Behavioral Health Three-Year Integrated Plan

2026 - 2029

Intermittent Update

OC health CARE AGENCY
BEHAVIORAL HEALTH SERVICES

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2026-2029 Integrated Plan

Orange 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 .

County, City, Joint Powers, or Joint Submission County
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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

In the tale 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)	13630
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	21005
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	498
Received mental health (MH) and SUD services from the mental health plan (MHP)	312

and DMC county or DMC-ODS plan	

Criteria	Number of Children and Youth Under Age 21
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	144
Were chronically homeless or experiencing homelessness or at risk of homelessness	1519
Were in the juvenile justice system	1185
Have reentered the community from a youth correctional facility	842
Were served by the Mental Health Plan and had an open child welfare case	1190
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	40

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	1409

Adults and Older Adults

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

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	2330
Received Medi-Cal SMHS	13403
Received DMC or DMC-ODS services	6751
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	1351
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	6034

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	5315
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	1270
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	1260
Were in the justice system (on parole or probation and not currently incarcerated)	421
Were incarcerated (including state prison and jail)	664
Reentered the community from state prison or county jail	567
Received acute psychiatric services	4133

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

Admitted or detained for 72-hour evaluation and treatment rate: 13,180

Admitted for 14-day and 30-day periods of intensive treatment: 5,299

Admitted for 180-day post certification intensive treatment: 0

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs: 31

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs): <11*

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

Please explain
For question #2:
For FY 2024/25:
For 5250 Fourteen Day Holds: 4747
For 5270 Thirty Day Holds: 552

Please describe the local data used during the planning process
Orange County Behavioral Health Services (BHS) used a comprehensive, data-informed planning approach to guide development of the Behavioral Health Integrated Plan and ensure alignment with BHSA, CalAIM, and DMC-ODS requirements. Data was used not only to assess service volume, but also to evaluate system performance, population needs, equity priorities, and long-term sustainability.

BHS reviewed multiple sources of quantitative and qualitative information, including trends in specialty mental health and substance use disorder service utilization, outcomes, and patterns of access across the continuum of care. Service data was shared with key system partners to support coordinated planning and identify opportunities to strengthen referral pathways, transitions of care, and service integration.

In preparation for BHSA implementation, BHS conducted an assessment of existing MHSA-funded programs using a structured screening tool and matrix to determine alignment with new BHSA service categories, policy requirements, and evidence-based practice expectations. This analysis informed decisions regarding program redesign, continued investments, and areas requiring new service development.

Financial and utilization data were also reviewed to evaluate available funding and support development of an updated financial model that maximizes sustainability through blended and braided financing approaches. This included consideration of how Medi-Cal reimbursement and other funding sources can support ongoing service delivery in combination with BHSA service expansion resources.

BHS incorporated population health and system performance measures, comparing local outcomes against statewide benchmarks and rates. Findings were shared with Medi-Cal Managed Care Plans and the Local Health Jurisdiction to support collaborative planning and

alignment with broader CalAIM transformation efforts.

To strengthen equity-focused planning, BHS also utilized findings from the County's Cultural Competency Plan and External Quality Review Organization (EQRO) reports. These sources provided additional insight into disparities, access barriers, quality improvement priorities, and opportunities to enhance culturally responsive service delivery across populations. Findings from these reports helped inform targeted planning strategies, including strengthening language access, community-based partnerships, peer support integration, and outreach approaches for underserved populations.

In addition, BHS integrated qualitative data and priorities identified through the Community Planning Process (CPP), including community-defined needs, stakeholder input, and focus population priorities. CPP findings were used to ensure that service planning reflects lived experience perspectives, addresses disparities, and responds to local community conditions.

Through these combined efforts, BHS utilized data to guide program design, funding strategy, and system transformation priorities, ensuring that the Integrated Plan is responsive, equitable, and aligned with BHSA and CalAIM goals.

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

Local CARE Act Implementation

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

CARE participants will be served through Orange County's existing behavioral health continuum of care, with priority access to services and enhanced coordination to support engagement, stabilization, and long-term recovery. Key service components include Full Service Partnership (FSP) programs, outpatient behavioral health services, the crisis continuum (including crisis residential and stabilization services), and housing interventions such as transitional rent, residential placements, and permanent supportive housing. These programs are designed to serve individuals with significant behavioral health needs and align with the clinical and support needs of CARE participants.

In addition, the County's Assisted Outpatient Treatment (AOT) programs, which operate within the FSP continuum, serve individuals with similarly high levels of need through intensive, community-based services. AOT programs provide assertive outreach, multidisciplinary care, and sustained engagement strategies for individuals who may have difficulty engaging in voluntary services. While AOT and CARE operate under distinct referral pathways, both connect individuals to similar service components within the continuum of care.

To ensure priority access, CARE participants will be identified within County systems and

supported through coordinated intake and navigation processes. The County will utilize multidisciplinary teams, including the internal HCA CARE team and forensic services teams, to provide proactive outreach, engagement, and care coordination for CARE participants. These teams have experience working with court-involved populations and will support CARE Court processes, service linkage, and ongoing engagement.

Housing supports will be integrated into care planning, as appropriate, to ensure that individuals have access to stable and supportive environments that promote recovery and reduce the risk of institutionalization or homelessness.

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

CARE referral pathways will be integrated into Orange County's broader behavioral health access system while maintaining the distinct legal and procedural requirements associated with CARE Court. CARE referrals originate through a court petition process and are received by the County following a prima facie determination. Upon receipt of a CARE referral, the County's internal HCA CARE team will play a central role in coordinating assessment, engagement, linkage to appropriate behavioral health services (including connection to FSP and other intensive service models) and participate in all court hearings and correspondence.

This pathway differs from existing County-operated referral processes, such as Assisted Outpatient Treatment (AOT), which allows the County and its partners to proactively identify and engage individuals in need of services outside of a formal court petition process. While referral pathways differ, both CARE and AOT participants are connected to similar service components within the behavioral health continuum, including FSP-level care, outreach, and intensive case management.

To support integration, the County will align CARE referrals with existing intake, assessment, and service linkage processes, including BH Connection, OC Links, and other system entry points. This approach supports a "no wrong door" model, reduces duplication, and ensures individuals receive appropriate services regardless of how they enter the system. The county has expanded it's referral pathways to include court to court referrals from 1370 court as well as LPS court. In addition, the development of a clinical stepdown committee to utilize CARE as a stepdown from conservatorship has been established and will continue to be expanded.

The County will also continue to coordinate with courts, hospitals, community-based providers, and managed care partners to support efficient referral pathways and timely access to care.

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

The County will utilize established clinical screening and assessment processes to identify individuals who

may be appropriate for alternative service pathways in cases where a formal CARE petition is not required or appropriate.

Individuals identified for redirection will be connected to services based on level of need, including specialty behavioral health services, AOT programs, managed care plan services for mild to moderate conditions, substance use disorder treatment, or other community-based supports. AOT programs may serve as an alternative pathway for individuals requiring intensive, community-based services but who do not meet criteria for CARE Court involvement.

The HCA internal CARE team contacts family petitioners monthly for 12 months after dismissal, in order to re-engage clients in CARE when appropriate. Additionally, upon dismissal from CARE, petitioners are contacted after dismissal to bring them back to CARE when appropriate. The county will continue coordination with other system partners, will facilitate outreach, engagement, and care coordination, including warm hand-offs between providers and ongoing support to promote service connection. BH Connection and other access points may also support linkage to services, as appropriate, depending on the individual's needs and entry pathway. Internal and external county partners contact HCA internal CARE team for aid with filling out petitions or referral forms. Court to court referrals from 1370 court and LPS court have been simplified via use of a court order or referral form consistent with recent legislation.

To ensure accountability, the County will implement processes to confirm and document successful connections to services. This includes tracking referrals within existing systems, supporting closed-loop referral processes, and conducting follow-up to verify engagement in services. These processes are designed to ensure that individuals are not only referred to but successfully linked to appropriate care and supports within the behavioral health system.

County Behavioral Health Technical Infrastructure

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

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

Please select which of the following EHRs the county uses
Oracle Cerner

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

Please select which QHIO the county participates in
Los Angeles Network for Enhanced Services (LANES)

Application Programming Interface Information

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

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://ochca.iqhealth.com

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

Please describe these challenges and concerns

Orange County Behavioral Health Services (BHS) has made significant progress toward implementation of Application Programming Interfaces (APIs) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and applicable federal interoperability requirements. BHS is currently in production and is working through a corrective action process to ensure full compliance prior to March 1, 2026. Implementation of Fast Healthcare Interoperability Resources (FHIR) capability has been completed within the Cerner Electronic Health Record (EHR) system. BHS is now focused on finalizing connectivity and integration steps necessary to support secure patient access to health information via third-party applications. A key implementation challenge has involved establishing and finalizing required agreements and technical connectivity with third-party consumer health applications, including Apple Health and Google Health. These agreements are necessary to ensure secure authentication, data exchange, and appropriate safeguards for patient access and privacy.

Once implementation is complete, patients will be able to use either of the supported consumer health applications and authenticate securely through the Cerner patient portal. Through the embedded API functionality, patients will have access to their health information in a manner that supports transparency, patient choice, and improved interoperability while maintaining required security and privacy protections. BHS will continue to monitor progress through the corrective action process and will validate all required functionality prior to full implementation to ensure alignment with BHIN 22-068 and federal law.

Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056 , 23-057 , and 24-016 .

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

Yes

Please describe these challenges and concerns

Orange County Behavioral Health Services (BHS) continues to advance implementation of admission, discharge, and transfer (ADT) data sharing requirements consistent with the attachments to BHINs 23-056, 23-057, and 24-016. Overall progress has been positive; however, implementation has required significant coordination across multiple health plan partners and technical approaches, which has created sequencing and interoperability challenges.

BHS has completed Memoranda of Understanding (MOUs) with both Medi-Cal Managed Care Plans (MCPs) serving Orange County members and has established foundational governance and data-sharing parameters necessary to operationalize ADT exchange. BHS is currently engaged in operationalizing bidirectional ("push/pull") data exchange with CalOptima and is continuing to expand the scope of shared data elements to support broader care coordination needs for mutual members.

Implementation challenges primarily relate to differences in information exchange protocols

and technical methodologies across partner organizations. BHS is actively working on finalizing an information exchange protocol with Kaiser, including alignment on technical approach, secure transmission requirements, and operational workflows. Establishing consistent processes across multiple partners requires careful coordination to ensure that shared ADT data supports timely notifications, accurate member matching, and appropriate use for screening, care transitions, and continuity of care.

BHS has successfully implemented initial functionality to support shared screening and transition processes, and this tool is currently operational. Current efforts are focused on expanding the use of ADT-related data and related information-sharing workflows to better support mutual members, including strengthening the consistency, timeliness, and completeness of shared information used for care coordination and discharge planning.

BHS will continue to work collaboratively with MCP partners to resolve remaining technical and operational issues, validate workflows, and expand data exchange capabilities to fully meet ADT-related requirements and support improved coordination across systems of care.

County Behavioral Health System Service Delivery Landscape

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

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

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

Please select all services the county behavioral health system plans to provide under the PATH grant
Alcohol or Drug Treatment Services

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

Community Mental Health Services Block Grant (MHBG)

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

Please select all set asides that the county behavioral health system plans to participate in under the MHBG
Dual Diagnosis Set-Aside

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

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

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

Please select all set-asides that the county behavioral health system participates in under SUBG
Discretionary
Primary Prevention Set-Aside
Perinatal Set-Aside
Adolescent/Youth Set-Aside

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

Opioid Settlement Funds (OSF)

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

Please check all set asides the county behavioral health system participates in under OSF Exhibit E
Address The Needs of Criminal Justice-Involved Persons
Address The Needs of Pregnant or Parenting Women and Their Families, Including Babies with Neonatal Abstinence Syndrome
Prevent Misuse of Opioids
Support People in Treatment and Recovery Treat Opioid Use Disorder (OUD)
Prevent Overdose Deaths and Other Harms (Harm Reduction)

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

Bronzan-McCorquodale Act

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

a. Case Management

b. Comprehensive Evaluation and Assessment

c. Group Services

d. Individual Service Plan

e. Medication Education and Management

f. Pre-crisis and Crisis Services

g. Rehabilitation and Support Services

h. Residential Services

i. Services for Homeless Persons

j. Twenty-four-hour Treatment Services

k. Vocational Rehabilitation

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

Not Applicable

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

No

Public Safety Realignment (2011 Realignment)

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

a. Drug Courts

b. Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)

c. Regular and Perinatal Drug Medi-Cal Services

d. Regular and Perinatal DMC Organized Delivery System Services, including EPSDT

e. Regular and Perinatal Non-Drug Medi-Cal Services

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

No

Medi-Cal Specialty Mental Health Services (SMHS)

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

a. Adult Residential Treatment Services

b. Crisis Intervention

c. Crisis Residential Treatment Services

d. Crisis Stabilization

e. Day Rehabilitation

f. Day Treatment Intensive

g. Mental Health Services

h. Medication Support Services

i. Mobile Crisis Services

j. Psychiatric Health Facility Services

k. Psychiatric Inpatient Hospital Services

l. Targeted Case Management

m. Functional Family Therapy for individuals under the age of 21

n. High Fidelity Wraparound for individuals under the age of 21

o. Intensive Care Coordination for individuals under the age of 21

p. Intensive Home-based Services for individuals under the age of 21

q. Multisystemic Therapy for individuals under the age of 21

r. Parent-Child Interaction Therapy for individuals under the age of 21

s. Therapeutic Behavioral Services for individuals under the age of 21

t. Therapeutic Foster Care for individuals under the age of 21

u. All Other Medically Necessary SMHS for individuals under the age of 21

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

ACT

CSC for FEP

Enhanced CHW

Services FACT

IPS Supported Employment

Peer Support Services

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

Yes

Please describe these challenges or concerns

Orange County Behavioral Health Services (BHS) is committed to meeting all Specialty Mental Health Plan requirements and implementing BHSA and CalAIM-aligned evidence-based practices with fidelity and sustainability. As the system undergoes significant transformation, BHS recognizes that implementation of new or expanded service requirements may involve operational challenges that require phased planning and capacity-building.

One challenge includes the availability of qualified provider organizations and workforce capacity to deliver specialized evidence-based practices. In some instances, procurement processes such as Requests for Proposals (RFPs) may yield limited responses, particularly for highly specialized services or high-acuity populations. Building sufficient provider capacity, staffing, and training infrastructure can take time, especially in the context of statewide behavioral health workforce shortages.

Additionally, the county's contracting and procurement processes are designed to ensure transparency, fiscal accountability, and alignment with local governance requirements. As a result, the development, issuance, and award of RFPs and new contracts may require structured timelines that can affect the pace of service expansion. BHS will continue to plan proactively within these processes to support timely implementation of required services.

BHS is actively addressing these challenges through early planning, expanded technical assistance, workforce development strategies, and ongoing partnership with community-based providers. The county will continue to strengthen recruitment and retention efforts, support cross-training in required EBPs, and utilize phased implementation approaches where appropriate to ensure services are delivered in accordance with program standards and in the least restrictive, clinically appropriate settings.

BHS will monitor implementation progress through continuous quality improvement processes and will adjust strategies as needed to ensure timely compliance, sustainable service expansion, and equitable access to high-quality care for county residents.

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

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

a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)

e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
f. Mobile Crisis Services
g. Recovery Services
h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
i. Traditional Healers and Natural Helpers
j. Withdrawal Management Services
k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21
l. Early Intervention for individuals under age 21

Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below as of June 30, 2026?
Recovery Incentives Program (Contingency Management)
Enhanced Community Health Worker (CHW)
Services IPS Supported Employment

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

Please describe these challenges or concerns
Orange County Behavioral Health Services (BHS) is committed to meeting DMC-ODS requirements, including advancing culturally responsive approaches such as the integration of Traditional Healers and Natural Helpers. BHS recognizes the importance of these services in improving engagement, reducing disparities, and supporting recovery for American Indian/Alaska Native and other communities who benefit from culturally grounded healing practices.

As part of implementation planning, BHS is leveraging its Behavioral Health Equity Committee (BHEC), a county-community led stakeholder committee that includes participation from representatives of local Indigenous communities. Through this forum, BHS is engaging community partners to ensure that program design reflects community-defined practices, cultural integrity, and appropriate service delivery approaches.

BHS is approaching this work through a process of community partnership and co-design, recognizing that traditional healing practices are best defined and guided by the communities they serve. Implementation efforts will emphasize culturally respectful engagement, flexibility in service delivery, and opportunities for services to occur in settings that are welcoming and appropriate for participants, including non-clinical and community-based environments where applicable.

BHS acknowledges that implementation of these services requires thoughtful capacity-building, including identification of qualified providers and development of contracting approaches that align with both

DMC-ODS standards and local procurement and accountability requirements. In addition, while Orange County does not currently have an established Indian Health Clinic, BHS is working with community-based organizations that have the appropriate cultural background and trusted relationships to support service development in this area.

BHS will continue to engage Tribal and community partners through the BHEC, strengthen provider capacity, and utilize phased implementation strategies to ensure these services are implemented in a manner that is culturally respectful, sustainable, and responsive to local community needs, consistent with DMC-ODS and CalAIM equity goals.

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
MHSSA (Mental health student services act), CCMU (crisis care mobile unit), BHCIP (BH continuum infrastructure program), BHBH (Behavioral health bridge housing), JJCPA (juvenile justice crime prevention act), TSR (tobacco settlement revenue), DOJ Opioid Prevention grant (federal other), Local County, In-Custody SUD Treatment Services

Care Transitions

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

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

Statewide Behavioral Health Goals

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

Population-Level Behavioral Health Measures

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

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

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

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures .

Mark page as complete

Priority statewide behavioral health goals for improvement

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

Access to care: Primary measures

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

How does your county status compare to the statewide rate?
For adults/older adults – Below
For children/youth - Below

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

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

How does your county status compare to the statewide rate?
For adults/older adults- Above
For children/youth - Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex
Other

Please describe other
Written Language

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

How does your county status compare to the statewide rate?
For adults/older adults - Not Applicable
For children/youth - Not Applicable

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

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

How does your county status compare to the statewide rate?
For adults/older adults – Below
For children/youth - Same

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

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

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

Access to care: Disparities Analysis

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

(1a) In FY 2021, the Orange County adult SMHS penetration rate is 1.9%. Adults 65+ and adults who are Hispanic or Asian/Pacific Islander fall below this rate, while Alaska Native or American Indian, Black, White, and adults with unknown race/ethnicity are above it.

(1b) For youth in FY 2021, the SMHS penetration rate is 3.3%. Children ages 0–5 and youth

who are Asian/Pacific Islander, Other race, or Unknown race are below the county rate. Youth ages 12–17 and those who are Black, Alaska Native or American Indian, White, or Hispanic are above it. No disparity data are available for primary language; only sex is reported.

(2a) In FY 2022, the adult NSMHS penetration rate is 10.5%. Adults 69+, Asian/Pacific Islander, Hispanic, males, and residents using non-English written languages, including Spanish, Korean, Vietnamese, and some Chinese languages, are below this rate. Adults 21–32, and those who are White, Alaska Native or American Indian, Other race, Black, female, or who use Farsi or English as a written language are above it.

(2b) For youth NSMHS in FY 2022, the rate is 20.1%. Children 6–11, youth 18–20, Black youth, and those using other non-English written languages are below the county rate. Children 0–2, youth 12–17, Asian/Pacific Islander, Other race, White youth, and those whose witten language is Cantonese, Farsi, or Vietnamese are above it. Language is reported as written language; only sex is available.

(3) There are no Orange County data for DMC penetration rates for adults or youth, so disparities for this measure cannot be assessed.

(4a & 4b) For DMC-ODS in CY 2022, the penetration rate for all ages is 0.8%. Asian/Pacific Islander residents are below this rate, while White and Native American residents are above. Data cannot be separated by age.
(5) Equity data are not available for IET-INI rates, so no disparity analysis is possible for this measure.

Access to care: Cross-Measure Questions

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

Beginning July 1, 2026, the Orange County Behavioral Health Services Department (OCBHS) plans to strengthen and further leverage existing programs, partnerships, and infrastructure that have demonstrated success in expanding access to specialty mental health and DMC-ODS services, while addressing local access gaps relative to statewide benchmarks. These efforts are aligned with CalAIM's goals of improving timely access, reducing disparities, and strengthening coordinated, person-centered systems of care.

OCBHS will continue to expand low-threshold, multiple points of entry into care through programs such as BH Links, Behavioral Health Services (BHS) navigation teams, peer support teams, mobile medication-assisted treatment (MAT), and Open Access clinics. Data from access line utilization, crisis encounters, and service initiation timelines indicate that individuals

experiencing acute need, co-occurring conditions, homelessness, and justice involvement benefit from flexible, community-based access models. Strengthening these programs is intended to reduce delays in assessment and treatment initiation and to improve engagement among populations for whom traditional clinic-based models present barriers.

BH Links serves as a central, coordinated access point for crisis response, triage, and referral, supporting improved timeliness and appropriate level-of-care placement. BHS navigation teams and peer teams further enhance access by providing outreach, engagement, and warm handoffs into specialty mental health and DMC-ODS services, particularly for individuals with complex needs and those who have historically experienced challenges navigating the behavioral health system. Expansion of mobile MAT services will improve access to evidence-based treatment for opioid use disorder by delivering care in community settings and reducing barriers related to transportation, stigma, and clinic availability.

OCBHS will also build upon the reliable partnerships established with Medi-Cal Managed Care Plans (MCPs through CalAIM implementation to improve coordination, referrals, and continuity of care. These partnerships support earlier identification of members in need of specialty behavioral health services, improved care transitions, and shared accountability for access-related outcomes. The county's closed-loop referral tracking infrastructure, including the CHORUS system, will continue to be leveraged and strengthened to support timely referrals, track follow-through, and identify gaps in access across systems.

Additionally, OCBHS will continue its established collaborative justice initiative, which addresses access barriers for justice-involved individuals who experience disproportionately high rates of mental health and substance use disorders. Transitional care supports further enhance access by ensuring continuity of services for individuals transitioning from inpatient, institutional, or correctional settings into the community, reducing the risk of treatment interruption and re-crisis.

OCBHS will use ongoing data analysis, including stratification by geography, population, and service type, to monitor performance on access-related measures and identify areas where outcomes remain below the statewide average or median. These data-driven quality improvement processes will inform adjustments to programs and resource allocation over time. Through the continued strengthening of these integrated access strategies, OCBHS aims to improve timely, equitable access to specialty mental health and DMC-ODS services in alignment with CalAIM and BHSA policy guidance.

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

- BHSA Behavioral Health Services and Supports (BHSS)
- BHSA Full Services Partnership (FSP) 2011 Realignment
- Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)
- Community Mental Health Block Grant (MHBG) Substance Use Block Grant (SUBG)

Homelessness: Primary measures

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

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

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

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

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

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Spoken Language

Homelessness: Supplemental Measures

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

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

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

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

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

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

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

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

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

Homelessness: Disparities Analysis

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

1) Orange County's 2024 PIT rate is 23 per 10k residents. Lower rates are seen among children under 18, females, people of multiple races, and Asian or Asian American residents. Higher rates occur among adults 35–44, males, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Black, and Hispanic/Latina/e/o residents, showing unequal risk of homelessness across age, race, and gender. For this measure, some gender categories are not available, so rates are reported only for cisgender males and females.

2) In AY 2023–2024, 6.7% of K–12 public school students in Orange County experienced homelessness. Lower rates are observed among Filipino, multiracial, White, and Asian students and several upper grades. Higher rates are seen among English learners, Hispanic or Latino students, American Indian or Alaska Native students, several elementary grades, migrant students, and students with disabilities, indicating disproportionate impact on younger students and high-need groups.

3) Equity data for people experiencing homelessness (PEH) with serious mental illness (SMI) are not available. Without demographic detail, it is not possible to determine which groups are more affected.

4) Equity data for PEH with substance use disorders (SUD) are also not available, limiting assessment of disparities or identification of populations facing greater risk or barriers.

5) In 2024, the overall rate of Orange County residents accessing CoC services is 76 per 10k. Lower access is seen among Asian or Asian American and White residents, females, children and youth, older adults, and several age bands. Higher access occurs among Black; American Indian, Alaska Native, or Indigenous; Native Hawaiian or Pacific Islander; Hispanic/Latina/e/o residents; males; and adults 35–44. These patterns indicate disparities in who connects with the homeless services system and may reflect differences in need or barriers to care.

Homelessness: Cross-Measure Questions

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

Housing interventions categorical funds. Significant Investments into capital for development of infrastructure and the related supports and services. Currently supporting over 1,024 households. Under the new HI categorical funds, we are targeting the ability to serve an estimated 2,800 households. Expanded treatment, FSP program expansion, transitional rent and the partnership between our MCPs, partnership with CoC and CDH – allows for us to do things quicker – maybe standing up a flex pool, different administrative methodologies. Leveraged relationships through the CPP process and being able to have continued engagement. Breaking down silos, etc.

Beginning July 1, 2026, the Orange County Behavioral Health Services Department (BHS) plans to strengthen and expand a coordinated set of housing, treatment, and cross-system partnerships to reduce homelessness among individuals experiencing severe mental illness, severe substance use disorders, and co-occurring conditions. These efforts are informed by county-level homelessness and behavioral health data and are designed to address areas where Orange County's performance remains below the statewide average or median, particularly for individuals with high acuity needs and repeated system involvement.

BHS has made significant investments through MHSA categorical funding to expand housing infrastructure and the related supportive services necessary to stabilize individuals with complex behavioral health needs. Currently, these investments support over 1,024 households. Under the new Housing Interventions (HI) I categorical funding beginning July 1, 2026, BHS plans to substantially scale these efforts, with the estimated capacity to serve approximately 2,800 households. These investments prioritize capital development, permanent supportive housing, and the integration of behavioral health services (funded through the system of care) to address both housing stability and ongoing treatment needs.

Data from the Homeless Management Information System (HMIS), behavioral health service

utilization, and coordinated entry processes indicate that individuals experiencing homelessness with severe mental illness or co-occurring conditions often experience delays in housing placement and challenges sustaining engagement in treatment. To address these gaps, BHS will expand treatment capacity through Full Service Partnership (FSP) program expansion, enhanced outpatient and field-based services, and transitional rent supports that allow for more rapid housing stabilization while permanent options are secured.

BHS will continue to strengthen partnerships with Medi-Cal Managed Care Plans (MCPs), the local Continuum of Care (CoC), and the County of Orange Office of Care Coordination (OCC) and OC Housing and Community Development to streamline access to housing and supportive services. These partnerships, supported by CalAIM and the Community Supports framework, enable improved coordination, shared accountability, and faster deployment of resources. Planned administrative enhancements, such as flexible funding pools and streamlined administrative methodologies, will further support timely housing placement and service initiation for high-need individuals.

Through the Collaborative Planning Process (CPP), BHS has leveraged established cross-sector relationships to reduce silos between behavioral health, housing, healthcare, and homelessness systems. Continued engagement through these partnerships supports coordinated outreach, referral, and engagement strategies, particularly for individuals with repeated episodes of homelessness, justice involvement, or emergency service utilization. These efforts are intended to improve housing retention, reduce returns to homelessness, and improve behavioral health outcomes.

BHS will continue to use data-driven quality improvement processes to monitor homelessness-related measures, including housing placement, housing retention, and service engagement for individuals with severe mental illness and substance use disorders. Setting up stratified data systems and analysis will inform ongoing adjustments to programs and resource allocation to ensure that investments effectively address disparities and improve outcomes. Through these coordinated and scaled strategies, BHS aims to reduce homelessness among individuals with complex behavioral health needs in alignment with CalAIM and BHSA policy guidance.

These investments represent long-term system capacity rather than time-limited interventions.

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

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

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

How does your county status compare to the statewide rate/average?
For adults/older adults - Not Applicable
For children/youth - Not Applicable

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

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 – 2022

How does your county status compare to the statewide rate/average?
14-day involuntary detention rates per 10,000 - Below
30-day involuntary detention rates per 10,000 - Same
180-day post-certification involuntary detention rates per 10,000 – Same

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

Conservatorships, FY 2021 – 2022

How does your county status compare to the statewide rate/average?
Temporary Conservatorships - Same
Permanent Conservatorships - Same

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

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

How does your county status compare to the statewide rate/average?
1a. Crisis Intervention
For adults/older adults - Below
For children/youth – Below

1b. Crisis Residential Treatment Services
For adults/older adults - Above
For children/youth - Below

1c. Crisis Stabilization
For adults/older adults - Above
For children/youth - Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex
Other

Please describe other
Written Language

Institutionalization: Disparities Analysis

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

1) Inpatient Administrative Days (FY 2023) No disparity analysis is possible. No disparity data are reported, and Orange County has no data for this measure, so group differences cannot be assessed.

2) Involuntary Detention Rates (FY 2021–2022) No disparity data are available. Results are not broken out by age, race/ethnicity, language, or other factors.

3) Conservatorships (FY 2021–2022) No disparity data are available for this measure either, so differences by population group cannot be identified.

4.

a) SMHS Crisis Intervention (minutes, FY 2023) Overall adult and youth use in Orange County is lower than statewide rates. Higher use is seen for adults ages 33–56 and Black adults, and for youth ages 12–17, White and Black youth, and English-language youth. Lower use is seen for younger and older adults; Hispanic, Asian/Pacific Islander, and "other" race/ethnicity adults; males; younger and transition-age youth; Hispanic, Asian/Pacific Islander, and "other" race/ethnicity youth; and youth whose primary language is Vietnamese or Spanish.

b) SMHS Crisis Residential Treatment (days, FY 2023) Adult use is slightly above statewide benchmarks, while youth use is lower. Higher use is seen for youth ages 18–20 and English-language youth. Lower use is seen across most adult race/ethnicity and age groups, for males and females, and for adults whose primary language is Spanish or English. Youth race/ethnicity data are not available and some youth data are suppressed.

c) SMHS Crisis Stabilization (hours, FY 2023) Adult and youth rates are higher than statewide rates. Higher use is seen among adults ages 33–44 and Black adults, and among youth ages 12–17; Black, White, and Asian/Pacific Islander youth; male youth; and English- and Vietnamese-language youth. Lower use appears for younger and older adults, White and Asian/Pacific Islander adults, females, Spanish- and Vietnamese-language adults, youth with "other" race/ethnicity, and Spanish-language youth.

Institutionalization: Cross-Measure Questions

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

Orange County Behavioral Health Services (BHS) uses multiple local data sources to monitor the current status of institutionalization and inform strategies that promote stabilization in the least restrictive, clinically appropriate setting. In addition to statewide cross-measure indicators, BHS reviews local crisis service utilization, crisis stabilization patterns, involuntary detention rates, and conservatorship trends as key system markers associated with institutional levels of care.

