director and two medical doctors reviewed 42 charts from the SUDS county-operated programs providing MAT, achieving an average of 97 percent compliance across the nine areas evaluated. The committee identified one finding related to: ensuring documentation indicates that laboratory panels were ordered and reviewed when necessary. This marked a decrease in identified findings compared to the prior fiscal year, which reported three issues.

Meanwhile, in FY 24-25, the Medical Director reviewed 24 charts from the NTP provider, with 100 percent compliance in all 18 areas, maintaining consistency with the previous fiscal year.

2) Chart Reviews

a) Quality of Care Reviews

ICBHS has the responsibility to detect and address concerns related to poor quality of care, including, but not limited to inaccurate diagnosis, medication malpractice, treatment that is

not medically necessary, clinical interventions that are outside the scope of the provider, underuse and overuse of treatment services, services that are unethical or culturally inappropriate, and treatment that jeopardizes the safety and well-being of the client. When quality of care concerns is identified by ICBHS staff or contracted providers, the QM Unit is notified by submitting a Quality-of-Care Referral Form. The QM Unit will assign the case for a second level review by the Medication Monitoring Committee or to an individual reviewer such as a Quality Improvement Specialist, Program Supervisor, Program Manager, licensed clinician, registered nurse, or the Medical Director. Findings are presented to the program supervisor and manager, as appropriate.

Additionally, ICBHS has established the Quality-of-Care Review Committees (QOC) that reviews documentation requirements and the quality of services provided, identifying opportunities for improvement and training needs, as appropriate. This committee is comprised of ICBHS staff across all the divisions within ICBHS and the QM Unit. When findings are identified, these are also presented to the program supervisor and manager, as appropriate.

During FY 24-25, the QM Unit reviewed a total of twenty-six clinical charts to assess the quality of services provided by ICBHS providers. The QM Unit received thirteen referrals submitted by the ICBHS Patients' Rights Advocate, the MHP QI Coordinator, QM staff, and the Compliance Unit and thirteen were discussed within the Quality-of-Care Committee. There were no quality-of-care concerns identified; however, recommendations for improvements were made to the treatment team(s) assigned to each case. Three corrective action plans were also issued. A summary of findings was presented to the QIC.
The QM Unit made the following recommendations to the QIC as a result of the quality of care reviews conducted during FY 24-25:

- Ensure meaningful care coordination occurs between mental health providers, significant supports, and/or community agencies to support the client towards improving their overall mental health condition. *(Repeat finding from FY 23-24).*
- Ensure the problem list is being updated on an ongoing basis to reflect the current presentation of the beneficiary and/or significant changes in their mental health condition or life events. Ensure that the beneficiaries are included in the development of the problem list.
- For Service providers to evaluate the effectiveness of interventions provided towards achieving treatment goals and/or reducing identified problems. Ensure that services provided to the beneficiary are medically necessary, according to the presenting program and/or given diagnosis.
- Ensure that safety plans are developed or reinforced when applicable.

b) ICBHS Quality Management Chart Reviews

The QM Unit conducts routine chart reviews to verify the overall quality of services provided by the ICBHS. Chart reviews were conducted for each SMHS service division using a chart review tool that evaluated the following areas: Access to Specialty Mental Health Services, Assessment/Reassessment, Problem List, Treatment Interventions, Care Coordination, and Other Areas of Review. The QM Unit compiled reports that identified opportunities for improvement and areas of concern, as appropriate. Division reports were provided to management, with each division receiving a corrective action plan. The QM Unit approved

corrective action plans, prior to implementation, and followed up with each division to ensure all corrective actions were completed, as appropriate. Compliance referrals were submitted to the Compliance Unit when instances of potential fraud, waste, or abuse were identified.

During FY 24-25, the QM Unit reviewed 128 charts, of which 29 were from Children Services, 17 were from Youth and Young Adults Services, 23 were from Adults Services, 25 were from Mental Health Triage and Engagement Services, 20 from SUD Services, and 13 from Narcotic Treatment Program (NTP). The summary of findings below were areas identified as needing correction:

Assessment /Re-Assessment

- No ongoing or thorough assessments, including but not limited to client's presenting problem (changes), risks factors, and strengths, impacting the treatment process *(Repeat finding from FY 23-24).*
- No exploration and/or updating of the client's diagnosis when client reports additional or new symptoms and behaviors that when not previously documented or assessed.
- Not completing outcome measurement tools, as required, to determine progress or lack of progress.
- A safety plan is not being developed when appropriate *(Repeated finding from FY 23-24).*

Problem List

- Problem List does not include a list of symptoms, conditions, diagnosis and/or risk factors identified through assessment, psychiatric diagnostic evaluation and/or crisis encounters *(Repeated finding from FY 23-24*).
- Providers are not updating or completing the Problem List according to the clients' current problems/needs and are not educating or involving the client in the development of Problem List *(Repeated finding from FY 23-24).*

Treatment Interventions

- No meaningful interventions provided in accordance with the client's presenting problems (interventions are not being linked to the problems list or what the client is reporting, no description of how interventions will benefit the client, vague care plan focus).
- Interventions do not focus on the identified client's needs and/or reported symptoms and behaviors.
- No timely access to services in accordance with the clients' mental health needs/presenting problem (no attempts to facilitate home and/or school visits, as appropriate, gaps in treatment) *(Repeated finding from FY 23-24).*
- No documentation of the follow up plan for future encounters for the provider and/or client and to evaluate effectiveness of the interventions and/or progress with mental health conditions *(Repeated finding from FY 23-24).*
- No timely documentation of the services provided to maintain the integrity of the service (late documentation, exceeding three working days) *(Repeated finding from FY 23-24).*

Care Coordination

- No meaningful (*something that provides a clinical value to the treatment)* coordination of care with other care providers within mental health and/or SUD treatment, and/or family support that will assist the client in making progress towards treatment and to assess barriers hindering progress, when appropriate *(Repeated finding from FY 23-24).*
- Cases are not taken to team as needed to discuss lack of progress, significant events/changes, appropriateness of diagnosis, need for additional interventions or higher level of services.

Other Areas of Review

- No valid Release of Information (missing required elements) *(Repeated finding from FY 23-24).*

The QM Unit also conducted a review of clients receiving residential treatment services to identify quality of care issues in both the pre-admission and post-discharge process. During FY 24-25, the QM Unit reviewed a total of 40 clinical charts for clients referred to the three contracted residential treatment providers; 5 from Adult Residential, 15 from Crisis Residential, and 20 from substance use disorder treatment. The summary of findings below were areas identified as needing correction:

Pre-Residential Treatment

- Client was not admitted into residential treatment within 14 days from the authorization date *(Repeated finding for FY 23-24).*
- No documented evidence to support the reason for referral to residential treatment (how residential treatment will assist client in alleviation symptoms).
- No evidence that the referring service coordinator contacted residential treatment providers to monitor the referral and/or treatment changes/outcomes or significant changes, as appropriate *(Repeated finding for FY 23-24).*

Post-Residential Treatment

- No evidence of meaningful coordination of care between ICBHS providers and residential treatment staff (not just merely providing updates, no documentation of how information provided/received will assist in making changes to treatment and regain stability, as appropriate) *(Repeated finding for FY 23-24).*
- No evidence the assigned service coordinator reviewed the residential treatment discharge summary/plan to follow recommendations, as appropriate. *(Repeated finding for FY 23-24).*
- Service coordinator did not schedule the client's next appointment within an appropriate amount of time, based on the client presenting problem and medical need. *(Repeated finding for FY 23-24).*
- No evidence the assigned service coordinator followed up with the client to ensure a smooth transition from residential treatment to the outpatient clinic and processed the appropriate referrals to support client treatment.
- No evidence of SUD staff updated the ASAM, after the residential discharge.

In addition to the regularly scheduled chart reviews conducted, the QM Unit also conducted ad hoc focus reviews. Focus reviews are assigned as a follow-up from any type of prior case review, as referred by management or supervisors, or as requested by individual providers.

During FY 24-25, the QM Unit conducted six focus reviews: two requested by the Compliance Unit, and four conducted as follow-up reviews. The following findings were identified during these focus reviews:

- No meaningful interventions provided to address the reported symptoms and behaviors.
- No care coordination amongst treatment team.
- No timely contact and/or follow up to provide treatment services.

Findings were reported to the individual(s) requesting each focus review, as well as the affected supervisor(s) and management.

Beginning FY 24-25, a targeted training initiative was launched to address documentation and billing related findings identified through ongoing chart reviews. The purpose of this initiative was to strengthen documentation and billing practices across direct treatment staff, supervisors, and program managers, thereby improving clinical record accuracy, compliance with standards, and overall service quality.

The training sessions provided comprehensive guidance on documentation standards, including claiming requirements, procedure codes, progress note documentation, Problem List, Care Coordination and Care Planning. These sessions focused on areas where chart reviews had previously revealed inconsistencies, non-compliance and areas identified as needing improvement. Each training included practical examples and clarified expectations in alignment with regulatory and internal quality.

To further support staff, regular office hours were implemented as an open forum for direct treatment staff, supervisors, and managers. These sessions offered opportunities to ask questions, clarify documentation requirements, delivery of services, and receive guidance on specific documentation challenges. This ongoing support mechanism encouraged a culture of continuous learning, accountability, and collaboration.

Based on positive staff feedback and observed improvements in documentation quality, both the training sessions and office hours will continue as needed throughout FY 25-26. This continued effort will ensure that staff remain informed and supported by maintaining high standards of clinical documentation, and that quality improvement efforts remain responsive to emerging needs identified through ongoing chart review and staff input.

3) Triage Services

The QM Unit tracks and monitors the admissions and re-admissions of the individuals who are admitted to the MHTU (5150). The Mental Health Triage Unit (MHTU) provides immediate crisis intervention services 24 hours a day, 7 days a week for individuals of all ages. The MHTU includes psychiatrists, nurses, clinicians, mental health rehabilitation technicians, and mental health workers who provide crisis interventions to individuals that are a danger to self, danger to others, or gravely disabled.

The monitoring process consists of reviewing the crisis log, removing entries for clients that remain on a voluntary hold or pre-screening. The MHTU tracks data relevant to age, city of origin, gender, admission and discharge dates, placement if applicable, type of hold, individuals

with high re-admission rates. Other areas tracked by QM include but are not limited to the following: foster youth, minors, unhoused individuals, active or inactive with the ICBHS SMHS, number of episodes, hospitalizations, conservatorships, care –coordination and aftercare from the MHTU.

During FY 24-25, there were 519 clients admitted to the MHTES Triage Unit, for a total of 722 admissions, which is an increase of 84 admissions from the previous fiscal year. A comparison of prior fiscal years is included below:

Table 5.1 MHTE Triage Unit Admissions		
Review Period	# of Clients	# of Admissions
FY 24-25	519	722
FY 23-24	456	638
FY 22-23	380	498

A comparison of the prior fiscal years is included below for age and gender demographics:

Table 5.2 MHTE Triage Unit				
Demographics		FY 22-23	FY 23-24	FY 24-25
Age	Minors	143	151	249
	Adults	355	487	473
Gender	Female	237	261	321
	Male	261	342	391
	Other	-	35	10

Of the 722 admissions during FY 24-25, 440 (61%) were actively receiving services from ICBHS at the time of Triage (5150) admission. The status by division is as follows:

- Children Services- 83 (11%) active clients at the time of Triage admission
- Youth & Young Adults Services- 117 (16%) active clients at the time of Triage admission
- Adults Services: 171 (24%) active clients at the time of Triage admission
- Mental Health Triage Engagement Services: 69 (10%) active clients and 282 (39%) inactive clients that were referred to ICBHS SMHS.

Triage Readmissions

Of the 722 admissions during FY 24-25, 203 were readmissions, which is an increase from FY 23-24. ICBHS' overall readmission rate is 28 percent. This remains the same from FY 23-24. There were 42 readmissions that occurred within 30 days of discharge, resulting in a 6 percent 30-day readmission rate. This is an increase from FY 23-24 when the 30-day readmission rate was 5 percent. The table below summarizes ICBHS Triage readmissions:

Table MHTU 5150 Triage Readmissions			
Table 5.3			
Review Period	FY 22-23	FY 23-24	FY 24-25
Total Readmissions	118	182	203
Total Admissions	498	638	722
Readmission Rate	**24%**	**28%**	**28%**
Readmissions Within 30 Days	31	31	42
Total Admissions	498	638	722
30-Day Readmission Rate	**6%**	**5%**	**6%**

Additional FY 24-25 Insights:

- For FY 24-25, there were a total of 537 Danger to Self, 134 Danger to Others and 57 Gravely Disabled individuals that were placed on an involuntary hold due to mental health concerns.
- At the time of the Triage admissions, 61 clients were actively receiving services with Substance Use Disorder Division.
- 78 (11%) clients were unhoused at the time of Triage admission for FY 24-25.
- Of those admitted to the Mental Health Triage Unit under 5150 hold, 159 (22%) were admitted to an inpatient psychiatric hospital.

4) NTP Utilization of Methadone and Non-Methadone MAT

The Quality Management (QM) Unit monitors the utilization of methadone and non-methadone medications within the Narcotic Treatment Program (NTP) to ensure that all approved and medically necessary treatments are accessible to beneficiaries. This oversight involves collecting and reviewing medication data extracted from the Electronic Health Record (EHR) via the "Services Report," which captures the types of medications prescribed within the NTP during a given review period.

During Fiscal Year 2024–2025, a total of 289 unduplicated clients received medication as part of NTP services. It is important to note that this total reflects unique individuals and not the number of doses administered. As such, the count may differ from the number of medication instances or doses provided throughout the year.

Most clients continued to receive Methadone, consistent with prior years. Utilization data for both methadone and non-methadone MAT options are summarized below:

Table 5.4 NTP Utilization of Methadone and non-Methadone MAT		
NTP - Medications	FY 23-24	FY 24-25
Methadone	224	275
Buprenorphine-Mono	3	2
Buprenorphine-Naloxone Combination	5	15
Disulfiram	0	0
Naloxone- Nasal Spray	0	0
Total	**232**	**289**

From FY 2023–2024 to FY 2024–2025, there was a notable increase in the number of clients receiving Methadone and Buprenorphine-Naloxone Combination, while slight decreases were observed in the number of clients receiving Buprenorphine-Mono. There was no reported utilization of Disulfiram or Naloxone Nasal Spray during this reporting period.

Methadone remains the primary medication utilized within the NTP setting. However, the gradual rise in the number of clients receiving Buprenorphine-Naloxone Combination suggests a growing application of alternative MAT options where clinically appropriate. According to feedback from the NTP program, all non-methadone MAT medications continue to be made available and are offered when medically necessary, although Methadone remains the preferred and most commonly prescribed treatment.