Local data on crisis intervention service utilization (measured in minutes per Medi-Cal beneficiary from 2019–2023) indicate that Orange County's overall rate (157.5 minutes) is below the statewide average (240.1 minutes). When disaggregated by race and ethnicity, utilization intensity varies, with higher average minutes among Black beneficiaries (183.45 minutes; n=66)

compared to White (156.78; n=605), Latino (149.87; n=460), and Asian/Pacific Islander beneficiaries (131.97; n=156). BHS also reviews utilization by age group, sex, and language to better understand engagement patterns and ensure equitable access to crisis response services across populations.

BHS also monitors crisis stabilization utilization as an upstream indicator of institutional care needs. Local data show that Orange County's crisis stabilization hours per beneficiary are slightly above statewide averages for both adults (25.8 hours locally compared to 24.0 statewide) and children (21.2 hours locally compared to 18.6 statewide), reinforcing the importance of continued investment in timely crisis diversion and community-based stabilization supports.

In addition, Orange County reviews involuntary detention trends as a measure of acute system reliance. Local data indicate that the County's 14-day involuntary detention rate (7.7 per 10,000) is below the statewide rate (10.2 per 10,000), and the combined 14/30-day detention rate (0.8 per 10,000) is also slightly below the statewide average (0.9 per 10,000). These measures help BHS assess the effectiveness of crisis response, stabilization, and step-down pathways.

BHS further tracks conservatorship trends as part of institutionalization monitoring. Local data show that Orange County's temporary conservatorship rate (1.2 per 10,000) and permanent conservatorship rate (3.4 per 10,000) are above statewide averages (0.7 and 2.8 per 10,000, respectively). These findings underscore the importance of strengthening intensive community-based service models, including ACT/FACT, Day Treatment Intensive, CARE Act services, and enhanced care coordination, to support individuals with the highest acuity needs and reduce reliance on restrictive interventions over time.

Through ongoing review of these local institutionalization-related indicators, BHS is advancing BHSA- and CalAIM-aligned strategies to reduce unnecessary institutional care, strengthen diversion and step-down capacity, and ensure equitable access to timely, recovery-oriented services in the community.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs.

Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

Beginning July 1, 2026, the Orange County Behavioral Health Services (BHS) plans to strengthen and expand a continuum of community-based treatment, crisis response, and diversion strategies designed to reduce unnecessary institutionalization and promote care delivery in the least restrictive, most clinically appropriate setting for individuals with severe mental illness, severe substance use disorders, and co-occurring conditions. These efforts are

informed by county-level utilization and outcome data and are intended to address Orange County's institutionalization-related measures, particularly for individuals with high acuity, repeated hospitalizations, or risk of conservatorship.

BHS will continue to leverage data from inpatient psychiatric utilization, long-term care (LTC) placements, Mental Health Rehabilitation Centers (MHRC), Skilled Nursing Facilities, and conservatorship trends to identify populations at elevated risk for institutionalization. This data demonstrates that individuals with complex needs often experience prolonged lengths of stay or repeated transitions between institutional settings due to gaps in step-down capacity, community-based treatment intensity, and coordinated care necessary to support stabilization in the least restrictive setting.

To address these gaps, BHS is strengthening community-based alternatives to institutional care, including implementation and expansion of high-intensity treatment models such as Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT). These multidisciplinary, field-based models are designed to provide intensive services in community settings, reduce psychiatric hospitalizations, prevent entry into long-term institutional settings, and support individuals in remaining safely housed and engaged in treatment in the least restrictive environment possible.

BHS is also strengthening its continuum of intermediate levels of care through the implementation of Day Treatment Intensive (DTI) services, which function similarly to partial hospitalization programs. DTI provides structured, clinically intensive treatment during daytime hours while allowing individuals to remain in the community, thereby supporting stabilization in a less restrictive setting than inpatient hospitalization.

Data on inpatient admissions, length of stay, and readmissions indicate that some individuals experience prolonged or repeated hospitalizations due to limited availability of intermediate levels of care. Expansion of DTI services is intended to address these gaps by offering a clinically appropriate step-down from inpatient care and step-up from outpatient services, reducing reliance on inpatient settings while maintaining treatment intensity.
DTI services complement other community-based alternatives, including ACT and FACT, crisis residential services, and outpatient treatment, by supporting individuals in transitioning to and sustaining care in the least restrictive, most clinically appropriate setting. DTI expansion also supports individuals meeting expanded SB 43 criteria by providing an intensive, community-based treatment option that may prevent unnecessary inpatient admission or conservatorship.

In alignment with recent statutory changes, including SB 43, BHS is strengthening its approach to conservatorship prevention and implementation by emphasizing early intervention, enhanced community-based treatment, and integrated care coordination. While expanded eligibility criteria support access to care for individuals with significant impairment, BHS remains committed to ensuring conservatorship is pursued only when clinically necessary and that individuals receive services in the least restrictive setting consistent with their clinical needs and safety.

BHS will further advance integrated care through campus-based and programmatic initiatives, including the Irvine campus, which co-locates behavioral health, crisis, perinatal, and

supportive services to reduce fragmentation and support smooth transitions across levels of care. Expanded crisis residential services and targeted diversion efforts will further support stabilization and recovery in community-based, least restrictive settings, particularly for individuals at heightened risk of institutionalization.

BHS will continue to use data-driven quality improvement processes to monitor institutionalization-related measures, including inpatient admissions, length of stay, readmissions, and conservatorship trends.

Stratified data analysis will inform ongoing adjustments to programs and resource allocation to ensure services promote recovery, reduce reliance on institutional care, and support individuals in receiving treatment in the least restrictive, most appropriate setting. Through these coordinated strategies, BHS aims to strengthen community-based care and reduce institutionalization in alignment with CalAIM and BHSA policy guidance.

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

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

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023
How does your county status compare to the statewide rate/average?
For adults/older adults - Above
For juveniles - Below

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

Justice-Involvement: Supplemental Measures
Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

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

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

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023
Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

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

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

Justice-Involvement: Disparities Analysis

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

(1a) Adult Arrest Rates - In 2024, Orange County's adult arrest rate is 2,848 per 100,000, higher than the FY23 rate of 2,705 and above the statewide rate and median. Adults 70+ (124 per 100k), ages 40–69 (2,217), ages 18–19 (2,480), and females (1,251) are below the county rate. Adults ages 20–29 (4,309), 30–39 (5,584), males (4,510), and residents who are Black (8,646) or Hispanic (3,320) are arrested at disproportionately higher rates. When adult and juvenile data are combined, the total population rate is 2,346 per 100k; above this are Black (8,646) and Hispanic (3,320) residents, especially Black males (13,000), Hispanic males (5,383), Black females (3,962), and White males (3,364). White females (1,236) and Hispanic females (1,249) are below the combined county rate.

(1b) Juvenile Arrest Rates - In 2024, the Orange County juvenile arrest rate is 373 per 100,000. Females (162 per 100k) are below the juvenile county rate, while males (573 per 100k) are well above it, indicating a clear sex-based disparity. Juvenile age-specific and race/ethnicity-specific rates are not available; race/ethnicity is only reported at the total population level.

(2) Adult Recidivism Conviction Rate - Orange County's three-year adult recidivism conviction rate for FY 2019–20 is 49.6%, above the statewide rate and median of 39.6%. Higher rates are seen among adults ages 20–24 (69.1%) and 25–29 (58.7%), and among White (51.4%) and Hispanic/Latino (51.4%) adults. Lower recidivism rates occur among adults ages 35–39, 40–44, 45–49, 50–54, 55–59, and 60+ (ranging from 45.4% down to 19.6%), as well as Asian (42.2%), Black/African American (37.6%), Other race/ethnicity (32.2%), and females (46.2%), showing disparities by age, race/ethnicity, and

sex.

(3) IST - No disparity data are available for individuals found Incompetent to Stand Trial (IST), so inequities for this measure cannot be assessed.

Justice-Involvement: Cross-Measure Questions

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

Beginning July 1, 2026, Orange County Behavioral Health Services (BHS) will strengthen and expand a comprehensive continuum of diversion, treatment, and re-entry initiatives to reduce justice involvement among individuals living with significant behavioral health needs, including severe mental illness, severe substance use disorders, and co-occurring conditions. These efforts are informed by county-level justice, behavioral health, and utilization data and are intended to address areas where Orange County's performance remains below the statewide average or median, particularly for individuals with repeated justice system involvement and high clinical acuity.

Data related to jail utilization, competency restoration referrals, recidivism, and post-release service engagement demonstrate that individuals with untreated or undertreated behavioral health conditions—especially justice-involved youth, individuals with co-occurring disorders, and individuals experiencing homelessness—experience poorer outcomes and higher rates of re-incarceration. In response, BHS will expand justice-involved service capacity across multiple funding categories, levels of care, and age groups.

BHS will implement an additional justice-involved youth program within the Behavioral Health Services and Supports (BHSS) category and expand Full Service Partnership (FSP) programs specifically designed for justice-involved youth. These programs emphasize early intervention, intensive care coordination, family engagement, and stabilization in community-based, least restrictive settings to prevent deeper justice system involvement and improve long-term outcomes.

For adults, BHS will expand justice-involved FSPs and other intensive treatment models to support individuals with repeated justice contact and complex needs. These services are designed to reduce incarceration and recidivism by providing comprehensive, field-based treatment, case management, and linkage to housing and supportive services. Expansion of these programs aligns with statutory and system changes, including SB 43, SB 27, and CARE Act

implementation, which broaden eligibility and emphasize timely access to treatment and diversion for individuals with significant impairment.

BHS will continue to support individuals found Incompetent to Stand Trial (IST) by strengthening coordination between the courts, inpatient and outpatient providers, and community-based treatment programs. Data demonstrating prolonged justice involvement and institutionalization among IST populations has informed efforts to improve access to appropriate treatment services and timely transitions to community-based care when clinically appropriate.

A cornerstone of BHS's programs to address justice involved populations is our re-entry strategy a set of programs, which provides comprehensive re-entry services to incarcerated individuals with mental illness and/or substance use disorders. Re-entry programs delivers pre-release in-custody and post-release behavioral health services, including individual therapy, group therapy, medication management, in-reach services from community providers, and development of comprehensive discharge plans. These plans link individuals to ongoing behavioral health treatment, housing, food supports, benefits, legal services, and other critical resources to support successful reintegration into the community and reduce recidivism.

BHS will further address justice-involved needs through implementation of Proposition 36, expansion of re-entry programs, and a unique peer-based service model that leverages lived experience to promote engagement, trust, and sustained connection to care. These efforts are complemented by the OC Cares initiative and broader justice-involved initiatives that strengthen cross-system collaboration, data sharing, and coordinated service delivery.

Across all justice-involved initiatives, BHS prioritizes treatment in the least restrictive, most clinically appropriate setting, consistent with CalAIM and BHSA policy guidance. Ongoing data analysis and quality improvement processes will monitor justice-involvement measures such as repeat bookings, time to treatment engagement, and continuity of care following release. Stratified analysis will inform targeted interventions for sub-populations demonstrating poorer outcomes. Through these coordinated strategies, BHS aims to reduce justice involvement, improve behavioral health outcomes, and strengthen pathways to recovery and community stability.

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

- BHSA BHSS
- BHSA FSP
- Other
- BHSA Housing Interventions SUBG
- Federal Financial Participation (SMHS, DMC/DMC-ODS)

Please describe other

DSH, BHBH

Removal Of Children from Home: Primary Measures

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

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

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

Removal Of Children from Home: Supplemental Measures

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

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

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

Child Maltreatment Substantiations (CWIP), 2022

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

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

Removal Of Children from Home: Disparities Analysis

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

1) In the 2025 PIT Count, Orange County's rate of children in foster care is 325 per 100,000. Children under age 1 (652 per 100k) and ages 1–2 (444 per 100k) have rates well above the county rate, suggesting very young children are disproportionately represented and may face greater vulnerability. Rates are lower for ages 3–5, 6–10, 11–15, 16–17, and 18–21, as well as for males and females overall. Data on intersex children and race/ethnicity denominators are not available, which limits more detailed disparity analysis.
2) For children and youth with open child welfare cases in FY 2021, the SMHS penetration rate is

28.4%. Lower use of SMHS is seen among children ages 0–2 (4.7%), 3–5 (15.1%), and those categorized as "other" race/ethnicity (21.2%). Higher use occurs among ages 6–11 (34.9%), 12–17 (47.7%), and 18–20 (36.8%), and among White (30.7%) and Black (35.2%) children and youth. These data indicate age- and race-based differences in access to SMHS among children involved in child welfare.

3) In 2024, Orange County's overall child maltreatment substantiation rate is 6.9 per 1,000. Lower rates are observed for youth ages 11–15 and 16–17, and for Asian or Pacific Islander and White children. Higher rates occur among children under age 1 (17.7 per 1k), ages 1–2 (8.5 per 1k), and among Latino (11.1 per 1k) and Black (16.5 per 1k) children, indicating that very young, Latino, and Black children experience substantiated maltreatment at rates above the county average.

Removal Of Children from Home: Cross-Measure Questions

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

Orange County Behavioral Health Services (BHS) is strengthening access to care beginning July 1, 2026 to address local child welfare trends related to children being removed from the home due to behavioral health needs affecting children and families. County data indicate that the majority of children removed from the home in Orange County are very young, particularly ages 0–5, and that neglect is the most common reason for removal. These findings highlight the importance of expanding early identification, family-centered supports, and timely access to behavioral health and recovery-oriented services during critical developmental years.

To address measures where outcomes are below statewide averages or medians, BHS partnered with First 5 and other system stakeholders to examine the unique needs of children ages 0–8, including families with multiple young children and siblings involved in the child welfare system. BHS also participates in collaborative planning processes with the Orange County Social Services Agency and is an active partner in the county's Child Welfare System Improvement Plan collaborative. In addition, BHS actively participates in the Orange County Juvenile Justice Committee to support coordinated, cross-system approaches for children and youth involved in multiple systems of care. BHS further supports interagency coordination through participation in the AB 2083 Interagency Leadership Team (ILT), which includes collaboration with schools and the Orange County Department of Education foster youth liaison to strengthen service alignment for system-involved children and youth. These partnerships help inform a targeted strategy to strengthen prevention, early intervention, and evidence-based family supports that reduce risk of separation and promote safe family stabilization.

Beginning July 1, 2026, BHS will implement and expand several initiatives designed to improve timely access to care for this population, including the Family, Infant, and Early Childhood Early Intervention

Program, which will provide developmentally appropriate behavioral health supports for very young children and their caregivers. BHS will also expand Perinatal behavioral health and substance use disorder services through BHSA service expansion and in partnership with a community-based organization supported through Behavioral Health Continuum Infrastructure Program (BHCIP) funding, improving access to outpatient treatment and early engagement for pregnant and postpartum individuals.

In addition, BHS will strengthen access to evidence-based practices that support family stabilization and reduce system involvement, including expansion of High Fidelity Wraparound (HFW) through age 21 beyond the child welfare population, implementation of Parent-Child Interaction Therapy (PCIT), enhanced mental health consultation services, and Multisystemic Therapy (MST). These services are designed to improve caregiver capacity, address trauma and co-occurring needs, and provide intensive

community-based supports in the least restrictive setting.
Through these coordinated investments and cross-system partnerships, BHS aims to improve access to early intervention and family-centered behavioral health care, reduce preventable child removals, and promote safety, stability, and equitable outcomes for young children and families consistent with BHSA and CalAIM goals.

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

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

Untreated Behavioral Health Conditions: Primary Measures

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

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

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

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

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

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

Untreated Behavioral Health Conditions: Supplemental Measures

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

How does your county status compare to the statewide rate?
For the full population measured - Below

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

Untreated Behavioral Health Conditions: Disparities Analysis

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

1) For FUA30, there are no publicly available disparity data, so differences by age, race/ethnicity, language,
2) or sex cannot be assessed.

3) For FUM30, there are also no publicly available disparity data. As with FUA30, we are unable to determine whether particular groups are experiencing higher or lower follow-up rates.

4) For adults who reported needing help for emotional or mental health problems or alcohol/drug use and had no related visit in the past year, Orange County's overall rate in FY23 is 43.6%, which is below the statewide mean (48.4%) and median (50.5%). Within the county, however, higher "unmet need" is seen among adults ages 18–24 and 25–64; individuals identifying as Asian, Latino, or two or more races; and both males and females in these groups, with especially high rates among Asian males, Asian females, and males of two or more races. Lower rates of unmet need are observed among White adults overall, including White males and White females. These patterns are based on self-reported survey data and indicate that adults of color and younger adults are more likely to report needing help but not receiving services.

Untreated Behavioral Health Conditions: Cross-Measure Questions

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

Orange County Behavioral Health Services (BHS) is strengthening programs, partnerships, and service delivery strategies beginning July 1, 2026 to reduce the level of untreated behavioral health conditions across the lifespan, consistent with BHSA and CalAIM goals of prevention, early intervention, timely access, and whole-person care.

Local planning efforts, service utilization trends, and Community Planning Process (CPP) input indicate that untreated behavioral health needs are often driven by delayed identification, difficulty navigating complex systems of care, stigma, and limited access to culturally and linguistically responsive engagement supports. Crisis utilization data and institutionalization indicators further reinforce the importance of early intervention strategies to prevent escalation to higher levels of care, including inpatient hospitalization and conservatorship. These findings informed targeted investments designed to improve early detection, engagement, and rapid connection to clinically appropriate services.

Beginning July 1, 2026, BHS will expand Early Identification for Psychosis and Coordinated Specialty Care for First Episode Psychosis (CSC-FEP) programming. These evidence-based models are designed to reduce the duration of untreated psychosis, improve early engagement in treatment, and promote long-term recovery and functional outcomes. Expansion of CSC-FEP will include outreach, screening, and rapid linkage pathways to ensure individuals experiencing early signs of psychosis receive timely, specialized intervention before conditions worsen or require more restrictive levels of care.

BHS is also developing programs specifically focused on very young children and families, recognizing that early developmental and family-centered supports can prevent escalation of untreated behavioral health conditions over time and reduce the likelihood of crisis system involvement later in life.

For older adults, BHS is strengthening coordination with Medi-Cal Managed Care Plans (MCPs) and primary care providers to support diagnostic clarity and whole-person assessment in cases where it may be clinically unclear whether presenting symptoms are attributable to an organic or medical condition versus a primary behavioral health disorder. Through enhanced care coordination, consultation, and integrated screening practices, BHS aims to reduce delays in appropriate treatment, prevent misdiagnosis, and ensure older adults receive timely, clinically appropriate interventions that address both behavioral health and medical needs.

In addition, BHS is significantly enhancing outreach and engagement capacity across the system of care to ensure individuals are supported in accessing services and maintaining connection once engaged. This includes strengthening navigation and care coordination approaches that "walk alongside" individuals and families as they move through assessment, linkage, treatment, and recovery supports.

Peer-delivered services will be expanded as a core strategy to reduce untreated conditions by improving trust, engagement, and continuity of care. Peer support specialists bring lived expertise that reduces stigma, strengthens therapeutic alliance, and increases participation in treatment and recovery-oriented services.

BHS will further invest in Enhanced Community Health Workers as part of an integrated workforce strategy, embedding trusted messengers with culturally and linguistically congruent experience into behavioral health teams. These roles will improve engagement among historically underserved populations and reduce disparities in service utilization and outcomes.

Through these coordinated investments in early identification, specialized early psychosis intervention, integrated care for older adults, strengthened outreach, peer support, and culturally responsive workforce expansion, BHS aims to reduce unmet behavioral health needs, decrease duration of untreated conditions, mitigate crisis and institutional utilization, and promote equitable, community-based care aligned with BHSA and CalAIM system transformation goals.

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

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

Additional statewide behavioral health goals for improvement

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

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

For related policy information, refer to E.6.2 Primary and Supplemental Measures .

Care Experience: Primary Measures

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

How does your county status compare to the statewide rate/average?
For adults/older adults - Below
For children/youth - Same

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

How does your county status compare to the statewide rate/average?
For adults/older adults - Above
For children/youth - Above

Engagement In School: Primary Measures

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

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

Above

Engagement In School: Supplemental Measures

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

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

Student Chronic Absenteeism Rate (Data Quest), 2022
How does your county status compare to the statewide rate/average?
Below

Engagement In Work: Primary Measures

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

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

Engagement In Work: Supplemental Measures

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

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

Overdoses: Primary Measures

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

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

For the full population measured - Below
For adults/older adults - Below
For children/youth - Above

Overdoses: Supplemental Measures

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

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

For the full population measured - Below
For adults/older adults - Below
For children/youth - Below

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

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

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

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service) - Below
For children/youth (specific to Child and Adolescent Well-Care Visits) - Above

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

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

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

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

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?
For the full population measured - Same
For adults/older adults - Same
For children/youth - Same

Quality Of Life: Supplemental Measures

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

How does your county status compare to the statewide rate/average?
For the full population measured - Same

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?
For the full population measured - Same
For adults/older adults - Same
For children/youth - Same

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides: Primary Measures

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?
For the full population measured - Same

Suicides: Supplemental Measures

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

How does your county status compare to the statewide rate/average?
For the full population measured - Below
For adults/older adults - Below
For children/youth - Below

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.

Prevention and treatment of co-occurring physical health conditions

Prevention and treatment of co-occurring physical health conditions

Please describe why this goal was selected.

Orange County Behavioral Health Services (BHS) selected prevention and treatment of co-occurring physical health conditions as a priority improvement goal based on local performance data, health equity considerations, and community input emphasizing the importance of whole-person care.

Individuals living with serious mental illness and substance use disorders experience significantly higher rates of chronic physical health conditions and premature mortality compared to the general population. Local data indicate that individuals engaged in specialty behavioral health services are not consistently accessing recommended preventive screenings and primary care services. Gaps in routine physical health monitoring, including screenings for chronic conditions such as diabetes, cardiovascular disease, and other metabolic disorders, contribute to preventable morbidity and increased healthcare utilization over time.

As part of an integrated Health Care Agency, BHS recognizes that behavioral health outcomes cannot be meaningfully improved without strengthening access to basic preventive and primary care services. This goal aligns directly with CalAIM's whole-person care framework and BHSA's emphasis on integrated, community-based service delivery.

In addition, the Community Planning Process (CPP) highlighted confusion among consumers and families regarding how to access the "right door" for care, particularly when behavioral health and physical health needs overlap. Stakeholders identified navigation challenges, fragmented care coordination, and limited clarity regarding roles between specialty behavioral health and primary care providers as barriers to timely and comprehensive treatment.

Selecting this goal reflects BHS's commitment to improving coordination with Medi-Cal Managed Care Plans (MCPs), strengthening referral pathways between specialty behavioral health and primary care, expanding integrated screening and care coordination practices, and ensuring individuals with behavioral health conditions receive appropriate preventive and physical health services. Addressing co-occurring physical health conditions is essential to reducing health disparities, improving quality of life, and advancing equitable whole-person care outcomes.

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.

Orange County Behavioral Health Services (BHS) reviewed statewide behavioral health goal measures related to the prevention and treatment of co-occurring physical health conditions and identified performance gaps relative to statewide benchmarks. While publicly available demographic stratification is limited for these measures, the County's overall performance indicates unmet need in preventive and metabolic health screening for individuals with significant behavioral health conditions.

For FY22, Orange County's rate of adult access to preventive and ambulatory health services was 63%, which is below the statewide rate (65.3%) and the statewide median (67.5%). In addition, Orange County is performing below statewide benchmarks on supplemental measures associated with this goal.

Specifically, the rate of diabetes screening for individuals with schizophrenia or bipolar disorder who are prescribed antipsychotic medications was 75% in Orange County, compared to the statewide rate of 81.5% and median of 82.1%. Similarly, metabolic monitoring for youth on antipsychotic medications—including blood glucose and cholesterol testing—was 36.9% in Orange County, compared to the statewide rate of 39.8% and median of 38.3%.

These findings highlight gaps in preventive and physical health screening for populations experiencing serious mental illness and youth receiving intensive psychotropic treatment, reinforcing the County's selection of this goal as a priority for improvement.
At this time, there is no publicly available equity-stratified data across demographic groups for these specific measures, and local data sources similarly did not include consistent stratification by race/ethnicity, language, or other priority population categories. BHS will continue to strengthen data infrastructure and cross-system collaboration with Medi-Cal Managed Care Plans and primary care partners to improve monitoring, advance equitable access to preventive services, and reduce unmet physical health needs among individuals receiving specialty behavioral health care.

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 Prevention and treatment of co-occurring physical health conditions and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

Beginning July 1, 2026, Orange County will strengthen prevention and treatment of co-occurring physical health conditions for individuals served in the behavioral health system by expanding whole-person care approaches, enhancing Community Health Worker (CHW) and Peer Navigation capacity, strengthening health and wellness coaching, and improving cross-system coordination with Medi-Cal Managed Care Plans (MCPs). These enhancements are specifically intended to improve the County's performance on Prevention and Treatment

measures where Orange County is currently below the statewide average and median.

Orange County's adult access to preventive/ambulatory health services in FY22 was 63%, which is below the statewide rate (65.3%) and below the statewide median (67.5%). In addition, Orange County is performing below the statewide average and median on key supplemental measures related to physical health monitoring for individuals receiving antipsychotic medications. In FY22, diabetes screening for people with schizophrenia or bipolar disorder using antipsychotic medications was 75% in Orange County, compared to the statewide rate (81.5%) and median (82.1%). Similarly, Orange County's rate of metabolic monitoring for youth on antipsychotics (blood glucose and cholesterol testing) was 36.9%, below the statewide rate (39.8%) and median (38.3%). These data indicate opportunities to strengthen preventive care and medical monitoring for individuals with serious mental illness and youth served in the behavioral health system, particularly those receiving medications with elevated metabolic risk.

To address these gaps, Orange County will expand Enhanced CHW and Peer Navigation supports within specialty behavioral health services to increase linkage to primary care, follow-through on preventive health services, and completion of recommended screenings and lab monitoring. CHWs and peers will support individuals in scheduling appointments, overcoming barriers to accessing medical care, and navigating MCP/provider systems to strengthen engagement in routine ambulatory care. This strategy is designed to directly improve preventive service access and increase monitoring rates for individuals at elevated risk for chronic health conditions.

Orange County will also strengthen accountability for whole-person outcomes by including Enhanced CHW/Peer Navigation expectations as required outcomes in contracted Full Service Partnership (FSP) programs, supporting consistency across providers in linking members to preventive and ambulatory care. These efforts will focus on improving screening and monitoring follow-through for populations with higher clinical complexity, including individuals served in FSPs who often experience higher rates of co-occurring medical needs and care access barriers.

In addition, Orange County will support health and wellness coaching training for HCA staff and contracted providers to further embed whole-person care practices across the system. This training will strengthen provider capacity to support physical health engagement through education, goal-setting, and wellness planning related to chronic disease prevention and management, and to reinforce preventive care routines for individuals with serious mental illness and youth receiving specialty behavioral health services.

To further strengthen service access and improve linkage rates, Orange County will expand cross-system coordination with MCPs beginning July 1, 2026, with emphasis on strengthening referral pathways, warm handoffs, and closed-loop communication between behavioral health providers, primary care, and specialty care. This coordinated approach will prioritize improving follow-through on diabetes screening and metabolic monitoring for members using antipsychotic medications and increasing overall access to preventive and ambulatory care services.

While there is no publicly available equity data for these measures, Orange County reviewed local data and similarly did not identify demographic stratification available for disparities analysis. As implementation moves forward, Orange County will continue efforts to strengthen data-sharing and reporting capacity across systems to better understand and address potential disparities in preventive care access and screening outcomes. Collectively, these initiatives are intended to improve Orange County's performance on preventive and ambulatory care access measures, increase diabetes screening and metabolic monitoring rates for individuals on antipsychotic medications, and strengthen integrated prevention and treatment of co-occurring physical health conditions across the behavioral health system.

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

BHSA BHSS

BHSA FSP

BHSA Housing Interventions

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

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

Please specify the other strategies that demonstrate the meaningful partnerships with stakeholders

Consistent with BHSA Community Program Planning (CPP) requirements, the County implemented a structured, inclusive, and continuous stakeholder engagement process designed to ensure meaningful participation, shared decision-making, and equity across all phases of planning and implementation.

In alignment with BHSA requirements to engage stakeholders in identifying community needs and priorities, the County conducted town hall meetings, focus groups, key informant interviews, surveys, and cross-system planning meetings. These activities provided multiple avenues for stakeholder input and ensured that diverse perspectives informed needs assessment, service gaps, priority setting, and recommended strategies.

To meet BHSA requirements for ongoing stakeholder involvement, the County established and facilitated planning workgroups, including workgroups focused on BHSA categorical funding, enabling stakeholders to directly participate in program design, funding prioritization, and implementation planning. Internal planning workgroups were also convened to integrate community input into fiscal, operational, and system-level decision-making.

To support transparency and accountability, the County shared relevant data throughout the CPP process and provided regular updates to the Behavioral Health Advisory Board, Board of Supervisors, county departments, and system partners. The County continued to convene the regular Planning Advisory Committee (quarterly), the Behavioral Health Equity Committee and affiliated workgroups, and is establishing implementation committees, ensuring stakeholder

engagement continued beyond planning and into implementation and monitoring, consistent with BHSA's emphasis on sustained participation.

In accordance with BHSA requirements to reduce barriers and ensure equitable access to CPP opportunities, the County offered engagement activities both in person and virtually, provided training and informational sessions to stakeholders and CPP facilitators, and ensured language access through translation services in threshold languages. Several activities were conducted fully in Vietnamese or Spanish. CPP opportunities were offered across all regions of the county, at multiple times and locations, across age groups and languages, to maximize participation.

To address BHSA requirements related to equity, cultural responsiveness, and inclusion of historically underserved populations, the County contracted with trusted community-based organizations to support and lead engagement efforts. These partnerships helped create culturally responsive environments and supported meaningful participation by communities that may experience historical trauma or distrust of government systems.

The County partnered with external evaluation experts to design and implement CPP processes and systems that streamlined engagement, supported transparency, and enabled independent evaluation of the CPP process. These experts also assisted with evaluating the selection of the County's seventh population health goal, ensuring alignment with data, stakeholder input, and equity considerations, as required under BHSA.

Consistent with BHSA requirements to engage consumers and families, the County ensured that individuals with lived experience and family members participated in all phases of CPP, including needs assessment, priority setting, program development, and implementation planning. To reduce participation barriers and recognize lived experience as expertise, the County provided transportation assistance, food, and gift cards to ease participation and engagement.

The County also implemented targeted CPP strategies for specific populations, including a partnership with OC First 5 to conduct a focused planning process for families, infants, and early childhood populations (ages 0–8), with families intentionally centered as primary stakeholders.

In further alignment with BHSA's cross-system and whole-person care requirements, County leadership and key staff participate in ongoing cross-system planning initiatives with child welfare, aging and adult services, TANF administrators, the Orange County Department of Education, courts and criminal justice partners, the Office of Care Coordination, the entity charged with administering the Homeless Continuum of Care, the Community and Housing Development Agency, and housing trust administrators. These partnerships support system alignment, resource coordination, and integrated service planning and allow streamlining of overlapping requirements of other systems.

Through these strategies, the County demonstrates compliance with BHSA CPP requirements by ensuring meaningful, ongoing stakeholder engagement; equitable access; cultural and linguistic responsiveness; transparency; and continuity from planning through implementation.