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will continue conducting chart reviews and other monitoring activities to identify relevant clinical issues affecting beneficiaries, including safety and effectiveness of medication practices and quality of care concerns.
- The QM Unit will develop and deliver focused documentation training as needed basis, as determined by the nature and scope of the chart review findings.
- The QM Unit will conduct routine chart reviews to assess compliance with established documentation requirements. The QM Unit will provide focused documentation training to ICBHS providers every six months.
- The QM Unit will continue to monitor and analyze Triage (5150) admission and readmission trends, with a focus on identifying high-utilizer populations and systemic barriers to stabilization.
- The Mental Health Triage Unit (MHTU) and program divisions will develop targeted interventions aimed at reducing the 30-day readmission rates, while enhancing care coordination, aftercare follow-up, and linkage to ongoing services for individuals admitted on involuntary holds.
- The QM Unit will continue to conduct a quarterly review of prescribing trends for non-methadone MAT (e.g., Buprenorphine-Naloxone) and provide feedback to NTP to support informed treatment planning and improve access to the full range of medically necessary MAT options.

V. Continuity and Coordination of Care with Medi-Cal Managed Care Plans

ICBHS is responsible for providing SMHS to Medi-Cal clients who meet both access and medical necessity criteria. ICBHS is expected to coordinate with local Medi-Cal Managed Care Plans (MCPs) to arrange services for clients who do not meet the criteria for SMHS. As of the beginning of FY 24-25, MOUs with both MCPs are pending execution, though agreements have been made regarding the language and scope of each MOU. Additionally, the QM Unit monitors the continuity and coordination of care with Physical Care Providers (PCPs) and other human services agencies used by its clients. This is achieved through providing information, training, and consultation to PCPs and other human services agencies, as well as through memorandums of understanding.

a. Update on the objectives and planned activities for FY 24-25:

1) Adult and Youth Screening Tools for Medi-Cal Mental Health Services

DHCS requires the use of the adult and youth screening tools to ensure Medi-Cal clients are guided to the appropriate Medi-Cal mental health system (i.e. MCP or ICBHS SMHS). The screening tools identify initial indicators of client's needs in order to make a determination for referral to either the client's MCP for a clinical assessment and medically necessary non-SMHS or to ICBHS for a clinical assessment and medically necessary SMHS.

The table below summarizes the screening tools implemented by ICBHS during FY 24-25:

Table 6.1 Adult and Youth Screening Tools

FY 24-25

Category	MCP Score (0-5)	ICBHS Score (6+)	Total Screenings	MCP %	ICBHS %	Urgent	Referred to SUD
Adult	1,830	319	2,149	85%	15%	270	408
Youth	2,268	290	2,558	89%	11%	127	90
Total	**4,098**	**609**	**4,707**	**87%**	**13%**	**397**	**498**

FY 23-24

Category	MCP Score (0-5)	ICBHS Score (6+)	Total Screenings	MCP %	ICBHS %	Urgent	Referred to SUD
Adult	1,828	337	2,165	84%	16%	209	317
Youth	2,234	321	2,555	87%	13%	104	73
Total	**4,062**	**658**	**4,720**	**86%**	**14%**	**313**	**390**

ICBHS implements the screening tool to all clients regardless of payor source.

The adult and youth screening tools have assisted ICBHS in the process of assessing the client's immediate needs to provide the needed care, especially when it is an urgent situation; however, they have not been effective in identifying the client's appropriate level of care. The implementation of the screening tools is facing significant challenges, which include lack of cultural competence and the stigma associated with behavioral health services within the Imperial County population. This results in individuals not feeling comfortable disclosing all of their symptoms and life-functioning impairments with the screening staff, the process which takes place over the phone in the majority of cases. Consequently, lower screening tool scores are typically reported, which do not accurately convey a measurement that will assist screening staff in identifying the proper level of care for the individual requesting services. As a result, all clients are referred for a full intake assessment, regardless of the outcome of the screening tool.

During FY 24-25, ICBHS determined that 2,240 Medi-Cal beneficiaries met access criteria and medical necessity for SMHS, illustrating that the adult and youth screening tools do not fully support their intended purpose.

2) Transition of Care Tool for Medi-Cal Mental Health Services

DHCS requires the use of the transition of care tool to ensure that Medi-Cal clients who are receiving mental health services from one delivery system (i.e. MCP or ICBHS) receive timely and coordinated care when either 1) their existing services need to be transitioned to the other delivery system; or 2) services need to be added to their existing mental health treatment from the other delivery system consistent with the No Wrong Door policies.

During FY 24-25, ICBHS completed a total of forty-one (41) transition of care tools; 40 from Adult Services and 1 from Children services.

3) Care Coordination and Continuity of Care

a. Outreach and Engagement

ICBHS has expanded its outreach efforts in the city of Winterhaven, serving both tribal and non-tribal residents. In collaboration with Indian Health Services, ICBHS conducted community education presentations to improve service accessibility, clarify the referral process, and identify treatment needs.

Community Service Workers continue to participate in a variety of activities, including outreach events and educational presentations, a kiosk at the Imperial Valley Mall, regular social media postings, hosting recurring web-based events, wellness radio shows, and participating in back-to-school events and health fairs. ICBHS remains committed to conducting outreach and engagement activities throughout Imperial County to ensure equitable access to substance use disorder (SUD) services, increase awareness of treatment options, and support recovery for individuals and families affected by substance use.

Additionally, SUD enhanced its outreach to Tribal communities through a combination of community events, educational sessions, and interagency partnerships. Presentations and resource dissemination took place at Tribal community sites, such as Fort Yuma Health Services. The SUD program also worked alongside school officials serving Tribal youth to develop referral pathways and support networks. SUD program supervisors and managers participated in outreach events to raise awareness about available services. Outreach efforts also aimed to engage elected Tribal officials or their designated representatives.

In fiscal Year 2024-2025, ICBHS served 29,204 individuals were served, an increase from 27,288 in the previous fiscal year. This growth was largely driven by increased school engagement, resulting in schools requesting educational presentations for students and staff. Interventions included harm reduction strategies, participation in community coalitions, and delivering community-based, culturally competent education. By tailoring evidence-based prevention strategies Imperial County’s demographic needs, SUD has been able to extend its reach and enhance participation, and maintained its focus on reducing stigma, building rapport, and removing barriers to care.

b. Harm Reduction

As part of its harm reduction efforts, ICBHS assembles and distributes personal hygiene kits tailored for both men and women, containing essential items such as feminine hygiene products, socks, hair ties, toothbrushes, toothpaste, condoms, deodorant, bar soap, hairbrushes, non-alcoholic mouthwash, shampoo, and conditioner. Designed for individuals experiencing homelessness, each kit also contains information about ICBHS services. Hygiene kits are available at all four county operated SUD clinics and are distributed during outreach and engagement activities. ICBHS remains committed to preventing overdoses and continues to lead proactive education and outreach initiatives in schools and communities, recognizing that prevention through education is one of the most effective strategies. These efforts are carried out in collaboration with schools, law enforcement, hospitals, and other community agencies. Additionally, ICBHS provides naloxone, a life-saving medication that reverses opioid overdoses involving substances such as heroin, fentanyl, and prescription opioids to clients and community members. The agency also distributes fentanyl and xylazine test strips to detect the presence of these substances in other drugs, further supporting harm reduction and overdose prevention efforts.

c. SUD Bridge Collaboration

ICBHS and El Centro Regional Medical Center (ECRMC) are collaborating to develop and implement strategic initiatives aimed at improving buprenorphine adherence among patients who initiate Medication for Addiction Treatment (MAT) in the emergency department. This partnership will focus on monitoring and evaluating a telehealth-based approach to enhance care coordination between the emergency department and SUD outpatient clinics. Through this collaborative effort, ICBHS and ECRMC strive to establish integrated care that not only supports patient retention in MAT programs but also strengthens the overall continuum of care for vulnerable populations affected by substance use.

ICBHS and Pioneers Memorial Hospital (PMH) have established a quarterly *SUD Champions Meeting* aimed at strengthening care coordination and communication between the hospital's emergency department and the SUD treatment programs. These meetings focus specifically on patients who receive MAT inductions in the emergency room, with the goal of streamlining patient transitions from emergency care to ongoing outpatient treatment.

The mission of ICBHS is to enhance the existing referral systems by incorporating a whole-person care approach with local hospitals. This approach emphasizes addressing the physical, mental, and social needs of patients to support sustained recovery. Through these efforts, ICBHS ensures that all patients who initiate MAT in the emergency department are successfully linked to comprehensive SUD treatment programs. These programs provide essential MAT follow-up services, counseling, behavioral health support, and other outpatient resources designed to promote long-term recovery and reduce the risk of relapse. By fostering collaboration between emergency departments and outpatient clinics, ICBHS and its partners aim to improve patient outcomes, reduce hospital readmissions, and ultimately strengthen the continuum of care.

d. School Partnerships

Minimal staffing continues to be a barrier, especially as the demand for substance use disorder (SUD) treatment services has increased compared to previous fiscal years. This growing need is largely due to ICBHS's continued collaboration with local school officials. Regular meetings, held before the end and beginning of each school year, have helped promote and offer SUD treatment and prevention services across school districts.

e. Health Management Associates – Systems of Care Learning Collaborative – Optimizing Programs and Systems to Meet the Needs of Populations with Opioid and Other Substance Use Disorder (OUD/SUD)

ICBHS continues its close collaboration with Health Management Associates (HMA) to implement targeted and approved strategies aimed at expanding access to Medication-Addiction Treatment (MAT), residential treatment, and enhanced care for individuals with co-occurring mental health and substance use disorders. Through this partnership, ICBHS seeks to improve and broaden substance use disorder (SUD) and mental health services, increase provider knowledge and awareness of co-occurring disorders, and strengthen community partnerships to support harm reduction efforts focused on preventing overdose deaths and reducing stigma associated with SUD and treatment.

HMA facilitated an intensive three-day Motivational Interviewing (MI) training for clinical staff specializing in the treatment of co-occurring disorders. The training included one full day of refresher courses, offered in both morning and afternoon sessions followed by two comprehensive days dedicated to advanced MI instruction. MI refresher sessions are intended to reinforce participants' existing MI skills and understanding. The following two days provided an in-depth exploration of MI's core principles and techniques, emphasizing essential conversational skills such as open-ended questions, affirmations, reflective listening, and summarization. This training was highly successful, with participants actively participating, equipping clinical teams to better engage and motivate individuals toward active participation in treatment and ultimately improve outcomes for clients with co-occurring disorders.

In addition to MI training, HMA conducted in-person MAT workshops aimed at improving the quality of patient care across Imperial County. These workshops attracted strong participation from key stakeholders, including government and community agencies, law enforcement, primary care providers, and ICBHS staff. Furthermore, ICBHS and HMA facilitated two in-person train-the-trainer sessions for ICBHS direct service staff, correctional officers, and probation officers. These sessions focused on the conceptualization and treatment of substance use and co-occurring disorders, MAT, stigma reduction, and harm reduction strategies.

Funding for these training events and ongoing consultations provided by HMA have been supported through the California Department of Health Care Services (DHCS) via State Opioid Response Grants awarded by Substance Abuse and Mental Health Services Administration (SAMHSA).

f. Youth Opioid Response Grant 3

ICBHS has actively participated in the California Youth Opioid Response (YOR) grant program, receiving consecutive funding through Rounds 3 and 4 under the State Opioid Response (SOR III) initiative to address the rising prevalence of opioid and stimulant use disorders among youth and young adults.

From April 2023 through September 2024, ICBHS implemented YOR Round 3, which provided an initial award of $500,000, along with an additional $142,000 to support expanded outreach and engagement activities in Imperial County. This funding focused on youth and young adults aged 12 to 24 and supported a wide range of services, including outreach, education, community engagement, harm reduction, early intervention, and youth-specific services related to opioid and stimulant use. During this period, ICBHS exceeded its target goals in multiple service delivery areas. These achievements were made possible through strong community partnerships and formalized Memoranda of Understanding (MOUs) with local school districts, which increased access to services in school settings. Additionally, ICBHS made significant efforts to reach the unhoused population by distributing hygiene kits and providing vital mental health and SUD resources.

Building on the success of Round 3, ICBHS was awarded $734,152 on May 1, 2025, by the California Institute for Behavioral Health Solutions (CIBHS) through YOR Round 4. This fourth round of SOR III funding expands the target population to include youth, transitional age youth (TAY), and young adults aged 16 to 25. YOR Round 4 emphasizes a comprehensive, youth-centered approach to addressing the opioid and stimulant crisis. The focus is on expanding access to life-saving medications for opioid use disorder and strengthening all stages of care from prevention and harm reduction to treatment and recovery support for young people affected by opioid and stimulant use disorders.

Together, YOR Rounds 3 and 4 reflect ICBHS’s continued commitment to combating the opioid and stimulant crisis through innovative, collaborative, and culturally responsive strategies aimed at improving the health and well-being of youth and young adults throughout Imperial County.

g. California Opioid Settlement Funds

Imperial County, as a participating California subdivision, will continue to receive opioid settlement funds managed by ICBHS. These funds will be dedicated to opioid care, treatment, and programs addressing misuse, related disorders, and the epidemic’s impacts. ICBHS will prioritize High Impact Abatement Activities (HIAA) to reduce and ultimately end the opioid crisis through care, treatment, outreach, and support services.

On February 25, 2025, Imperial County Behavioral Health Services (ICBHS) entered into an agreement with Health Management Associates (HMA) to support efforts in addressing substance use and mental health needs, enhancing stakeholder engagement and collaboration, and identifying and overcoming resource barriers within Imperial County. As part of this agreement, HMA will provide facilitation services to prioritize the allocation of opioid abatement settlement funds through an impartial and equitable community engagement process. To prepare for upcoming in-person collaborative meetings, ICBHS and

HMA have established a steering committee composed of community agency stakeholders tasked with facilitating discussions and guiding the allocation process.

Together, ICBHS and HMA will host four Community Conversations. These sessions are designed to encourage open dialogue among residents, local leaders, healthcare providers, and other stakeholders, ensuring diverse voices and perspectives are included. The primary goal is to identify the most pressing community needs and to develop effective strategies to address the impact of opioid use and misuse. Through this collaborative and inclusive approach, ICBHS and HMA aim to build a stronger, healthier community by addressing the root causes of opioid use and supporting individuals and families affected by this crisis.

h. PATH Justice-Involved Round 3

ICBHS will provide pre-release behavioral health services to justice-involved individuals beginning 90 days prior to release and continuing post-release from correctional facilities. Pre-release services will include comprehensive assessments and intensive care coordination to ensure continuity of care for individuals identified with mental health or substance use disorders.