Moving forward, the County will continue to test and incorporate innovative approaches to CPP, as we continue to implement that OAC approved Innovative Community Planning project.

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

Type of engagement: Key informant interviews with subject matter experts
Date: 9/9/2025

Type of engagement: Key informant interviews with subject matter experts
Date: 9/10/2025

Type of engagement: Key informant interviews with subject matter experts
Date: 9/8/2025

Type of engagement: Focus group discussions
Date: 8/14/2025

Type of engagement: Focus group discussions
Date: 8/13/2025

Type of engagement: Focus group discussions
Date: 8/13/2025

Type of engagement: Focus group discussions
Date: 8/13/2025

Type of engagement: Focus group discussions
Date: 8/11/2025

Type of engagement: Focus group discussions
Date: 8/8/2025

Type of engagement: Focus group discussions
Date: 8/8/2025

Type of engagement: Focus group discussions
Date: 8/6/2025

Type of engagement: Focus group discussions
Date: 8/6/2025

Type of engagement: Focus group discussions
Date: 8/5/2025

Type of engagement: Focus group discussions
Date
8/4/2025

Type of engagement: Focus group discussions
Date: 8/3/2025

Type of engagement: Focus group discussions
Date: 8/1/2025

Type of engagement: Focus group discussions
Date: 7/30/2025

Type of engagement: Focus group discussions
Date: 7/29/2025

Type of engagement: Key informant interviews with subject matter experts
Date: 7/30/2025

Type of engagement: Key informant interviews with subject matter experts
Date 7/29/2025

Type of engagement: Focus group discussions
Date: 7/29/2025

Type of engagement: Focus group discussions
Date: 7/25/2025

Type of engagement: Focus group discussions
Date: 7/22/2025

Type of engagement: Focus group discussions
Date: 7/24/2025

Type of engagement: Focus group discussions
Date: 7/22/2025

Type of engagement: Focus group discussions
Date: 7/21/2025

Type of engagement: Focus group discussions
Date: 7/21/2025

Type of engagement: Focus group discussions
Date: 7/18/2025

Type of engagement: Focus group discussions
Date: 7/18/2025

Type of engagement: Focus group discussions
Date: 7/17/2025

Type of engagement: Focus group discussions
Date: 7/15/2025

Type of engagement: Focus group discussions
Date: 7/3/2025

Type of engagement: Focus group discussions
Date: 6/25/2025

Type of engagement: Focus group discussions
Date: 6/24/2025

Type of engagement: Focus group discussions
Date: 6/19/2025

Type of engagement: Focus group discussions
Date: 6/16/2025

Type of engagement: Focus group discussions
Date: 6/12/2025

Type of engagement: Focus group discussions
Date: 6/11/2025

Type of engagement: Focus group discussions
Date: 6/11/2025

Type of engagement: Focus group discussions
Date: 6/9/2025

Type of engagement: Focus group discussions
Date: 5/29/2025

Type of engagement: Focus group discussions
Date: 5/13/2025

Type of engagement: Training, education, and outreach related to community planning
Date: 5/13/2025

Type of engagement: Training, education, and outreach related to community planning
Date: 5/5/2025

Type of engagement: Focus group discussions
Date: 5/2/2025

Type of engagement: Training, education, and outreach related to community planning
Date: 5/1/2025

Type of engagement: Training, education, and outreach related to community planning
Date: 4/30/2025

Type of engagement: County outreach through townhall meetings
Date: 4/24/2025

Type of engagement: County outreach through townhall meetings
Date: 3/20/2025

Type of engagement: County outreach through townhall meetings
Date: 3/19/2025

Type of engagement: County outreach through townhall meetings
Date: 3/6/2025

Type of engagement: County outreach through townhall meetings
Date: 1/30/2025

Type of engagement: Meeting(s) with county
Date: 9/3/2025

Type of engagement: Meeting(s) with county
Date: 10/1/2025

Type of engagement: Meeting(s) with county
Date: 7/2/2025

Type of engagement: Meeting(s) with county
Date: 4/2/2025

Type of engagement: Meeting(s) with county
Date: 3/5/2025

Type of engagement: Meeting(s) with county
Date: 5/7/2025

Type of engagement: Meeting(s) with county
Date: 2/5/2025

Type of engagement: Meeting(s) with county
Date: 1/7/2026

Type of engagement: Focus group discussions
Date: 1/8/2026

Type of engagement: Meeting(s) with county
Date: 1/14/2026

Type of engagement: Meeting(s) with county
Date: 12/3/2025

Type of engagement: Meeting(s) with county
Date: 10/1/2025

Type of engagement: County outreach through townhall meetings
Date: 10/16/2025

Type of engagement: Focus group discussions
Date: 10/21/2025

Type of engagement: County outreach through townhall meetings
Date: 10/23/2025

Type of engagement: County outreach through townhall meetings
Date: 11/6/2025

Type of engagement: Training, education, and outreach related to community planning
Date: 12/11/2025

Type of engagement: Focus group discussions
Date: 1/8/2026

Type of engagement: County outreach through townhall meetings
Date: 1/21/2026

Type of engagement: County outreach through townhall meetings
Date: 1/22/2026

Type of engagement: County outreach through townhall meetings
Date: 1/26/2026

Type of engagement: County outreach through townhall meetings
Date: 1/27/2026

Type of engagement: County outreach through townhall meetings
Date: 1/29/2026

Type of engagement: Workgroups and committee meetings
Date: 6/11/2025

Type of engagement: Workgroups and committee meetings
Date: 6/9/2025

Type of engagement: Workgroups and committee meetings
Date: 6/9/2025

Type of engagement: Workgroups and committee meetings
Date: 6/26/2025

Type of engagement: Workgroups and committee meetings
Date: 7/10/2025

Type of engagement: Workgroups and committee meetings
Date: 7/24/2025

Type of engagement: Workgroups and committee meetings
Date: 8/14/2025

Type of engagement: Workgroups and committee meetings
Date: 8/28/2025

Type of engagement: Workgroups and committee meetings
Date: 9/25/2025

Type of engagement: Workgroups and committee meetings
Date: 10/9/2025

Type of engagement: Workgroups and committee meetings
Date: 10/23/2025

Type of engagement: Workgroups and committee meetings
Date: 11/6/2025

Type of engagement: Workgroups and committee meetings
Date: 11/20/2025

Type of engagement: Workgroups and committee meetings
Date: 12/4/2025

Type of engagement: Workgroups and committee meetings
Date: 12/18/2025

Type of engagement: Workgroups and committee meetings
Date: 6/25/2025

Type of engagement: Workgroups and committee meetings
Date: 7/9/2025

Type of engagement: Workgroups and committee meetings
Date: 7/23/2025

Type of engagement: Workgroups and committee meetings
Date: 8/13/2025

Type of engagement: Workgroups and committee meetings
Date: 8/27/2025

Type of engagement: Workgroups and committee meetings
Date: 9/10/2025

Type of engagement: Workgroups and committee meetings
Date: 9/24/2025

Type of engagement: Workgroups and committee meetings
Date: 10/8/2025

Type of engagement: Workgroups and committee meetings
Date: 10/22/2025

Type of engagement: Workgroups and committee meetings
Date: 11/12/2025

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

- Providers- Older Adult Providers
- Providers- Homelessness Services Agencies and County Office of Care Coordination Providers- Independent Living Centers
- Providers- Mental Health Services Orgnazations Providers- SUD treatment organizations Providers- Regional Centers
- Providers- Veterans Organizations Providers- other services providers

- Community Member/Orgs- consumers of mental health services Community Members/Orgs- Consumers of SUD disorders treatment
- "Community Members/Orgs- Families of consumers (all ages) who who receive mental health services"
- "Community Members/Orgs- Families of consumers (all ages) who who receive substance use disorder services"
- Community Members/Orgs- Veterans or Military Service
- Community Members/Orgs- Community Based organization/Non-profit Community Member/Orgs - Lived experience with homelessness "Community Member/Orgs -Domestic violence and/or sexual abuse representatives"
- Health Care Orgs - First responders
- Health Care Orgs - Health Care Service plans
- Health Care Orgs - Hospitals
- Health Care Orgs - Public Health organizations Health Care Orgs - Primary Care
- Public Entities - Education
- Public Entities - Public safety agencies
- Public Entities - County Social Services agencies Public Entities - Juvenile justice agencies
- Public Entities - Tribal and Indian Health Program representatives Public Entities - Disability insurers/Social Security
- Public Entities - Community Development and Housing Public Entities - Managed Care Plans
- Public Entities - Office of Care Coordination (Homeless Services and CoC) Providers - Other service providers

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

Largest City Population Rank	City name
1	Anaheim
2	Irvine
3	Santa Ana
4	Huntington Beach
5	Garden Grove

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

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:
Development of the Integrated Plan was guided by a robust, inclusive engagement process designed to ensure that community voices and diverse stakeholder perspectives shaped every stage of planning. The Orange County Health Care Agency (HCA), in collaboration with local partners, conducted a series of community forums, focus groups, surveys, and listening sessions targeting populations most impacted by health disparities, including people with lived experience of homelessness, behavioral health conditions, substance use, and chronic illness.

Stakeholders included community-based organizations, faith groups, health providers, advocacy coalitions, education partners, and representatives from diverse racial, ethnic, linguistic, and cultural communities.

Input was gathered in multiple languages and through accessible formats to maximize participation. Data from these sessions were synthesized and reviewed by a multi-sector planning committee to identify shared priorities and ensure equitable representation.

Community members identified key strengths, such as strong local partnerships, dedicated outreach workers, and a growing commitment to culturally responsive care. They also highlighted needs for expanded mental health and substance use services, improved access to housing and transportation, and stronger integration between physical and behavioral health systems. Priorities that emerged—such as prevention, equity, and cross-system collaboration—were embedded throughout the Integrated Plan's goals, strategies, and measurable outcomes.

By centering community expertise and maintaining transparency throughout the process, the Plan reflects both data-driven insights and lived experience. This participatory approach has fostered shared ownership and alignment across agencies and community partners, ensuring that the Plan not only addresses identified gaps but also builds upon community strengths to advance health equity.

BHSA Forum Jan 2026 Translation_Vietnamese_Formatted_1.22.26.pdf BHSA Forum Jan 2026 Translation_Spanish_Formatted_1.22.26.pdf BHSA Forum Jan 2026 FINAL CLEAN version_MASTER_1.23.26.pdf

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 .

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

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:

Orange County Behavioral Health Services (BHS) plays an active and collaborative role in the Local Health Jurisdiction's (LHJ) Community Health Improvement Plan (CHIP) leadership structure. BHS maintains representation on both the CHIP Executive and Steering Committees and provides leadership through chairing the Substance Use Disorder and Mental Health Workgroups. As part of the most recent Community Health Assessment (CHA) process, BHS reviewed and analyzed community data and incorporated key findings into its own Community Assessment to ensure alignment with countywide health priorities. BHS, the LHJ, and Medi-Cal Managed Care Plans (MCPs) have established regular coordination meetings to advance shared planning and improve data integration. In partnership with local hospitals and other community stakeholders, BHS also participates in a multi-sector data-sharing workgroup designed to enhance collective assessment efforts and promote unified health improvement strategies with alignment targeted for 2028.

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

Yes

Collaboration

Please select how the county collaborated with the LHJ:

Attended key CHA and CHIP meetings as requested.

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

Data-Sharing

Data-Sharing to Support the CHA/CHIP

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

Overdoses

Access to Care

Was data shared?

Yes

Data-Sharing from MCPS and LHJs to Support IP development

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

Prevention of Co-Occurring Physical Health Conditions

Stakeholder Activities

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

Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.

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.

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

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

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

In developing the Orange County Behavioral Health Integrated Plan, the County carefully reviewed and

incorporated key findings, priorities, and strategies identified in the Local Health Jurisdiction's (LHJ) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). These documents provided a foundation for understanding broader community health needs, disparities, and population-level trends that inform behavioral health planning and service delivery. The BHS planning team continues to collaborate closely with LHJ leadership to ensure that goals, objectives, and performance measures in the Integrated Plan align with broader countywide health improvement priorities. Where applicable, BHS integrated CHA and CHIP focus areas—such as behavioral health access, substance use prevention, and health equity—into program development, data collection, and evaluation frameworks to strengthen coordination and advance shared outcomes across the public health system.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

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

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

Through the BHSA Community Program Planning (CPP) process and ongoing collaboration with managed care plans (MCPs) and the Local Health Jurisdiction (LHJ)/Public Health the County identified priority needs related to improving access to care, reducing barriers to enrollment and continuity of coverage, strengthening provider capacity, advancing behavioral health quality, and improving outcomes and equity for historically underserved communities. In response, the MCP's Community Reinvestment Plan strategies align with several CPP-identified priorities and support coordinated implementation of the County's Integrated Plan.

Specifically, the MCP has identified Community Reinvestment strategies to increase access to health and well-being, including activities focused on eligibility, enrollment, and retention supports for Medi-Cal and other assistance programs, as well as provider access grants intended to expand appointment availability through extended hours, Saturday hours, and same-day services. These activities align with community input and identified system needs to reduce access barriers, improve timeliness of care, and strengthen service navigation and continuity across systems.

The MCP also identified behavioral health-related initiatives intended to support and align with quality improvement expectations, including initiatives connected to the MCP Quality Achievement and Enforcement framework and the County's behavioral health oversight and transformation efforts. These strategies reflect CPP stakeholder priorities related to improved accountability, care coordination, and stronger alignment between managed care and specialty behavioral health systems.

In addition, the MCP's focus on improving health outcomes and advancing health equity, including prevention-focused strategies and approaches to address social drivers of health (SDOH) consistent with APL 25-004, aligns with CPP-identified needs to reduce disparities and improve outcomes for populations experiencing the greatest inequities and unmet needs. The County, in partnership with the LHJ and MCPs, will continue using shared data review, coordinated planning structures, and stakeholder engagement to refine Community Reinvestment activities and ensure they remain responsive to CPP findings and Integrated Plan priorities.

Comment Period and Public Hearing

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 B.3 Public Comment and Updates to the Integrated Plan .

Comment Period and Public Hearing

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

Confirm that the data is up to date and reflects the correct information for a Final Plan

Date the draft Integrated Plan (IP) was released for stakeholder comment:
2/23/2026

Date the stakeholder comment period closed:
3/27/2026

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

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality:
https://www.ochealthinfo.com/BHSA3yearplan

Please provide the link to the public posting:
https://www.ochealthinfo.com/BHSA3yearplan

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:
https://www.ochealthinfo.com/services-programs/mental-health-crisis-recovery/mental-health-services-act-mhsa/m

Please select the process by which the draft plan was circulated to stakeholders:
Public posting Other
Email outreach

Attach email:
Behavioral Health Integrated Plan 30-Day Public Comment.pdf

Please specify the other process the draft plan was circulated to stakeholders:
Advertising on social media, email distribution, announcements at standing meetings and county partner meetings.

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
Housing, Continuum of Care representatives, including a City

Summarize the substantive revisions recommended this stakeholder during the comment period:
The housing representatives recommended BHS increase Housing Intervention funding for capital development by $375,000 annually in the Integrated Plan, reaching the maximum allowable 25% set-aside and representing a $1.125 million increased investment over the three-year planning cycle. BHS incorporated the update as is reflected in the budget modification.

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

County Behavioral Health Services Care Continuum

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.

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 .

Medi-Cal Quality Improvement Plans

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

For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027:
QAPI Work Plan Summary FY25-26 FINAL.xlsx

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	73
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	107

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	31
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	107

All BHSA Provider Locations

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

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?
9%

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:
Orange County recognizes that a limited percentage of BHSA-funded Specialty Mental Health Services (SMHS) provider locations currently contract with at least one Medi-Cal managed care plan (MCP) for the delivery of non-specialty mental health services (NSMHS). This reflects both the historical role of these providers within the specialty behavioral health system and broader structural and operational barriers that impact MCP contracting.

While Orange County Behavioral Health Services (BHS) supports improved alignment between payer responsibility and service delivery, the County does not have authority over MCP contracting decisions. Many community-based organizations (CBOs) funded through MHSA and now BHSA were developed to provide community-based, prevention, and early intervention services and/or specialty behavioral health services and may not currently meet MCP network participation requirements, including staffing, licensure, billing infrastructure, and administrative capacity.

Beginning July 1, 2027, and over the subsequent two years, BHS will implement a phased approach to support increased readiness for MCP contracting among BHSA-funded provider locations where appropriate. This approach includes:

Assessment of BHSA-funded provider locations to identify those that may be positioned to deliver NSMHS-reimbursable services.

Supporting provider readiness through targeted capacity-building efforts, including a portion of the County's OAC approved Innovation PIVOT project, which assists CBOs in evaluating infrastructure, workforce, and certification pathways related to Medi-Cal Behavioral Health Plan (BHP), Drug Medi-Cal Organized Delivery System (DMC-ODS), and MCP participation.

Facilitating coordination and information-sharing between providers and MCPs to clarify expectations related to contracting, credentialing, and service delivery.

Incorporating MCP alignment considerations into future program design, procurement, and contract renewal processes where feasible.

Through these efforts, Orange County aims to improve long-term alignment between service delivery and payer responsibility while maintaining access to culturally responsive, community-based services for priority populations.

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

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

Please describe any implementation challenges or concerns with the requirements for BHSA providers:
Orange County has identified several challenges that impact the ability of BHSA-funded provider locations, particularly community-based organizations (CBOs), to contract with Medi-Cal managed care plans (MCPs). Many CBOs that serve underserved and priority populations do not have the infrastructure required to participate in MCP networks, including administrative capacity, billing systems, and access to licensed clinical leadership required to meet "head of service" or supervision requirements.

Additionally, variability in MCP contracting requirements, limited network expansion in certain service areas (e.g., Enhanced Care Management), and workforce shortages further constrain opportunities for CBO participation. These factors are particularly impactful for smaller, community-rooted organizations that play a critical role in engaging hard-to-reach populations but were not designed to operate within insurance-based delivery systems.

These challenges create barriers to rapidly increasing MCP contracting rates and highlight the need for sustained capacity-building efforts, flexible funding, and continued coordination across county, MCP, and provider partners to support long-term system alignment.

Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least

once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county.

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

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

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

Behavioral Health Services Act/ Fund Programs

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

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General

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

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

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

For each program or service of the county's BHSS funded Children's System of Care (non-FSP) program, provide the following information. 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 .

Please select the service types provided under Program

- Supportive Services
- Mental health services

Please describe the specific services provided:

Children's System of Care Expansion will strengthen access to timely, clinically appropriate outpatient clinic services for BHSA-eligible children and adolescents who have no health coverage and require structured, ongoing behavioral health treatment and supports. This expanded service capacity aligns with BHSA priorities and CalAIM goals by increasing equitable access to care, improving care coordination and linkage, and supporting intervention and stabilization in the least restrictive, community-based setting.

Children's System of Care outpatient clinic care will provide comprehensive, clinic-based specialty behavioral health services tailored to individual clinical needs and may include assessment and treatment planning; individual and group outpatient therapy; crisis intervention and stabilization support; medication supports; case management; and other clinically appropriate interventions. In addition, funding may support the provision of Day

Rehabilitation services for youth who require a higher intensity of structured therapeutic programming to prevent hospitalization, support step-down from more restrictive settings, or stabilize emerging symptoms. Day Rehabilitation services will provide developmentally appropriate,

skill-based group interventions, therapeutic activities, family engagement, and coordinated clinical oversight designed to improve functioning and promote community integration.

Services will be designed to support symptom reduction, functional improvement, school and family engagement, and continuity of care across levels of need. The inclusion of Day Rehabilitation strengthens the continuum of care by offering an intermediate level of support that helps youth remain in their homes, schools, and communities while receiving intensive therapeutic intervention.

The program strengthens referral and linkage pathways through coordinated entry points and partnerships, including referral and linkage provided through OC Links, educational entities, child welfare and justice systems, and other outpatient services and supports. The program will emphasize coordinated transitions and connection to community-based resources, including evidence-based practices (EBPs), to support sustained engagement and improved outcomes for children and youth.

Through this expansion, Orange County Behavioral Health Services (BHS) aims to reduce barriers to outpatient and structured day treatment services, enhance coordinated access for uninsured BHSA-eligible children and adolescents, and strengthen a responsive Children's System of Care that supports recovery, resiliency, and improved well-being.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	500
FY 2027 – 2028	510
FY 2028 – 2029	520

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care.
OC used the data provided by DHCS to estimate the number of uninsured children and youth that may be in need of behavioral health services.

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

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 .

Please select the service types provided under Program

- Mental health services
- Supportive services

Please describe the specific services provided:

Short-Term Residential Therapeutic Program (STRTP): STRTPs provide time-limited, trauma-informed, and clinically intensive residential behavioral health services for BHSA-eligible children and youth, with a focus on system-involved populations who require 24/7 care due to significant mental health and/or substance use treatment needs. STRTPs primarily serve youth involved in the child welfare and/or juvenile justice systems, including youth with complex trauma histories, high acuity symptoms, functional impairment, and co-occurring needs that cannot be safely or effectively addressed in a lower level of care.

STRTP services are designed to stabilize youth in the least restrictive residential setting while supporting timely transition to family-based or community-based placement whenever clinically appropriate. Services include comprehensive assessment and individualized treatment planning; individual and group therapy; medication supports; crisis stabilization; rehabilitation and skill-building interventions; care coordination; and structured support for developmental, educational, and permanency-related needs. STRTPs also emphasize family engagement, youth voice and choice, and culturally responsive practices to support long-term recovery and resilience.

In alignment with BHSA and CalAIM goals, STRTPs strengthen access to intensive treatment for youth with the highest needs while promoting continuity of care across systems. BHS coordinates STRTP services with outpatient providers, Children's System of Care programs, OC Links referral pathways, and other evidence-based practices (EBPs) to support step-down transitions, prevent re-entry into higher levels of care, and improve outcomes for system-involved children and youth.

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	215

FY 2027 – 2028	215
FY 2028 – 2029	215

Please describe any data or assumptions your county used to project the number of individuals served through the Children's System of Care Projected numbers to be served were estimated using a capacity-based approach informed by historical utilization.

For residential services, BHS used staffed bed capacity and historical occupancy rates, combined with average length of stay, to estimate annual throughput and unduplicated individuals served. For outpatient services, BHS used projected staffed clinical capacity and historic productivity/utilization patterns to estimate annual unduplicated clients. Projections were then compared to recent utilization trends and adjusted to reflect expected demand and implementation timelines.

BHS will monitor actual utilization and update projections as needed based on referral patterns, workforce capacity, and shifts in demand, including for system-involved youth and populations experiencing disparities in access.

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

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

Please select the service types provided under Program

- Supportive services

Please describe the specific services provided:

Recovery Supports for Adults and Older Adults

Recovery Supports for Adults and Older Adults is a community-based, recovery-oriented system support program that provides voluntary, non-crisis behavioral health supports for adults and older adults seeking to strengthen wellness, social connection, and long-term stability in the community. Services are designed to promote recovery, independence, and resilience through accessible, person-centered supports that complement clinical treatment and reduce reliance on higher levels of care.

Recovery Supports are delivered through peer-run models, including Center-Based services, and other recovery-focused settings, and emphasize lived experience, mutual support, and community connection. These peer-operated environments provide walk-in access and voluntary participation, creating welcoming spaces that foster empowerment, hope, and self-determination. Services may include peer support, skill-building and wellness activities, social engagement opportunities, resource navigation, and linkage to community-based services, with flexibility to respond to local needs and preferences.

Recovery Supports also include the provision of supported employment services for individuals with mental health, substance use, or co-occurring conditions. Employment supports are grounded in recovery-oriented principles and the belief that meaningful, competitive, and integrated employment is an essential component of wellness and community inclusion. Individuals who express a desire to work are supported through personalized, strengths-based approaches that emphasize rapid engagement, individualized job development, and ongoing support.

Supported employment services may be delivered within behavioral health teams, peer-run recovery support settings, clinics, or through community partnerships, and are designed to coordinate closely with employers, families, and treatment providers. Service delivery is intentionally flexible to allow adaptation to local conditions while maintaining alignment with evidence-informed supported employment practices.

Through this integrated system of peer-run recovery supports and employment services, BHS seeks to strengthen community-based infrastructure, elevate the role of peers in service delivery, and support adults and older adults in achieving sustained recovery, purpose, and improved well-being in alignment with BHSA and CalAIM goals.

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	1750
FY 2027 – 2028	1785
FY 2028 – 2029	1821

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:
Projected numbers to be served under Recovery Supports for Adults and Older Adults were developed using historical utilization data, available funding, service design, and anticipated staffing capacity.

For peer-run Centers and recovery support services, BHS estimates serving approximately 1,750 unduplicated individuals annually with incremental increases each year. This estimate is informed by prior utilization patterns across peer-operated wellness centers, the walk-in and group-based nature of services, and the availability of approximately $5.3 million to support these recovery-oriented, non-clinical supports. The projected service level reflects the ability of peer-run models to engage a broad population through flexible, community-based approaches while maintaining fiscal sustainability.

For the supported employment component, BHS recognizes that statewide estimates indicate a significantly larger population may be eligible for supportive employment services. However, given current funding, workforce availability, and the intensity of evidence-informed supported employment models, BHS estimates serving approximately 200–300 individuals annually, with an initial planning estimate of approximately 250 individuals. This projection reflects expected per-participant service costs, staffing requirements, and the need for phased implementation to ensure service quality and fidelity.

BHS will prioritize supported employment services for individuals with the highest need and greatest potential benefit, including individuals with serious mental illness, substance use disorders, and co-occurring conditions, and will coordinate these services with peer-run recovery supports and clinical treatment when appropriate. Actual utilization will be monitored regularly and adjusted over time based on demand, workforce capacity, and available resources.

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

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

Please select the service types provided under Program

Mental health services

Please describe the specific services provided:

A2: Behavioral Health System Access, Intake, and Outpatient Clinical Services Program:

This program provides system-wide behavioral health access, coordination, and outpatient treatment services designed to improve timely entry into care, continuity of services, and engagement across the behavioral health system of care. The program integrates 24/7 phone-based system access, centralized intake and care transition services, and outpatient clinic-based treatment, serving as a coordinated entry point and service hub for adults and families with behavioral health needs.

As part of the Behavioral Health Services and Supports (BHSS) System of Care under the Behavioral Health Services Act (BHSA), the program strengthens access to care, reduces system fragmentation, and ensures individuals are connected to appropriate services based on clinical need rather than coverage status. The program supports early identification, crisis response coordination, timely outpatient engagement, and continuity following discharge from higher levels of care.

The program operates through a braided funding model combining Medi-Cal reimbursement with BHSS funding. Medi-Cal funds support covered services for eligible individuals, while BHSS funding ensures access for BHSA-eligible adults and families with no coverage, as well as individuals who are uninsured, underinsured, or otherwise ineligible for Medi-Cal.

Program Components and Services Delivered

1. 1.24/7 Behavioral Health System Access and Crisis Coordination The program operates a 24/7 centralized phone-based access line that serves as a single point of contact for individuals, families, providers, and system partners. Services include:
    - Real-time screening, triage, and referral to appropriate levels of care
    - Crisis consultation and coordination, including dispatch and coordination of the Crisis Assessment Team (CAT) when clinically indicated Information and referral to behavioral health, medical, and community-based services Warm handoffs and follow-up to promote successful connection to services Support for early intervention and diversion from higher levels of care when appropriate. A portion of program costs may be allocated to Early Intervention to account for crisis supports and CAT-related activities that prevent escalation and promote stabilization. Past utilization records indicate that approximately 45,000 calls were answered in FY 24/25. The number of unique callers was not quantified and the projected numbers

of individuals to be served includes an estimates number of unduplicated callers.

2. Centralized Intake and Care Transition Services

   The program functions as centralized intake locations to support timely access to behavioral health services, particularly for individuals transitioning from psychiatric hospitals, emergency departments, and select carceral settings. Services include:

   - Intake screening and assessment to determine service needs and level of care Eligibility verification and benefits screening
   - Appointment scheduling and linkage to outpatient and community-based services Care coordination to ensure access to services within 7–14 days of discharge
   - Short-term engagement and follow-up to support successful transitions and reduce readmissions Medication support services
   - Centralized intake services are primarily funded through Medi-Cal, with BHSS funding used to support individuals without coverage and ensure equitable access.

3. Outpatient Clinic Care Services

   The program includes Outpatient Clinic Care, providing ongoing, clinic-based mental health and/or substance use treatment for BHSA-eligible adults and families with no coverage who require structured therapeutic services but do not need crisis, inpatient, or intensive levels of care.

   Outpatient Clinic Care services include:

   - Comprehensive behavioral health assessments and diagnosis Individual, group, and family therapy
   - Medication support and psychiatric services, as appropriate Treatment planning and ongoing clinical monitoring Psychoeducation and skill-building interventions
   - Coordination with primary care, specialty providers, and community supports
   - These services support stabilization, symptom management, and recovery, and serve as a critical step in maintaining engagement in care following crisis episodes or system entry.
   - Across all components, services are delivered in a culturally responsive and linguistically appropriate manner, emphasizing equity and accessibility. The integrated design ensures seamless movement across levels of care, promotes early intervention, and supports continuity within the BHSS System of Care under BHSA.

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	16000

FY 2027 – 2028	17300
FY 2028 – 2029	18200

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:
Projected numbers of individuals to be served through the Combined System Support Program were developed using historical utilization data and conservative growth assumptions. Baseline estimates were informed by prior-year service utilization, including outpatient services for adults and older adults (approximately 4,591 individuals served), a centralized intake program supporting hospital discharges and timely access (approximately 700 individuals served), and a 24/7 access and triage line.

For the access and triage line, historical call volume (approximately 45,000 calls annually) was converted to an estimated unduplicated individual count using a conservative assumption of multiple calls per individual per year, recognizing that callers may include repeat callers, caregivers, and providers. For planning purposes, this resulted in an estimated 10,000 individuals served annually through access and triage functions.

Projections also reflect the addition of funding to expand substance use disorder services for previously unfunded individuals, as well as enhanced system coordination across outpatient, intake, access, and crisis response functions. To avoid overestimation and potential duplication across service components, conservative annual growth rates were applied.

Based on these assumptions, the Combined System Support Program is projected to serve approximately 16,000 individuals in Year 1, increasing to approximately 17,300 individuals in Year 2 and 18,200 individuals in Year 3 as services reach full implementation and demand increases.

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

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

Please select the service types provided under Program:

- Mental health services

Please describe the specific services provided:

A3: Crisis System of Care Programs

The Crisis Residential Program is a short-term, voluntary, 24/7 community-based mental health treatment program that provides a safe, structured, and home-like environment for individuals experiencing an acute psychiatric crisis. The program serves individuals who do not require inpatient psychiatric hospitalization but need more intensive support than outpatient services

can provide. The program is designed to stabilize acute symptoms, reduce crisis intensity, and support timely transition back to community-based care.

As part of the Behavioral Health Services and Supports (BHSS) System of Care under the Behavioral Health Services Act (BHSA), the program strengthens the crisis continuum by offering a least restrictive alternative to inpatient hospitalization. The program promotes recovery-oriented, trauma-informed care and improves system flow by diverting individuals from emergency departments and inpatient settings while maintaining continuity of care.

The program operates through a braided funding model that combines Medi-Cal reimbursement with BHSS funding, ensuring access to services for Medi-Cal-eligible individuals as well as those who are uninsured or otherwise not eligible for Medi-Cal.

The Crisis Residential Program provides 24/7 clinical and supportive services focused on stabilization, engagement, and transition planning. Services include, but are not limited to, the following:

- Crisis Stabilization and Assessment
- 24/7 supervision and staffing in a safe, supportive, residential setting
- Comprehensive mental health assessments, including risk assessment and crisis evaluation Development of individualized stabilization and treatment plans
- Ongoing monitoring of symptoms and safety Therapeutic and Clinical Services
- Individual and group therapeutic interventions focused on crisis stabilization and coping skills Psychiatric services, including medication support and coordination with prescribing providers Psychoeducation to support understanding of symptoms, treatment options, and recovery strategies Trauma-informed and recovery-oriented interventions tailored to individual needs
- Care Coordination and Continuity of Care
- Coordination with outpatient behavioral health providers, primary care, and community-based services Collaboration with hospitals, emergency departments, crisis teams, and other system partners Discharge planning beginning at admission, including linkage to follow-up services and supports Support for transitions back to the community to reduce risk of readmission or relapse
- Supportive Services
- Assistance with activities of daily living during the crisis period Supportive counseling and engagement services
- Family and natural support involvement, as appropriate and with consent Coordination of transportation and other practical supports as needed Equity and Access Supports
- Services delivered in a culturally responsive and linguistically appropriate manner
- Support for individuals regardless of insurance status through braided Medi-Cal and BHSS funding Coordination with benefits assistance and linkage to coverage when applicable
-

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	1250

FY 2027 – 2028	1275
FY 2028 – 2029	1300

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

Projected numbers of individuals to be served through the Crisis Residential Program were developed based on program capacity, historical utilization patterns, and the characteristics of the eligible population. Crisis residential services are designed to serve a defined subset of individuals experiencing acute behavioral health crises who meet specific clinical and programmatic criteria, which naturally limits the size of the eligible population.

The program is expected to operate at or near maximum capacity throughout the three-year planning period. As a result, the number of individuals served annually is driven primarily by bed capacity, average length of stay, and client turnover rather than by changes in demand. Given these operational realities, large year-to-year increases in the number of individuals served are not anticipated.

Modest incremental increases in projected individuals served across the planning period reflect operational efficiencies, improved care coordination, and minor reductions in average length of stay as system integration efforts mature. However, overall projections assume a largely stable service volume due to the finite number of beds and the limited size of the eligible client population.

Based on these assumptions, the Crisis Residential Program is projected to serve approximately 1,250 individuals in Year 1, 1,275 individuals in Year 2, and 1,300 individuals in Year 3.

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 .

Program or service name

The CEI1: Family, Infant, and Early Childhood Continuum of Care Services program provides a comprehensive Children and Youth Early Intervention (CEI) continuum of care for children ages 0–8 and their families, with an emphasis on infants and young children ages 0–5. The program is designed to identify, engage, and support families experiencing early behavioral health concerns or elevated risk due to trauma exposure, perinatal substance exposure, adverse childhood experiences, and other psychosocial stressors. Outreach is conducted across each component with focus on early childhood partners including but not limited to early childhood educational settings, child welfare, primary care, and system of care partners.

The program promotes early identification, timely intervention, and coordinated care to reduce barriers to services and improve developmental, social-emotional, and family outcomes. Services are developmentally appropriate, trauma-informed, culturally and linguistically responsive, and grounded in evidence-based and relationship-focused practices. The program prioritizes trauma-exposed children, caregivers, and families, recognizing the central role of caregiver-child relationships in early childhood development and healing.

As part of the BHSA Children and Youth Early Intervention system of care, the program emphasizes cross-system collaboration and care integration, working closely with social services, early care and education providers, physical health and perinatal care providers, managed care plans, and community-based organizations. The integrated model supports families across settings and stages, promoting stability, resilience, and long-term well-being.

Services Delivered

1. Early Identification, Screening, and Assessment
   The program provides developmentally appropriate screening and assessment services to identify early behavioral health needs and risk factors in children ages 0–8, with emphasis on ages 0–5. Services include: Developmental, social-emotional, and behavioral health screenings
2. Trauma and psychosocial risk screening, including perinatal substance exposure
   Multidisciplinary assessments involving behavioral health, developmental, and family systems perspectives Ongoing monitoring to support early identification and timely intervention
3. Early Intervention Treatment and Family-Centered Care
   The program delivers early intervention behavioral health treatment tailored to the developmental needs of young children and their caregivers. Services include:
4. Individual, family, and dyadic therapeutic interventions

Trauma-informed and attachment-based treatment approaches

5. Evidence-based and evidence-informed models, including Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), and attachment-focused therapies Strengthening caregiver-child relationships to support emotional regulation, attachment, and resilience
6. Early Childhood Mental Health Consultation (ECMHC)
   The program includes Early Childhood Mental Health Consultation, a relationship-based service in which licensed or licensed-eligible mental health professionals partner with early childhood providers to support social-emotional development and reduce behavioral challenges. Services include: Consultation to preschools, childcare centers, family childcare homes, and early learning environments Observation and coaching to support child behavior and emotional development. Support for caregivers and providers in understanding trauma, development, and behavior Direct therapeutic intervention with the child and caregiver when clinically indicated Capacity-building for early childhood systems to promote inclusive, supportive environments
7. Perinatal Substance Use Disorder (SUD) Services
   The program incorporates Perinatal Substance Use Disorder services to support pregnant and postpartum individuals and their infants, recognizing the critical importance of early intervention during the perinatal period. Services include: Family-centered substance use treatment for pregnant and postpartum individuals Integrated behavioral health, medical, and care coordination services, support for safe pregnancies, infant health, and early bonding Trauma-informed counseling and relapse prevention supports Coordination with obstetric, pediatric, and primary care providers. These services promote maternal health, infant safety, and stable family functioning while reducing risks associated with prenatal and postpartum substance use.
8. Care Coordination, Case Management, and System Linkages
   The program provides care coordination and case management to ensure families are supported across systems and services. Activities include: Linkage to behavioral health, medical, developmental, and social services Coordination with child welfare, early intervention, and education systems Collaboration with managed care plans and community partners, support with referrals, follow-up, and engagement in ongoing services
9. Caregiver Support, Education, and Engagement
   Recognizing caregivers as essential partners in early intervention, the program offers: Psychoeducation on child development, trauma, attachment, and substance exposure Parenting support and skill-building, Emotional support and stress reduction for caregivers, Services delivered in culturally and linguistically responsive ways.
   Early Childhood Mental Health Consultation is a relationship-based service in which a mental-health professional partners with early childhood providers, such as preschools, childcare centers, family childcare homes, and other early-learning environments, to support the social-emotional well-being of young children. This updated scope includes warm hand-offs and linkages to therapeutic intervention for the child and caregiver—often aligned with evidence-based models such as Child-Parent Psychotherapy (CPP), Parent-Child Interaction Therapy (PCIT), or Attachment-based therapies—provides direct, dyadic mental-health treatment that focuses on the relationship between the young child

(ages 0–5) and their primary caregiver.

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
- Outreach

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

Child Parent Psychotherapy (CPP) Parent Child Interaction Therapy (PCIT)

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Child Parent Psychotherapy (CPP)
Parent Child Interaction Therapy

Please describe intended outcomes of the program or service

1. Increase the percentage of infants, young children, and caregivers who receive a completed behavioral health assessment and initiation of early intervention services within a defined timeframe following identification or referral. This outcome advances BHSA priorities related to early identification and timely access to behavioral health services for children and families. By measuring time from referral to assessment and service initiation, the program supports CalAIM access standards and promotes early intervention during critical developmental periods.

2. Improve social-emotional functioning and reduce trauma-related behavioral health needs among infants and young children receiving early intervention services. This outcome reflects BHSA's emphasis on trauma-informed, intervention-oriented services and supports CalAIM's whole-person care framework. Improvements in child social-emotional functioning will be measured using developmentally appropriate tools, including Early Childhood CANS domains, to capture meaningful change during early development.

3. Increase caregiver capacity and strengthen caregiver–child relationships to support emotional regulation, attachment, and long-term resilience. This outcome aligns with BHSA priorities that recognize caregivers as essential partners in early childhood behavioral health intervention. By strengthening caregiver capacity and caregiver–child relationships, the program supports CalAIM's family-centered care principles and promotes long-term stability and resilience for children and families.

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	1150
FY 2027 – 2028	1250
FY 2028 – 2029	1300

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

Because this is a new early childhood behavioral health program in Orange County, historical utilization data are not available to directly project individuals served. To develop a realistic estimate, HCA applied a tiered service model based on anticipated clinical intensity and typical engagement patterns for children ages 0–5 and their caregivers. Tier A includes screening, brief intervention, and linkage services (generally 1–3 touchpoints). Tier B includes multidisciplinary assessment and a short episode of early intervention (generally 4–8 touchpoints) and incorporates dyadic elements and structured caregiver coaching. Tier C represents a smaller subset of children requiring ongoing specialty mental health treatment (approximately 12–30+ encounters annually).

For planning purposes, HCA assumed a service distribution of approximately 55% Tier A, 30% Tier B, and 15% Tier C. To reflect Orange County's higher service delivery costs (including workforce, overhead, and capacity constraints such as bilingual staffing needs and engagement-related administrative time), per-child cost assumptions were adjusted upward. Applying these tier costs to the projected service mix yields a blended estimated cost of approximately $2,400 per unduplicated child served.

Using the program's annual BHSA funding allocation of approximately $3.0 million and the blended cost estimate, the program is projected to serve approximately 1,150 unduplicated children in Year 1, 1,250 in Year 2, and 1,300 in Year 3 as implementation stabilizes and referral pathways mature. Projections are intentionally conservative and will be refined as utilization data become available.

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.

Program or service name

CEI2: Early Psychosis Identification is an early intervention-focused program designed to recognize early warning signs and risk indicators of emerging psychosis in adolescents and young adults and to connect individuals to appropriate specialty mental health services before symptoms become severe. The program emphasizes early detection, rapid referral, and timely linkage to coordinated specialty care to reduce the duration of untreated psychosis and improve long-term clinical and functional outcomes.

The program utilizes developmentally appropriate screening, outreach, and assessment strategies to identify individuals experiencing prodromal symptoms or early stages of psychosis. CEI2 works in close collaboration with schools, primary care and pediatric providers, emergency departments, behavioral health providers, and community-based organizations to strengthen referral pathways and ensure timely access to care.

A limited but important component of the program includes technical training and consultation for clinical staff and community partners who are positioned to identify early signs of psychosis. Training activities focus on increasing awareness of early warning signs, improving screening and referral practices, and reinforcing appropriate pathways to specialty mental health and early psychosis programs. These training activities are intended to support and enhance identification and referral efforts and are not the primary driver of individuals served.

Once identified, individuals are supported through warm handoffs, care coordination, and linkage to specialized early psychosis intervention programs. CEI2 operates as part of the BHSA Children and Youth Early Intervention continuum of care and aligns with CalAIM's focus on prevention, early intervention, and integrated behavioral health systems.

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)

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs. No

Please describe intended outcomes of the program or service
Increase the percentage of adolescents and young adults identified with early signs of psychosis who are linked to appropriate specialty mental health or early psychosis services with a completed specialty mental health assessment within 30 days of identification, and linkage to an early psychosis or specialty mental health program within 60 days.

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	750
FY 2027 – 2028	765
FY 2028 – 2029	780

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
The projected number of individuals to be served through CEI2: Early Psychosis Identification was developed using historical utilization data from prior early psychosis identification and referral activities. Previous utilization demonstrated a stable volume of adolescents and young adults identified and referred through similar outreach, screening, and linkage efforts.

Based on this historical utilization, the program estimates serving approximately 750 unduplicated individuals annually through screening, assessment, and referral activities. This projection reflects realistic throughput given the size of the eligible population, the targeted nature of early psychosis identification, and the program's emphasis on timely linkage rather than high-volume service delivery.

Technical training and consultation activities are included to strengthen identification capacity among clinical staff and community partners; however, these activities are not counted toward individuals served and are not the primary driver of the projected service volume. The estimate of 750 individuals served is therefore based on direct identification, assessment, and linkage activities rather than training reach.

Overall projections are intentionally conservative and align with prior utilization patterns, expected referral capacity, and the program's intervention-focused scope. The projected numbers to be served are increased by 2% year over year to account for ramp up and growth.

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 .

Program or service name

The Youth Substance Use Disorder (SUD) Early Intervention Program

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

- Access and Linkage: Screenings
- Treatment Services and Supports: Other Access and Linkage: Assessments

Please specify "other" type of Treatment Services and Supports

This program provides developmentally appropriate substance use services for adolescents and young adults, consistent with Drug Medi-Cal Organized Delivery System (DMC-ODS) requirements and BHSA priorities. The program focuses on early identification, timely engagement, and coordinated service delivery to address substance use concerns among youth and support improved health and behavioral health outcomes.

Services are designed to engage youth through screening, assessment, brief intervention, counseling, family engagement, and care coordination. The program works in collaboration with schools, behavioral health providers, primary care settings, child welfare, juvenile justice, and community-based organizations to facilitate timely referrals and streamlined access to services.

Core service components include developmentally appropriate substance use screening and assessment, individual and family-centered counseling, care coordination, and linkage to appropriate ongoing services based on clinical need. Services are trauma-informed, culturally and linguistically responsive, and delivered using evidence-based and/or evidence-informed approaches appropriate for adolescents and young adults.

As a newly implemented service, the program is structured to expand youth access to substance use services, strengthen system capacity for early intervention, and support coordination across behavioral health and community partners. The program aligns with CalAIM's emphasis on timely access, integrated care, and improved outcomes for children, youth, and families.The Early Intervention SUD Program provides screening, assessment, brief counseling, evidence-based early intervention treatment (e.g., Motivational Interviewing, CBT-informed approaches), family engagement, and care coordination to support timely linkage and sustained engagement in substance use and behavioral health services, consistent with DMC-ODS requirements.

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

- Drug counseling (individual and group)
- Motivational Enhancement Therapy (MET) / Motivational Interviewing

Please provide the name of the EBPs and CDEPs that apply

EBPs and CDEPs
Motivational Interviewing
Drug Counseling (Individual and Group)

Please describe intended outcomes of the program or service

Increase engagement in early intervention services and appropriate linkage to ongoing substance use or behavioral health treatment when clinically indicated. This outcome supports BHSA's emphasis on continuity of care and CalAIM's integrated, whole-person approach by measuring engagement and appropriate care transitions. Successful engagement in early intervention and timely linkage to additional services promotes recovery, reduces escalation of substance use severity, and strengthens youth and family support systems. As a new service, outcomes focus on access, engagement, and early intervention rather than service volume, consistent with DMC-ODS requirements and BHSA priorities. These measures will inform ongoing program development and future refinement of service capacity estimates.

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	300
FY 2027 – 2028	325

FY 2028 – 2029	350

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Estimated numbers of individuals to be served were developed based on the annual funding level for the Youth Substance Use Disorder Early Intervention Program and typical service intensity for developmentally appropriate youth substance use services delivered under the DMC-ODS framework. As a newly implemented program, projections assume a phased implementation and gradual ramp-up as referral pathways are established and service capacity is fully operationalized.

Estimates reflect a conservative per-individual cost assumption that accounts for screening, assessment, counseling, family engagement, and care coordination services. Based on these assumptions, the program is projected to serve approximately 300 individuals in Year 1, increasing to approximately 325 individuals in Year 2 and 350 individuals in Year 3 as the program reaches full implementation.

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
CEI4: System-Involved Youth Program provides specialized, community-based behavioral health services for adolescents and transitional-aged youth who are involved with, at risk of involvement with, or reentering from the justice system. The program focuses on early identification, timely engagement, and coordinated intervention to address behavioral health needs and other factors that contribute to justice system involvement and impede successful community reintegration.

Services are delivered through a multidisciplinary, youth-centered model that emphasizes engagement, stabilization, and continuity of care. The program integrates clinical services, care coordination, family engagement, and system collaboration to support youth across behavioral health, justice, education, and social service systems. Services are trauma-informed, culturally and linguistically responsive, and tailored to the developmental needs of adolescents and transitional-aged youth.

To enhance engagement and support service delivery, the program may incorporate peer support specialists and individuals with lived experience who can support outreach, engagement, and continuity of care. Peer supports are intended to complement clinical

services by strengthening trust, reducing barriers to participation, and supporting youth and families in navigating systems and services.

CEI4 operates as part of the BHSA Children and Youth Early Intervention continuum of care and aligns with CalAIM's focus on coordinated, whole-person care for justice-involved populations. The program emphasizes collaboration with probation, courts, schools, community-based organizations, and other partners to promote stability, accountability, and positive long-term outcomes for youth and families.

The Young Adult Court Innovation Project utilizes a Randomized Control Trial (RCT) to evaluate the effectiveness of a specialized collaborative court model for young adults ages 18-25 compared to traditional court services. The program provides direct behavioral health and support services to eligible participants who voluntarily enroll in the program.

Please select which of the three EI components are included as part of the program or service
Access and Linkage:

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

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs. No

Please describe intended outcomes of the program or service
Increase engagement and connection to appropriate mental health and/or substance use disorder treatment among system-involved adolescents and transitional-aged youth. This outcome aligns with BHSA and CalAIM priorities by measuring engagement and continuity of care for justice-involved youth with behavioral health and co-occurring substance use needs. Engagement in treatment following identification is a critical indicator of successful service delivery for this population and is conceptually aligned with HEDIS measures related to initiation and engagement in mental health and substance use treatment.

Support improved stability and reduced justice system involvement among youth receiving program services. This outcome reflects BHSA's emphasis on rehabilitation and long-term stability for system-involved youth and supports CalAIM's focus on coordinated, cross-system care. By addressing behavioral health and substance use needs and supporting engagement in treatment, the program seeks to improve stability and reduce justice system involvement.

Outcomes emphasize engagement in treatment, continuity of care, and improved stability for justice-involved youth with behavioral health and co-occurring substance use needs, consistent with BHSA priorities and CalAIM transformation goals.

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	425
FY 2028 – 2029	450

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Estimated numbers of individuals to be served through the CEI4 System-Involved Youth Program were developed based on the annual funding level and anticipated service intensity for justice-involved adolescents and transitional-aged youth with behavioral health and potential co-occurring substance use needs.

Projections assume an average annual cost of approximately $7,500 per individual, reflecting the provision of clinical behavioral health services, substance use disorder services when indicated, care coordination, family engagement, system collaboration, and engagement supports, including the use of peer support.

As a newly implemented program, projections assume a phased implementation and gradual ramp-up as referral pathways are established and youth are connected to and engaged in appropriate treatment.

Based on these assumptions, the program is projected to serve approximately 400 individuals in Year 1, increasing to approximately 425 individuals in Year 2 and 450 individuals in Year 3.

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.

Program or service name
A/OAEI1 Justice Involved programs: The Justice-Involved Early Intervention Program provides coordinated, community-based behavioral health services for adults and transitional-aged individuals involved in, or transitioning from, the justice system who are experiencing serious behavioral health and/or co-occurring substance use conditions. The program emphasizes early identification, timely engagement, and continuity of care beginning during incarceration and extending through reentry into the community.

Services are designed to stabilize individuals during critical transition points, reduce barriers to care, and support successful reintegration through coordinated behavioral health treatment and system navigation. Core service components include screening and assessment, brief therapeutic interventions, psychiatric evaluation and medication support, care coordination, discharge planning, and linkage to ongoing mental health, substance use, and supportive services upon release.

The program utilizes a multidisciplinary approach that integrates clinical services, case management, rehabilitative supports, and peer-based engagement. Peer support specialists with lived experience may be incorporated to enhance trust, engagement, and continuity of care, particularly during the transition from custody to the community. Services are trauma-informed, culturally and linguistically responsive, and grounded in evidence-based and evidence-informed practices.

The program emphasizes strong cross-system collaboration with justice partners, behavioral health providers, housing and social service systems, and community-based organizations to ensure seamless transitions and reduce gaps in care. By supporting timely access to treatment, addressing social determinants of health, and strengthening engagement during reentry, the Justice-Involved Early Intervention Program advances recovery, stability, and reduced justice system involvement for individuals with serious behavioral health needs.

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

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

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs. No

Please describe intended outcomes of the program or service

Increase timely engagement and continuity in behavioral health treatment for justice-involved individuals with serious behavioral health conditions during transition from custody to the community. This outcome advances BHSA and CalAIM priorities by measuring timely access to care and continuity of treatment during a high-risk transition period for justice-involved individuals. Engagement in behavioral health services shortly before or after release is conceptually aligned with HEDIS follow-up and engagement measures and is associated with improved stability, reduced crisis utilization, and stronger reentry outcomes.

Support improved behavioral health stability and reduced justice system re-involvement among individuals receiving early intervention services. This outcome reflects BHSA's emphasis on recovery-oriented, rehabilitative services and CalAIM's focus on improving outcomes for individuals with complex needs through coordinated care. By addressing behavioral health conditions early and supporting engagement during reentry, the program aims to improve stability and reduce future justice system involvement.

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	5000

Plan Period by FY	Projected Number of Individuals Served
FY 2027 – 2028	5100
FY 2028 – 2029	5200

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
The estimated number of individuals to be served through the Justice-Involved Early Intervention Program was developed using historical utilization data from existing justice-involved behavioral health programs that provide similar services and serve comparable populations. These programs collectively serve approximately 5,000 individuals annually through coordinated in-reach, reentry, and community-based behavioral health services. A conservative annual growth rate of 2% applied over the three-year planning period to reflect incremental expansion of service capacity and improved engagement strategies.

Historical utilization data reflect stable demand and consistent service volume across multiple program components, including in-custody engagement, discharge planning, care coordination, and post-release behavioral health services. The estimated number of individuals served is therefore based on demonstrated service capacity and actual utilization rather than projected demand or expanded eligibility.

Projections assume continued operation at similar service levels and do not assume significant expansion in program scope or changes in the size of the eligible population. As such, the estimate of individuals served annually is considered conservative and reflective of existing service delivery patterns.

Estimates account for individuals receiving varying levels of early intervention services across the justice continuum, recognizing that some individuals may receive brief engagement or linkage services while others receive more intensive early intervention supports. Duplication across program components was considered in developing the estimate to avoid overstating the total number of unduplicated individuals served.

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 .

Program or service name

Orange County Behavioral Health Services (BHS) supports a comprehensive Continuum of Crisis Intervention Services designed to provide timely, trauma-informed, and community-based crisis response for children, youth, adults, and older adults experiencing acute behavioral health needs. Funded under BHSS Early Intervention, these services advance BHSA and CalAIM goals by promoting early identification, rapid stabilization, and connection to ongoing care in the least restrictive setting, while reducing reliance on emergency departments and inpatient hospitalization.

The crisis continuum includes mobile crisis response services that provide field-based intervention, evaluation, de-escalation, and linkage for individuals in crisis across community settings. These services are designed to meet individuals where they are, support immediate safety and stabilization, and facilitate warm handoffs to appropriate levels of care and recovery supports.

BHS also provides crisis stabilization services, including crisis stabilization units and in-home crisis stabilization, to support individuals who require urgent intervention but can be safely served outside of inpatient settings. These services emphasize rapid stabilization, care coordination, and timely transition to ongoing outpatient, intensive, or recovery-oriented services in the least restrictive setting.

For children and youth, BHS offers Children's Specialized Services (CSS), a voluntary, short-term crisis program serving youth ages 12–17 (up to age 18 if enrolled in high school) who are experiencing Serious Emotional Disturbance (SED) and a behavioral health crisis but do not meet criteria for psychiatric hospitalization. CSS provides a safe respite care as an alternative to inpatient care with the goal of stabilizing youth, preventing unnecessary hospitalization, and supporting reintegration into home, school, and community settings. Services include crisis intervention, individual and family therapy, targeted case management, educational support, structured group activities, transportation assistance, support for

co-occurring disorders, and post-discharge support. Referrals are accepted through BHS Children and Youth Services and approved provider pathways.

In addition, BHS supports suicide intervention efforts, including hotline support, crisis outreach, and postvention services following suicide-related events. These services strengthen community response, reduce risk of future crises, and provide support to individuals, families, and communities impacted by suicide.

Through this integrated crisis continuum, BHS aims to ensure rapid access to early intervention and stabilization services for individuals across the lifespan, strengthen coordinated pathways into ongoing treatment, and support recovery and well-being consistent with BHSA and CalAIM priorities.

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

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

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs. No

Please describe intended outcomes of the program or service

The Continuum of Crisis Intervention Services is expected to improve timely access to stabilization supports and strengthen continuity of care for individuals experiencing acute behavioral health needs. Consistent with BHSA and CalAIM goals, the program will support recovery-oriented crisis response across the lifespan while promoting care in the least restrictive, clinically appropriate setting.

First, the program will improve rates of timely follow-up and linkage to ongoing outpatient and community-based behavioral health services following a crisis episode. This outcome aligns with CalAIM continuity-of-care expectations and applicable HEDIS measures, including Follow-Up After Emergency Department Visit for Mental Illness (FUM), by strengthening transitions from crisis services to ongoing treatment and supports.

Second, the program will increase the ability to stabilize individuals in community-based settings and reduce avoidable emergency department utilization and psychiatric hospitalization. By providing mobile crisis response, crisis stabilization, and supportive transition pathways, the continuum advances BHSA and CalAIM priorities to deliver effective crisis care in the least restrictive setting and improve long-term stability and engagement in recovery-oriented services.

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	13400
FY 2027 – 2028	13800
FY 2028 – 2029	14200

Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Orange County Behavioral Health Services (BHS) projected the number of individuals to be served through Early Intervention (EI) crisis continuum programs using historical utilization data and expected service capacity across core crisis program components. Baseline projections were informed by recent annual service volumes for crisis assessment, crisis stabilization, in-home crisis stabilization, Children's Specialized Services (CSS), and suicide intervention and postvention supports.

The county's baseline estimate reflects approximately 13,000–14,000 individuals served annually across the crisis continuum, based on current utilization levels, including approximately 6,700 individuals receiving crisis assessment services, 5,200 individuals served through crisis stabilization services, 1,000 individuals receiving in-home crisis stabilization, 240 youth served through CSS, and 250 individuals served through suicide intervention and postvention services.

Projections for the three-year period assume relatively stable demand with modest annual growth as BHSA Early Intervention investments continue to strengthen access, expand community-based crisis response capacity, and improve linkage to ongoing care. Because individuals may access more than one crisis service component during a single episode of care, these projections represent estimated annual service reach across the continuum rather than unduplicated counts within a single program element.

BHS will continue to monitor utilization trends, service demand, and capacity over time and will adjust projections as needed to ensure timely access to crisis intervention, stabilization in the least restrictive setting, and effective transitions to ongoing behavioral health services consistent with BHSA and CalAIM goals.

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 .

Program or service name

Orange County Behavioral Health Services (BHS) will provide an Older Adult Early Intervention and Peer Support Program designed to address the unique behavioral health needs of individuals ages 60 and older and Veterans aged 55+ who are at elevated clinical risk for developing a serious mental illness (SMI), substance use disorder (SUD), or co-occurring behavioral health condition. Funded under BHSS Early Intervention, the program aligns with BHSA and CalAIM goals by promoting timely identification of emerging needs, preventing escalation to crisis-level services, increasing access to medication supports, and supporting recovery and well-being in the community.

The program will offer developmentally and culturally responsive early intervention services tailored to older adults, including screening, assessment, short-term therapeutic interventions, care coordination, and referral and linkage to ongoing behavioral health and supportive services as clinically appropriate. Services are intended to support older adults experiencing early signs of behavioral health challenges, functional decline, isolation, grief, or substance-related concerns, with an emphasis on prevention, stabilization, and maintaining independence in the least restrictive setting.

A core component of the program includes peer support and recovery-oriented engagement, providing opportunities for older adults to connect with peers, build social supports, and reduce stigma associated with seeking behavioral health care. Peer-informed services may include group-based wellness activities, socialization opportunities, resource navigation, and connection to community-based recovery supports that strengthen resilience and promote sustained well-being.

Providers delivering this program will be required to operate within the county's specialty behavioral health system and bill Specialty Mental Health Medi-Cal, as applicable, to support sustainability and integration within the broader continuum of care.

Program design will also be informed by countywide aging priorities, including alignment with the County's Master Plan for Aging, to ensure services are age-friendly, accessible, and responsive to the needs of older adults and their families.

Through this integrated early intervention approach, BHS aims to improve access to age-appropriate behavioral health supports, reduce disparities in service engagement among older adults, prevent progression to higher levels of care, and promote healthy aging and community stability consistent with BHSA and CalAIM priorities.

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

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

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:

- Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) Cognitive Behavioral Therapy (CBT) for Anxiety
- Cognitive Behavioral Therapy (CBT) for Late Life Depression

Please provide the name of the EBPs and CDEPs that apply:

EBPs and CDEPs
PEARLS
Cognitive Behavioral Therapy

Please describe intended outcomes of the program or service

The program will increase early identification and engagement of individuals age 60 and older who are at elevated risk of developing serious behavioral health conditions, supporting timely connection to appropriate specialty behavioral health services. BHS will monitor program performance using service utilization and care engagement indicators consistent with early intervention goals for older adults.

Measures will focus on timely follow-up after initial contact, sustained engagement in early intervention services, and reduction in avoidable crisis escalation. Data will be drawn from specialty behavioral health documentation and service records to assess access, continuity, and community-based stabilization outcomes for older adults served through the program. Findings will inform ongoing quality improvement and program refinement to ensure alignment with BHSA and CalAIM priorities.

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	1200
FY 2027 – 2028	1300
FY 2028 – 2029	1350

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

Orange County Behavioral Health Services (BHS) projected the number of individuals to be served in the Older Adult Early Intervention and Peer Support Program using historical utilization from a comparable existing older adult program, which currently serves just over 1,000 individuals annually. Projections also reflect the planned use of Specialty Mental Health Medi-Cal billing to offset a portion of program costs and expand service capacity over time.

BHS anticipates contributing approximately $2 million in BHSA Early Intervention funding to support program implementation, with an estimated 25% of allowable services billed through Medi-Cal. This blended funding approach is expected to increase overall service capacity beyond the BHSA allocation alone and support gradual expansion as billing and workforce capacity mature.

Based on these assumptions, BHS estimates the program could serve approximately 1,200–1,350 older adults annually once fully implemented. BHS will monitor utilization, revenue generation, and service demand over time and adjust projections as needed to ensure timely access and sustainable delivery of age-friendly early intervention services consistent with BHSA and CalAIM goals.