In partnership with the Imperial County Sheriff's Office, ICBHS continues to develop an implementation plan to enable the secure seamless data exchange for individuals with a history of mental health and substance use treatment. This plan will streamline referrals, assessments, and care coordination, ensuring incarcerated individuals are effectively linked to appropriate services both before and after release.

Additionally, PATH funds will be utilized to support investments in personnel, infrastructure, and IT systems necessary to facilitate collaborative planning and successful implementation of these pre-release services.

i. BHCIP Round 5: Crisis and Behavioral Health Continuum

On February 19, 2024, ICBHS and DHCS executed a Program Funding Agreement (PFA) for the Behavioral Health Continuum Infrastructure Program (BHCIP) Round 5: Crisis and Behavioral Health Program, providing up to $17,285,302 in grant funding. The funds will be used to establish a 16-bed Adult Residential SUD Treatment Facility with Incidental Medical Services (IMS), designated by DHCS/ASAM as Level of Care 3.5 and Level of Care 3.2 for Withdrawal Management. This facility will address barriers to care and significantly expand local treatment access.

ICBHS meets monthly with Advocates for Human Potential (AHP), contracted by DHCS to provide consulting and oversight, ensuring compliance with construction milestones and project phases. The facility is scheduled for completion by June 30, 2027.

To support project delivery, ICBHS has contracted with Vanir Construction Management, Inc. for project management oversight and assistance in securing a highly qualified construction management entity to execute the project under a progressive design-build model. ICBHS anticipates selecting the construction entity by November 2025, with a groundbreaking ceremony planned for February 2025.

j. Recovery Incentives Program: California's Contingency Management (CM) Benefit

The Recovery Incentives Program is part of California's Contingency Management (CM) Benefit, implemented by ICBHS to support individuals with stimulant use disorders. The program provides financial incentives, in the form of gift cards, to reinforce abstinence from stimulant use, as verified by twice-weekly drug testing over a 24-week period. Participants receive incentives for each drug test that returns a negative result, with increasing rewards for continued abstinence.

ICBHS places strong emphasis on individualized support through consistent counseling that validates participants' progress. Program outcomes are closely monitored, and data is actively used to inform ongoing improvements. The success of the program is further reinforced by counselors who provide continuous encouragement and behavioral support. Through regular affirmations and personalized guidance, counselors play a vital role in sustaining participant motivation and creating a recovery-focused environment.

k. Bond Behavioral Health Continuum Infrastructure Program (BHCIP) Round 1 Launch Ready – Northern Horizons Campus Behavioral Health Expansion:

On May 6, 2025, ICBHS was conditionally awarded the Bond BHCIP Round 1: Launch Ready grant in the amount of $22,405,797.58 to support the Northern Horizons Campus Behavioral Health Expansion Project. The funding from this grant will allow both ICBHS to expand its mental health and SUD services in the north-end area of Imperial County to address the urgent needs in the care continuum for people with mental health and substance use conditions including unhoused individuals, veterans, older adults and adults with disabilities. By addressing these needs, ICBHS will foster a healthier environment, reduce stigma, and promote recovery and resilience among those individuals living with both mental health and SUDs.

Through this project, ICBHS plans to renovate a county owned site at 220 E. Main Street, Brawley, California 92227 by constructing and utilizing a campus-type model that will provide multiple levels of care on the continuum by providing accessible, community-based, and client-centered behavioral health services that offer both immediate support and long-term care. By co-locating SUD and mental health treatments within a one site. The Northern Horizons Campus will deliver integrated, whole-person care through intensive outpatient programs, effectively addressing significant behavioral health service gaps in this underserved community.

l. Recovery Residence for women and parenting women:

On January 7, 2025, ICBHS executed an agreement with Open Door Ministry for the Broken (ODM), an organization that provides recovery residences for women and parenting women aged 18 and older, undergoing medically necessary treatment for SUD or recovery services. The ministry offers a stable, safe, and drug and abstinent living environment essential for supporting clients' recovery journeys.

ODM maintains a safe clean setting that helps reduce relapse risk, supports recovery and treatment maintenance, and assists clients in fulfilling probation or child protective service

requirements. The ODM also aids women in achieving reliable income and successfully reintegrating them into the community.

In addition to housing and supportive services, ODM offers guidance on accessing community resources for both women and their children. Counseling and mental, emotional, and spiritual support services are available to clients and their families. Furthermore, ODM connects women with external resources, including job training, educational programs, trade schools, health and wellness services, and childcare assistance as needed.

4) Memorandum of Understanding with Manage Care Plans

As the designated SUDS Plan for Imperial County, ICBHS is responsible for delivering SMHS and SUDS to Medi-Cal clients who meet both access and medical necessity criteria. ICBHS is also expected to collaborate with local Medi-Cal Managed Care Plans (MCPs) to coordinate care for Medi-Cal clients who do not meet criteria for SMHS and/or SUDS. In FY 2022–2023, Imperial County transitioned from its previous MCPs—Molina Healthcare and California Health & Wellness—to Kaiser Permanente and the Community Health Plan of Imperial Valley (CHPIV). In FY 2024–2025, Memoranda of Understanding (MOUs) were executed with both new MCPs.

b. Overview of the objectives and planned activities for FY 25-26:

- ICBHS will provide training, as needed to ensure Access Unit complies with requirements for member access, continuity and coordination of care as indicated in BHIN 25-020.
- ICBHS Access Unit will be responsible for implementing Medi-Cal screening and transition of care tools to ensure timely access, appropriate referrals, and coordinated behavioral health services in collaboration with Medi-Cal Managed Care Plans.
- ICBHS Access Unit will ensure consistent implementation of the Transition of Care Tool, including efforts to initiate appropriate transitions from and to MCPs, supported by finalized MOUs and clear referral pathways.
- QM will continue monitoring the implementation and effectiveness of the adult/youth screening and TOC tool for Medi-Cal SMHS to assess consistent implementation and assess whether clients are receiving timely access to medically necessary care.
- ICBHS will update its Policies and Procedures to align with the requirements of BHIN 25-020.
- ICBHS will actively collaborate with local Tribal officials through regular meetings to identify and address service delivery barriers and will implement targeted outreach and culturally responsive presentations to educate the community, enhance service accessibility, streamline referral pathways, and assess treatment needs within Imperial County’s Native American population.
- Partnership with Imperial County Sheriff’s Office, ICBHS will deliver comprehensive pre-release and post-release behavioral health services for justice-involved individuals, initiating care coordination 90 days prior to release and continuing through post-release, in alignment with the CalAIM Justice-Involved Initiative, to support successful community reintegration, reduce recidivism, and improve overall health outcomes.

- ICBHS will continue collaborating with El Centro Regional Medical Center and Pioneer Memorial Hospital to implement a streamlined referral system that ensures timely, efficient access to services and expedites care coordination for clients receiving MAT in emergency departments and urgent outpatient care centers.

- ICBHS will expand countywide outreach and engagement initiatives and strengthen collaborations with key community agencies to increase awareness, promote prevention, and reduce stigma associated with Opioid Use Disorder (OUD), Stimulant Use Disorder (StUD), and other SUDS among youth and adults, fostering earlier intervention and greater access to treatment and recovery supports.

- ICBHS will explore and pursue opportunities to expand recovery housing options in Imperial County to better serve clients with SUD and co-occurring conditions to support clients' recovery, stability, and successful reintegration into the community.

- ICBHS will enhance education, expand resource availability, and strengthen support systems to prevent and address substance use among youth and young adults, with the goal of reducing high-risk behaviors, promoting healthy decision-making, and ensuring timely connection to evidence-based interventions throughout the next academic year.

VI. Provider Complaints and Appeals

The QM Unit monitors provider disputes with ICBHS concerning the request for authorization or payment for SMHS or SUDS. The QM Unit also monitors provider appeals through the written appeals submitted to ICBHS by providers for denial of authorization or payment, or modification of requests for authorization.

a. Update on the objectives and planned activities for FY 24-25:

During FY 24-25, the QM Unit fulfilled SMHS and SUDS provider relations responsibilities, as needed. All providers are encouraged, as outlined in the Provider Handbook, to present complaints to the Provider Relations staff by telephone, in person, or in writing. Provider Relations staff makes every effort to resolve complaints quickly and at the lowest possible level. If providers are not satisfied with the outcome of the complaint process, they are provided information on the appeals process.

In FY 24-25, no complaints were reported to the QM Unit. Similarly, no appeals were submitted. The lack of submission of both complaints and appeals is consistent with previous years. All requests for services requiring prior or concurrent authorization were processed as requested, except for 6 inpatient authorization requests; however, the inpatient providers did not appeal the decision by ICBHS to deny payment.

Meanwhile, in FY 24-25, the current process for providing services that require prior authorization (residential and inpatient) involve the client first being assessed by ICBHS. If it is identified that a client meets the ASAM level of care for residential or inpatient service, ICBHS coordinates referral and admission to an appropriate provider. Therefore, during FY 24-25, there were no requests for authorization of service by a SUDS provider, and subsequently no need for a provider appeal. Likewise, no requests were made by beneficiaries for a service that requires prior authorization. This is a consistent finding over time.

b. Overview of the objectives and planned activities for FY 25-26:

- The Provider Relations staff will provide technical assistance to providers and/or SMHS and/or SUDS staff as needed to resolve complaints at the lowest possible level.

VII. Hospitalization Monitoring

The QM Unit tracks and monitors the admission and readmission of the SMHS inpatient psychiatric hospitalizations to identify any potential quality of care issues. Additionally, the QM Unit also conducts chart reviews for all hospitalizations to ensure SMHS complies with the care coordination standards outlined in Procedure 01-115, Hospitalization Discharge/Placement Coordination. The QM Unit also tracks and monitors the admission and readmission of beneficiaries hospitalized for SUD-related issues to identify any potential quality of care concerns or emerging trends.

a. Update on the objectives and planned activities for FY 24-25:

1) Inpatient Psychiatric Admissions

During FY 24-25, there were 162 Medi-Cal beneficiaries, and 60 non-Medi-Cal clients hospitalized, for a total of 292 admissions, which is a decrease from the previous fiscal year. A comparison of prior fiscal years is included below:

Table 8.1 Inpatient Psychiatric Admissions

Review Period	# of Clients Hospitalized			# of Admissions		
	Medi-Cal	Non Medi-Cal	Total	Medi-Cal	Non Medi-Cal	Total
FY 24-25	162	60	222	227	65	292
FY 23-24	177	63	240	232	72	304
FY 22-23	80	77	157	112	93	205

Of the 292 admissions during FY 24-25, 169 (58%) were active clients receiving services from ICBHS at the time of the hospitalization. The status by division is as follows:

- Children Services – 12 (4%) active clients at time of hospitalization.
- Youth & Young Adults Services – 27 (9%) active clients at time of hospitalization.
- Adults Services – 77 (26%) active clients at time of hospitalization.
- Mental Health Triage & Engagement Services – 53 (18%) active clients at time of hospitalization, 123 (43%) were inactive with ICBHS and assigned for follow-up.

2) *Inpatient Psychiatric Readmissions*

Of the 292 admissions during FY 24-25, 70 were readmissions. ICHBS overall readmission rate is 24 percent. This is an increase from FY 23-24 when the readmission rate was 15 percent.

There were 19 readmissions that occurred within 30 days of discharge, resulting in a 7 percent 30-day readmission rate. This is a decrease from FY 23-24 when the 30-day readmission rate was 15 percent. The table below summarizes the ICBHS inpatient psychiatric readmissions:

Table 8.2 Inpatient Psychiatric Readmissions			
Review Period	**FY 22-23**	**FY 23-24**	**FY 24-25**
Total Readmissions	48	47	70
Total Admissions	205	304	292
Readmission Rate	**23%**	**15%**	**24%**
Readmissions Within 30 Days	33	26	19
Total Admissions	205	304	292
30-Day Readmission Rate	**16%**	**15%**	**7%**

3) *Hospital Chart Reviews*

The QM Unit is responsible for conducting hospitalization chart reviews to monitor if the ICBHS is following established policies and procedures regarding hospitalization discharge planning and placement coordination. This allows the QM Unit to determine whether or not clients are receiving the appropriate follow up care after a psychiatric hospitalization and implement corrective interventions if necessary.

During FY 24-25, the QM Unit reviewed 126 hospitalizations: 61 for Adults Services, 24 for YAYA Services, 14 for Children Services, and 27 for Mental Health Triage and Engagement Services. A review tool with the following three categories was utilized: 1) Hospitalization Monitoring; 2) Hospitalization Discharge Planning; and 3) After Hospitalization Discharge Summary. The QM Unit identified the following as areas for improvement:

<u>Hospitalization Monitoring</u>

- Present case during treatment team meetings to care coordinate and receive treatment recommendations and/or changes after the inpatient psychiatric treatment. *(Repeat finding from FY 23-24)*

<u>Hospitalization Discharge Planning</u>

- Contact the hospital staff to ensure the client is discharged with sufficient medication supply. *(Repeat finding from FY 23-24)*
- Complete the Hospital Discharge Summary to ensure discharge instructions and/or recommendations are followed by other service providers to coordinate treatment. *(Repeat finding from FY 23-24)*
- Contact client and/or support person (s) the same day of discharge (via phone or face-to-face) to verify a smooth transition between levels of care.
- Inform client /support person of scheduled appointments to ensure continuity of care and avoid a readmission.

After Hospitalization Discharge Care

- Conduct a home visit/Zoom appointment within 3 business days of discharge and complete a thorough assessment (mental status, adherence to medication, coordination of care and/or needed referrals). *(Repeat finding from FY 23-24)*
- Present case during treatment team meetings to care coordinate and receive treatment recommendations and/or changes after the inpatient psychiatric treatment.
- Is there evidence the treatment plan was updated or at least reviewed as a result of the client's hospitalization

Opportunities for improvement were also identified at the division level. The deputy directors were provided with individual reports by division to implement appropriate interventions to address areas of concern.

4) Follow-Up After Hospitalization for Mental Illness (FUH)

Follow-up after hospitalization for mental illness is a HEDIS measure that assesses the percentage of inpatient discharges for diagnosis of mental illness or intentional self-harm among patients age 6 years and older that resulted in follow-up care with a mental health provider within 7 days and 30 days. Monitoring for timeliness of follow-up after hospitalization is essential as individuals hospitalized for mental health disorders often do not receive adequate follow-up care. By receiving appropriate and timely follow-up care, clients are more likely to have positive outcomes and have a reduced risk for readmission to a hospital.

During FY 24-25 the QM Unit monitored the timeliness to first service appointment after a hospitalization, after hospitalization, as ICBHS has established a standard of providing a first service SMHS appointment within 7 business days of discharge for all clients who are hospitalized.

The monitoring process entailed collecting data for all clients who are discharged from a psychiatric hospital. The data sources utilized are the Payment Authorization Unit Hospitalization Log, which identifies the clients who were hospitalized, their date of admission, and their date of discharge, and the EHR, which includes documentation regarding clients' treatment history, claims, and the date of the first psychiatric appointment and other appointments scheduled.

During FY 24-25, there were 292 hospitalizations. Of those, 97 clients did not receive a SMHS follow-up appointment with ICHBS due to the clients non-adhering toward services (45%); re-admitted back to inpatient psychiatric hospital (18%); residing out of county (19%); refusing services (5%); or other reasons (13%).

Of the 195 clients that received follow-up appointments, 126 (65%) were actively receiving SMHS services from ICBHS and 69 (35%) were not. The average waiting time to receive an appointment was 3 days for active clients and inactive clients.

During FY 24-25, ICBHS was 63 percent compliant in meeting the standard for scheduling a follow-up appointment within 7 business days after a hospitalization, which is a slight increase from the previous year.

Of the 195 clients that received a follow-up appointment during FY 24-25, 6 percent received an appointment within 8 to 30 days after hospitalization.

A comparison of prior years is included below:

Table 7.3 Timeliness of First Service Appointment After a Hospitalization					
Active Clients					
Review Period	**Clients Hospitalized**	**Received F/U Appt. in 7 Days**	**Received F/U Appt. in 8-30 Days**	**Avg. Wait Time For Appt.**	**Compliance Rate**
FY 24-25	170	121	5	3 days	71%
FY 23-24	185	126	8	3 days	68%
FY 22-23	86	70	85	5 days	84%
Inactive Clients					
Review Period	**Clients Hospitalized**	**Received F/U Appt. in 7 Days**	**Received F/U Appt. in 8-30 Days**	**Avg. Wait Time For Appt.**	**Compliance Rate**
FY 24-25	122	62	7	3 days	51%
FY 23-24	119	60	5	3 days	50%
FY 22-23	32	22	30	10 days	69%

5) SUD Related Hospitalizations

The QM Unit monitoring process consisted of collecting data related to hospitalizations from the ICBHS SUD Hospitalizations Log. The log records the number of hospitalizations, the client' status (active/inactive) at ICBHS at time of hospital admission, the number of days the client was hospitalized, the number of ICBHS program episodes prior to the hospitalization as well as ASAM level of care, and the timeliness of follow-up care after hospital discharge. If any hospitalizations are reported, the QM Unit will investigate the efforts made to prevent the hospitalization.

During FY 24-25, there were 5 hospitalizations made by SUD treatment programs, which is a decrease from prior years, as indicated below:

Table 7.4 Hospital Admissions & Readmissions						
Review Period FY	**Adolescent SUD Program**		**Adult SUD Program**		**Total**	
	Admissions	**Readmissions**	**Admissions**	**Readmissions**	**Admissions**	**Readmissions**
24-25	0	0	5	0	5	0
23-24	1	0	5	0	6	0
22-23	4	1	11	0	14	1

The average hospitalization timeframe for the Adult SUD programs was 1 day. After hospitalization, the average timeframe for follow-up care was within 2 days.

Current efforts being implemented by the county-operated SUD treatment programs to prevent hospitalization involve assessing clients in a consistent and timely manner upon admission and throughout the course of treatment as needed. For those individuals engaging in high-risk behaviors, clinical staff provide additional support, such as care coordination, to reduce the risk of emergencies and hospitalizations. Additionally, ICBHS continues to collaborate with local hospitals to effectively coordinate treatment for clients requiring SUD and MAT services.

b. Overview of the objectives and planned activities for FY 25-26:

- The QM Unit will investigate why the number of inpatient psychiatric hospital admissions increased by nearly 50 percent from FY 22-23 to FY 23-24.
- SMHS will provide training to providers to ensure a home visit or Zoom appointment is provided to clients within 3 business days of discharge from an inpatient psychiatric hospital.
- The QM Unit will calculate timeliness of first follow-up after hospitalization for mental illness by measuring against the first service provided to the client, regardless of the service type.
- SUDS will continue to assess clients throughout the course of treatment and provide timely interventions to prevent avoidable hospitalizations.
- The QM Unit will continue conducting chart reviews and other monitoring activities to identify relevant clinical issues affecting beneficiaries, including safety and effectiveness of medication practices and quality of care concerns.
- The ICBHS SUD programs will implement interventions to ensure service coordinators collaborate with residential staff throughout treatment, schedule follow-up appointments within 7 days of discharge, and utilize discharge summaries to support beneficiaries in maintaining sobriety.

VIII. No Show Rates

To maximize service delivery capacity and expand service delivery, the QM Unit monitors, tracks, and analyzes the no-show rates for SMHS services delivered by psychiatrists, clinicians, and nurses, as well as for SUDS services including ASAM assessments, MAT, and individual counseling appointments. Data related to these services was collected from the EHR to evaluate client engagement in services and identify possible barriers to treatment or causes of non-adherence.

As part of this effort, the QM Unit presented no-show data to the QIC, highlighting key reasons for considering the adoption of a lower no-show benchmark across all appointment types. The proposal included an approach targeting incremental improvements of 5% until the new benchmark was achieved; however, the QIC decided to place this initiative on hold, and no changes to the existing no-show benchmarks will be implemented at this time. In addition, the QM Unit conducted an analysis to identify the causes of high no-show rates in youth services, which involved administering 80 surveys via mail and phone to gather insight into reasons behind youth clients missing scheduled appointments, though only minimal responses were received.

a. Update on the objectives and planned activities for FY 24-25:

1) Psychiatric No Show Rates

a) No Show Rates to Initial Psychiatric Assessments (IPA)

ICBHS no show rate to IPA was 23 percent during FY 24-25, which is a decrease from 25 percent in FY 23-24. The Children, Adults, and Mental Health Triage & Engagement Services divisions exceed their no-show benchmarks. Trends for the divisions were identified

at the program level and were shared with management. The current benchmarks by division are as follows:

- Children Services – 18 percent
- YAYA Services – 25 percent
- Adults Services – 23 percent
- Mental Health Triage & Engagement Services – 16 percent

The results by division are summarized below:

Table 8.1 No Show Rates - Initial Psychiatric Assessment

Review Period	Children Services		Youth & Young Adults Services		Adults Services		MHTES		ICBHS Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rates	No Show Appts.	No Show Rate
FY 24-25	86	21%	126	24%	223	25%	139	19%	574	23%
FY 23-24	105	19%	129	24%	355	33%	121	19%	710	25%
FY 22-23	63	23%	63	24%	71	19%	13	7%	210	19%

b) No Show Rates to Medication Support Appointments

The no show rate to psychiatrist medication support appointments was 21 percent during FY 24-25, which is a decrease from 22 percent in FY 23-24. The Youth & Young Adults Division exceeded its no-show benchmark. Trends for the divisions were identified at the program level and were shared with management. The current benchmarks by division are as follows:

- Children Services – 18 percent
- YAYA Services – 22 percent
- Adults Services – 23 percent

The results by division are summarized below:

Table 8.2 No Show Rates - Psychiatrist Medication Support Appointments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		ICBHS Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	589	17%	690	24%	1,709	22%	2,988	21%
FY 23-24	861	18%	895	24%	2,575	23%	4,331	22%
FY 22-23	399	14%	380	18%	742	15%	1,521	15%

2) Clinician No Show Rates

a) No Show Rates to Intake Assessments

ICBHS no show rate to SMHS initial intake assessment was 28 percent during FY 24-25, which is a slight increase from 27 percent in FY 23-24. The Children's, Adults and Mental Health Triage & Engagement Services divisions exceeded their no-show benchmark. Trends

for the Children's, Adults and Mental Health Triage & Engagement Services divisions were identified at the program-level and were shared with management. The current benchmarks by division are as follows:

- Children Services – 20 percent
- YAYA Services – 30 percent
- Adults Services – 30 percent
- Mental Health Triage & Engagement Services – 26 percent

The results by division are summarized below:

Table 8.3 No Show Rates – Intake Assessment

Review Period	Children Services		Youth & Young Adults Services		Adults Services		Mental Health Triage Engagement Services		ICBHS Total	
	No Show Appts	No Show Rate	No Show Appts	No Show Rate	No Show Appts	No Show Rate	No Show Appts	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	352	22%	242	23%	549	31%	441	35%	1,584	28%
FY 23-24	345	20%	322	25%	544	33%	327	34%	1,538	27%
FY 22-23	170	20%	157	27%	230	29%	152	31%	709	26%

b) *No Show Rates to Psychotherapy Appointments*

ICBHS no show rate for SMHS psychotherapy appointments was 20 percent during FY 24-25, which is an increase from 19 percent in FY 23-24. All divisions met their benchmarks for FY 24-25. The current benchmarks by division are as follows:

- Children Services – 20 percent
- YAYA Services – 25 percent
- Adults Services – 18 percent

The results by division are summarized below:

Table 8.4 No Show Rates – Psychotherapy Appointments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		ICBHS Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	1,524	18%	1,452	23%	639	18%	3,633	20%
FY 23-24	1,426	17%	1,186	22%	579	19%	3,191	19%
FY 22-23	365	13%	282	24%	108	9%	755	15%

3) *Nurse No Show Rates*

a) *No Show Rates to Nursing Evaluations*

ICBHS no show rate to SMHS nursing evaluations was 20 percent during FY 24-25. The Children's division exceeded their no-show benchmark. Trends were identified at program level and were shared with management. The current benchmarks by division are as follows:

- Children Services – 15 percent
- YAYA Services – 22 percent
- Adults Services – 25 percent
- Mental Health Triage & Engagement Services – 17 percent

Effective FY 24-25, the no-show rate for nursing evaluations only included initial nursing assessments. The annual nursing assessments were not included, as they are no longer tracked by ICBHS.

The results by division are below:

Table 8.5 No Show Rates – Initial Nursing Evaluations

Review Period	Children Services		Youth & Young Adults Services		Adults Services		Mental Health Triage Unit		ICBHS Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	126	18%	125	20%	273	25%	131	16%	655	20%
FY 23-24	424	14%	590	26%	669	17%	188	20%	1,871	18%

b) *No Show Rates to Medication Support Appointments*

ICBHS no show rate to SMHS nurse medication support appointments was 13 percent during FY 24-25, which is a decrease from 17 percent in FY 23-24. All divisions met their benchmark and no trends were identified. The current benchmarks by division are as follows:

- Children Services – 22 percent
- YAYA Services – 25 percent
- Adults Services – 25 percent
- Mental Health Triage & Engagement Services – 25 percent

The results by division are summarized below:

Table 8.6 No Show Rates – Nurse Medication Support Appointments

Review Period	Children Services		Youth & Young Adults Services		Adults Services		ICBHS Total	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	1,009	13%	1,007	20%	1,705	11%	3,721	13%
FY 23-24	918	18%	1,091	25%	991	12%	3,000	17%
FY 22-23	58	12%	76	27%	208	10%	342	12%

4) *ASAM Assessment No Show Rates*

The overall no show rate for ASAM assessment appointments was 34 percent during FY 24-25, which is a decrease from the previous FY, and neither the Adolescent SUD nor the Adult SUD program exceeded their benchmarks. Any trends identified at the program level were shared with management. The current benchmarks for ASAM assessment appointments are as follows:

- Adolescent SUD Program – 40 percent
- Adult SUD Program – 55 percent

The results by program are summarized in the table below:

Table 8.7 No Show Rates – ASAM Assessment

Review Period	Adolescent SUD		Adult SUD		SUD Division	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	62	21%	441	37%	503	34%
FY 23-24	133	38%	545	45%	678	43%
FY 22-23	76	33%	267	40%	343	38%

5) *Individual Counseling No Show Rates*

The overall no show rate for individual counseling appointments was 29 percent during FY 24-25, which is a decrease from the previous FY, neither the Adolescent SUD nor the Adult SUD program exceeded their benchmarks. Any trends identified at the program level were shared with management. The current benchmarks for individual counseling appointments are as follows:

- Adolescent SUD Program – 41 percent
- Adult SUD Program – 50 percent

The results by program are summarized in the table below:

Table 8.8 No Show Rates – Individual Counseling

Review Period	Adolescent SUD		Adult SUD		SUD Division	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	273	25%	1,968	30%	2,241	29%
FY 23-24	373	31%	1,645	35%	2,018	34%
FY 22-23	610	41%	2,325	48%	2,935	46%

6) *MAT No Show Rates*

The overall no show rate for MAT appointments was 40 percent during FY 24-25, which is an increase from the previous FY. While the Adolescent SUD Program did not exceed its benchmark, the Adult SUD Program did with a 40 percent no show rate. Any trends identified at the program level were shared with management. The current benchmarks for individual counseling appointments are as follows:

- Adolescent SUD Program – 50 percent
- Adult SUD Program – 30 percent

The results by program are summarized in the table below:

Table 8.9 No Show Rates – MAT						
Review Period	Adolescent SUD		Adult SUD		SUD Division	
	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate	No Show Appts.	No Show Rate
FY 24-25	14	27%	541	40%	555	40%
FY 23-24	18	33%	774	37%	792	37%
FY 22-23	14	31%	539	34%	553	34%

While the SUD programs have generally demonstrated improvement in appointment show rates during FY 24–25, the established benchmarks remain high, and in some cases—such as with MAT—no-show rates continue to be significantly elevated. This suggests that, despite progress, challenges with client engagement persist and warrant further analysis and targeted interventions.

b. Overview of the objectives and planned activities for FY 25-26:

- QM Unit will continue to monitor and analyze no-show rates for SMHS and SUDS and will report findings to QIC.

- SMHS and SUDS will implement targeted interventions with the goal of increasing client engagement and decreasing no show rates.