Early Intervention (EI) Programs #8

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

Perinatal Substance Use Disorder (SUD) Early Intervention Services

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

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

Please specify "other" type of Treatment Services and Supports

Perinatal Substance Use Disorder Services. Funded under BHSS Early Intervention, this program aligns with DMC-ODS, CalAIM, and Behavioral Health Transformation priorities by promoting early identification of substance use needs, reducing barriers to treatment initiation, and improving outcomes for parents and infants through whole-person, family-centered care.

Perinatal SUD Early Intervention services will include outreach and engagement, screening and assessment, individualized service planning, outpatient counseling interventions, and care coordination tailored to the perinatal population. Services will emphasize trauma-informed, culturally responsive approaches and will address common co-occurring needs, including mental health concerns, housing instability, intimate partner violence risk, and social drivers of health.

The program will support warm handoffs and linkage to the broader DMC-ODS continuum, including medications for addiction treatment when clinically appropriate, as well as connection to prenatal care, pediatric and family supports, and recovery-oriented community resources. By providing early, coordinated intervention, BHS aims to prevent escalation to higher levels of care, improve retention in treatment, and support healthy pregnancies, family stability, and long-term recovery. Perinatal Substance Use Disorder (SUD) Early Intervention Services to expand access to timely, developmentally appropriate SUD supports for uninsured BHSA-eligible individuals during pregnancy and the postpartum period.

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs. No

Please describe intended outcomes of the program or service

Perinatal Substance Use Disorder (SUD) Early Intervention Services are intended to improve timely access to outpatient SUD supports for uninsured, BHSA-eligible individuals during pregnancy and the postpartum period. Consistent with BHSA, CalAIM, and DMC-ODS priorities, the program will promote early identification of substance use needs, reduce barriers to treatment initiation, and support engagement in recovery-oriented services during a critical period for both parent and infant well-being.

A primary intended outcome is increased timely engagement in outpatient SUD treatment following initial screening or assessment, supporting earlier connection to clinically appropriate care and improving retention in services. The program also aims to strengthen continuity of care through coordinated outpatient counseling, care coordination, and linkage to the broader DMC-ODS continuum, including medications for addiction treatment when appropriate.

In addition, the program is expected to reduce escalation to crisis-level or higher-intensity services by providing accessible, trauma-informed early intervention supports that promote stability, healthy pregnancies, family functioning, and long-term recovery. Through these outcomes, BHS seeks to advance whole-person, community-based care and improve behavioral health and recovery outcomes for perinatal individuals consistent with BHSA and CalAIM goals.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	200
FY 2027 – 2028	230
FY 2028 – 2029	240

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Orange County Behavioral Health Services (BHS) projected the number of individuals to be served through Perinatal Substance Use Disorder (SUD) Early Intervention services using available funding levels, expected outpatient service intensity, and typical DMC-ODS outpatient cost structures. Projections assume delivery of community-based perinatal SUD supports for uninsured BHSA-eligible individuals, including outreach and engagement, screening and assessment, outpatient counseling, care coordination, and linkage to ongoing treatment and recovery supports.

Based on the planned allocation of approximately $1.2 million annually, BHS applied a conservative per-participant planning estimate consistent with outpatient perinatal SUD service delivery and the additional care coordination needs of pregnant and postpartum individuals. Using these assumptions, BHS estimates the program will serve approximately 200 individuals in Year 1, increasing to approximately 230 individuals in Year 2 and 240 individuals in Year 3 as capacity and outreach efforts mature.

BHS will monitor utilization, service demand, and program capacity over time and will adjust projections as needed to ensure timely access to perinatal SUD early intervention services consistent with BHSA, CalAIM, DMC-ODS, and Behavioral Health Transformation goals.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

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

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

CSC program name

CSC1: Orange County Center for Resiliency, Education, and Wellness (OC CREW)

CSC program description

The Orange County Center for Resiliency, Education, and Wellness (OC CREW) serves as Orange County's Coordinated Specialty Care (CSC) program for individuals experiencing a First Episode of Psychosis (FEP). OC CREW provides a comprehensive, evidence-based, recovery-oriented approach designed to promote early engagement, improve outcomes, and reduce the long-term impact of psychotic disorders.

OC CREW offers multidisciplinary, person-centered services that include clinical assessment, psychiatric care, psychotherapy, family education and support, case management, supported education and employment, and peer support. The program emphasizes shared decision-making and collaboration between participants, families, and providers to help individuals achieve their recovery goals and maintain meaningful roles in school, work, and community life.

Grounded in early intervention and resiliency principles, OC CREW seeks to identify and treat psychosis as early as possible—helping participants stabilize symptoms, build coping skills, strengthen natural supports, and foster hope for recovery. Through a coordinated, trauma-informed, and culturally responsive model, OC CREW enhances continuity of care across the behavioral health system and supports long-term wellness and independence. OC CREW is intended to be implemented in FY 2026/27.

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

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

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

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	402
Number of Uninsured Individuals	48

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	51
Number of Teams Needed to Serve Total Eligible Population	12

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	2	2	2

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

Please list the other funding source(s)

Funding sources for the CSC-First Episode for Psychosis program will be supported through BHSA-BHSS categorical funds; Federal Financial Participation (Medi-Cal) funding.

Outreach and Engagement (O&E) Program #1

For each program or activity that is part of the county's standalone O&E programs provide the following information. 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 .

Program or activity name

Behavioral Health (BH) Connection: Behavioral Health Navigation, Outreach, and Engagement Services

Please describe the program or activity

BH Connection provides proactive, person-centered outreach, engagement, and navigation services for individuals with behavioral health needs across Orange County. The program is designed to identify, engage, and support individuals who are disconnected from care, at risk of falling through service gaps, or experiencing challenges maintaining engagement in behavioral health services. BH Connection emphasizes timely linkage to appropriate behavioral health, medical, and social supports through sustained, relationship-based engagement. The program is structured to reach any individual with a behavioral health condition and ensure they are connected to outpatient services, even when ongoing care may ultimately transition back to a Medi-Cal managed care plan (MCP) provider network.

Navigation services under BH Connection focus on engaging individuals where they are—both physically and along their recovery journey—and recognize that individuals with serious mental illness (SMI), substance use disorders, and co-occurring conditions often require multiple, varied engagement attempts before successfully linking to and remaining in care. The program operates under a no wrong door philosophy, ensuring that every interaction represents an opportunity to build trust, provide support, and facilitate connection to services. BH Connection serves as an access point and continuity bridge, ensuring individuals do not fall through gaps between systems of care and supporting seamless transitions to the appropriate outpatient provider, including MCP-covered services when applicable.

Multidisciplinary BH Connection teams include peer support specialists, enhanced community health workers (CHWs), clinicians, case managers, and substance use disorder counselors who work collaboratively to deliver flexible, field-based services. Teams conduct outreach and in-reach across community and treatment settings, including sobering centers, crisis residential programs, other residential care settings, hospitals, and additional points of contact within the behavioral health system. Through these activities, BH Connection supports warm hand-offs, continuity of care, and successful transitions between levels of care and funding systems.

Core navigation activities include field-based outreach, engagement and re-engagement, screening, assessment, case management, care coordination, follow-up, and linkage to behavioral health treatment, substance use disorder services, primary care, and social supports. Navigators also engage individuals identified through cross-system coordination efforts—including justice, health, child welfare, and homelessness systems—to provide outreach, stabilization support, and connection to behavioral health and recovery-oriented services. When appropriate, navigators also support timely transition and linkage back to MCP outpatient networks to ensure continuity and long-term service alignment.

Peer support specialists with lived experience play a central role within BH Connection, fostering engagement through empathy, shared understanding, and trust-building. Peers support individuals who may be hesitant or ambivalent about seeking services, model recovery, and assist with navigation of complex systems, helping to reduce barriers and sustain engagement over time.

BH Connection also includes services delivered by Enhanced Community Health Workers (CHWs), who provide culturally and linguistically responsive outreach, engagement, and care coordination. CHWs serve as trusted community-based supports who help individuals navigate behavioral health and medical systems, including primary care, and address barriers related to language, culture, and system complexity. CHW services include health education, appointment scheduling, care navigation, follow-up, and linkage to medical, behavioral health, and social services. By addressing social determinants of health and systemic barriers, enhanced CHW services promote continuity of care, improve engagement, and support positive health outcomes.

Through sustained outreach, coordinated navigation, and strong partnerships with community providers and systems of care, BH Connection strengthens access to services, reduces avoidable hospitalizations and crisis utilization, and supports long-term recovery, stability, and wellness for individuals with complex behavioral health needs. By ensuring that anyone with a behavioral health condition can be engaged and connected to outpatient care—regardless of entry point or payer source—BH Connection plays a central role in preventing gaps in service delivery and supporting seamless transitions across systems, including transitions back to MCP-covered care when appropriate.

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	4200
FY 2027 – 2028	4284
FY 2028 – 2029	4370

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

With approximately $14.6 million in BHSA funding, Orange County's Outreach and Engagement services are projected to support an estimated 3,200 to 5,500 unique individuals annually, with an expected average of contacts that could be approximately 17 outreach and engagement contacts per individual prior to successful linkage and sustained engagement in care. This estimate reflects the intensive, relationship-based nature of outreach required for individuals with serious mental illness, co-occurring conditions, and SUD, and accounts for multiple engagement attempts across providers and settings. At steady state, the program is expected to engage approximately 4,000–4,500 unique individuals annually. Because outreach and engagement activities may involve multiple staff, service modalities, and repeated contacts over time, individuals will be tracked using unique identifiers to avoid double counting while allowing for multiple engagement episodes as clinically appropriate. Projected service estimates are based on a baseline of 4,200 individuals served in Year 1, with a conservative annual growth rate of 2% applied over the three-year planning period to reflect incremental expansion of service capacity and improved engagement strategies.

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 .

Program or activity name

WET 01: Centralized Internship and Apprenticeship Program

Please select which of the following categories the activity falls under

Internship and Apprenticeship Programs

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

Orange County Behavioral Health Services (BHS) is implementing a comprehensive workforce strategy aligned with the Behavioral Health Services Act (BHSA) and CalAIM goals to expand

access, advance equity, and strengthen system capacity across the behavioral health continuum of care. Persistent workforce shortages driven by competition across systems, administrative and licensure barriers, limited pipeline coordination, and workforce burnout disproportionately impact access to services for underserved populations. In response, BHS is advancing innovative, equity-centered workforce development approaches designed to recruit, retain, and support a culturally and linguistically responsive workforce.

BHS is focused on building and sustaining workforce infrastructure that reflects the racial, ethnic, cultural, and linguistic diversity of the communities served. Workforce Education and Training (WET) initiatives prioritize recruitment and retention of bilingual and bicultural staff, expand training opportunities for County and contracted providers, and offer financial incentives to support workforce entry and career advancement. These efforts are complemented by targeted hiring strategies, including streamlined recruitment processes and on-the-spot hiring events for hard-to-fill licensed and pre-licensed positions, resulting in measurable reductions in vacancy rates and improved service capacity.

A core component of BHS's workforce strategy is the expansion and centralization of paid clinical internship and apprenticeship-style learning opportunities. Through the PIVOT Innovation Project, BHS is testing alternative workforce pathways that reduce barriers between education, licensure, and employment. Utilizing a third-party "employer of record," the project supports extended paid learning opportunities beyond educational requirements, standardized compensation structures that incentivize retention, and financial support during the transition period between graduation and clinical registration. These strategies are designed to create seamless pathways from internship to employment for diverse professionals and paraprofessionals.

In alignment with CalAIM's emphasis on whole-person care and integrated service delivery, BHS is intentionally expanding workforce pathways beyond traditional clinical roles. This includes development and career advancement opportunities for substance use disorder (SUD) counselors, Community Health Workers, peer specialists at all levels, health and wellness coaches, and other non-licensed roles that are essential to engagement, care coordination, and culturally responsive service delivery. These roles are particularly critical in addressing disparities in access, improving engagement for historically marginalized populations, and supporting community-based and preventive approaches to care.

BHS is also prioritizing targeted workforce development and placement in specialized and high-need service areas. Internship and workforce incentive strategies are being designed to encourage participation in programs serving individuals with co-occurring mental health and substance use disorders; infants, children, families, and early childhood populations; and Veterans. Incentives may include extended paid learning opportunities, enhanced supervision and training, and prioritized pathways to employment in these specialized units. This approach supports CalAIM goals to strengthen capacity in complex and underserved service areas while building a workforce with specialized competencies and lived experience relevant to the populations served.

The expansion of the peer workforce remains a key equity strategy. Through the Peer

Workforce Development Initiative (PWDI), BHS continues to recruit, train, and support peer specialists and Community Health Assistants, recognizing their unique role in advancing recovery-oriented, trauma-informed, and culturally responsive care. BHS has supported County and contracted peers in obtaining California State Peer Certification at no cost and has integrated certified peers into crisis and community-based programs, including the Crisis Assessment Team (CAT), thereby expanding access to services and supporting Medi-Cal reimbursement for eligible peer-delivered services.

Collectively, these workforce initiatives advance BHSA and CalAIM priorities by strengthening workforce infrastructure, expanding culturally responsive and community-based roles, reducing systemic barriers to workforce entry, and building sustainable pipelines into high-need service areas. Through these efforts, Orange County BHS is improving access to care, addressing workforce disparities, and supporting a behavioral health system that is equitable, integrated, and responsive to the diverse needs of its communities.

Lastly, PIVOT funding may support the development and testing of innovative workforce strategies, including paid apprenticeship and internship pilots, the exploration of braided funding approaches in collaboration with WIOA administrators, and the identification of additional opportunities to strengthen and sustain the workforce pipeline.

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.

Program or activity name

WET2: Workforce Training and Development

Please select which of the following categories the activity falls under

Continuing Education

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

Orange County Behavioral Health Services (BHS) addresses disparities in the behavioral health workforce by implementing continuing education and training strategies that support the Behavioral Health Services Act (BHSA) goals of advancing health equity, reducing disparities in access to care, and strengthening workforce capacity across the behavioral health continuum. These efforts are aligned with CalAIM priorities to improve quality, equity, and outcomes through a culturally and linguistically responsive, trauma-informed, and person-centered system of care.

All BHS County and contracted staff are required to complete cultural competence training on an annual basis, consistent with Integrated Plan expectations for ensuring the delivery of culturally and linguistically appropriate services. Cultural competence requirements are embedded in all provider contracts and reinforced through departmental policy and leadership oversight. In collaboration with executive leadership, BHS continues to develop and update training curricula focused on cultural humility, implicit bias, stigma reduction, and the practical application of culturally responsive practices in clinical, operational, and community-facing roles.

Consistent with State guidance emphasizing that equity be integrated throughout workforce development activities, cultural and linguistic considerations are embedded across all Continuing Education (CE/CME) offerings. Training descriptions, learning objectives, instructional materials, and reference sources incorporate cultural perspectives relevant to the populations served. Trainers are expected to integrate culturally responsive approaches across all subject areas, including evidence-based practices, clinical skill development, ethics, supervision, and trauma-informed care, rather than limiting cultural competence to standalone trainings.

BHS's continuing education strategy supports BHSA objectives related to workforce readiness, recruitment, and retention by offering training opportunities for a wide range of workforce roles, including licensed and pre-licensed clinicians, paraprofessionals, peer specialists, supervisors, medical providers, and community partners. Trainings are inclusive of individuals with lived experience and are designed to support staff serving populations that experience disparities in access and outcomes, including racially and ethnically diverse communities, LGBTQ+ individuals, Veterans, older adults, individuals with disabilities, and children, youth, and families. These efforts align with CalAIM's emphasis on whole-person care and population-focused service delivery.

To address linguistic access barriers, which are identified in State guidance as a contributor to disparities in care, BHS provides training and educational resources for staff who translate materials into threshold languages and for staff serving monolingual individuals, individuals with limited English proficiency or literacy, and persons who are Deaf or Hard of Hearing. Training materials and learning opportunities are adapted to ensure accessibility, supporting CalAIM goals to improve care experiences and engagement for underserved populations.

BHS also provides continuing education that supports integrated service delivery and cross-system collaboration, consistent with CalAIM's focus on coordination across behavioral health,

medical, and community-based systems. Trainings related to clinical supervision, leadership development, ethics, medical–behavioral health collaboration, interagency coordination, linkage to appropriate level of care, and appropriate use of technology strengthen workforce capacity to deliver coordinated, high-quality care. These efforts contribute to workforce sustainability and retention by supporting professional development and reducing factors associated with burnout.

In addition, BHS offers ongoing education in trauma-informed, recovery-oriented, and evidence-based practices to ensure the workforce is equipped to serve individuals with complex behavioral health needs. Trainings in areas such as suicide prevention, substance use disorder assessment and treatment, psychosis-risk assessment, dialectical behavior therapy, grief and loss, neurodiversity-affirming care, and trauma treatment support CalAIM and BHSA priorities to improve outcomes through evidence-based, culturally responsive interventions.

Through these continuing education efforts, BHS advances State Integrated Plan priorities by embedding equity into workforce development, strengthening cultural and linguistic responsiveness, supporting diverse workforce roles, and enhancing system capacity. Continuing education serves as a key strategy for addressing behavioral health workforce disparities and ensuring equitable access to high-quality behavioral health services for Orange County residents.

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 .

Program or activity name

WET3: Workforce Recruitment, Development, Training, and Retention

Please select which of the following categories the activity falls under

Workforce Recruitment, Development, Training, and Retention

Please describe efforts to address disparities in the Behavioral Health workforce.

Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9

Orange County Behavioral Health Services (BHS) is implementing a comprehensive, equity-centered workforce strategy to recruit, develop, train, and retain a diverse behavioral health workforce in alignment with the Behavioral Health Services Act (BHSA) and CalAIM priorities. These efforts are designed to strengthen workforce infrastructure, advance health equity, reduce disparities in access to care, and ensure system capacity across the full behavioral health continuum.

Workforce Recruitment and Pipeline Development

Consistent with BHSA's emphasis on workforce infrastructure and CalAIM's focus on access and capacity, BHS is advancing coordinated recruitment and pipeline strategies to address persistent workforce shortages and disparities. BHS is in the process of establishing a countywide behavioral health workforce development coalition that brings together key partners, including educational institutions, workforce development agencies, community-based organizations, and other system stakeholders. This coalition is intended to strengthen and align workforce pathways for both behavioral health professionals and paraprofessionals, reduce fragmentation, and expand entry points into the behavioral health field.

BHS is also expanding and centralizing paid internship, apprenticeship-style, and early-career learning opportunities to create seamless pathways from education to employment. These strategies support recruitment of individuals who reflect the racial, ethnic, cultural, linguistic, and lived experience diversity of Orange County communities, including pathways into clinical, peer, Community Health Worker, and substance use disorder (SUD) counselor roles. Targeted recruitment efforts prioritize high-need and specialized service areas, including programs serving individuals with co-occurring conditions, infants and families, children and youth, and Veterans.

Workforce Development and "Grow Our Own" Strategies

To promote workforce sustainability and leadership continuity, BHS is developing a leadership development program designed to "grow our own" workforce. This program supports career advancement for existing staff, including those from underrepresented backgrounds, by providing structured opportunities for skill development, mentorship, and succession planning. These efforts align with BHSA goals to strengthen workforce readiness and retention while supporting CalAIM's emphasis on quality, accountability, and system transformation.

BHS's workforce development strategy intentionally includes professional, paraprofessional, and peer career ladders. Opportunities are designed to support advancement across roles, including transitions from paraprofessional and peer positions into supervisory, leadership, or licensed roles where applicable. These pathways help reduce disparities by lowering barriers to advancement and retaining staff with strong community ties and lived experience.

Training, Continuing Education, and Clinical Competency

BHS leverages training and continuing education as a core workforce development and equity strategy, consistent with State Integrated Plan guidance. County and contracted staff have access to a broad range of Continuing Education (CE) and Continuing Medical Education (CME)

opportunities that support culturally and linguistically appropriate services, trauma-informed care, and evidence-based practices (EBPs).

Cultural humility, stigma reduction, and culturally responsive service delivery are embedded across all trainings, rather than limited to standalone offerings.

Training opportunities address both clinical and non-clinical competencies and support a wide range of workforce roles, including clinicians, peers, Community Health Workers, supervisors, medical providers, and administrative staff. Education includes EBPs, technical and operational aspects of behavioral health work, ethics, supervision, integrated care, and cross-system collaboration—advancing CalAIM goals related to quality improvement, whole-person care, and coordinated service delivery.

Workforce Retention, Wellness, and Incentives

Recognizing that workforce retention is essential to access and equity, BHS has implemented strategies to support staff well-being and reduce burnout. A workplace wellness program is being offered to BHS staff to promote resilience, compassion satisfaction, and long-term workforce sustainability. These efforts align with BHSA and CalAIM priorities to maintain a stable, effective workforce capable of meeting community needs.

BHS also supports retention through financial and professional incentives. In coordination with State workforce initiatives, BHS offers opportunities for loan repayment and loan assumption to recruit and retain qualified staff in hard-to-fill roles and underserved service areas. Additional incentives include paid learning opportunities, access to CE/CME training, leadership development, and clear pathways for career advancement.

A*dvancing Workforce Diversity and Equity*

Across recruitment, development, training, and retention efforts, BHS prioritizes building a workforce that reflects the diversity of the communities served. Strategies emphasize recruitment and retention of bilingual and bicultural staff, individuals with lived experience, and staff with expertise serving populations that experience disparities in access and outcomes. Workforce initiatives support roles that are critical to culturally responsive engagement, including peer specialists, Community Health Workers, and SUD counselors, and strengthen capacity to serve diverse populations across community-based, clinical, and crisis settings.

Summary

Through coordinated recruitment pipelines, leadership development, continuing education, wellness and incentive strategies, and a strong emphasis on cultural and linguistic responsiveness, Orange County BHS advances BHSA and CalAIM requirements to build a sustainable, equitable behavioral health workforce. These integrated workforce efforts strengthen system capacity, reduce disparities, and support equitable access to high-quality behavioral health services for Orange County residents.

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.

Program or activity name

Centralized Supervision to Support Internship and Apprenticeship Program

Please select which of the following categories the activity falls under

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

Please describe efforts to address disparities in the Behavioral Health workforce.

Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9

Orange County Behavioral Health Services (BHS) is committed to addressing disparities in the behavioral health workforce by strengthening internship, residency, and career pathway programs that expand access to the profession for individuals from historically underserved and underrepresented communities. BHS recognizes that staff time spent supervising interns and residents is a critical workforce investment that supports long-term system capacity, improves cultural responsiveness, and promotes equitable service delivery.
BHS is prioritizing the development of structured internship opportunities across key clinical disciplines, including Marriage and Family Therapy (MFT), Social Work (MSW), and Psychology, with the goal of expanding the pipeline of licensed behavioral health practitioners who reflect the diversity of the communities served. Supervision and training supports are being incorporated into program planning to ensure interns receive high-quality mentorship, competency-based learning, and exposure to evidence-based practices within specialty behavioral health settings.
In addition to traditional clinical disciplines, BHS is exploring expanded paraprofessional and community-defined workforce pathways to reduce disparities in access and representation. This includes potential internship and apprenticeship opportunities for Certified Peer Specialists, Substance Use Disorder counselors, Health and Wellness Coaches, and Enhanced Community Health Workers. These roles strengthen engagement and trust in underserved communities and support more equitable, whole-person care delivery.

BHS also supports residency training opportunities for medical students and physicians, which contribute to addressing shortages in psychiatry and integrated care and strengthen the county's ability to meet the needs of high-acuity populations.
By investing in supervision capacity, career ladders, and multidisciplinary training pathways, BHS aims to reduce workforce disparities, support recruitment and retention of a diverse workforce, and build sustainable local capacity to deliver culturally responsive, trauma-informed behavioral health services consistent with BHSA, CalAIM, and BH-CONNECT goals.

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 .

Project name

Orange County BHCIP Project Portfolio - upon state approval Capital Funds will be made available to support each of these project to support expansion of the continuum of care.

Please select the type of project

Capital facilities project

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

Meeting match requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award

Please describe the project

Orange County Behavioral Health Services (BHS) is advancing a coordinated, countywide capital strategy to expand behavioral health infrastructure, address critical service gaps, and strengthen the continuum of care in alignment with the Behavioral Health Services Act (BHSA) and CalAIM. This strategy prioritizes development of facilities and service capacity that improve timely access to care, reduce reliance on emergency departments, and ensure services are delivered in the least restrictive and most appropriate settings.

To support this approach, Orange County intends to leverage unspent Capital Facilities and Technological Needs funds as local match for Behavioral Health Continuum Infrastructure Program (BHCIP) and other state capital funding opportunities. These resources will be used to advance high-priority projects that are in various stages of readiness and that collectively expand crisis stabilization, residential treatment, outpatient services, and inpatient psychiatric capacity.

The projects outlined below reflect a deliberate, system-level investment strategy developed in partnership with hospitals, academic institutions, and community-based providers. Together, they address current and emerging demand driven by state behavioral health reforms, including expanded eligibility and referral pathways, while advancing equity and access for Medi-Cal beneficiaries and other vulnerable populations across Orange County.

1. UCI Medical Center – High Acuity Crisis Stabilization Unit (CSU)

Project Overview

Orange County Behavioral Health Services (BHS), in partnership with UCI Health, proposes development of a 12-slot High Acuity Crisis Stabilization Unit (CSU) adjacent to the UCI Medical Center Emergency Department. The CSU will serve up to 36 individuals per day and provide medically capable crisis stabilization for individuals with co-occurring medical, psychiatric, and substance use disorders.

Service Gap Addressed / System Impact

This project addresses critical shortages in crisis stabilization capacity that contribute to emergency department boarding and delays in care. The CSU will function as an alternative to inpatient hospitalization and emergency department boarding, supporting timely stabilization and transition to the appropriate level of care across the continuum.

Target Population

Medi-Cal–eligible adults, including individuals experiencing homelessness, veterans, older adults, and justice-involved individuals.

Readiness & Sustainability

Site control is secured, and design and permitting activities are underway. The project is positioned to move forward rapidly once capital funding is secured. Ongoing operations will be supported through Medi-Cal reimbursement and County contracts.

Alignment with BHSA, CalAIM, and BHCIP

The project advances BHSA goals to expand behavioral health infrastructure and improve access for underserved populations, while supporting CalAIM priorities to reduce emergency department utilization, strengthen crisis response, and deliver care in the least restrictive setting.

2. Salvation Army – Expansion of Substance Use Disorder (SUD) Residential and Recovery Services

Project Overview

Orange County BHS proposes to partner with The Salvation Army to expand residential substance use disorder treatment and recovery services, increasing local capacity for individuals requiring structured, community-based care.

Service Gap Addressed / System Impact

This project addresses gaps in residential SUD treatment capacity that limit timely step-down from acute and crisis settings and contribute to prolonged system utilization. Expanded

residential services will support recovery-oriented care and reduce recidivism across emergency, hospital, and justice systems.

Target Population

Medi-Cal–eligible adults with substance use disorders, including individuals experiencing homelessness and justice-involved individuals.

Readiness & Sustainability

The project builds on an established provider with operational experience and community presence. Ongoing services will be supported through Medi-Cal reimbursement and County contracts.

Alignment with BHSA, CalAIM, and BHCIP

The project supports BHSA priorities to expand SUD treatment infrastructure and CalAIM goals related to whole-person care, continuity of treatment, and recovery-oriented service delivery.

3. ***KC Services, Serve the People, and Easterseals – Intensive Outpatient Treatment Infrastructure***

Project Overview

Orange County BHS proposes to support the development and expansion of intensive outpatient and community-based treatment infrastructure through partnerships with KC Services, Serve the People, and Easterseals.

Service Gap Addressed / System Impact

This project addresses insufficient outpatient and step-down capacity that limits timely transitions from higher levels of care. Expanded intensive outpatient services will improve continuity, reduce unnecessary inpatient utilization, and increase access to culturally responsive community-based treatment.

Target Population

Medi-Cal–eligible individuals with mental health and/or substance use disorders, including underserved and culturally diverse communities.

Readiness & Sustainability

Projects leverage existing community-based providers and facilities, allowing for scalable and sustainable expansion. Services will be supported through Medi-Cal and County funding mechanisms.

Alignment with BHSA, CalAIM, and BHCIP

These projects advance BHSA goals to strengthen community-based behavioral health infrastructure and CalAIM priorities to shift care to lower-acuity, community settings when clinically appropriate.

4. Providence and Serve the People – Expansion of Inpatient Psychiatric Capacity

Project Overview

Orange County BHS proposes to partner with Providence and Serve the People to expand inpatient psychiatric capacity to meet increasing demand for acute behavioral health services.

Service Gap Addressed / System Impact

Limited inpatient capacity contributes to emergency department boarding and delays in access to acute psychiatric care. This project will increase local inpatient capacity and support smoother transitions across levels of care.

Target Population

Medi-Cal–eligible adults experiencing acute psychiatric crises, including individuals with co-occurring conditions.

Readiness & Sustainability

Projects build on existing hospital and provider infrastructure, supporting efficient implementation and long-term sustainability through Medi-Cal reimbursement and County contracts.

Alignment with BHSA, CalAIM, and BHCIP

The project aligns with BHSA and CalAIM goals to expand acute care capacity, improve access, and reduce reliance on emergency departments.

5. Irvine Campus

Project Overview

Orange County is completing development of the Irvine Campus to expand access to mental health and substance use disorder services for children, adolescents, adults, and families. The campus encompasses 110,275 square feet across four separate buildings bringing crisis stabilization, and residential treatment services together in one location. Service providers are in place, and the campus will be operational by the end of December 2026.

The campus will provide a 12 bay sobering space; voluntary crisis stabilization services for 16 adults and eight adolescents; 15 adult crisis residential beds; 32 adult substance use and co-occurring disorder residential beds; 16 withdrawal management beds; 34 adolescent substance use residential beds; and 24 mother/child perinatal substance use treatment beds.

Following the campus opening, the County will begin planning future development to expand the continuum of care.

The Irvine Campus will address gaps in care for individuals with significant mental health needs and/or moderate to severe substance use disorders, including Medi-Cal members and BHSA

priority populations, such as eligible individuals experiencing or at risk of homelessness, involved in the justice system, or at risk of institutionalization. Specific facility types, service capacity, construction schedules, and ongoing operating needs for future developments will be determined through the planning process.[

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 .

Project name
Technological Needs and Systems Modernization

Please select the type of project
Technological needs project

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

- Electronic health record system Data warehouse
- Data security and privacy
- Data exchange and interoperability

Please describe the project
Orange County Behavioral Health Services (BHS) is advancing a comprehensive technology modernization strategy to support Behavioral Health Services Act (BHSA) and CalAIM requirements related to access, quality, accountability, and system integration. These efforts are essential to ensure that behavioral health services are delivered through secure, interoperable, and data-driven systems capable of meeting new and evolving state reporting, oversight, and care coordination requirements.

Electronic Health Record (EHR) Modernization
BHS is initiating a procurement process for a new behavioral health Electronic Health Record (EHR) system to replace aging technology and better support integrated, person-centered care delivery. The new EHR will be designed to support clinical, administrative, and fiscal operations across County-operated and contracted behavioral health programs, with functionality that aligns with CalAIM requirements for care management, service documentation, utilization management, and quality reporting. Modernizing the EHR is a critical component of strengthening behavioral health infrastructure and supporting timely, accurate data capture across the continuum of care.