PERFORMANCE IMPROVEMENT PROJECTS

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

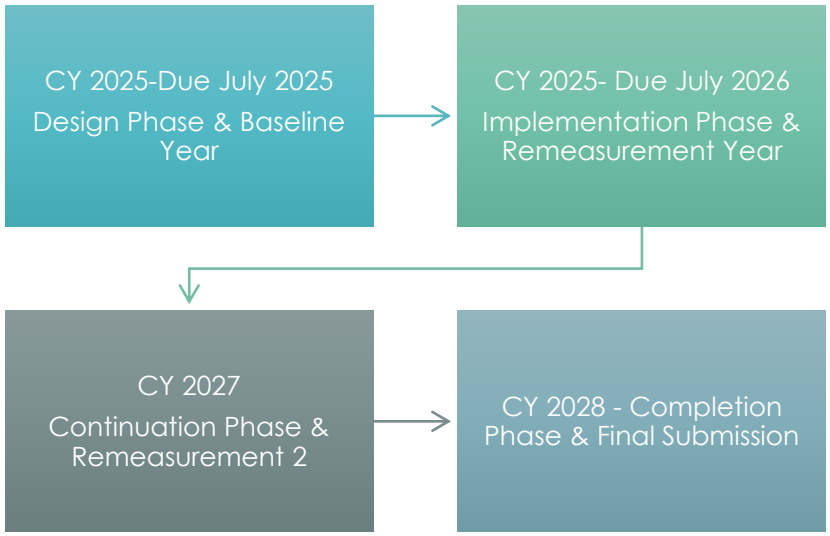
Performance Improvement Projects

I. Service Delivery Capacity

QIC oversees the development of clinical and non-clinical Performance Improvement Projects (PIPs). The QIC reviews data indicating the need for quality improvement activities, taking into consideration recommendations made by the QM Unit, and selects the PIPs and the individuals assigned to participate in a PIP taskforce. Members of the PIP taskforce are responsible for developing the PIPs, collecting and analyzing data, developing goals and key performance indicators, implementing interventions, and measuring outcomes. Progress on each PIP is presented during the monthly QIC meetings and to the Health Services Advisory Group (HSAG) who serve as the External Quality Review Organization (EQRO) during the annual external quality review.

The California Department of Health Care Services (DHCS) requires ICBHS SMHS and SUDS to implement two performance improvement projects (PIPs) per contract—one clinical and one nonclinical. Additionally, DHCS has instructed the County to discontinue any previously mandated PIPs. The new PIPs will commence in 2025, with the first annual submission due in July 2025, and conclude in 2027, with the final annual submission due in July 2028. ICBHS has been provided with two nonclinical and two clinical PIP topics to choose from for the next three years.

The QIC selected to focus on a Nonclinical PIP focusing on increasing the percentage of clients who receive at least one Peer Support Service and on al Clinical PIP focusing on improving the rate of Follow-Up After Emergency Department Visit for Mental Illness and/or Substance Use. The table below is the PIP timeline overview for the next three years:



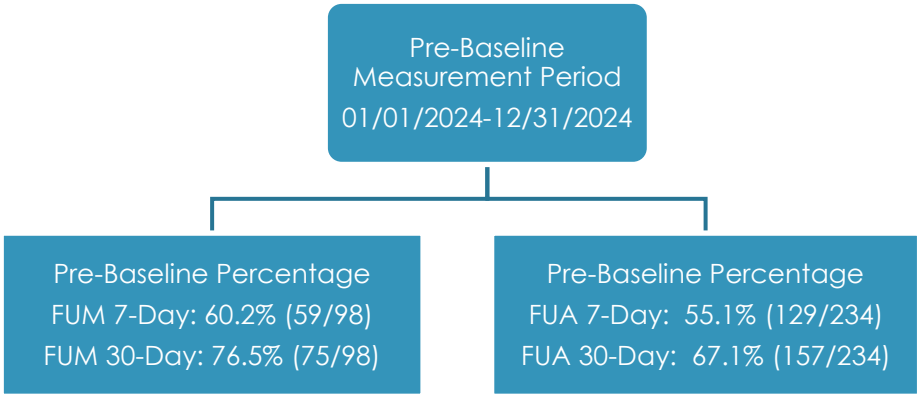
a. Update on the objectives and planned activities for FY 24-25:

1) SMHS & SUDS Clinical PIP: Follow-Up After Emergency Department Visit for Mental Illness (FUM) & Follow-Up After Emergency Department Visit for Substance Use (FUA)

The aim of the Clinical PIP is to determine whether targeted interventions increase the percentage of emergency department (ED) visits for clients 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm and clients 13 years and older with a principal diagnosis of substance use disorder or any diagnosis of drug overdose who receive a follow-up visit within 7 and 30 days of the ED visit. These follow-up measures are formally known as Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA).

The FUM and FUA are apart from the Behavioral Health Accountability Sets (BHAS) designated by the Department of Health Care Services (DHCS) for annual reporting by County Behavioral Health Plans. These measures aim to promote post-ED coordinated care; improve engagement in outpatient services; and reduce readmissions by addressing the needs of clients most at risk of disengagement from care. The target for these measures is set at the 50th percentile national performance rate or a 5% improvement over baseline if the current rate already exceeds the 50th percentile.

In July 2025, ICBHS submitted the required design phase and baseline year template to HSAG. The table below reflects the Pre-Baseline Measurement Period and Percentage for 1/1/2024 through 12/31/2024 for ICBHS



To lead the 3-year Clinical PIP initiative, ICBHS established a PIP Workgroup Committee, which convenes monthly to monitor progress, review performance data, and address implementation challenges. The QIC met on July 10, 2025, and agreed to implement an intervention centered around developing a mental health and substance use educational video to guide patients discharged from the ED toward a pathway for continuous care with ICBHS. The video is intended to make information more accessible, engaging, and easier to understand, while increasing motivation among individuals to follow up with aftercare services post ED.

ICBHS is working collaboratively with CalMHSA who have been providing technical assistance for the Clinical PIP. SMHS and SUDS will continue to move forward with increasing the percentage of emergency department (ED) visits for clients 6 years of age and older with a

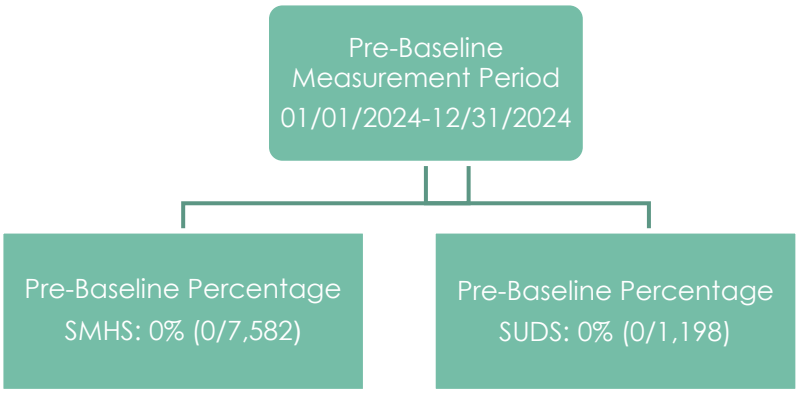
principal diagnosis of mental illness or intentional self-harm and 13 years and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose, for which the client received a follow-up visit within 7 and 30 days of the ED for FY 25-26.

2) ***SMHS & SUDS Nonclinical PIP: Increase the percentage of clients who receive at least one Peer Support Service***

The aim of the Nonclinical PIP is to determine whether targeted interventions increase the percentage of clients accessing SMHS and SUDS who also receive at least one peer support service provided by a certified peer support specialist during the reported remeasurement period.

Peer Support Services are culturally competent, strength-based individual and group interventions that promote recovery, resilience, engagement, and self-advocacy. These services include structured coaching to help set and achieve recovery goals, prevent relapse, enhance community and family support, and link clients and their families to community resources. Services can be delivered in both clinical and non-clinical settings and may involve family or support people, even in the client's absence, if clinically appropriate and centered on the client's recovery. Peer Support Specialists must pass an exam covering 17 Core Competencies, with certification administered by CalMHSA. Certified specialists are recognized under the Medi-Cal Peer Benefit by participating counties in agreement with DHCS.

In July 2025, ICBHS submitted the required design phase and baseline year template to HSAG. The table below reflects the Pre-Baseline Measurement Period and Percentage for 1/1/2024 through 12/31/2024 for ICBHS



SMHS and SUDS baseline is zero as there are no Peer Support Services being offered at this

To lead the 3-year Nonclinical PIP initiative, ICBHS established a PIP Workgroup Committee, which convenes monthly to monitor progress, review performance data, and address implementation challenges. This PIP aims to strengthen engagement and retention in behavioral health services through the integration of Peer Support Services.

On March 24, 2025, ICBHS submitted its Peer Support Services Opt-In letter to DHCS. Approval was granted, allowing ICBHS to begin rendering and billing for Peer Support Services effective July 1, 2025.

As of July 2025, the following staff have successfully completed Peer Support Specialist certification: three direct service providers and one administrative staff member from the Mental Health Triage & Engagement Services Division, two administrative staff from the Youth and Young Adult Division, and one direct service provider and one administrative staff member from SUDS.

The QIC met on July 10, 2025, the Quality Improvement and agreed to implement an intervention centered in having the Peer Support Specialists focus on engaging clients prior to appointments for the purpose of reducing missed appointments.

ICBHS is working collaboratively with CalMHSA who have been providing technical assistance for the Nonclinical PIP. ICBHS will continue to move forward with increasing the percentage of clients who receive at least one Peer Support Service for FY 25-26.

b. Overview of the objectives and planned activities for FY 25-26:

- SMHS and SUDS will implement targeted interventions to increase the percentage of eligible emergency department (ED) discharges that receive a follow-up visit within 7 and 30 days of the ED encounter.
- SMHS and SUDS will continue to work with the local MCPs to establish data exchange processes to better coordinate care for Imperial County Medi-Cal beneficiaries who are accessing the local EDs for a mental illness and substance use disorders.
- ICBHS and SUDS will implement intervention focused on pre-appointment client engagement**,** led by certified Peer Support Specialists**,** with the goal of increasing the percentage of clients who receive at least one Peer Support Service during FY 2025–2026.
- QM will continue to produce quarterly No-Show reports for targeted programs. Trends will be analyzed to compare no-show rates pre- and post-intervention to evaluate the effectiveness of Peer Support Services.
- QM will continue to work with the Clinical and Nonclinical PIP workgroup committees, contributing to discussions on data trends, barriers to success, intervention strategies, and quality findings.
- QM will continue to collaborate with CalMHSA to ensure PIP interventions are consistent with statewide standards and BHAS metric requirements, providing technical input to maintain fidelity and compliance.
- QM will ensure that all PIP narratives, data summaries, performance analyses, and evaluation components are completed accurately and submitted according to DHCS timelines and format specifications.

- QM will work with the Information Systems (IS) team to design and implement tracking mechanisms within the Electronic Health Record (EHR) system, supporting accurate and automated data pulls for FUM, FUA, and Peer Services.

CULTURAL & LINGUISTIC COMPETENCE

IMPERIAL COUNTY
Behavioral Health Services
MENTAL HEALTH & SUBSTANCE USE RECOVERY

Cultural and Linguistic Competence

ICBHS utilizes the Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards as the framework for its Cultural Competence Plan. The Cultural Competence Plan outlines the department's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, and gender identity. As part of the Cultural Competence Plan, ICBHS will select specific training courses to increase the knowledge and proficiency of staff and evaluate the cultural and linguistic competence of services and staff through continuous QI activities.

a. Overview of the ICBHS objectives and activities for FY 24-25:

I. Continuous Quality Improvement Plan

The QM Unit monitored the existing state mandated cultural and linguistic competence requirement under the QI Program. The process for monitoring entailed: 1) ensuring proficiency of staff and interpreters; 2) reviewing and assisting with updating ICBHS Cultural Competence Plan; and 3) monitoring the process for incorporating relevant cultural competence standards, such as access, quality of care, and quality management, into the QI Work Plan for FY 24-25. These QM monitoring activities support and foster a philosophy that attaining cultural and linguistic competence is an ongoing developmental process, which was designed around the framework of the CLAS Standard, as indicated in the Cultural Competence Plan.

a) Proficiency of Staff

Cultural Competence Training Plan

The QM Unit produced an annual Cultural Competence Training Plan, which includes all training activities planned for the fiscal year for mental health and SUD program staff. The training plan includes a description of each training, audience, and proposed schedule. The plan is used by management to deliver effective training as well as meet the requirements of the Cultural Competence Plan.

Cultural Competence Training Report

The QM Unit produced an annual Cultural Competence Training Report summarizing training activities for the fiscal year for mental health and SUD program staff. The data is used by management to assess the department's attempt to deliver effective training as well as monitor the progress towards meeting requirements of the Cultural Competence Plan.

During FY 2024–2025, the Quality Management (QM) Unit monitored ICBHS's compliance with the annual requirement for all staff to attend at least one cultural competence training. Of the 586 ICBHS employees, 94.54% (554 staff) successfully completed the training. An additional 4.95% (29 staff) did not fulfill the requirement, while 0.51% (3 staff) were either on medical leave or

recently hired. The QM Unit will continue to monitor these individuals to ensure that all employees complete the required cultural competence training.

Client Culture Training

ICBHS provided the Client Culture Training and the Client Culture Refresher Course to ~~221~~ 88 SMHS and SUDS program staff during FY 24-25. These trainings provide staff with an understanding that consumers of behavioral health services have a set of values, beliefs, and lifestyles that are developed as a result of their own personal experiences with mental illness, the mental health system, and their own ethnic culture. The trainings covered areas such as definitions of client culture, three levels of staff cultural competence, stigma and anti-stigma facts, discrimination and social distance, early steps in the recovery movement, recovery definitions and SAMHSA is guiding principles of recovery, among other topics.

Language Assistance Services Training

During FY 24-25, the Access Unit supervisor provided two training courses to approximately 16 staff from the Access Unit and after-hours staff. The Access Unit supervisor provided training to SUD program and mental health staff on the use of language assistance services, policies, and procedures in order to improve staff knowledge of how to utilize language assistance services.

Transgender, Gender-Diverse, and Intersex (TGI) Cultural Competency Training

California law (SB 923, 2022) requires behavioral health providers to complete mandatory cultural competency training focused on serving Transgender, Gender-Diverse, and Intersex (TGI) individuals. The training equips providers with the knowledge and skills to deliver inclusive, respectful, and affirming care by covering topics such as gender diversity, appropriate use of names and pronouns, reducing stigma and discrimination, and addressing the unique behavioral health needs of TGI communities. This requirement helps ensure compliance with state law while also supporting equitable, high-quality behavioral health services that improve engagement, trust, and outcomes for TGI clients.

During FY 24-25, the identification of a TGI training called The TGI Affirming Care & Equity Training offered by OutCare commenced with only 2 staff passing. The training requirement for all affiliated service providers is to be completed by July 31, 2025, with renewals required every 2 years.

b) Proficiency of Interpreters

Interpreter Training for Staff and Interpreters

In an effort to ensure that staff have the proper skills and knowledge to provide accurate interpretation from one language to another, the ICBHS contracted with the National Latino Behavioral Health Association (NLBHA) to provide the Behavioral Health Interpreter Training. During FY 24-25, one interpreter training course took place via Zoom on May 12-15, 2025, for 27 staff.

The interpreter training focused on many areas, including the complexity of language and how there are different communication styles within each cultural group. The training covered the verbal and non-verbal communication styles used by some cultural groups and how important it is to understand each communication styles in order to convey the right message, as well as how many cultures reflect either a high context (telling the whole story, indirect) or low context (straight forward, direct) style of communication. Understanding the high and low context styles is crucial to the interpreter as it presents challenges for an interpreter who works with both.

In addition, the training covered the important roles of an interpreter: as a clarifier, the interpreter helps simplify technical terms; as a cultural broker, the interpreter provides cultural information to improve communication; as an advocate, the interpreter works on behalf of the client when their needs are not being met; and as a conduit, the interpreter provides verbatim or word for word interpreting and, as much as possible, not changing the message.

New Employee Orientation (Cultural Competence Training Course)

The ICBHS Center for Clinical Training continued to implement an eLearning cultural competence training course for new hires during FY 24-25. This training course allows newly hired staff to understand what cultural competence is and how ICBHS implements the National Standards for Culturally and Linguistically Appropriate Services (CLAS) standards in the department and our community. During FY 24-25, 147 staff received the new employee orientation eLearning course.

County Formal Testing Process

In an effort to ensure bilingual staff are proficient in the Spanish language, the County of Imperial has a formal testing process in place. The County's Department of Human Resources and Risk Management provides a written literacy test, which must be passed in order to be deemed bilingual and receive bilingual differential pay. As of June 30, 2025 a total of 258 ICBHS employees who utilize a language other than English when performing work duties through the mental health, substance use disorders, and administrative programs have passed the written literacy test.

c) *Cultural Competence Taskforce*

ICBHS has a Cultural Competence Taskforce (CCTF) committed to promoting the delivery of services and provision of information to residents of Imperial County in a manner that is responsive to and respectful of the individual attitudes, beliefs, customs, and practices of the various cultural and ethnic groups we serve.

In FY 24-25, CCTF continued its work toward achieving its CY 2025 goals, which are based on the Culturally and Linguistically Appropriate Services (CLAS) Standards of Care. The CLAS Standards are intended to advance health equity, improve quality of care, and eliminate health disparities by establishing a blueprint for health and healthcare organizations. A complete report of activities is included in the 2025 Annual Cultural Competence Plan. Some of the CCTF achievements include:

- The QM Unit conducted random test calls, during business and after hours, in both English and Spanish, the County's threshold language. During FY 24-25 the QM Unit followed the DHCS Protocol when conducting random test calls. The Access Logs were also reviewed to verify the test calls were logged, as required.

  Test callers assessed Access Unit Staff's knowledge in the following areas: 1) language capability, 2) material alternative format, 3) request for TTY/TDY services 4) request for Interpreters Services, 5) Provider Directory and/or Beneficiaries Handbook was available upon request. The test calls are made at random times of the day and days of the week, verified that the 24-hour-toll-free telephone line was in operation 24 hours a day, seven-days a week.

  During FY 24-25, the QM Unit conducted a total of 52 test calls, 30 during business hours and 22 after-hours. The Access Unit was 100 percent compliant when providing services, including language capabilities.

- During FY 24-25, the translation subcommittee reviewed four documents to ensure the accuracy of translation and cultural appropriateness. The following documents were reviewed and approved: SmartCare Forms (Consent for email, Service Notes, Coordinated Care Consent, and Mental Health Exam). The CCTF subcommittee reviewed the forms and recommendations were provided to the appropriate program.

d) *Cultural Competence Plan Update*

In an effort to ensure that quality assurance activities were incorporated into the Cultural Competence Plan (CCP), the QM Unit participated in the revision of the CCP Plan. During FY 24-25, the QM Unit prepared a CCP Update, which included the activities conducted by ICBHS CCTF. The CCP is updated annually as required.

e) *Other Activities*

<u>Informing Clients of Their Right to Language Assistance Services</u>
In order to inform clients of the availability of language assistance services, ICBHS displays posters that provide information on the interpreter services available through Language Line

Solutions at all mental health and SUD clinics. Additionally, upon admission for treatment, all clients enrolling in a mental health or SUD clinic are informed by staff of the availability of interpreter services. Services are also offered by bilingual staff, as 89 percent of the workforce is bilingual, and 88 percent is proficient in the Spanish language.

During FY 24-25, the Access and Benefits Workers continued to identify clients' primary language when scheduling appointments and logging if interpreter services were needed in languages other than the established threshold language, Spanish. To monitor if services are offered to clients, the Access Unit supervisor reviews the Access Log to ensure that language assistance services are offered to clients requesting them. The QM Unit conducts random test calls to assess if the Access Unit staff offers interpreter services.

Interpreter Services Contracts

In order to facilitate timely access to services, ICBHS contracts interpreter services for in-person and over the phone interpreter services. ICBHS contracts with Deaf Communities of San Diego and Hanna Interpreting Services, independent contractors, for sign language translation and interpretation. In addition, the ICBHS allocates funds for the Language Line Solutions annually to provide interpreters services in languages not spoken by ICBHS staff.

Quality Improvement Committee

The CCTF chairperson participates in the QIC and attends on a monthly basis. The CCTF chairperson reports on activities, any issues/concerns, and progress towards meeting objectives under CLAS Standards on behalf of the CCTF and makes recommendations, as appropriate.

Mental Health Service Act Steering Committee

The CCTF chairperson and other members of the CCTF are members of the Mental Health Services Act (MHSA) Steering Committee. The members actively participate in the planning of MHSA services, ensuring the inclusion of cultural competencies, and provide input and make recommendations, as appropriate. With the passage of Proposition 1 on March 1, 2024, California began transforming the behavioral health system, including transitioning MHSA into the Behavioral Health Services Act (BHSA). The CCTF chairperson will continue to be part of any BHSA committee that is established because of this transformation in support of culturally competent activity planning.

II. Capacity of Service

A profile of the County of Imperial reflects that Hispanics account for 86 percent of the population and 75 percent speak a language other than English at home. The most recent DHCS data indicates Spanish is Imperial County's primary threshold language.

ICBHS ensures that SMHS and SUD services are rendered by staff that are culturally competent and linguistically proficient to meet the needs of the population(s) served. This is measured by an analysis of the Medi-Cal beneficiaries served compared with the data collected annually that evaluates staff's cultural competency.

a) *Number of Clients by Team and Region*

In FY 24-25, the MHP and SUD Divisions provided services to 9,385 (8,388 MHP Division, 997 SUD Division) unduplicated beneficiaries per division. Of these, 86 percent were Hispanic, and 31 percent were Spanish speaking. The distribution by division is included below:

Table 9.1 MHP & SUD Distribution of Beneficiaries and Staff by Division

MHP Division	Number of **Beneficiaries** FY 24/25	Number of ***Staff** FY 24/25	Ethnicity **Beneficiaries** FY 24/25		Ethnicity ***Staff** FY 24/25		Language **Beneficiaries** FY 24/25		Language ***Staff** FY 24/25	
Children Services	2270 (27%)	68 (20%)	89%	Hispanic	90%	Hispanic	47%	Spanish	88%	Spanish
Youth and Young Adult Services	1464 (18%)	47 (14%)	89%		94%		32%		89%	
Adult Services	2969 (35%)	73 (22%)	82%		78%		34%		78%	
Mental Health Triage & Engagement	1685 (20%)	86 (26%)	81%		93%		29%		95%	
SUD Division	Number of **Beneficiaries** FY 24/25	Number of ***Staff** FY 24/25	Ethnicity **Beneficiaries**		Ethnicity ***Staff**		Language **Beneficiaries**		Language ***Staff**	
Adolescent SUD	213 (21%)	29 (9%)	94%	Hispanic	93%	Hispanic	25%	Spanish	83%	Spanish
Adult SUD	784 (79%)	49 (15%)	80%		88%		16%		92%	

Staff data was collected for comparison from the Staff Cultural Competency Survey 2025, excluding "Administration and Network " staff.

Children Services: 90 percent of Children Services division staff were Hispanic with 88 percent fluent in Spanish. In addition, 66 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Youth and Young Adults Services: 94 percent of Youth and Young Adults Services division staff were Hispanic with 89 percent fluent in Spanish. In addition, 72 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Adults Services: 78 percent of Adults Services division staff were Hispanic with 78 percent fluent in Spanish. In addition, 62 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Mental Health Triage & Engagement Services: 93 percent of MHTES Services division staff were Hispanic with 95 percent fluent in Spanish. In addition, 72 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Adolescent SUD Services: 93 percent of division staff were Hispanic with 83 percent fluent in Spanish. In addition, 28 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

Adult SUD Services: 88 percent of Adult Services direct services staff were Hispanic with 92 percent fluent in Spanish. In addition, 65 percent of staff reported feeling knowledgeable about the Hispanic/Latino culture.

ICBHS ensures that beneficiaries have access to SMHS and SUDS treatment services that are culturally and linguistically competent by providing information and services in the client's preferred language. ICBHS also ensures that language assistance and interpretive services are available to all beneficiaries upon request. Interpretive services for Spanish speaking beneficiaries are provided by bilingual staff (English and Spanish) and Language Line Services in all programs and clinics. Interpretive services in other languages are also available through Language Line Services. ICBHS also has American Sign Language Interpretive Services available for beneficiaries with speech and/or hearing impairments.

III. Staff Cultural Competence and Linguistic Capabilities

In FY 24-25 the QM Unit assessed the cultural competence and linguistic capabilities of staff by conducting a staff survey. The survey elements included: 1) staff identifying information; 2) ethnicity; 3) language capabilities; 4) interpretation; 5) cultural awareness; and 6) cultural training needs. In an effort to ensure that staff complete and return the survey, ICBHS director has made this a mandatory survey. The survey was conducted during April 2025 for all ICBHS staff and contract providers.

444 surveys were completed by staff, which represents a 70 percent response rate. The total number of surveys includes:

- 82 in administrative services
- 99 in direct services-licensed (includes licensed/registered interns)
- 138 in direct services-unlicensed, and;
- 125 in support services.

A Staff Cultural Competence Survey Report was prepared and included findings for ethnicity, linguistic capabilities, interpretation, cultural awareness, cultural training needs, and self-identified client/family member. The report was presented in two sections: results by function and results by division and function.

The survey results indicate that of the completed surveys, Hispanic/Latino population continues to be the largest portion of the department's population representing 84 percent of the population, while the second highest race, White, accounted for 13 percent. When addressing the language that the staff is competent enough to provide services to clients beside English, Spanish (88%) continues to be the most fluent language among the staff. Staff were also asked to identify if they had provided interpretation services in the last year, 14 percent of the staff reported that they provided interpretation services for clients in the last year.

The survey results also reported staff feeling quite a bit knowledgeable to very knowledgeable of the population staff work with; Hispanic/Latino (236), Mental Health Clients (192), and White (145). Staff

that provide services were also asked if they felt they have received the training(s) they need to be culturally knowledgeable of the population you regular work with to which 59 percent responded agreed or strongly agreed. However, for the remaining staff who expressed a need for training, American Indian/Alaskan Native, Asian/Pacific Islander, Physical Disabilities and Mental Health, and LGBTQ.

28 surveys were completed by contract providers, which represents a 6.3 percent response rate.

The total number of surveys includes:

- 43 percent in direct services-licensed (includes licensed/registered interns), and;
- 57 percent in support services.

The survey results indicate that 84% of staff identified as Hispanic/Latino and 13% as White, with Spanish (88%) being the most fluent non-English language among staff. Fourteen percent reported providing interpretation services in the past year. Staff felt most knowledgeable about Hispanic/Latino, mental health, and White populations, and 59% agreed they had received sufficient cultural training. However, staff also expressed the need for more training related to American Indian/Alaskan Native, Asian/Pacific Islander, individuals with physical disabilities, mental health, and LGBTQ populations. Contract provider participation was low, with only a 6.3% response rate.

b. Overview of the ICBHS objectives and planned activities for FY 25-26:

- ICBHS will ensure the Cultural Competence Plan is updated annually and contains an assessment of the department's overall cultural competence and ability to meet the cultural needs of beneficiaries, including goals for improving cultural competence and access to care.

- ICBHS will ensure to evaluate training needs to enhance the ability to meet the cultural needs of beneficiaries.

- The QM Unit will monitor the cultural and linguistic activities of the Department to ensure the cultural and linguistic needs of beneficiaries are met.