Data Integration, Reporting, and Analytics
To meet expanded state reporting standards and oversight obligations, BHS must upgrade and

maintain its data integration and data warehouse systems. These systems support aggregation, validation, and analysis of data across multiple sources, including County-operated programs, contracted providers, and external partners. Enhancements to data infrastructure will enable BHS to meet BHSA and CalAIM expectations for performance monitoring, equity analysis, outcomes measurement, and transparency. Improved analytics capacity will also support population-based planning, identification of disparities, and continuous quality improvement.

Interoperability and Data Exchange

Consistent with CalAIM's emphasis on integrated care and cross-system coordination, BHS is investing in technology that supports secure data exchange and interoperability across behavioral health, medical, and community-based systems. These efforts will align with state and federal interoperability standards and support participation in health information exchange, facilitating timely sharing of information to improve care coordination, transitions between levels of care, and continuity of services for Medi-Cal beneficiaries.

Data Security and Privacy

Maintaining the confidentiality, integrity, and availability of sensitive behavioral health information is a core requirement under BHSA, CalAIM, and applicable state and federal privacy laws. BHS will continue to invest in cybersecurity, system safeguards, and privacy protections to ensure compliance with HIPAA, 42 CFR Part 2, and other applicable regulations. Technology upgrades will strengthen system resilience, protect client information, and support secure access for authorized users across County and contracted provider settings.

Funding Strategy

These technology investments will be supported through a combination of existing and unspent Mental Health Services Act (MHSA) funds, recognizing that modern, interoperable data systems are foundational to delivering equitable, high-quality behavioral health services. Leveraging MHSA resources for technology modernization ensures Orange County can meet new state requirements, support system transformation under CalAIM, and maintain accountability and transparency across the behavioral health system.

Summary

Through EHR modernization, enhanced data integration and analytics, strengthened interoperability, and robust data security, Orange County BHS is investing in the technological infrastructure necessary to meet BHSA and CalAIM requirements. These investments support improved access, quality, equity, and accountability while enabling the County to respond effectively to new reporting obligations and system transformation initiatives.

Full Service Partnership Program

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

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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	33945
Number of Uninsured Individuals	5204
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	2749

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

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

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	922

Number of Uninsured Individuals	141

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	461
Number of Uninsured Individuals	71

ACT/FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	160
Number of Teams Needed to Serve Total Eligible Population	16

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	60	60	60
Total Number of Teams	6	6	6

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

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

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	5585
Number of Uninsured Individuals	860

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	260
Number of Teams Needed to Serve Total Eligible Population	52

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	55	55	55
Total Number of Teams	11	11	11

High Fidelity Wraparound (HFW) Eligible Population

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	0
Number of Uninsured Individuals	0

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	0
Number of Teams Needed to Serve Total Eligible Population	0

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	198	210	222

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Teams	33	35	37

Individual Placement and Support (IPS) Eligible Population

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

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	9584
Number of Uninsured Individuals	1524

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	695
Number of Teams Needed to Serve Total Eligible Population	278

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	21	22	23
Total Number of Teams	8	9	10

Full Service Partnership (FSP) Program Overview

Please provide the following information about the county's BHSA FSP program
Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?
Yes

Please describe how the estimated practitioners will provide more than one EBP
Orange County Behavioral Health Services (BHS) anticipates that some practitioners funded through Full Service Partnership (FSP) programs will be trained and utilized to deliver more than one evidence-based practice (EBP) and/or evidence-informed model in order to meet service needs efficiently, ensure timely access to care, and maintain flexibility across service settings and populations. This approach supports a nimble service delivery system that can respond to changing demand while maintaining fidelity to required EBPs and trauma-informed, culturally responsive care.

BHS will implement a cross-training and workforce development strategy that prepares clinicians and multidisciplinary team members to deliver multiple EBPs aligned with CYBHI

requirements and broader system transformation goals. For children and youth, practitioners may be cross-trained in EBPs and service models that support high-acuity, trauma-exposed populations, including interventions that integrate family engagement, care coordination, and stabilization supports. This approach supports individualized care and reduces delays associated with multiple referrals or handoffs, particularly for children and youth with complex needs and co-occurring conditions.

BHS will also apply cross-training strategies within the adult and older adult system of care to strengthen workforce capacity to deliver community-based EBPs that reduce crisis utilization and prevent institutionalization. Adult FSP practitioners may be trained to support more than one EBP or evidence-informed model (as clinically appropriate), including intensive field-based approaches and recovery-oriented interventions that support stabilization in the least restrictive setting. This may include cross-training for team members supporting Assertive Community Treatment (ACT), Flexible Assertive Community Treatment (FACT), and the FSP-Intensive Case Management (FSP-ICM) model, as well as integrated co-occurring treatment approaches and other evidence-informed practices aligned with the county's service continuum.

BHS will support multi-EBP delivery through structured training, coaching, and technical assistance, including participation in state-supported Centers of Excellence and other fidelity-focused training resources. Ongoing supervision, case consultation, and quality improvement processes will reinforce EBP fidelity and ensure that practitioners use the appropriate intervention based on clinical presentation, developmental needs, acuity, and individual and family goals.

In addition, BHS expects multidisciplinary FSP teams—including licensed clinicians, care coordinators, peers, and other workforce roles—to be organized to maximize capacity across EBPs and service models, with clear role definitions and the ability to flex across functions when needed. This team-based structure supports continuity of care and reduces service disruption by enabling staff to respond to changes in demand, workforce availability, and service needs across the continuum.

Through cross-training, supervision, and team-based implementation supports, BHS will ensure that practitioners can deliver more than one EBP and/or evidence-informed model when appropriate, while maintaining fidelity, trauma-informed practice standards, and the flexibility needed to meet local needs and evolving BHSA, CalAIM, and CYBHI requirements.

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

Orange County Behavioral Health Services (BHS) employs a whole-person, trauma-informed approach that recognizes the interconnected impact of behavioral health, physical health, social needs, and lived experience on recovery and well-being. Services are designed to be person-centered, culturally responsive, and grounded in principles of safety, trust, empowerment, and collaboration. BHS prioritizes engagement strategies that reduce barriers to care and support individuals in receiving services in the least restrictive, most clinically appropriate settings.

BHS integrates trauma-informed practices across the continuum of care, including outreach and engagement, assessment and treatment planning, crisis response, and ongoing services. This includes emphasizing strengths-based approaches; recognizing the prevalence of trauma and adverse experiences; avoiding re-traumatization; and supporting individuals through consistent, respectful communication and predictable service processes. Staff are supported through training, supervision, and ongoing quality improvement efforts to ensure trauma-informed care is applied in a manner consistent with evidence-based and evidence-informed practices.

BHS also prioritizes partnership with families and individuals' natural supports as an essential component of whole-person care. When clinically appropriate and consistent with confidentiality requirements, BHS engages families, caregivers, and other natural supports in care planning, coordination, and transition planning to strengthen engagement, improve continuity of care, and reduce risk of crisis or service disruption.

To support recovery and long-term stability, BHS ensures that individuals enrolled in Full Service Partnership (FSP) programs have access to a comprehensive continuum of supports. This includes connection to peer-run recovery supports, such as Wellness Centers and other peer support services, that promote hope, community connection, and self-determination. FSP clients are also linked to crisis services and stabilization supports as needed, as well as long-term recovery-oriented programs that support sustained wellness, community integration, and reduced reliance on higher levels of care. These recovery and crisis supports complement clinical services and reinforce whole-person outcomes.

BHS coordinates with community-based partners and other systems that serve individuals and families, including primary care providers, schools, child welfare, juvenile justice, housing and homelessness systems, and other community supports. Care coordination and linkage activities may include connection to benefits, food supports, housing resources, physical healthcare, educational supports, employment services, and other services that address social drivers of health and strengthen long-term stability.

Through these strategies, BHS ensures trauma-informed, family- and support-inclusive care is embedded throughout service delivery and connected to recovery and crisis continuums, promoting recovery, resiliency, and equitable outcomes consistent with BHSA and CalAIM goals.

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

Orange County Behavioral Health Services (BHS) is committed to reducing disparities among Full Service Partnership (FSP) participants by strengthening equitable access, culturally responsive service delivery, and continuous quality improvement across the FSP continuum. These efforts align with BHSA and CalAIM goals to improve outcomes for populations that have historically experienced barriers to behavioral health services and poorer behavioral and physical health outcomes.

BHS reviews available data and program performance information to identify disparities in

access, engagement, service utilization, and outcomes among FSP participants. This includes monitoring trends across key populations and service areas and using findings to inform program planning, service enhancements, emerging behavioral and physical health needs and targeted outreach strategies to reduce barriers and improve outcomes.

BHS advances equitable service delivery through culturally and linguistically responsive approaches designed to reduce barriers related to language, stigma, transportation, and trust in service systems. This includes use of bilingual and bicultural staff where available, interpretation services, culturally responsive engagement practices, and community-based service delivery models that promote access for underserved communities. BHS also supports workforce development efforts that strengthen cultural humility and trauma-informed practices across FSP teams.

BHS further reduces disparities by partnering with community-based organizations (CBOs) that have specialized expertise and trusted relationships in underserved communities. These partnerships support culturally responsive outreach, engagement, and service delivery for populations experiencing disparities in access and outcomes, including individuals with limited English proficiency, communities of color, and other historically underserved groups. Collaboration with CBOs strengthens community presence, improves engagement, and supports more effective linkage to ongoing services and natural supports.

To improve engagement and retention in services, BHS also leverages peer support and recovery-oriented approaches, including linkage to peer-run recovery supports and Wellness Centers when appropriate.

These supports strengthen outreach, reduce stigma, and improve connection to care, particularly for individuals who may have experienced historical disinvestment or negative experiences with service systems.

BHS will continue to incorporate stakeholder feedback, including community planning input, to refine strategies over time. Through these combined efforts, BHS aims to reduce disparities and improve equitable outcomes for individuals served through FSP programs in alignment with BHSA and CalAIM requirements.

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

- Access to care
- Justice involvement
- Removal of children from home Homelessness Institutionalization

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

Orange County Behavioral Health Services (BHS) provides ongoing engagement services for individuals receiving Full Service Partnership–Intensive Case Management (FSP-ICM) through coordinated outreach, in-reach, and cross-system collaboration designed to support continuity of care and reduce disengagement. Engagement strategies are grounded in person-centered and recovery-oriented practices and emphasize timely connection to clinically

appropriate services in the least restrictive setting.

BHS invests in targeted in-reach and outreach activities to identify individuals with significant behavioral health needs who may benefit from FSP-ICM services, including individuals experiencing repeated crises, justice involvement, or transitions from higher levels of care. Engagement activities include proactive follow-up, warm handoffs, and coordination with system partners to reduce barriers to access and improve linkage to ongoing services.

Peer supports are also integrated into engagement efforts to strengthen trust, increase participation, and support sustained connection to care. Individuals receiving FSP-ICM may be linked to peer support services, including peer specialists embedded on multidisciplinary teams and access to peer-run recovery supports such as Wellness Centers, which provide voluntary, recovery-oriented supports that promote community connection, hope, and self-determination.

To strengthen engagement and continuity, BHS coordinates with key partners across the continuum of care, including justice system stakeholders and other community-based systems that serve individuals with complex needs. BHS also supports engagement through implementation of CARE Act services and Assisted Outpatient Treatment (AOT), which provide additional pathways for individuals with serious behavioral health needs to access treatment, supports, and structured care coordination.

In addition, BHS is preparing for upcoming policy and eligibility changes by strengthening internal processes and cross-system referral pathways, including developing systems and workflows to support presumptive eligibility and timely engagement into FSP services. These efforts are intended to ensure that individuals who meet criteria for FSP-ICM are identified earlier, connected to services more quickly, and supported in maintaining engagement over time.

Through these coordinated strategies, BHS aims to ensure that individuals receiving FSP-ICM have consistent access to engagement supports, coordinated care pathways, and ongoing recovery-oriented services that promote stability and reduce reliance on crisis and institutional settings.

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:

Orange County Behavioral Health Services (BHS) will provide ongoing engagement services beyond those required under ACT, FACT, IPS, and High Fidelity Wraparound (HFW) by strengthening system-level continuity supports and coordinated connections across county behavioral health programs and partner systems. These engagement strategies are intended to reduce disengagement, improve continuity of care, and ensure individuals remain connected to clinically appropriate services over time.

In addition to engagement activities embedded within each EBP model, BHS will support ongoing engagement through countywide care coordination practices, including warm

handoffs between programs, proactive follow-up during transitions, and linkage to recovery-oriented and supportive services that promote long-term stability. Individuals receiving ACT, FACT, IPS, and HFW may also be connected to additional county resources as needed, including crisis services, peer supports and peer-run recovery programs, outpatient services, housing-related supports, and other community-based services.

BHS will continue to coordinate with internal county programs and external partners to ensure individuals are connected to the right level of care and can transition smoothly across services as their needs change. These engagement efforts support continuity, improve service navigation, and reinforce whole-person outcomes consistent with BHSA and CalAIM goals.

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.)
The county is committed to delivering comprehensive Full Service Partnership (FSP) services through a balanced utilization of both specialized contracted programs and robust internal county programs. This blended approach is designed to maximize reach, leverage external expertise, and ensure a stable core capacity. The FSP service array will primarily include Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Intensive Case Management (ICM).

To delineate roles and optimize specialized support, the county will designate contracted providers specifically to operate as high-fidelity ACT and FACT teams. These external partners are equipped to provide the operational hours necessary to uphold ACT/FACT fidelity requirements. Concurrently, a combination of both internal county programs and contracted providers will be utilized to deliver FSP Intensive Case Management (ICM) services.

A competitive procurement process is underway to establish the full complement of contracted programs. This procurement will specifically seek providers capable of delivering ACT, FACT, and ICM services by July 1, 2026. This timeline is critical to ensure a seamless transition and expansion of services.

Recognizing the role of meaningful employment in recovery, the Individual Placement and Support (IPS) model of supported employment will be systematically embedded across all Adult FSP teams. The only planned exception to this universal embedding is the Older Adult team. This exception is based on the general understanding that Older Adults often do not share the same immediate, competitive employment goals as adults in FSP. However, access to IPS services will still be provided to Older Adults through a clear, referral-based pathway where such goals are applicable and desired by the client.

To ensure seamless transitions and continuity of care across the FSP service spectrum, the county will design and rigorously implement specific operational processes.

- A standardized, universal assessment tool will be identified, adopted, and deployed across all FSP providers (ACT, FACT, and ICM) to accurately and consistently determine an individual's required level of care. This tool will serve as the foundational mechanism for initial placement and subsequent step-up/step-down decisions.

- A formal "warm handoff" protocol will be established and mandated to ensure active co-management and communication during transitions, particularly between ACT and ICM teams. This protocol mandates that the transferring and receiving clinicians connect directly with the client present to ensure that the client feels supported, understands the transition, and experiences no lapse in care or therapeutic alliance.

- A critical safety-net policy will be established to protect internal ICM clients who experience a significant clinical decompensation or crisis that necessitates a higher level of care. This policy will institute a

"fast-track" mechanism to enable these clients to be swiftly and efficiently transferred back to external, high-intensity ACT providers, bypassing typical waitlists where clinically appropriate.

Adhering to FSP best practices, providers will integrate the discussion of progress toward a "step-down" in services as a continuous, client-centered dialogue. This conversation will commence from the client's initial engagement with the FSP program and will be maintained consistently throughout their participation, reinforcing the program's goal of recovery and self-management. Beyond these ongoing conversations, a formal, comprehensive progress check-in will be conducted with every client every six months to review goals, service utilization, and discuss next steps in their recovery journey.

The county has formally partnered with Third Sector, an organization with a proven track record of collaborating with multiple county behavioral health departments to promote equity and drive consumer-centered transformation within FSP programs. Third Sector will provide dedicated technical assistance crucial for the successful implementation and project management of these proposed systemic changes. Furthermore, Third Sector will facilitate the development of a collaborative workgroup to develop, propose, and standardize operational tools, processes, policies, and procedures across the entire FSP network to ensure consistency and quality.

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

Orange County Behavioral Health Services (BHS) will not implement a Substance Use Disorder (SUD)-only Full Service Partnership (FSP) program during the initial implementation cycle of this Integrated Plan. BHS is taking a phased approach to system development and intends to evaluate and scale capacity over time, including consideration of a SUD-only FSP model in a future Integrated Plan update based on local needs, implementation readiness, and available resources.

Although a SUD-only FSP will not be implemented at this time, BHS is strengthening the ability of all FSP programs to provide integrated co-occurring services and ensure timely linkage to appropriate SUD treatment. FSP teams will collaborate closely with county and community-based partners delivering assertive field-based initiation of SUD treatment services to support engagement, warm handoffs, and continuity of care for individuals with co-occurring needs.

In addition, BHS will continue to support outreach and engagement activities related to

enrolling individuals living with significant behavioral health needs into FSP services. These outreach efforts are designed to reduce barriers to care, strengthen coordinated access pathways, and ensure individuals with high-acuity needs are connected to intensive, community-based services in the least restrictive setting.

Primary substance use disorder (SUD) FSPs
No

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

Please describe the outreach activities the county will engage in to enroll individuals living with significant behavioral health needs into the county's FSP program
Orange County Behavioral Health Services (BHS) will engage in coordinated outreach activities to identify and enroll individuals living with significant behavioral health needs into Full Service Partnership (FSP) programs. Outreach strategies will be implemented in alignment with fidelity standards for each FSP model to ensure engagement activities are consistent with evidence-based practice expectations, support timely access, and promote continuity of care.

BHS will utilize multiple entry points to identify individuals who may benefit from FSP services, including referrals from outpatient clinics, crisis services, hospitals and higher levels of care, justice and re-entry partners, homelessness and housing-related systems, and community-based providers. BHS will leverage its outpatient locations as accessible points for assessment, screening, and referral to FSP services, including timely evaluation of clinical needs and level of care placement.

In addition, BHS will conduct outreach through a network of contracted providers and community-based organizations that support engagement of underserved and high-need populations. This includes field-based outreach and engagement, warm handoffs, and coordinated referral processes that reduce barriers to enrollment and improve linkage to services. Outreach activities will prioritize individuals with high acuity needs, co-occurring conditions, repeated crisis utilization, and individuals experiencing housing instability or justice involvement.

Through these coordinated outreach strategies and fidelity-driven implementation, BHS will strengthen pathways into FSP programs, improve timely access to intensive community-based services, and support stabilization and recovery in the least restrictive setting.

Other recovery-oriented services
Yes

Please describe the other recovery-oriented services the county's FSP program will include:
The Orange County Recovery and Wellness Centers are a vital resource for the FSP

continuum, providing a network of three peer-run, recovery-oriented facilities. They are designed as a recovery environment for adults (18+), and are a particularly valuable resource for those who have stabilized and "stepped down" from higher levels of care, such as FSP. Stakeholders describe these centers as a critical "lifeline" that provides the community and positive atmosphere many fear losing when they transition out of intensive FSP services.

These centers prioritize community connection. Their core services are similar across all three regional centers and are built around the "Four Pillars of Recovery":

- Peer Support Groups: Non-clinical, drop-in groups that focus on practical coping skills (e.g., Anxiety Management, Anger Management, Dual Recovery Anonymous for substance use).
- Socialization: A low-pressure environment to combat isolation and build community.
- Employment & Education: Access to dedicated Peer Employment Specialists who assist members with building resumes, applying for jobs, and practicing mock interviews.
- Community Integration: Organized outings to help members practice social engagement in the wider community.

In one-on-one key informant interviews with FSP members, most stated interest in utilizing the Wellness Centers after graduation. Clients emphasized that the "lived experience" of staff is the most valuable component, as it fosters a non-judgmental environment where they feel truly understood. Clients noted interest in using the Wellness Center to support specific life goals, such as employment. They noted that the low-pressure environment is appreciated for combating isolation, and that they would benefit from meaningful enrichment, and desire a balance between structured activities and open, common-space engagement. The organized outings offered were frequently cited by clients as a major incentive for staying connected and practicing social skills in the wider community.

The FSP exit strategy includes a formal overlapping transition period and a "warm handoff," allowing clients who stabilize in FSP to seamlessly transition to a Wellness Center. This enables them to maintain their recovery progress without requiring the high-intensity FSP intervention. To ensure supportive FSP transitions, clients will be introduced to Wellness Center services early in their FSP journey, shortly following enrollment. The FSP team will integrate Wellness Center services and activities into client treatment plans, thereby strengthening and complementing current FSP offerings. Existing Wellness Center connections and services will also provide community support as clients transition between FSP levels of care and eventually graduate from FSP programs.

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

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

In, or at-risk of being in, the juvenile justice system:
Orange County Behavioral Health Services (BHS) engaged in extensive planning activities to ensure Full Service Partnership (FSP) programming reflects the unique needs of eligible children and youth who are in, or at risk of being in, the juvenile justice system. Planning efforts included ongoing data review, structured interagency collaboration, and robust community and stakeholder engagement to inform service design and implementation.

BHS reviewed local service utilization trends and system-level data to better understand behavioral health needs and barriers impacting justice-involved and justice-at-risk youth. This included consideration of high-acuity clinical needs, co-occurring mental health and substance use conditions, crisis episodes, and challenges associated with transitions from custody or other system involvement. These findings informed priorities for intensive engagement, continuity of care, and coordinated referral pathways across systems. BHS also leveraged established cross-system planning structures, including participation in the Orange County Juvenile Justice Committee, ongoing coordination with Child Welfare partners, and other collaborative forums involving probation, courts, education, community providers, and youth-serving agencies. These partnerships support shared problem-solving, diversion and re-entry planning, and timely linkage to community-based treatment in the least restrictive setting.

In addition, BHS incorporated substantial input through the Community Planning Process (CPP). The County conducted BHSA educational sessions, community listening sessions, key informant interviews, targeted focus groups, and community forums to identify strengths, gaps, and priority needs across diverse communities and BHSA priority populations. These activities included engagement with justice-involved youth, transitional age youth, child welfare-involved youth, LGBTQ+ youth, and families of young children. Feedback was gathered through structured protocols and community-defined activities designed to elevate lived experience perspectives and reduce disparities.

CPP findings highlighted the importance of continuity of care following release, family engagement and psychoeducation, culturally responsive and trauma-informed services, and stronger coordination between behavioral health and justice partners. Stakeholders also emphasized the need to expand

community-based recovery supports, mentorship opportunities, education and employment pathways, transportation assistance, and inclusive pro-social programming for youth with justice involvement histories. Input further underscored the value of forensic-informed training and service alignment across systems to support appropriate treatment planning.

Under BHSA, BHS will continue and strengthen Children and Youth FSP programming that addresses justice involvement through implementation of required levels of care, High Fidelity Wraparound and intensive care management models, expansion of assertive field-based strategies for initiation of substance use disorder treatment and rapid access to medications for addiction treatment, and increased access to evidence-based supported employment approaches such as Individual Placement and Supports.

Through these coordinated data-driven, cross-system, and community-informed planning

efforts, BHS has developed an approach to Children and Youth FSP services that is responsive to justice-involved and justice-at-risk youth and supports recovery, continuity of care, and community stability in alignment with BHSA and CalAIM goals.

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

Orange County Behavioral Health Services (BHS) engaged in multiple planning activities to ensure Full Service Partnership (FSP) programming reflects the unique needs of eligible children and youth who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+). These efforts included community planning engagement, review of available data, and targeted stakeholder input to inform culturally responsive, affirming, and trauma-informed program design consistent with BHSA and CalAIM goals.

Through the Community Planning Process (CPP), BHS identified LGBTQ+ children and youth as a priority population and gathered targeted input regarding barriers to access, service gaps, and engagement needs. BHS reviewed available local trends to better understand the behavioral health needs of LGBTQ+ youth, including elevated risk factors related to stigma, discrimination, family or school-related stressors, crisis utilization, and suicide risk. BHS also incorporated relevant findings from the County's Community Health Assessment (CHA) developed by Public Health as part of PHAB accreditation activities to ensure alignment with broader countywide health equity priorities.

BHS conducted focus groups, listening sessions, and community forums to elevate youth and family perspectives and to identify strategies that improve engagement and service effectiveness for LGBTQ+ youth. Specific CPP activities included a targeted focus group with LGBTQ+ youth, a focus group with parents of LGBTQ+ youth, and a high school listening session that included breakout groups with parents of LGBTQ+ students. Additional youth-focused CPP activities (including transitional age youth, child

welfare-involved youth, and justice-involved youth groups) also provided relevant feedback regarding LGBTQ+ needs and service access challenges. Stakeholders working with LGBTQ+ youth further participated in BHSA workgroups, including the FSP Workgroup, which served as an additional venue for system partners, providers, families, and community members to inform implementation planning.

Qualitative analysis of CPP and workgroup feedback highlighted several key considerations for LGBTQ+ youth. Stakeholders emphasized the importance of safe, inclusive, and affirming service environments, culturally responsive engagement practices, and strengthened partnerships with community-based organizations specializing in LGBTQ+ youth support. Input also underscored the need for workforce development and training related to gender identity, sexual orientation, and culturally affirming care, as well as improved coordination with schools and other youth-serving systems to address bullying, discrimination, and access to supportive spaces.

Stakeholders also identified the importance of tailoring family-centered models, such as High Fidelity Wraparound, in ways that ensure youth safety and trust when family support may be limited or complex. Additional priorities included strengthening linkage to crisis and suicide prevention resources, addressing housing instability and displacement risks among LGBTQ+

transitional age youth, supporting education and employment pathways, and improving access across all regions of the county, including transportation supports where needed.

Through these coordinated data-informed and community-driven planning efforts, BHS incorporated the needs of LGBTQ+ children and youth into the development of Children and Youth FSP programming. This approach will support equitable access, affirming care delivery, and strengthened partnerships to improve outcomes for LGBTQ+ youth in alignment with BHSA and CalAIM system transformation goals.

In the child welfare system

Orange County Behavioral Health Services (BHS) engaged in multiple planning activities to ensure Full Service Partnership (FSP) programming reflects the unique needs of eligible children and youth who are involved with, or at risk of involvement with, the child welfare system. These efforts included review of local data, structured interagency planning, and targeted community and stakeholder engagement to inform trauma-informed, family-centered program design consistent with BHSA and CalAIM goals.

BHS reviewed available local data and system trends to better understand behavioral health needs, service utilization patterns, and access barriers for child welfare–involved children and youth. This included consideration of the prevalence of trauma exposure, placement instability, higher-acuity clinical needs, and challenges engaging youth and caregivers across transitions. These findings informed service design priorities such as intensive care coordination, continuity of care across placement changes, and culturally responsive approaches that support stabilization in the community.

BHS also leveraged established cross-system planning structures to inform program development and ongoing quality improvement. This includes ongoing coordination meetings with child welfare partners and participation in collaborative forums such as the Child Welfare System Improvement Partnership, which includes broad stakeholder participation (including schools), and Continuum of Care Reform (CCR)

System of Care planning efforts focused on strengthening services and placement stability for

system-involved youth. BHS also participates in SSA/HCA quarterly meetings to identify areas of concern and jointly address treatment needs and service access barriers for children and families involved in child welfare.

In addition, BHS engages through the Interagency Leadership Team (ILT) under AB 2083, which strengthens coordination for children and youth with complex needs through multi-system collaboration, including coordination with schools and the Orange County Department of Education foster youth liaison. BHS also incorporates stakeholder input through the Behavioral Health Advisory Board Children's Workgroup, which provides ongoing community perspective to inform children's behavioral health priorities and system improvement strategies.

Through the Community Planning Process (CPP), BHS gathered targeted input related to the needs of child welfare–involved children and youth, including feedback on service access

barriers, caregiver engagement needs, and priority supports to strengthen continuity of care and placement stability. CPP activities included a targeted focus group with child welfare–involved youth, as well as additional focus groups and listening sessions with families of young children, transitional age youth, justice-involved youth, LGBTQ+ youth, and other stakeholders. Stakeholders serving child welfare–involved youth also actively participated in BHSA workgroups, including the FSP Workgroup, which provided further input into implementation planning.

Qualitative analysis of CPP and workgroup feedback highlighted several key considerations for child welfare–involved youth, including the need for clear access pathways across departments, strengthened collaboration and shared understanding of intensive service models, and effective step-down workflows for youth and families transitioning from high-intensity services. Stakeholders emphasized the importance of independent living skill development, education and employment supports, family engagement and parenting supports, and linkage to behavioral health and recovery services for caregivers when appropriate. Input further underscored the need for trauma-informed, whole-person care that addresses both clinical needs and social drivers of health for children and families involved in the child welfare system.

Under BHSA, BHS will continue and strengthen Children and Youth FSP programming that supports child welfare–involved youth through implementation of required levels of care, High Fidelity Wraparound and intensive care management models, coordinated referral pathways, and evidence-based practices that promote placement stability, family support, and long-term recovery.

Through these coordinated data-driven, cross-system, and community-informed planning efforts, BHS has developed an approach to Children and Youth FSP services that is responsive to the needs of child welfare–involved children and youth and promotes equitable access, continuity of care, and community stability in alignment with BHSA and CalAIM goals.

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

Older adults

Orange County Behavioral Health Services (BHS) engaged in multiple planning activities to ensure Full Service Partnership (FSP) programming reflects the unique needs of eligible older adults. These efforts included targeted stakeholder engagement, review of relevant planning data, and alignment with broader countywide priorities related to aging populations and whole-person care.

BHS hosted specialized focus groups with diverse older adult populations to better understand behavioral health needs, barriers to access, and service preferences. These discussions highlighted factors affecting engagement in behavioral health services, including stigma, social isolation, mobility limitations,

co-occurring medical conditions, technology barriers, transportation challenges, and the need for culturally and linguistically appropriate services. Feedback emphasized the importance of age-friendly, trauma-informed, and community-based approaches that support stability, connection, and quality of life.

BHS also incorporated findings from the County's Master Plan for Aging and engaged in focused cross-system conversations to align FSP planning with broader aging initiatives. These discussions informed decisions related to outreach strategies, care coordination, housing supports, and integration with primary care and community-based services to better meet the needs of older adults with complex behavioral health and medical conditions.

Through the Community Planning Process (CPP), BHS reached broad and diverse stakeholders, including older adults. A Listening Session was held at the Council on Aging program, which included multiple breakout groups conducted in six languages. Across all CPP activities, a significant portion of participants identified as adults aged 60 and over, ensuring meaningful representation of older adult perspectives.

Stakeholders serving older adults also actively participated in BHSA workgroups, including the FSP Workgroup, providing further input into implementation planning.