APPENDIX E

IMPERIAL COUNTY BEHAVIORAL HEALTH SERVICES
FY 2025-26 TOTAL ALLOCATIONS, VACANCY AND FILL RATES

Job Classification	Total Allocation	Total Filled	Vacant Funded	Vacancy Rate	Fill Rate	
Access & Benefits Worker	14	13	1	7%	93%	
Account Clerk	11	9	2	18%	82%	
Accountant	5	5	0	0%	100%	
Administrative Analyst	41	41	0	0%	100%	
Administrative Secretary	8	7	1	13%	88%	
Administrative Services Supervisor	2	2	0	0%	100%	
Assistant Director of Behavioral Health	1	1	0	0%	100%	
Behavioral Health Fiscal Supervisor	1	0	1	100%	0%	
Behavioral Health Manager	19	18	1	5%	95%	
Behavioral Health Medical Director	1	1	0	0%	100%	
Behavioral Health Office Assistant	75	59	16	21%	79%	
Behavioral Health Office Technician	40	36	4	10%	90%	
Behavioral Health Peer Support Specialist	13	4	9	69%	31%	New Position
Behavioral Health Supervising Therapist	5	4	1	20%	80%	
Behavioral Health Therapist	84	57	27	32%	68%	
Behavioral Health Worker	55	46	9	16%	84%	
Behavioral Health Worker Supervisor	8	7	1	13%	88%	
Clinical Psychologist	2	0	2	100%	0%	
Community Service Worker	41	27	14	34%	66%	
Deputy Director of BHS	6	6	0	0%	100%	
Director	1	1	0	0%	100%	
Mental Health Rehabilitation Specialist	10	10	0	0%	100%	
Mental Health Rehabilitation Specialist - Shift Lead	5	5	0	0%	100%	
Mental Health RehabilitationTechnician	116	92	24	21%	79%	
Nursing Supervisor	2	2	0	0%	100%	
Office Supervisor I	8	6	2	25%	75%	
Program Supervisor	42	38	4	10%	90%	
Psychiatric MH Nurse Practitioner	1	0	1	100%	0%	
Psychiatric Nurse	1	0	1	100%	0%	
Psychiatrist - At Will	8	5	3	38%	63%	
Quality Improvement Specialist	10	10	0	0%	100%	
Substance Use Disorder Counselor	19	9	10	53%	47%	
Supervising Clinical Psychologist	2	1	1	50%	50%	
Supervising Vocational Nurse/Psychiatric Technician	4	4	0	0%	100%	
Vocational Nurse/Psychiatric Technician	31	25	6	19%	81%	
Total	**692**	**551**	**141**	**20%**	**80%**	

APPENDIX F

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	☑	$ -	$ -	$ -	$ 259,171.00	$ 272,130.00	$ 272,778.00	0.00	562.00
Early Intervention Services	☑	$ 180,854.00	$ 189,897.00	$ 196,869.00	$ 574,016.00	$ 602,717.00	$ 624,846.00	46	146.00
Outpatient Services	☑	$ 5,332,115.00	$ 5,873,085.00	$ 6,159,272.00	$ 2,163,854.00	$ 2,383,388.00	$ 2,499,528.00	791	321.00
Intensive Outpatient Services	☑	$ 861,721.00	$ 927,244.00	$ 913,026.00	$ 45,958.00	$ 49,453.00	$ 48,695.00	225	12.00
Crisis and Field-Based Services	☑	$ 308,103.00	$ 323,508.00	$ 339,683.00	$ 324,723.00	$ 340,959.00	$ 358,007.00	241	254.00
Residential Treatment Services	☑	$ 2,717,232.00	$ 2,853,094.00	$ 2,991,227.00	$ 179,158.00	$ 188,116.00	$ 197,224.00	91	6.00
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0.00
Mental Health (MH) Services									
Primary Prevention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0
Early Intervention Services	☑	$ 7,163,579.00	$ 5,495,885.00	$ 5,753,391.00	$ 3,050,015.00	$ 2,339,966.00	$ 2,449,603.00	815	347
Outpatient and Intensive Outpatient Services	☑	$ 24,999,714.00	$ 25,547,407.00	$ 27,800,744.00	$ 22,826,795.00	$ 23,326,884.00	$ 25,384,366.00	4487	4097
Crisis Services	☑	$ 1,833,058.00	$ 2,368,510.00	$ 1,343,323.00	$ 885,045.00	$ 1,143,575.00	$ 648,589.00	1048	506
Residential Treatment Services	☑	$ 9,293,755.00	$ 9,606,482.00	$ 9,997,549.00	$ 1,858,751.00	$ 1,921,296.00	$ 1,999,510.00	115	23
Hospital and Acute Services	☑	$ 679,117.00	$ 713,073.00	$ 748,726.00	$ 240,883.00	$ 252,927.00	$ 265,574.00	234	83
Subacute and Long-Term Care Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	0	0
Housing Services (MH + SUD)									
Housing Services	☑	$ 3,347,063.00	$ 5,149,930.00	$ 5,106,097.00	$ 97,144.00	$ 149,470.00	$ 148,198.00	379	11
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 56,716,311.00	$ 59,048,115.00	$ 61,349,907.00	$ 32,505,513.00	$ 32,970,881.00	$ 34,896,918.00	8472	6368

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	$ 48,169,005.00	$ 1,777,926.00	$ 1,646,719.00
Workforce Investment Activities	$ 381,150.00	$ 418,150.00	$ 306,150.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 11,461,769.00	$ 11,984,253.00	$ 12,583,466.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 3,350,185.00	$ 3,431,155.00	$ 3,102,713.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 63,362,109.00	$ 17,611,484.00	$ 17,639,048.00

Instructions

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Tab Three.

Rows 18 through 33: counties shall report projected expenditures for each funding source/program.

Row 21: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 26: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 35: total expenditures will be auto-populated from rows 18 through 33.

Row 36: will be auto-validated by DHCS against rows 35, 37, and 38. Validation: total projected expenditure variance should total out to $0.

Rows 37 and 38: will be auto-validated by DHCS against total projected expenditures in Tabs One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the 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	$ 25,574,913.00	$ 23,347,831.00	$ 23,620,188.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 4,707,530.00	$ 4,707,530.00	$ 4,707,530.00
2011 Realignment (Public Safety Realignment)	$ 14,936,195.00	$ 15,683,005.00	$ 16,467,155.00
State General Fund	$ 3,562,725.00	$ 3,740,862.00	$ 3,927,905.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 50,339,039.00	$ 54,991,311.00	$ 57,559,999.00
Projects for Assistance in Transition from Homelessness (PATH)	$ 62,924.00	$ 62,924.00	$ 62,924.00
Community Mental Health Block Grant (MHBG)	$ 764,945.00	$ 764,945.00	$ 764,945.00
Substance Use Block Grant (SUBG)	$ 1,047,050.00	$ 1,047,050.00	$ 1,047,050.00
Commercial Insurance	$ 328,482.00	$ 344,907.00	$ 362,152.00
County General Fund	$ -	$ -	$ -
Opioid Settlement Funds	$ 750,000.00	$ 787,500.00	$ 925,228.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 750,000.00	$ -	$ -
Other state funding (including DSH funding)	$ 978,624.00	$ 1,027,555.00	$ 1,078,933.00
Other county mental health or SUD funding	$ -	$ -	$ -
Other foundation funding	$ 48,781,506.00	$ 3,125,060.00	$ 3,361,864.00
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)	$ 152,583,933.00	$ 109,630,480.00	$ 113,885,873.00

Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 89,221,824.00	$ 92,018,996.00	$ 96,246,825.00
Auto-validation: Table 2: Other County Expenditures	$ 63,362,109.00	$ 17,611,484.00	$ 17,639,048.00

Instructions

Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet.**

Rows 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)	$ 4,914,000.00	$ 5,733,000.00	$ 5,733,000.00	$ 16,380,000.00
Year 2 Component Allocation (dollars)	$ 4,963,140.00	$ 5,790,330.00	$ 5,790,330.00	$ 16,543,800.00
Year 3 Component Allocation (dollars)	$ 5,012,771.40	$ 5,848,233.30	$ 5,848,233.30	$ 16,709,238.00
Summary (auto-populated)				
	Housing Intervention	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Year One				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	23%	42%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 3,767,400.00	$ 6,879,600.00	$ 5,733,000.00	$ 16,380,000.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ -	$ 11,131,204.00	$ 9,313,457.00	$ 20,444,661.00
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)	$ 4,963,140.00	$ 5,790,330.00	$ 5,790,330.00	$ 16,543,800.00
Year Three				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 5,012,771.40	$ 5,848,233.30	$ 5,848,233.30	$ 16,709,238.00

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%	$ 4,914,000.00
Percentage Reduced	-7%	$ 1,146,600.00
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	23%	$ 3,767,400.00
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 5,733,000.00
Percentage Reduced	0%	$ -
Percentage Added	7%	$ 1,146,600.00
New FSP Base Percentage (auto-populated)	42%	$ 6,879,600.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 5,733,000.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 5,733,000.00

Transfers

	Housing Intervention (1)	Full-Service Partnership	Behavioral Health Services and Support	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	23%	42%	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)	23%	42%	35%	Row Equals 100%

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%	$ 4,963,140.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -

New Housing Interventions Base Percentage (auto-populated)	30%	$ 4,963,140.00
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 5,790,330.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 5,790,330.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 5,790,330.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 5,790,330.00

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%

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%	$ 5,012,771.40
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 5,012,771.40
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 5,848,233.30
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 5,848,233.30
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 5,848,233.30
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 5,848,233.30

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%

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	$ 10,511,590.00	$ -	$ 9,511,204.00	$ 1,000,386.00
PEI	$ 7,488,410.00	$ -	$ 1,620,000.00	$ 5,868,410.00
Encumbered INN	$ 2,444,661.00	$ -	$ -	$ 2,444,661.00
Unencumbered INN	$ -	$ -	$ -	$ -
WET	$ -			$ -
CFTN	$ -			$ -
Total (auto-populated)	$ 20,444,661.00	$ -	$ 11,131,204.00	$ 9,313,457.00

Excess Prudent Reserve to BHSA Components

Transfer from Prudent Reserve to BHSA Component Allocation	Amount
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 1,030,047.00
Local Prudent Reserve Maximum (2)	$ 3,722,454.00
Excess Prudent Reserve Funding that must be transferred	**$ (2,692,407.00)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.

2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).

3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.

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.

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)	$ 3,767,400.00	$ 4,963,140.00	$ 5,012,771.00
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)	$ 3,767,400.00	$ 4,963,140.00	$ 5,012,771.00

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	$ 540,000.00	$ 540,000.00	$ 540,000.00	$ -	$ 125,894.00	$ 174,288.00
Operating Subsidies	$ -	$ 546,857.00	$ 525,981.00	$ -	$ 365,957.00	$ 327,758.00
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 622,500.00	$ 630,000.00	$ 638,971.00	$ -	$ 548,934.00	$ 491,637.00
Operating Subsidies	$ 600,000.00	$ 600,000.00	$ 600,000.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ 100,000.00	$ 100,000.00	$ 142,279.00	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 289,218.00	$ 497,145.00	$ 497,316.00	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 150,000.00	$ 150,000.00	$ 150,000.00	$ 725,835.00	$ 762,127.00	$ 727,039.00
Other Housing Supports: Outreach and Engagement (2)	$ 100,000.00	$ 100,000.00	$ 101,094.00	$ -		$ -
Capital Development Projects	$ 800,572.00	$ 1,054,667.00	$ 1,065,214.00	$ 71,959.00	$ 142,083.00	$ 131,536.00
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 3,202,290.00	$ 4,218,669.00	$ 4,260,855.00	$ 797,794.00	$ 1,944,995.00	$ 1,852,258.00

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	$ 565,110.00	$ 744,471.00	$ 751,916.00
Total Housing Interventions Expenditures (auto-populated)	$ 3,767,400.00	$ 4,963,140.00	$ 5,012,771.00

Housing Interventions Populations to be Served	Year 1	Year 2	Year 3
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 250,000.00	$ 250,000.00	$ 250,000.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 600,000.00	$ 600,000.00	$ 600,000.00
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)	21.2%	21.2%	21.3%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	6.6%	5.0%	5.0%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	2.7%	2.0%	2.0%
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)	75	80	85
Eligible Adults/Older Adults	379	398	418
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)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.

2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.

3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.

4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.
5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).
6. W&I Code § 5892, subdivision (b)(2).
7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development.
8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Instructions
Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six.
Rows 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)	$ 6,879,600.00	$ 5,790,330.00	$ 5,848,233.00
Transfers into Full Service Partnership component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$ 5,009,042.00	$ 3,061,081.00	$ 3,061,081.00
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 11,888,642.00	$ 8,851,411.00	$ 8,909,314.00

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)	$ 101,358.00	$ 101,358.00	$ 106,425.00	$ 79,986.00	$ 96,974.00	$ 78,705.00	$ -	$ -	$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 147,628.00	$ 147,628.00	$ 155,009.00	$ 79,986.00	$ 96,974.00	$ 78,705.00	$ -	$ -	$ -
FSP Intensive Case Management	$ 4,551,315.00	$ 3,259,840.00	$ 3,076,346.00	$ 997,078.00	$ 1,727,607.00	$ 1,268,294.00	$ 252,526.00	$ 795,798.00	$ 150,160.00
High Fidelity Wraparound	$ 2,766,445.00	$ 1,839,039.00	$ 2,108,791.00	$ 686,658.00	$ 1,720,877.00	$ 1,205,364.00	$ 342,146.00	$ 416,740.00	$ 19,961.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 505,702.00	$ 530,671.00	$ 542,885.00	$ 110,786.00	$ 281,238.00	$ 223,817.00	$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$ 250,050.00	$ 250,050.00	$ 262,553.00	$ 9,000.00	$ 16,538.00	$ 8,855.00	$ -	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ 782,849.00	$ 1,395,113.00	$ 1,320,908.00	$ 3,096,576.00	$ 3,230,784.00	$ 3,546,806.00	$ 692,759.00	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 9,105,347.00	$ 7,523,699.00	$ 7,572,917.00	$ 5,060,070.00	$ 7,170,992.00	$ 6,410,546.00	$ 1,287,431.00	$ 1,212,538.00	$ 170,121.00

FSP Transfer Information	Year 1	Year 2	Year 3
Transfers out of FSP component into Local Prudent Reserve	$ 1,000,000.00	$ -	$ -

FSP Administrative Information	Year 1	Year 2	Year 3
FSP Component Admin Expenses	$ 1,783,295.00	$ 1,327,712.00	$ 1,336,397.00
Total Full Service Partnership Expenditures (auto-populated)	$ 11,888,642.00	$ 8,851,411.00	$ 8,909,314.00

Projected Individuals to be Served (Unduplicated)	Year 1	Year 2	Year 3
Eligible Children/TAY (25 years and younger)	400	450	500
Eligible Adults/Older Adults	750	775	800

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.

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)	$ 5,733,000.00	$ 5,790,330.00	$ 5,848,233.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 2,773,797.00	$ 2,047,500.00	$ 2,047,500.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 8,506,797.00	$ 7,837,830.00	$ 7,895,733.00

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)	$ 269,553.00	$ 177,681.00	$ 145,780.00	$ -	$ -	$ -	$ 114,974.00	$ 129,499.00	$ 126,759.00
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 1,417,154.00	$ 814,667.00	$ 1,130,260.00	$ 689,113.00	$ -	$ -	$ 1,083,420.00	$ 2,087,978.00	$ 1,119,885.00
Early Intervention Expenditures	$ 3,640,255.00	$ 4,083,378.00	$ 4,062,756.00	$ 4,039,504.00	$ 4,351,360.00	$ 5,504,696.00	$ 1,972,024.00	$ 2,271,231.00	$ 1,888,818.00
Coordinated Specialty Care for First Episode Psychosis	$ 83,170.00	$ 97,828.00	$ 102,720.00	$ 88,262.00	$ 97,829.00	$ 102,720.00	$ -	$ -	$ -
All Other EI Expenditures	$ 3,557,085.00	$ 3,985,550.00	$ 3,960,036.00	$ 3,951,242.00	$ 4,253,531.00	$ 5,401,976.00	$ 1,972,024.00	$ 2,271,231.00	$ 1,888,818.00
Outreach and Engagement	$ 786,270.00	$ 587,103.00	$ 616,458.00	$ 205,056.00	$ 215,309.00	$ 226,074.00	$ 111,872.00	$ 98,805.00	$ 33,075.00
Workforce Education and Training (WET)	$ 350,658.00	$ 418,150.00	$ 306,150.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ 350,658.00	$ 418,150.00	$ 306,150.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 766,887.00	$ 581,176.00	$ 449,969.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ 766,887.00	$ 581,176.00	$ 449,969.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 2,444,661.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 9,675,438.00	$ 6,662,155.00	$ 6,711,373.00	$ 4,933,673.00	$ 4,566,669.00	$ 5,730,770.00	$ 3,282,290.00	$ 4,587,513.00	$ 3,168,537.00

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	$ 1,276,019.00	$ 1,175,675.00	$ 1,184,361.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 10,951,457.00	$ 7,837,830.00	$ 7,895,734.00

Youth-Focused Early Intervention Expenditures	Year 1	Year 2	Year 3
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 2,906,772.00	$ 2,718,160.00	$ 2,738,241.00

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)	60.0%	52.1%	51.5%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	79.9%	66.6%	67.4%

Projected Individuals to be Served (Unduplicated)	Year 1	Year 2	Year 3
Eligible Children/TAY (25 years and younger)	750	995	1035
Eligible Adults/Older Adults	715	760	875

Projected BHSS Funds transferred to WET or CF/TN	Year 1	Year 2	Year 3
BHSS transfer to WET	$ 381,150.00	$ 418,150.00	$ 306,150.00
BHSS transfer to CF/TN	$ 769,080.00	$ 581,176.00	$ 449,969.00

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	$ -	$ -	$ -
Estimated MHSA CF/TN Funds	$ -	$ -	$ -
MHSA "Encumbered" INN	$ 2,444,661.00	$ -	$ -

References

1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).
2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.
3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.
4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.
5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

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	$ 960,000.00	$ 866,000.00	$ 872,000.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 1,200,000.00	$ 1,082,000.00	$ 1,090,000.00
New and Ongoing Administrative Costs			

Select County Population Size:	Less than 200k

Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 24,162,839.00	$ 21,652,381.00	$ 21,817,818.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	4.0%	4.0%	4.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	5.0%	5.0%	5.0%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

References
1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision.

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	$ 1,030,047.00
Local Prudent Reserve Maximum (1)	$ 3,722,454.00
Excess Prudent Reserve Funds (auto-populated)	$ (2,692,407.00)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -
Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ 1,000,000.00
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -

References
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).

Instructions

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 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	23%	42%	35%	100%
Component Allocations	$ 3,767,400.00	$ 6,879,600.00	$ 5,733,000.00	$ 16,380,000.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 4,963,140.00	$ 5,790,330.00	$ 5,790,330.00	$ 16,543,800.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 5,012,771.00	$ 5,848,233.00	$ 5,848,233.00	$ 16,709,237.00

BHSA Funding Summary	**Housing Interventions**	**Full Service Partnerships**	**Behavioral Health Services and Supports**	**Totals**
Year One				
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 3,767,400.00	$ 6,879,600.00	$ 5,733,000.00	$ 16,380,000.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ -	$ 11,131,204.00	$ 9,313,457.00	$ 20,444,661.00
Estimated Total Available Funding for Year One	$ 3,767,400.00	$ 18,010,804.00	$ 15,046,457.00	$ 36,824,661.00
Transfers from Component Into PR	$ -	$ 1,000,000.00	$ -	$ 1,000,000.00
Estimated Total Year One Expenditures	$ 3,767,400.00	$ 11,888,642.00	$ 10,951,457.00	$ 26,607,499.00
Year Two				
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 4,963,140.00	$ 5,790,330.00	$ 5,790,330.00	$ 16,543,800.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ 9,183,243.00	$ 6,142,500.00	$ 15,325,743.00
Estimated Total Available Funding for Year Two	$ 4,963,140.00	$ 14,973,573.00	$ 11,932,830.00	$ 31,869,543.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 4,963,140.00	$ 8,851,411.00	$ 7,837,830.00	$ 21,652,381.00
Year Three				
Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 5,012,771.00	$ 5,848,233.00	$ 5,848,233.00	$ 16,709,237.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ 9,183,243.00	$ 6,142,500.00	$ 15,325,743.00
Estimated Total Available Funding for Year Three	$ 5,012,771.00	$ 15,031,476.00	$ 11,990,733.00	$ 32,034,980.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -

Estimated Total Year Three Expenditures	$ 5,012,771.00	$ 8,909,314.00	$ 7,895,734.00	$ 21,817,819.00

BHSA Plan Admin Expenses				
Plan Admin Category	**Year One**	**Year Two**	**Year Three**	**Total**
Total Projected Improvement and Monitoring Expenditures	$ 960,000.00	$ 866,000.00	$ 872,000.00	$ 2,698,000.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 1,200,000.00	$ 1,082,000.00	$ 1,090,000.00	$ 3,372,000.00
Total Projected New and Ongoing Administrative Expenditures	$ -	$ -	$ -	$ -

Budget Template Updates			
Version	**Revision Date**	**Description of Changes**	**Effective Date of Change**
2.0	10/25/2025	Tab 10 (BHSA Summary): Formula updated to avoid double counting of MHSA unspent carryover funds.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): EI Threshold calculation should exclude MHSA transferred WET and CFTN funds as they are exempt from suballocation requirements, formula revised to remove WET and CFTN. Added a BHSS transfer to WET/CFTN for reversion tracking.	10/25/2025
2.0	10/25/2025	Tab 8 (BHSA Plan Admin): Updated instructions to clarify DHCS will not pre-populate data for "Total Projected Annual Revenues of BHSF". Counties must enter in the data.	10/25/2025
2.0	10/25/2025	Tab 5, 6, 7 (BHSA Conponents): Added unspent MHSA funds row for year 1, 2 and 3.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): Added separate rows for unspent MHSA WET/CFTN expenditures.	10/25/2025
2.0	10/25/2025	Tabs 1-10: Fixed formula and instruction errors	10/25/2025
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added Year 2 and Year 3 for exemption requests	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added validation check for funding transfers	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added two new rows for unspent MHSA “Encumbered” INN Funds and unspent MHSA “Unencumbered” INN Funds.	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Moved transfers from prudent reserve into the BHSA component funding section to be included with total revenue	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Added a row for projected MHSA “Encumbered” INN Project expenditures.	2/18/2026
3.0	2/18/2026	Tab 5 (Housing Interventions): Removed projected encumbered MHSA INN fund expenditures from the 50% HI funds dedicated to chronically homeless suballocation requirement calculation.	2/18/2026
3.0	2/18/2026	Tab 7 (BHSS): Removed projected encumbered MHSA INN fund expenditures from the 51% BHSS funds dedicated to Early Intervention suballocation requirement calculation	2/18/2026
3.0	2/18/2026	Tab 8 (BHSA Plan Admin): Updated to include a validation check for “Improvement and Monitoring” (2% or 4%) and “Planning” (5%)	2/18/2026
3.0	2/18/2026	Tab 9 (Prudent Reserve Assessment): Updated PR validation checks to “No Excess” or “Reduce Excess”	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Included component percentage breakdowns for all three years	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Include total administrative and planning expenditures from tab 8	2/18/2026

APPENDIX G

Imperial County Behavioral Health Services
FY 2026-27

FY 2026-27 Estimated expenditures associated to BHSA-FSP	$	11,888,643
BHSA-FSP Allocation 35% (Only)	$	5,733,000
MHSA - BHSA Roll-over	$	5,009,042
7% transfer to cover FSP expenditures for FY 2026–27	$	1,146,600
Surplus / Deficit	$	1

Transfer from BHSA Housing

BHSA Care Continuum Category	Imperial County FSP Programs	FSP
MH Outpatient and Intensive Outpatient Services	Access and Benefits - FSP	$ 598,979
MH Outpatient and Intensive Outpatient Services	PET-FSP(CCT)	$ 206,296
MH Outpatient and Intensive Outpatient Services	Children CLX Team 1 - FSP	$ 149,681
MH Outpatient and Intensive Outpatient Services	Vista Sands CLX - FSP	$ 8,282
MH Outpatient and Intensive Outpatient Services	Children EC Team 1 - FSP	$ 170,435
MH Outpatient and Intensive Outpatient Services	Children EC Team 2 - FSP	$ 241,746
MH Outpatient and Intensive Outpatient Services	Vista Sands EC - FSP	$ 26,933
MH Outpatient and Intensive Outpatient Services	Middle School EC- FSP	$ 21,859
MH Outpatient and Intensive Outpatient Services	Children BLY Team 1 - FSP	$ 204,148
MH Outpatient and Intensive Outpatient Services	Vista Sands BLY-FSP	$ 12,706
MH Outpatient and Intensive Outpatient Services	Children SP Team 1-FSP	$ 15,706
MH Outpatient and Intensive Outpatient Services	YAYA CLX Team 1-FSP	$ 408,940
MH Outpatient and Intensive Outpatient Services	YAYA EC Team 1-FSP	$ 420,703
MH Outpatient and Intensive Outpatient Services	YAYA EC Team 2-FSP	$ 420,703
MH Outpatient and Intensive Outpatient Services	YAYA Com. School BLY-FSP	$ 78,339
MH Outpatient and Intensive Outpatient Services	YAYA BLY Team 1-FSP	$ 483,397
MH Outpatient and Intensive Outpatient Services	Adults BLY Team 1 - FSP	$ 348,768
MH Outpatient and Intensive Outpatient Services	Adults BLY Team 2- FSP	$ 348,842
MH Outpatient and Intensive Outpatient Services	Adults CLX Team 1 - FSP	$ 255,334
MH Outpatient and Intensive Outpatient Services	Adults CLX Team 2 - FSP	$ 255,334
MH Outpatient and Intensive Outpatient Services	Adults EC Team 1 - FSP	$ 319,636
MH Outpatient and Intensive Outpatient Services	Adults EC Team 2 - FSP	$ 319,636
MH Outpatient and Intensive Outpatient Services	Adults EC Team 3 - FSP	$ 319,636
MH Outpatient and Intensive Outpatient Services	Adults EC Team 4 - FSP	$ 319,636
MH Outpatient and Intensive Outpatient Services	Adult SP Team 1-FSP	$ 47,285
MH Outpatient and Intensive Outpatient Services	BHTC EC- FSP	$ 194,716
MH Outpatient and Intensive Outpatient Services	ICP EC- FSP	$ 115,675
SUD Intensive Outpatient Services	Adults SUD CLX Team 1-FSP	$ 244,832
SUD Intensive Outpatient Services	Adol. SUD CLX Team 1 -FSP	$ 43,233
SUD Intensive Outpatient Services	Adults SUD EC Team 1-FSP	$ 367,855
SUD Intensive Outpatient Services	Adol. SUD EC Team 1 -FSP	$ 70,345
SUD Intensive Outpatient Services	Adults SUD BRY Team 1-FSP	$ 82,237
MH Residential Treatment Services	Helping Hearts- Provider	$ 256,565
MH Residential Treatment Services	Jackson House- Provider	$ 256,564
MH Residential Treatment Services	Varsity- Provider	$ 63,424
MH Outpatient and Intensive Outpatient Services	Parashar, Aditi (Dr)	$ 75,000
MH Outpatient and Intensive Outpatient Services	Flores, Ernest, (Dr)	$ 37,500
MH Outpatient and Intensive Outpatient Services	IrisTelehealth (Dr.)	$ 50,000
MH Outpatient and Intensive Outpatient Services	Kurada, Manjusha (Dr)	$ 133,310
MH Outpatient and Intensive Outpatient Services	Aguilar, BH (Dr)	$ 100,000
MH Outpatient and Intensive Outpatient Services	Marilyn Moskowitz - Provider	$ 27,399
MH Outpatient and Intensive Outpatient Services	Orbit Health (Dr)	$ 642,494
MH Outpatient and Intensive Outpatient Services	Sathpathy Sanjoy (Dr)	$ 72,000
MH Outpatient and Intensive Outpatient Services	Jaga Nath Glassman (Dr)	$ 94,989
MH Outpatient and Intensive Outpatient Services	Peter Dimano - Provider	$ 59,250

MH Outpatient and Intensive Outpatient Services	Roxana Palacios LMFT - Provider	$	75,000
MH Outpatient and Intensive Outpatient Services	Patricia Valenzuela	$	40,000
Quality & Accountability and Plan Mngmt & Admin	Administration	$	267,494
Quality & Accountability and Plan Mngmt & Admin	Fiscal	$	401,241
Quality & Accountability and Plan Mngmt & Admin	Purchasing	$	178,330
Quality & Accountability and Plan Mngmt & Admin	Billing	$	89,165
Quality & Accountability and Plan Mngmt & Admin	Information Systems/ Systems Technology	$	401,241
Quality & Accountability and Plan Mngmt & Admin	Archiving/ Medical Records	$	89,165
Quality & Accountability and Plan Mngmt & Admin	Human Resources	$	267,494
Quality & Accountability and Plan Mngmt & Admin	Payroll	$	89,165
	Prudent Reserve Transfer	$	1,000,000
	TOTAL	**$**	**11,888,643**

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APPENDIX H

Behavioral Health Director Certification

Certification

1. I hereby certify that Imperial County has complied with all statuses, regulations, and guidelines in preparing and submitting this Three-Year Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that:

   - [x] The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
   - [x] I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
   - [x] The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
   - [x] Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
   - [x] BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
   - [x] The IP was submitted to the local behavioral health board

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

   - [ ] Yes
   - [x] No

a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

N/A

County Behavioral Health Agency Director contact information

3. County Name

Imperial County

4. Certification for

- [x] Three-Year Integrated Plan
- [ ] Annual Update
- [ ] Intermittent Update

4a. Submission type

- [x] Draft
- [ ] Final

5. County Behavioral Health Agency Director name

Leticia Plancarte-Garcia

6. County Behavioral Health Agency Director phone number

442-265-1601

7. County Behavioral Health Agency Director email

letyplancarte@co.imperial.ca.us

Additional contact information for counties with separate MH and SUD directors (optional)

8. Name

9. Title

10. Phone

11. Email

County Behavioral Health Agency Director signature

12. Print name

Leticia Plancarte-Garcia

13. Title

Imperial County Behavioral Health Director

14. Date

03/17/2026

15. Signature

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

17. Title

18. Date

19. Signature

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APPENDIX I

County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Certification

1. I hereby certify that:
   - ✔ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
   - ✔ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
   - ✔ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   - ○ Yes
   - ◉ No

a. If answered yes above, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

N/A

Signature

3. Print name

Dr. Kathleen Lang

4. Date

03/17/2026

5. Signature

Contact information

6. County Name

Imperial County

7. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

7a. Submission type

- (•) Draft

8. County Chief Administration Officer Name

Dr. Kathleen Lang

9. County Chief Administration Officer Phone number

442-265-1001

10. County Chief Administration Officer Email

kathleenlang@co.imperial.ca.us