Qualitative analysis of CPP and workgroup feedback identified several key considerations for Adult and Older Adult FSP implementation. Stakeholders emphasized the need for improved identification of

co-occurring substance use disorders among older adults, noting that symptoms may be misattributed to age-related conditions. Implementation of the BHSA requirement to conduct ASAM assessments at intake will strengthen identification and appropriate treatment planning for older adults with co-occurring needs. Workgroup discussions also highlighted challenges related to transitions from intensive FSP services, particularly concerns about housing stability and social connection. Under BHSA, older adults may remain eligible for Housing Intervention supports independent of FSP enrollment, which reduces the risk of destabilization associated with step-down transitions. BHS will continue to develop clear level-of-care criteria and bi-directional referral workflows to support appropriate transitions while maintaining stability. Additional themes included the need to address technology and transportation barriers, strengthen culturally and linguistically appropriate services, and tailor employment-related supports to reflect the preferences of older adults, including volunteerism and community engagement opportunities rather than traditional competitive employment models. Stakeholders also raised concerns regarding housing insecurity among the growing older adult population, reinforcing the importance of coordinated housing supports within BHSA Housing Interventions.

Under BHSA, BHS will continue and strengthen Adult and Older Adult FSP programming through implementation of required levels of care, intensive care management and High Fidelity Wraparound approaches where applicable, assertive field-based engagement strategies, ASAM screening, and integration with housing and community supports. Culturally

responsive service delivery and coordination with community-based organizations serving diverse older adult populations will remain central to implementation.

Through these coordinated data-driven, cross-system, and community-informed planning efforts, BHS has developed an approach to Adult and Older Adult FSP services that is responsive to the unique needs of older adults and promotes equitable access, stability, and recovery in alignment with BHSA and CalAIM goals.

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

Orange County Behavioral Health Services (BHS) engaged in multiple planning activities to ensure Full Service Partnership (FSP) programming reflects the unique needs of eligible adults who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+). These efforts included review of available data, targeted stakeholder engagement, and incorporation of community planning input to inform culturally responsive, affirming, and trauma-informed program design consistent with BHSA and CalAIM goals.

Through the Community Planning Process (CPP), BHS identified LGBTQ+ adults as a priority population and gathered input regarding barriers to access, service gaps, and engagement needs. Specific CPP activities included two targeted focus groups with LGBTQ+ adults, participation from a key informant who identified as a member of the LGBTQ+ community, and structured community forum discussions that solicited information regarding gaps and needs specific to the LGBTQ+ community. These activities ensured that lived experience perspectives informed service planning.

BHS reviewed available local data and community-informed information to better understand behavioral health needs among LGBTQ+ adults, including risk factors associated with stigma, discrimination, trauma exposure, social isolation, co-occurring conditions, and social drivers of health such as housing instability and economic insecurity. Stakeholder feedback emphasized the importance of safe and welcoming service environments, affirming engagement practices, culturally and linguistically appropriate services, and stronger partnerships with community-based organizations that specialize in serving LGBTQ+ individuals.

Stakeholders working with LGBTQ+ adults also actively participated in BHSA workgroups, including the FSP Workgroup, providing further insight into implementation considerations. Qualitative analysis of CPP and workgroup discussions identified several priority areas for Adult and Older Adult FSP implementation.
These included the need to strengthen outreach strategies that promote trust and safety in accessing services; expand workforce training focused on cultural responsiveness, sexual orientation, and gender identity; and enhance coordination with LGBTQ+-serving community organizations.

Stakeholders also highlighted suicide risk within the LGBTQ+ community and emphasized the importance of ensuring FSP participants are aware of crisis resources such as the 988 Suicide & Crisis Lifeline and County Mobile Crisis services. Housing and employment were identified as

critical concerns, particularly for transgender individuals and LGBTQ+ adults experiencing homelessness. FSP implementation will prioritize coordination with BHSA Housing Intervention supports and community housing partners to address displacement risks and promote stability.

Additional themes included the need for improved collection of sexual orientation and gender identity and expression (SOGIE) data to better understand population needs; the importance of access to gender-affirming care; transportation challenges impacting access to community-based supports; and interest in expanding peer support pathways, including opportunities for FSP participants to pursue peer certification and support others within the system.

Under BHSA, BHS will continue and strengthen Adult and Older Adult FSP programming by implementing required levels of care, intensive care management, assertive field-based engagement strategies, integration with housing supports, ASAM screening for co-occurring substance use disorders, and evidence-based supported employment approaches. Culturally responsive service delivery, workforce training, peer integration, and strengthened partnerships with LGBTQ+-serving organizations will remain central components of implementation.

Through these coordinated, data-informed, and community-driven planning efforts, BHS has developed an approach to Adult FSP services that promotes equitable access, affirming care, and community stability for LGBTQ+ adults in alignment with BHSA and CalAIM goals.

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

Orange County Behavioral Health Services (BHS) engaged in multiple planning activities to ensure Full Service Partnership (FSP) programming reflects the unique needs of eligible adults who are involved in, or at risk of involvement in, the justice system. These efforts included review of local justice and behavioral health trends, ongoing cross-system planning, and stakeholder engagement to inform diversion- and reentry-focused program design consistent with BHSA and CalAIM goals.

BHS reviewed available data and system information related to justice involvement, including patterns of behavioral health need among justice-involved individuals, service utilization trends, and barriers to engagement and continuity of care following incarceration or justice contact. This review supported identification of high-need populations and informed planning priorities such as early engagement, intensive care coordination, timely linkage to treatment, and continuity of care during transitions from custody to the community.

BHS also leveraged established justice partnerships and collaborative planning structures across the county to inform FSP program development. This includes ongoing coordination with justice system partners and continued participation in collaborative courts, which provide structured pathways to connect individuals with significant behavioral health needs to treatment and supports as an alternative to deeper justice involvement. BHS will continue to strengthen referral pathways, support diversion and reentry initiatives, and ensure timely linkage to FSP services and recovery-oriented supports when appropriate.

In addition, BHS incorporated stakeholder input through the Community Planning Process

(CPP), including feedback related to service access barriers, transition needs, and strategies to reduce recidivism for individuals with significant behavioral health needs. Specific CPP activities included a targeted focus group with justice-involved adults and key informant interviews with individuals with lived justice involvement, including Conditional Release Program (CONREP) consumers. Stakeholders serving justice-involved populations also actively participated in BHSA workgroups, including the FSP Workgroup, providing further input into implementation planning.

Qualitative analysis of CPP and workgroup discussions identified several key considerations for Adult and Older Adult FSP implementation. Stakeholders emphasized the importance of forensic-informed care and the need to address disconnects between legal mandates and clinical realities. BHS will invest in workforce training related to court systems, probation collaboration, Assisted Outpatient Treatment and CARE Court processes, and appropriate substance use disorder treatment levels of care, including ASAM-informed service planning.

Input also highlighted the importance of establishing medication continuity and care plans prior to discharge from forensic settings, strengthening peer support models for justice-involved individuals, and ensuring rapid linkage to detoxification and ongoing SUD treatment resources when clinically indicated. Stakeholders further identified the value of hybrid team structures within evidence-based supported employment approaches, such as Individual Placement and Supports (IPS), to address the complexity of serving individuals involved in multiple systems.

Under BHSA, BHS will continue and strengthen Adult FSP programming for justice-involved individuals through implementation of required levels of care, intensive care management and forensic-informed engagement strategies, integrated co-occurring services, ASAM screening at intake, expanded peer supports, and coordinated partnerships with courts, probation, and reentry systems. These efforts will support diversion, continuity of care, and stabilization in the community.

Through these coordinated data-driven, cross-system, and community-informed planning efforts, BHS has developed an approach to Adult FSP services that is responsive to justice-involved adults and promotes recovery, equitable access, and community stability in alignment with BHSA and CalAIM goals.

Assertive Field-Based Substance Use Disorder (SUD) Questions

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

Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic

requirements to expand existing programs and/or stand up new initiatives before July 1, 2029. Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

Existing Programs for Assertive Field-Based SUD Treatment Services:

Targeted outreach

Existing programs

The county partners with an existing contracted provider agency, to implement a Mobile Narcotic Treatment Program (NTP) Unit as an extension of the provider's established "brick and mortar" medication-assisted treatment (MAT) infrastructure. This mobile capability will support rapid access to medications for addiction treatment, including methadone, and enable initiation of SUD treatment in community-based settings. Targeted outreach is a part of the delivery of this program. OC BHS works with community partners in planning for a service delivery route and locations for addressing the needs of priority populations, including those most at risk of overdosing.

Program descriptions:

The Mobile NTP Program provides community-based outreach, engagement, and linkage services for individuals with significant behavioral health and/or substance use needs who may not be connected to care. This model aligns with BHSA and CalAIM priorities by reducing barriers to access, strengthening "no wrong door" entry points, and improving early identification and connection to appropriate services.

The contracted provider and BHS will work collaboratively to implement an outreach plan focused on field-based engagement in locations where individuals live or seek services, including shelters, transitional

housing sites, residential programs, and other community settings. Services focus on relationship-building, trust development, motivational engagement, and addressing immediate barriers to care. Outreach activities may include screening and needs assessment, basic service navigation, referral and linkage to treatment programs, coordination with partner systems (e.g., homelessness, justice reentry), and warm handoffs to ongoing behavioral health and SUD treatment providers.

This outreach model is designed to improve access and continuity by connecting individuals to the medically necessary level of care and supports, including clinic-based and community-based treatment services, recovery supports, and crisis resources. Furthermore, providing individuals with harm reduction supplies and connecting to primary care, including wound care, Hepatis C and HIV testing and care are key focuses.

Current funding source:

Drug Medi-Cal, SUBG, 2011 Realignment, County General Fund

BHSA changes to existing programs to meet BHSA requirements:

Orange County Behavioral Health Services (BHS) will implement assertive field-based initiation

for substance use disorder (SUD) treatment services in alignment with BHSA Policy Manual Chapter 7, Section B.6, and DMC-ODS requirements. BHS's approach is grounded in CalAIM principles of timely access, "no wrong door" engagement, and whole-person care, with a focus on reducing barriers to initiating SUD treatment for individuals with significant behavioral health needs.

To meet BHSA programmatic requirements by July 1, 2029, BHS will leverage and expand existing county infrastructure, and contracted provider capacity to deliver targeted outreach and field-based initiation of treatment. The county will partner with an existing contracted provider to implement a Mobile Narcotic Treatment Program (NTP) Unit as an extension of the provider's established "brick and mortar" infrastructure. This mobile capability will support rapid access to medications for addiction treatment, including methadone, and enable initiation of SUD treatment in community-based settings.

The Mobile NTP Unit will be used to conduct targeted outreach and assertive engagement of eligible BHSA individuals with SUD treatment needs, including those facing barriers to accessing traditional clinic-based services. BHS will utilize available data, including substance use related death, emergency department and overdose data, and referral pathways to ensure outreach is focused on priority populations, including individuals in residential programs, shelters, transitional housing, individuals recently released from jail, justice-involved populations, and other individuals who may have limited ability to access services due to transportation challenges, stigma, or wait times. Furthermore, BHS will partner with the Manage Care Plan, hospitals, SUD programs, first responder and community based organizations to inform community need for services, Field-based services will promote continuity of care by supporting both initiation and continuation of treatment and facilitating linkage to ongoing DMC-ODS services. This approach is intended to reduce delays in treatment initiation, improve engagement, and strengthen retention through coordinated transitions into ongoing MAT and recovery supports. The Mobile NTP Unit will also support a proactive "no wrong door" approach by ensuring every community contact is an opportunity to engage individuals in treatment and connect them to appropriate services.

Funding Source / BHSA Service Expansion: BHS will implement this initiative through a combination of existing DMC-ODS/MAT provider infrastructure and planned BHSA service expansion to support assertive field-based initiation requirements. BHS will ensure the Mobile NTP Unit and associated outreach activities meet BHSA program requirements and will adjust service design as needed to support fidelity, access, and sustainability.

Expected timeline of operation

Timeline: BHS will continue planning and implementation activities during the Integrated Plan cycle, including operational development, outreach coordination, and service workflow refinement, to ensure the Mobile NTP Unit and related field-based initiation services are fully implemented and meet BHSA programmatic requirements prior to July 1, 2029.

Mobile-field based programs

Existing programs

As previously mentioned, the county partners with an existing contracted provider to implement a Mobile Narcotic Treatment Program (NTP) Unit as an extension of the provider's established "brick and mortar" infrastructure. This mobile capability will support rapid access to medications for addiction treatment, including methadone, and enable initiation of SUD treatment in community-based settings.

Program descriptions

The Mobile Field-Based SUD Treatment Program provides assertive, community-based initiation of substance use disorder (SUD) treatment services for individuals with significant SUD needs who face barriers to accessing traditional clinic-based care. This model supports BHSA requirements for assertive field-based initiation and aligns with CalAIM goals to expand timely access to evidence-based care, reduce avoidable crises, and strengthen continuity of treatment in the least restrictive setting.

Unlike mobile outreach-only models, this program is designed to deliver clinical SUD services directly in the field, including assessment and evaluation, treatment planning, and initiation of evidence-based interventions. Services may include initiation and continuation of medications for addiction treatment (MAT), including coordination with Narcotic Treatment Program (NTP) services such as methadone dosing when applicable, as well as counseling, care coordination, and linkage to ongoing DMC-ODS treatment and recovery supports.

The mobile field-based program emphasizes rapid engagement and timely treatment initiation for priority populations, including individuals experiencing homelessness, individuals transitioning from justice settings, and individuals residing in shelters, transitional housing, or residential programs. The program reduces barriers such as transportation, stigma, and wait times and supports continuity of care through warm handoffs and coordination with ongoing treatment providers.

Current funding source

Drug Medi-Cal, SUBG, 2011 Realignment, County General Fund

BHSA changes to existing programs to meet BHSA requirements

As part of BHSA implementation, Orange County Behavioral Health Services (BHS) is making targeted enhancements to existing SUD treatment and MAT programs to ensure they meet requirements for assertive field-based initiation. These BHSA-driven changes expand current provider capacity beyond traditional clinic-based settings by adding mobile, community-based service delivery that supports same-day engagement, screening, and initiation of treatment for individuals with urgent SUD needs. Through these modifications, existing programs will be able to reach individuals where they are, reduce barriers such as transportation and wait times, and provide timely access to medications for addiction treatment (MAT) with rapid linkage to the appropriate ongoing level of care within the DMC-ODS continuum. These enhancements increase the county's ability to

meet BHSA requirements through expansion of existing infrastructure rather than reliance solely on new program development.

Expected timeline of operation

Orange County Behavioral Health Services (BHS) will implement mobile field-based initiation of SUD treatment services through phased expansion of Mobile Narcotic Treatment Program (NTP) capacity. The county anticipates having the first Mobile NTP Unit fully operational by July 1, 2026, supporting same-day access to medications for addiction treatment (MAT) and field-based engagement for individuals with urgent SUD needs. Building on early implementation and demand, BHS expects to establish a second Mobile NTP Unit by January 2028 to expand geographic coverage, increase capacity, and further strengthen access for priority populations. These planned enhancements will ensure the county meets BHSA programmatic requirements for assertive field-based initiation well in advance of the July 1, 2029, deadline.

Open-access clinics

Existing programs

Orange County Behavioral Health Services (BHS) currently supports access to medications for addiction treatment (MAT) through existing county-operated open-access clinics, which serve as key entry points for individuals seeking timely substance use disorder (SUD) treatment services. These clinics are designed to reduce barriers to care by providing walk-in access, rapid screening and assessment, and connection to the appropriate level of care within the DMC-ODS continuum. Individuals presenting for services can be evaluated and routed quickly to outpatient treatment, ongoing MAT services, or other clinically appropriate supports.

In addition to clinic-based access, BHS is expanding the reach of open-access services through mobile field-based capacity. The county's Mobile Narcotic Treatment Program (NTP) Unit is able to provide and dispense methadone in community settings, extending access beyond traditional clinic locations. This model creates additional points of engagement at trusted community sites such as Federally Qualified Health Centers (FQHCs), county health departments, and other community-based drop-in centers. These expanded access points strengthen the county's ability to meet individuals where they are, support

same-day initiation of treatment, and improve continuity of care for populations who may face barriers to accessing clinic-based services.

Through this combination of open-access county clinics and mobile community-based MAT delivery, BHS is strengthening timely, equitable access to evidence-based SUD treatment consistent with BHSA, CalAIM, and DMC-ODS requirements.

Program descriptions

Orange County Behavioral Health Services (BHS) provides Open-Access Outpatient Substance Use Disorder (SUD) Treatment Services as part of the county's DMC-ODS continuum of care. These clinics are designed to reduce barriers to treatment by offering walk-in, same-day access to SUD evaluation,

assessment, and medically necessary services without requiring scheduled appointments or referrals. The open-access model supports rapid engagement, early stabilization, and timely connection to ongoing treatment and recovery supports.

Services provided through open-access clinics include SUD evaluation and assessment, individualized treatment planning, and evidence-based therapeutic interventions delivered through individual counseling and group counseling. Clinics also offer psychoeducation groups focused on substance use, recovery skills, and relapse prevention to support early engagement and ongoing participation in care.

Open-access clinics provide case management, care coordination, and referral and linkage to additional supports and resources, including medical care, housing services, employment supports, and recovery-oriented community programs. Collateral services may be provided to engage family members or natural supports when clinically appropriate. Drug screening is conducted as part of treatment monitoring and individualized care planning.

As part of the open-access model, clinics support continuity of care through discharge planning and timely linkage to appropriate ongoing levels of care within the DMC-ODS continuum. Clinics also provide assessments for medications for addiction treatment (MAT) and facilitate rapid linkage to MAT services, including same-day or expedited access when clinically indicated.

Through this open-access approach, BHS ensures individuals can enter SUD treatment quickly, receive appropriate clinical services, and be routed to the right level of care, consistent with BHSA, CalAIM, and DMC-ODS requirements.

Current funding source

Drug Medi-Cal, SUBG, 2011 Realignment, County General Fund

BHSA changes to existing programs to meet BHSA requirements

These enhancements to open-access outpatient SUD treatment services will directly support Full Service Partnership (FSP) programs by strengthening timely access to co-occurring substance use disorder treatment and medications for addiction treatment (MAT) for individuals with significant behavioral health needs. Open-access clinics serve as a rapid-entry point for FSP participants who require immediate SUD assessment, same-day engagement, or expedited linkage to MAT services as part of an integrated, whole-person care approach. Improved workflows and expanded provider capacity will support warm handoffs between FSP teams and SUD treatment providers, reduce delays in initiating care, and promote continuity across levels of service. Through these coordinated access points, BHS will ensure FSP participants can more readily receive comprehensive, integrated behavioral health and recovery supports consistent with BHSA and CalAIM goals.

Expected timeline of operation

Orange County Behavioral Health Services (BHS) will implement a phased approach to expand access to assertive, community-based SUD treatment and same-day medications for addiction treatment (MAT) through mobile and open-access service models.
BHS anticipates having the first Mobile Narcotic Treatment Program (NTP) Unit operational by

July 1, 2026, supporting field-based initiation of treatment and expanded community access to MAT, including methadone, in non-traditional settings.
Beginning in July 2027, BHS will initiate a second phase of expansion by incorporating updated scopes of work and service expectations into upcoming provider procurement and contracting cycles. As Requests for Proposals (RFPs) are issued and renewed, BHS will strengthen requirements for open-access workflows, rapid engagement, and integration of MAT capacity across contracted provider agencies beyond county-operated clinics.

Through ongoing year-over-year expansion, these service enhancements will become embedded into standard county practice, ensuring sustained system capacity and full alignment with BHSA programmatic requirements well in advance of the July 1, 2029 deadline.

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs

Orange County Behavioral Health Services (BHS) does not plan to establish new standalone targeted outreach programs to meet BHSA requirements for assertive field-based initiation of substance use disorder (SUD) treatment services. Instead, BHS will strengthen and integrate existing outreach functions across the system to support coordinated, timely engagement for individuals with significant behavioral health needs.

As part of this approach, Full Service Partnership (FSP) outreach activities will be intentionally integrated and cross-trained with SUD outreach functions, allowing outreach teams to identify co-occurring needs and rapidly connect individuals to medically necessary SUD services, including same-day assessment and medications for addiction treatment (MAT). Outreach staff will be equipped to operate within a “no wrong door” framework, ensuring that individuals engaged through mental health-focused outreach can be seamlessly linked to SUD treatment access points and vice versa.

Rather than creating separate outreach programs, BHS will promote cross-pollination of outreach efforts by aligning workflows, training, and referral pathways between FSP teams, mobile field-based services, and open-access clinics. This integrated model will improve engagement, reduce delays in treatment initiation, and support continuity of care across the behavioral health continuum.

Through these enhancements, BHS will meet BHSA requirements by embedding assertive outreach and field-based initiation capabilities into existing programs, strengthening access while maintaining a coordinated and sustainable system of care.

Program descriptions

N/A

Planned funding

Drug Medi-Cal, SUBG, 2011 Realignment, County General Fund. In addition, include BHSA FSP funds to enhance connections and services.

Planned operations

N/A

Expected timeline of implementation

Orange County Behavioral Health Services (BHS) will implement an integrated targeted outreach approach for assertive field-based initiation of SUD treatment services in alignment with the start of new Full Service Partnership (FSP) contracts on July 1, 2026. Initial implementation will focus on establishing coordinated outreach workflows, cross-training FSP and SUD outreach teams, and strengthening referral pathways to open-access clinics, mobile field-based MAT services, and other DMC-ODS treatment providers.

During FY 2026–27, BHS will prioritize workforce onboarding, training, and early implementation supports to ensure outreach teams are equipped to identify co-occurring needs and rapidly connect individuals to same-day SUD assessment and medications for addiction treatment (MAT) when clinically indicated.

In FY 2027–28, BHS will expand and refine outreach integration through continued staff development, enhanced collaboration across programs, and increased operational capacity as teams mature and service coordination becomes embedded into standard practice.

By FY 2028–29, targeted outreach functions will be fully implemented across FSP and SUD service delivery systems, ensuring sustained compliance with BHSA requirements for assertive field-based initiation of SUD treatment services well in advance of the July 1, 2029 deadline.

Mobile-field based programs

New programs

BHS does not plan to stand up new standalone mobile field-based programs beyond those already in development. BHSA requirements for assertive field-based initiation of SUD treatment will be met through expansion and enhancement of existing mobile treatment infrastructure, including increased capacity, geographic coverage, and integration with established MAT and DMC-ODS provider networks.

Rather than creating separate programs, BHS will incorporate BHSA service expectations into current mobile service models, enabling these programs to deliver same-day engagement, assessment, initiation of treatment, and warm handoffs to ongoing care. This approach ensures that mobile field-based services function as an integrated extension of the broader SUD treatment continuum.

Program descriptions

N/A

Planned funding

Drug Medi-Cal, SUBG, 2011 Realignment, County General Fund. In addition, include BHSA FSP funds to enhance connections and services.

Planned operations
N/A

Expected timeline of implementation
Please see above Mobile Field-Based sections.

Open-access clinics

New programs
Orange County Behavioral Health Services (BHS) does not plan to establish new standalone open-access clinic programs. Instead, BHSA requirements for timely access and assertive initiation of substance use disorder (SUD) treatment services will be met through enhancements to existing county-operated and contracted outpatient SUD treatment clinics, with intentional integration into Full Service Partnership (FSP) workflows.

Open-access clinics will serve as critical access points for FSP participants and individuals identified through outreach or mobile field-based services who require rapid assessment, same-day engagement, and expedited linkage to medications for addiction treatment (MAT) and ongoing care. Enhancements to existing clinics will focus on strengthening walk-in access, streamlining intake and clinical workflows, and improving coordination with FSP teams to support warm handoffs and continuity of care.

Rather than creating new programs, BHS will embed open-access expectations into standard service delivery practices across existing clinics and progressively extend these expectations to contracted provider agencies through updated scopes of work and contracting requirements.

Program descriptions
N/A

Planned funding
Drug Medi-Cal, SUBG, 2011 Realignment, County General Fund. In addition, include BHSA FSP funds to enhance connections and services.

Planned operations
N/A

Expected timeline of implementation

Enhancements to open-access clinic services will begin in alignment with the start of new FSP contracts on July 1, 2026. During FY 2026–27, BHS will focus on updating clinic schedules, revising clinical workflows, and strengthening coordination between open-access clinics and FSP teams to support timely access and integrated care.

In FY 2027–28, BHS will expand the open-access model to additional contracted provider agencies as contracts are renewed or re-procured, incorporating updated service expectations and operational standards. This phase will emphasize technical assistance, workflow alignment, and system-wide consistency in open-access practices.

By FY 2028–29, open-access service delivery will be fully embedded across county-operated and contracted outpatient SUD treatment clinics, ensuring sustainable, system-wide compliance with BHSA requirements and supporting timely access to care well in advance of the July 1, 2029 deadline.

Medications for Addiction Treatment (MAT) Details

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

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs:
Orange County Behavioral Health Services (BHS) uses a data-informed, systemwide approach to assess gaps between existing medications for addiction treatment (MAT) capacity and the level of access needed to meet population demand, including same-day MAT access, prior to July 1, 2029. This assessment considers both the availability of MAT services across the DMC-ODS continuum and broader access challenges related to timely engagement, geographic distribution, and coordination across systems of care. BHS maintains MAT availability across multiple levels of care within the county's DMC-ODS continuum, including outpatient treatment clinics, Narcotic Treatment Programs (NTPs), and residential treatment providers. Currently, MAT services are available through outpatient SUD treatment clinics located in four cities, NTP providers operating multiple clinic locations, and residential treatment programs offering MAT as part of comprehensive services. MAT access is also provided at all appropriate levels of care, including telehealth-supported models where clinically appropriate. However, this inventory does not fully capture access limitations related to same-day initiation, follow-up after emergency department (ED) visits, or transitions from custody.

To assess unmet need, BHS reviews population-level data and system performance indicators, including estimates of opioid use disorder prevalence among Medi-Cal beneficiaries and rates of MAT utilization. Recent analyses, including a CHPS Policy Brief on access to MAT for Medi-Cal beneficiaries, estimate that approximately 25,000 Medi-Cal beneficiaries in Orange County are at risk for opioid misuse, while only about 24 percent of at-risk Medi-Cal adults are currently receiving MAT. This gap indicates that existing MAT capacity, while available, is not yet sufficient to fully meet estimated population need—particularly for timely, same-day access.

BHS also reviews emergency department follow-up trends and continuity-of-care measures to identify opportunities to strengthen linkage to MAT following acute care episodes. In alignment with CalAIM

goals, BHS and CalOptima Health are working collaboratively to improve timely follow-up and access to appropriate SUD treatment services for Medi-Cal members, regardless of whether individuals receive services within the county behavioral health system or through managed care networks. These efforts emphasize coordinated strategies to expand MAT access and improve engagement following ED visits and other points of care.

In addition, BHS considers trends in opioid-related overdose data and community access patterns. While opioid-related deaths have declined since 2021, rates remain higher than pre-2020 levels. Data also indicate that Hispanic residents account for a significant proportion of opioid-related deaths, highlighting the importance of culturally responsive and Spanish-speaking providers and community-based access points. BHS further recognizes that many individuals with substance use disorders access care as walk-ins, often while experiencing active withdrawal, and that same-day MAT access is a critical intervention to reduce overdose risk and improve engagement.

As part of gap assessment, BHS evaluates geographic distribution of MAT providers, availability of same-day appointments, access points beyond traditional DMC-ODS settings, and integration with community clinics that serve as trusted hubs for engagement. BHS also considers the role of MAT access in supporting individuals transitioning from emergency care and custody, as well as the importance of integrated care models that address co-occurring physical and behavioral health needs.

Through this multifaceted assessment—combining provider capacity, utilization data, performance trends, overdose data, and community access considerations—BHS identifies priority gaps in same-day MAT availability and informs strategies to expand access in coordination with CalOptima Health and community partners, consistent with CalAIM, BHSA, and DMC-ODS goals.

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

- Operate MAT clinics directly
- Contract directly with MAT providers in the County

What forms of MAT will the county provide utilizing the strategies selected above?
Buprenorphine Naltrexone Other Methadone

Please specify other forms of MAT
NA

Housing Interventions

Planning

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

System Gaps

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

Supportive housing: Medium gap

Apartments, including master-lease apartments: Medium gap

Single and multi-family homes: Large gap

Housing in mobile home communities: Large gap

(Permanent) Single room occupancy units: Medium gap

(Interim) Single room occupancy units: Medium gap

Accessory dwelling units, including junior accessory dwelling units: Not applicable

(Permanent) Tiny homes: Not applicable

Shared housing: Medium gap

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

Hotel and Motel stays: Small gap

Non-congregate interim housing models: Medium gap

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

Recuperative Care: Large gap

Short-Term Post-Hospitalization housing: Large gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units: Not applicable

Peer Respite: Not applicable

Permanent rental subsidies: Medium gap

Housing supportive services: Medium gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals?
The Orange County Behavioral Health System will leverage multiple non-BHSA resources and partnerships to expand housing supply and increase access for BHSA-eligible individuals. The County will continue to collaborate with local housing authorities, including the Anaheim Housing Authority, Santa Ana Housing Authority, and the Orange County Housing Authority, to secure rental vouchers and housing subsidies dedicated to individuals with serious behavioral health needs. These partnerships provide essential access to permanent supportive housing opportunities across jurisdictions. (Note: The City of Garden Grove does not currently collaborate with OCHCA on housing voucher programs.)

The County also utilizes the Homeless Management Information System (HMIS) as the state-required, shared data system for housing referrals, placement tracking, and coordination across the Continuum of Care (CoC). Through HMIS integration, the County ensures accurate referrals for all Permanent Supportive Housing (PSH) placements, improved coordination with partner agencies, and data-driven decision-making to optimize available housing resources.

In addition, the County continues to coordinate with OC Community Resources (OCCR) and other regional housing partners to identify and align new funding opportunities and capital development initiatives that complement BHSA Housing Interventions. Marcy will confer with technical advisors and OCCR leadership to further evaluate additional state, local, and federal funding sources to strengthen housing capacity and sustain long-term supportive housing expansion.

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?

The Orange County Behavioral Health System will continue its strong collaboration with local Housing Authorities, OC Community Resources (OCCR), and other housing partners to ensure alignment of BHSA Housing Interventions with ongoing housing development initiatives. These partnerships are integral to expanding the continuum of housing supports available to BHSA-eligible individuals and ensuring access to a sustainable supply of Permanent Supportive Housing (PSH) units.

The County will continue to coordinate housing referrals, tenant support, and service linkages for individuals identified through the Homeless Management Information System (HMIS) and Continuum of Care (CoC) processes. This coordination allows BHSA participants to benefit from a unified system of care that includes Enhanced Care Management (ECM), Community Supports (CS), and behavioral health services integrated with housing navigation and tenancy-sustaining supports.

Through its ongoing collaboration with OCCR and housing authorities, the County is actively engaged in the development of new PSH projects with approved funding and construction schedules over the next three to four years. These projects are anticipated to yield approximately 60 new PSH units in FY 2026–27, 90 new units in FY 2027–28, and additional units to be determined in FY 2028–29.

By aligning BHSA Housing Interventions with these new developments and leveraging existing partnerships, the County will strengthen housing access, improve coordination of care, and expand permanent housing opportunities for individuals with serious behavioral health needs, supporting long-term stability and recovery.

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

The County Behavioral Health System promotes permanent housing placement and retention through an integrated, Housing First and recovery-oriented approach. Housing is recognized as foundational to wellness and engagement in treatment. The system combines behavioral health services with housing supports to ensure individuals achieve and sustain stable housing.

Through Enhanced Care Management (ECM), Community Supports (CS), and Full Service Partnership (FSP) programs, the County provides field-based behavioral health care, housing navigation, and

tenancy-sustaining services. These include assessment of housing needs, development of individualized Housing Support Plans, landlord coordination, budgeting and life skills coaching, and early intervention to prevent eviction or housing loss.

The County collaborates with local housing authorities, developers, and community-based

organizations to expand permanent supportive housing and prioritize BHSA participants through the Coordinated Entry System (CES). Housing resources such as BHSA capital funds, No Place Like Home (NPLH), and CoC funding are leveraged to increase housing availability.

Ongoing retention services emphasize education on tenant rights, benefits advocacy, and coordination with landlords and property managers to address challenges that may jeopardize tenancy. Data-driven tracking through HMIS and EHR systems supports evaluation of housing outcomes and continuous quality improvement.

The strategy ensures equitable access for individuals with serious mental illness, transition-age youth, and other vulnerable populations, emphasizing cultural responsiveness and community integration to achieve long-term housing stability and recovery.

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)?
The County Behavioral Health System shall continue existing strategies and activities that effectively connect BHSA-eligible individuals to Permanent Supportive Housing (PSH). The County utilizes a coordinated housing pathway that includes the use of interim and bridge housing as an entry point for individuals transitioning to PSH. Individuals are placed into Bridge Housing programs connected to the Homeless Management Information System (HMIS), ensuring inclusion in the Continuum of Care (CoC) process for prioritization and referral into permanent housing opportunities.

Within Full Service Partnership (FSP) programs, each team designates a Housing Specialist responsible for assisting participants with housing navigation, documentation, and certification. These staff coordinate directly with OCHCA Housing to facilitate matching, certification processing, and placement into appropriate PSH units. Additionally, OCHCA Housing has staff stationed at outpatient clinics to help get clients connected to interim, and permanent housing.

The County further supports housing placement and retention through Enhanced Care Management (ECM) and Community Supports (CS), providing Housing Transition and Tenancy Sustaining Services, benefits advocacy, life skills education, and coordination with landlords and property managers to promote long-term stability.

Additionally, the County collaborates with housing developers, community-based organizations, and CoC partners to expand PSH capacity through the use of capital development funding, operating subsidies, and rental assistance programs. These combined efforts ensure that BHSA-eligible individuals are successfully connected to and supported in permanent housing environments that foster recovery, stability, and community integration.

Please describe how the county behavioral health system will ensure all Housing Interventions

settings provide access to clinical and supportive behavioral health care and housing services:
The Orange County Health Care Agency (OCHCA) will ensure that all Housing Intervention settings provide comprehensive access to clinical and supportive behavioral health care and housing services through an integrated system of onsite and field-based service delivery. HCA's Behavioral Health Housing Supportive Services (BH HSS) and Housing Unit Response Services) programs are designed to align behavioral health treatment with housing stabilization supports to meet the needs of individuals residing in Permanent Supportive Housing (PSH) developments and scattered sites across Orange County.

The BHS HSS program provides Specialty Mental Health Services (SMHS) pursuant to W&I Code

§14184.400(a), including assessment, therapy, case management, medication management, and co-occurring disorder treatment. Services are trauma-informed, recovery-oriented, and based on participant choice, empowerment, and resilience. Onsite clinical staff—including licensed clinicians, psychiatrists, certified substance use disorder counselors, and peer support specialists—deliver individualized, whole-person care integrating mental health, substance use, and physical health needs.

The BH Housing Unit Response team operates 24/7, providing rapid front-line interventions and housing stabilization services, including unit condition response and crisis prevention. Both programs coordinate closely with property managers, service providers, and community partners to promote tenancy, prevent eviction, and strengthen resident engagement.

All services adhere to CalAIM ECM and Community Supports requirements and are funded through BHSA/MHSA. Continuous quality improvement, data reporting through IRIS, and coordination with OCHCA Housing ensure that every Housing Intervention setting provides timely, equitable, and coordinated access to behavioral health and supportive housing services promoting long-term recovery and housing retention.

Eligible Populations

Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions:
Orange County Behavioral Health Services (BHS) will identify, screen, and refer individuals eligible for BHSA Housing Interventions through multiple coordinated entry points, consistent with BHSA guidance, DHCS requirements, and Housing First principles. Eligibility will be focused on BHSA-eligible individuals with significant behavioral health needs (serious mental illness, serious emotional disturbance, and/or moderate-to-severe substance use disorder) who are experiencing homelessness, housing instability, or are at risk of homelessness.

BHS will utilize field-based and clinic-based identification strategies to ensure timely access across the system of care. Unsheltered individuals residing in encampments or other non-congregate settings will be identified through County Outreach and Engagement (O&E) teams, which provide proactive engagement, screening, and linkage to housing and

supportive services. Individuals receiving services through outpatient clinics and Full Service Partnership (FSP) programs will be screened for housing needs by program staff and connected to appropriate Housing Interventions through warm handoffs and coordinated referral pathways.

BHS will also identify individuals with moderate-to-severe substance use disorders through contracted SUD providers and through the County's 24/7 Behavioral Health Access Line, which serves as a centralized point for screening, referral, and linkage for individuals seeking behavioral health and housing-related supports. Callers demonstrating clinical necessity and housing instability will be assessed using DHCS-required tools to support eligibility determination and appropriate service matching.

In collaboration with Medi-Cal managed care plans (MCPs), BHS will coordinate referrals for individuals receiving Transitional Rent and other Community Supports, ensuring continuity of housing assistance and preventing returns to homelessness as time-limited benefits end. Justice-involved individuals will be identified through established partnerships with correctional and reentry systems, including screening for Medi-Cal eligibility, behavioral health need, and housing transition planning, with referrals supported through BH Links and designated County coordination processes.

Additionally, individuals referred from hospitals or emergency settings will be connected through the Behavioral Health Navigation Team for mobile assessment, rapid screening, and linkage to Housing Interventions. BHS will also leverage Performance Improvement Projects and other system monitoring efforts to identify individuals with high needs who meet BHSA eligibility criteria and would benefit from housing stabilization supports.

Through these integrated identification, screening, and referral pathways, BHS will ensure that BHSA Housing Interventions are accessible, equitable, and responsive to individuals with significant behavioral health needs across all points of entry into the County behavioral health system.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only ?
Yes

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:
In, or at-risk of being in, the juvenile justice system Orange County Behavioral Health Services (BHS) engaged in extensive planning activities to ensure Housing Intervention services reflect the unique needs of eligible children and youth who are in, or at risk of being in, the juvenile justice system. These efforts included comprehensive community engagement through the Community Planning Process (CPP), structured cross-system collaboration, targeted housing stakeholder input, and data-informed planning to support safe, developmentally appropriate, and family-centered housing

pathways.

Through the CPP, the County conducted five BHSA Educational Sessions, three Community Listening Sessions (including 20 breakout groups), six key informant interviews, 57 targeted focus groups representing diverse communities and BHSA priority populations, and three Community Forums. A "Graffiti Wall" activity was used during forums to solicit feedback on gaps and needs across age groups, cultural communities, and priority populations. A targeted focus group was held with twelve justice-involved youth, and additional youth-focused engagement included focus groups with transitional age youth, child welfare–involved youth, LGBTQ+ youth, and parents of young children. These activities ensured that the County reached all required BHSA stakeholders and incorporated youth and family perspectives into housing planning.

In addition, the County convened BHSA Workgroups focused on each funding category, including a dedicated Housing Interventions Workgroup that met twice per month over seven months. Juvenile justice system partners actively participated in these meetings. The County's housing leaders also convened Children & Youth Behavioral Health (CYBH) clinical staff to provide internal consultation on age-specific safety, developmental, and family-centered requirements for housing interventions serving justice-involved and justice-at-risk youth.

To strengthen housing pathways for youth and families, the County conducted targeted stakeholder engagement with family- and youth-serving providers and shelter partners, including the Family Care Center, Orange County Rescue Mission, Colette's House, domestic violence shelters accepting children, Orangewood programs serving emancipated and transitional age youth, Laguna Beach Youth Shelter, Family Solutions Collaborative, Illumination Foundation, Pathways of Hope, and WisePlace. The County also coordinated with family shelters and CalWORKs-connected providers to align screening, documentation, and time-limited rental support strategies for households with minors.

Planning activities further included resource mapping and referral pathway design to address gaps in awareness and access. The County cataloged child- and youth-appropriate shelter and bridge housing options, formalized warm handoffs from CYBH programs and the 24/7 Behavioral Health Access Line, integrated 2-1-1 as a navigation hub, and began refining referral workflows to ensure timely linkage to appropriate housing supports.

BHS also conducted data review and housing gap analysis, examining utilization and referral patterns to identify capacity needs such as family emergency shelter beds, domestic violence placements, and transitional age youth stabilization options. Justice-involved youth and community stakeholders emphasized stressors related to housing instability, rising housing costs, discrimination, and the need for trauma-informed shelter environments that support safety, stability, and developmental needs.

In alignment with BHSA requirements, the County is applying the core components of the Housing First model across all Housing Interventions while also incorporating child- and youth-specific best practices, including trauma-informed care, family stabilization, school continuity, and developmental supports. The County has also begun integrating equity, safety, and

compliance considerations into housing workflows, including language access, confidentiality protections for minors and domestic violence survivors, and age-appropriate consent practices. Through these coordinated planning, engagement, and implementation activities, BHS is ensuring that BHSA Housing Interventions reflect the distinct clinical, safety, and stabilization needs of children and youth impacted by juvenile justice involvement. These efforts will strengthen referral pathways, expand community-based housing supports, coordinate with Medi-Cal managed care housing benefits, utilize HMIS tracking, and promote equitable access to safe housing and recovery-oriented services for youth and families.

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

Orange County Behavioral Health Services (BHS) engaged in extensive planning activities to ensure Housing Intervention services reflect the unique needs of eligible children and youth who identify as Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+). These efforts included robust community engagement through the Community Planning Process (CPP), structured cross-system collaboration, targeted stakeholder input, and data-informed planning to support safe, affirming, and developmentally appropriate housing pathways consistent with BHSA goals.

Through the CPP, the County conducted targeted engagement specific to LGBTQ+ children and youth, including a focus group with LGBTQ+ youth, a focus group with parents of LGBTQ+ youth, and a high school listening session that included breakout groups with parents of LGBTQ+ students. Additional CPP activities focused on children, transitional age youth, and other priority populations and included feedback relevant to LGBTQ+ housing needs, including focus groups with transitional age youth, child welfare–involved youth, justice-involved youth, LGBTQ+ adults, and key informant interviews with LGBTQ+ community members.

Community forums also solicited input regarding gaps and needs for the LGBTQ+ community and youth experiencing housing instability. These activities ensured that LGBTQ+ youth and families were meaningfully represented in housing intervention planning.

In addition, stakeholders working with LGBTQ+ youth actively participated in the BHSA Housing Workgroup and targeted housing-specific stakeholder engagement. County leaders from Housing, Children & Youth Behavioral Health (CYBH), and Adult Mental Health/Substance Use Disorder systems collaborated to establish workflows and service parameters that address the specific safety, access, and stabilization needs of LGBTQ+ individuals across the lifespan.

Qualitative analysis of CPP input, Housing Workgroup discussions, and targeted stakeholder consultations highlighted several priority considerations for LGBTQ+ youth housing interventions. Stakeholders emphasized the need for safe, gender-affirming environments and improved cultural responsiveness among housing and shelter providers. In response, the County is embedding nondiscrimination standards, gender-affirming placement practices, and chosen name/pronoun policies into screening, referral, and housing stabilization workflows. The County is also strengthening workforce and provider training requirements, including culturally responsive and transgender/gender identity (TGI) training, to support affirming

service delivery across housing settings.

BHS also conducted data review and gap analysis, examining Behavioral Health Access Line call trends, shelter diversion outcomes, utilization patterns by age cohort (including transitional age youth), and available sexual orientation and gender identity (SOGI) data to better understand entry barriers, placement stability, and returns to homelessness for LGBTQ+ populations. Stakeholders identified additional barriers such as shelter safety concerns, documentation mismatches, bathroom and rooming policies, and heightened risk of discrimination, particularly for transgender individuals experiencing homelessness.

Community input further underscored the importance of safe housing options for LGBTQ+ youth who are running away from or displaced from unsupportive home environments. The County currently funds a Youth Runaway Shelter that serves this population and will continue this program under BHSA as part of a broader continuum of youth-appropriate housing supports. Stakeholders also identified broader needs for trauma-informed shelter environments, expanded family emergency shelter capacity, and geographically distributed access points across the county.

Through these coordinated planning, policy, and implementation activities, BHS is ensuring that BHSA Housing Interventions reflect the distinct clinical, safety, and stabilization needs of LGBTQ+ children and youth. These efforts will strengthen referral pathways, improve access to affirming and trauma-informed housing supports, coordinate with Medi-Cal managed care housing benefits, utilize HMIS tracking, and promote equitable housing stability and recovery-oriented outcomes for LGBTQ+ youth and families.

In the child welfare system

Orange County Behavioral Health Services (BHS) engaged in comprehensive planning activities to ensure that BHSA Housing Interventions reflect the unique needs of children and youth who are involved with, or at risk of involvement with, the child welfare system. These efforts included extensive community engagement through the Community Planning Process (CPP), structured interagency collaboration, targeted housing stakeholder input, and data-informed planning to strengthen housing stabilization pathways for foster youth, families pursuing reunification, Non-Minor Dependents (NMDs under AB 12), and crossover youth.

As described previously, the County conducted a robust CPP that included a targeted focus group with child-welfare–involved youth, as well as additional youth-focused engagement activities that may have included feedback relevant to child welfare populations, such as focus groups with parents of children ages 0–8, Transitional Age Youth (TAY), justice-involved youth, LGBTQ+ youth, and a key informant interview participant identified as a former foster youth. Community Forums and Listening Sessions further solicited input on behavioral health and housing-related needs for children ages 0–5, children ages 6–15, and TAY ages 16–25. Stakeholders serving system-involved youth actively participated in the BHSA Housing Workgroup and related housing-specific planning discussions.

In addition, the County convened a dedicated Children & Youth Behavioral Health (CYBH)–Child

and Family Services (CFS) Workgroup, including Probation and dependency court liaisons, to define referral, screening, and housing pathways for child welfare–involved youth and families. The County also gathered targeted input from key family- and youth-serving housing providers, including Orangewood Foundation, Human Options, Family Solutions Collaborative partners, Illumination Foundation, Pathways of Hope, WisePlace, Colette's House, the Family Care Center, and youth shelters such as the Laguna Beach Youth Shelter. These partners provided feedback on barriers to placement stability, reunification-focused housing needs, domestic violence–safe environments, and transitional housing supports for TAY.

To further inform implementation, the County conducted a housing-focused data review and gap analysis using Child Welfare Services (CWS)/CMS and County Behavioral Health utilization data, including placement stability and re-entry trends, shelter utilization patterns, and psychiatric emergency department visits. This analysis identified capacity gaps in family shelter beds, domestic violence–safe units, transitional housing for TAY, and rapid re-housing supports for families pursuing reunification. These findings informed prioritization of BHSA Housing resources, refinement of eligibility workflows, and development of clear access pathways for child welfare–involved households.

Consistent with Continuum of Care Reform (CCR) and the Family First Prevention Services Act (FFPSA), the County integrated Child and Family Team (CFT) processes and trauma-informed, family-centered care principles into housing eligibility, transition planning, and stabilization services. Dedicated referral pathways were established to support warm handoffs from CFS social workers, Orangewood programs, and court-ordered service providers to the 24/7 Behavioral Health Access Line and the Behavioral Health Navigation Team for rapid screening and linkage to BHSA Housing Interventions, including Transitional Rent supports where eligible.

Planning activities also emphasized the importance of safety, confidentiality, and permanency supports for youth and families, particularly those impacted by domestic violence. The County implemented DV-informed housing placement practices in partnership with Human Options and allied providers, incorporated confidentiality safeguards and youth-appropriate consent protocols, and embedded school continuity coordination, caregiver coaching, and reunification or guardianship stabilization supports within housing case management. The County also delivered cross-training and technical assistance to CFS, providers, and dependency court partners on DHCS-required screening tools, Medi-Cal eligibility processes, and BHSA Housing Intervention pathways.

Qualitative findings from CPP activities and housing stakeholder engagement further highlighted the need for reunification-focused housing models, expanded access to trauma-informed shelter environments appropriate for children, increased availability of longer-term safe housing that accommodates families with minors, and clearer eligibility pathways for households experiencing "doubling" situations. Community participants also emphasized the importance of expanding shelter access points across regions of the county.

Through these coordinated planning, data, and implementation activities, BHS is ensuring that BHSA Housing Interventions reflect the distinct clinical, safety, and stabilization needs of child

welfare–involved children, youth, and families while leveraging established provider networks and access pathways. The County will continue funding the Youth Runaway Shelter and will implement BHSA Housing Intervention requirements, including housing status tracking, application of Housing First core components, coordination with Medi-Cal Managed Care Plans to leverage Community Supports, use of HMIS, and development of clear referral and warm handoff protocols. These efforts support housing stability, family preservation, and equitable outcomes for system-involved youth consistent with BHSA and CalAIM goals.

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

Older adults

Orange County Behavioral Health Services (BHS) engaged in comprehensive planning activities to ensure BHSA Housing Interventions reflect the unique needs of eligible older adults. As described previously, the County reached broad and diverse stakeholders through a robust Community Planning Process (CPP).

Specific to older adults, the County held a Listening Session at the Council on Aging program with 39 older adult participants, including seven breakout groups conducted in six languages. Older adults represented a significant portion of CPP engagement overall, with 27% of participants completing demographic surveys identifying as age 60 and over. These planning efforts ensured that the voices and lived experiences of older adults informed housing service design, access pathways, and stabilization priorities.

In addition to CPP activities, stakeholders who work closely with older adults actively participated in the BHSA Housing Workgroup meetings. Older adult partners included the Council on Aging/Area Agency on Aging, senior service providers, senior centers, and Adult Protective Services (APS). These stakeholders collaborated with County housing and behavioral health leadership to co-design screening tools, referral pathways, and stabilization supports tailored to older adults experiencing or at risk of homelessness.

Qualitative analysis of Housing Workgroup discussions and CPP findings highlighted several priority needs for older adults related to housing insecurity. Stakeholders emphasized the importance of aligning housing interventions with California's Master Plan for Aging and incorporating geriatric best practices, including trauma-informed, dementia-capable, disability-forward, and culturally responsive approaches. Community input also underscored the growing lack of affordable housing options for older adults, particularly those living on fixed incomes, and the compounded impact of social isolation, food insecurity, chronic health conditions, and barriers to accessing care.

To strengthen implementation, the County conducted a housing-focused data review and gap analysis using Point-in-Time (PIT) Count data, Homeless Management Information System

(HMIS) information, and Behavioral Health Access Line trends to better quantify older adult homelessness, chronicity, acuity of behavioral health needs, and service utilization patterns. The County also reviewed waitlist and placement outcomes to identify gaps in ADA-accessible units, medically fragile placements, and the need for intensive housing stabilization supports. An inventory scan of existing senior-designated housing was completed to guide siting and capacity targets, including MHSA-funded senior housing assets totaling 115 units across eight sites, as well as approximately 488 senior-designated units countywide, to determine where BHSA Housing Interventions such as Transitional Rent, bridge housing, and rapid rehousing supports can be layered.

Stakeholders identified the need for improved referral and engagement pathways for older adults, including warm handoffs from outreach and engagement teams, outpatient and Full Service Partnership (FSP) programs, substance use disorder providers, hospitals, APS, and the 24/7 Behavioral Health Access Line to senior-appropriate shelters, supportive housing, and board-and-care–like settings with mobile assessment options. Planning efforts also emphasized accessibility and safety standards, including universal design expectations, fall-risk screening, dementia-competent safety planning, transportation assistance, and coordination of medication management and health care supports.

The County also recognized the importance of benefits coordination and stabilization services for older adults and linked housing case management with SSI/SSDI, Medi-Cal, In-Home Supportive Services, CalFresh, veterans benefits, and primary and behavioral health care. Cross-training and technical assistance were provided to strengthen provider capacity in gerontology, elder abuse indicators, language access, and the unique needs of diverse older adult populations. Performance measures such as time to placement, housing retention, and linkage to care will be reviewed regularly to support continuous quality improvement.

Through these coordinated planning, data, and implementation activities, BHS is ensuring that BHSA Housing Interventions reflect the clinical, accessibility, safety, and income-support needs of older adults while leveraging existing senior housing assets and coordinated entry points. The County will continue implementing BHSA Housing Intervention requirements, including housing status tracking, application of Housing First core components, coordination with Medi-Cal Managed Care Plans to leverage Community Supports, use of HMIS, and development of clear referral pathways to promote housing stability, recovery, and equitable outcomes for older adults.

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

Orange County Behavioral Health Services (BHS) engaged in comprehensive planning and cross-system coordination to ensure that BHSA Housing Interventions reflect the unique needs of adults who are involved in, or at risk of involvement in, the justice system. These efforts included structured interagency collaboration, targeted stakeholder engagement through the Community Planning Process (CPP), and data-informed analysis to strengthen pre-release planning, diversion pathways, and housing stabilization supports for justice-involved adults.

As previously described, the County conducted a robust CPP that included a targeted focus group with justice-involved adults and three key informant interviews with individuals who had justice involvement, including two Conditional Release Program (CONREP) participants. Stakeholders serving justice-involved populations actively participated in BHSA Housing Workgroup meetings, contributing lived experience and system-level insight into housing access barriers, reentry challenges, and coordination gaps between behavioral health and criminal justice systems.

To operationalize housing supports for this population, the County established a justice-involved housing workstream that includes Correctional Health Services, Social Services Agency (SSA), Orange County Sheriff's Department (OCSD), Probation, the Public Defender and District Attorney's Offices, Collaborative Courts (including Proposition 36), and community partners such as Project Kinship. This interagency planning structure was designed to define referral, screening, and housing stabilization pathways for adults exiting custody or participating in diversion programs.

The County conducted a housing-focused data review and gap analysis that included jail release data, referral and linkage trends, and utilization of the MHSA-funded Justice Care and Reentry Program (JCRP) and Behavioral Health Links. This analysis identified the need for strengthened pre-release screening, time-limited bridge and rapid rehousing options, and intensive case management supports. The County also reviewed OC CARES materials, including Orange County Criminal Justice Coordinating Council (OCCJCC) planning efforts, to align pathway development and capacity targets across justice and behavioral health systems. In response to identified gaps, the County expanded pre-release in-reach efforts, with Project Kinship conducting routine jail outreach to complete Medi-Cal and clinical screenings for serious mental illness and moderate-to-severe substance use disorders, develop individualized housing plans, and schedule

post-release appointments. Dedicated BHSA bridge-housing slots are prioritized for individuals with high criminogenic and clinical risk to reduce homelessness and recidivism. Workflows were co-designed with Correctional Health Services and SSA to operationalize CalAIM justice-involved pre-release services, including screening, care management, and referrals, and to connect eligible individuals to BHSA Housing Interventions and Enhanced Care Management upon release.

Planning efforts also emphasized warm handoffs and 24/7 access. Referrals may be initiated from custody, courts, Probation, and Outreach and Engagement (O&E) teams to the 24/7 Behavioral Health Access Line and Behavioral Health Navigation Team for mobile assessment and rapid linkage to housing supports, including Transitional Rent where eligible. The County also strengthened coordination for diversion and warrant resolution by maintaining O&E as a first point of contact; individuals with non-violent warrants may be referred to a structured engagement track coordinated with the District Attorney to facilitate warrant resolution and connection to treatment and housing.

Stakeholder feedback further identified the difficulty justice-involved adults face securing housing due to criminal history, stigma, and limited availability of appropriate placements. Community participants emphasized the need for improved monitoring of certain housing settings, enhanced cleanliness and safety standards, and greater oversight to ensure consumers' basic needs are met. In response, the

County strengthened provider engagement and contracting strategies, including partnerships with Project Kinship and other reentry providers to deliver bridge housing, peer support, benefits enrollment, and tenancy-sustaining services. Performance monitoring measures such as time to placement, 30- and 90-day housing retention, and returns to custody are reviewed quarterly to support continuous quality improvement. Cross-training was provided to providers and justice partners on criminogenic risk, reentry best practices, court documentation, and behavioral health screening requirements.

Through these coordinated planning, data, and implementation efforts, BHS is ensuring that BHSA Housing Interventions reflect the clinical, safety, accessibility, and stabilization needs of justice-involved adults while leveraging existing housing assets and coordinated entry systems. The County will continue implementing BHSA Housing Intervention requirements, including housing status tracking, application of Housing First core components, coordination with Medi-Cal Managed Care Plans to leverage Community Supports, use of HMIS, and development of structured referral and warm handoff pathways. These efforts are designed to promote housing stability, reduce recidivism, and improve recovery outcomes for justice-involved adults consistent with BHSA and CalAIM goals.

In underserved communities

Orange County Behavioral Health Services (BHS) engaged in extensive planning activities to ensure BHSA Housing Interventions equitably serve eligible adults and older adults from underserved communities, including individuals experiencing co-occurring mental health and substance use conditions and veterans at heightened risk of homelessness. These efforts included targeted stakeholder engagement through the Community Planning Process (CPP), additional housing-specific consultations with culturally specific partners, and data-informed planning to strengthen culturally responsive access pathways, reduce disparities in housing placement and retention, and improve stabilization outcomes for communities experiencing inequitable housing insecurity.

As described previously, the County conducted a robust CPP that included significant engagement with underserved populations. Of the 57 targeted focus groups held during CPP, 41 were conducted with diverse racial and ethnic communities that are often underserved, and 22 focus groups were conducted in languages other than English, including American Sign Language, Arabic, Farsi, Khmer, Korean, Mandarin, Spanish, and Vietnamese. In addition, seven focus groups were held with BHSA priority and other underserved populations, including the Deaf and Hard of Hearing community and persons with disabilities. Key informant interview participants also represented underserved communities. Stakeholders serving these populations actively participated in the BHSA Housing Workgroup meetings, ensuring that equity considerations were incorporated into housing intervention design and implementation.

In addition to CPP engagement, the County convened listening sessions with culturally specific community-based organizations, faith partners, and tenant and legal aid groups to identify barriers and co-design solutions for linguistically isolated and low-income neighborhoods. These discussions emphasized the need to strengthen language access, culturally affirming

service environments, and trusted community-based access points for individuals who may face stigma, discrimination, limited awareness of housing resources, or complex clinical needs, including co-occurring substance use disorders.

Qualitative analysis of CPP findings and Housing Workgroup discussions highlighted several key priorities for underserved communities. Community participants identified disproportionate homelessness among BIPOC populations and emphasized the need to better understand utilization and outcomes of housing services across demographic groups. In response, the County conducted a housing equity gap analysis using Point-in-Time (PIT) Count data, Homeless Management Information System (HMIS) information, and Behavioral Health Access Line trends, disaggregated by language, race and ethnicity, geography, disability, and other relevant proxies. This analysis is being used to identify service deserts, longer time-to-placement, and lower housing retention rates, and to inform placement targets, resource deployment, and service intensity for populations experiencing the greatest inequities.

Stakeholders also identified the need to improve language access and cultural responsiveness within shelters and housing programs, particularly for Asian American Pacific Islander communities and other linguistically diverse populations. To address this, the County expanded multilingual outreach, screening, and housing stabilization case management, including interpretation and translation services, plain-language materials, and culturally affirming engagement practices. Cultural brokers and peers are being embedded within Outreach and Engagement teams, the 24/7 Behavioral Health Access Line, and Navigation Team workflows to strengthen trust and improve linkage for historically underserved populations. The County also developed monolingual community access points by deploying field-based screeners in trusted community locations such as clinics, libraries, and other local sites, and integrated 2-1-1 as an information and referral hub.

Planning efforts also addressed the needs of individuals with disabilities through coordination with the Regional Center, including development of referral pathways and alignment of reasonable accommodations, tenancy supports, behavioral supports, and ADA modifications for individuals with intellectual or developmental disabilities and co-occurring behavioral health needs. Transportation and digital equity barriers were also identified, and the County added transit assistance, field-based document collection, and low-tech or phone-first scheduling options to reduce access challenges for individuals without broadband or devices.

Community input further emphasized the importance of strengthening housing pathways for veterans and individuals with significant co-occurring conditions, including the need for integrated behavioral health and recovery-oriented supports that promote long-term housing stability. In response, the County is prioritizing coordination with benefits systems and supportive service networks, including Medi-Cal, CalFresh, SSI/SSDI, veterans benefits, and linkages to substance use disorder treatment and recovery services as part of housing stabilization planning.

Stakeholders also identified the importance of integrating benefits enrollment and legal

supports within housing stabilization services. The County strengthened connections to eviction defense, reasonable accommodation advocacy, and public benefits enrollment. Training and quality improvement efforts were also emphasized, and the County provided workforce training on language justice, cultural responsiveness, disability inclusion, and culturally affirming service delivery, with ongoing monitoring to support continuous improvement.

Through these coordinated planning, engagement, and implementation efforts, BHS is ensuring that BHSA Housing Interventions embed language access, disability inclusion, culturally responsive practices, and integrated supports for veterans and individuals with co-occurring conditions across identification, screening, referral, and stabilization. The County will continue implementing BHSA Housing Intervention requirements, including housing status tracking, application of Housing First core components, coordination with Medi-Cal Managed Care Plans to leverage Community Supports, use of HMIS, and development of clear referral pathways to promote equitable housing stability and recovery outcomes.

Local Housing System Engagement

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

For FY 2026/27 through FY 2028/29, Orange County Behavioral Health Services (BHS) will coordinate Housing Intervention referrals in close partnership with the Continuum of Care (CoC) by aligning with the CoC's Coordinated Entry System (CES) as the primary access point for permanent housing resources and standardized eligibility determination. All Permanent Supportive Housing (PSH) placements funded through BHSA Housing Interventions will continue to be matched through CES to ensure consistent prioritization, documentation, and equitable allocation of housing resources consistent with CoC policies and Housing First principles.

BHS will strengthen referral pathways by promoting consistent screening and assessment practices across behavioral health, outreach, shelter, hospital, and community-based partner programs to identify individuals who meet BHSA Housing Intervention eligibility criteria as early as possible. This includes individuals exiting interim housing, justice settings, or time-limited rental assistance programs who are at risk of returning to homelessness. Where Medi-Cal Managed Care Plans (MCPs) provide transitional rent or housing-related Community Supports, BHS housing staff will coordinate structured warm handoffs and assume stabilization support as transitional assistance concludes, reducing gaps in service and promoting continuity of housing stability.

To improve access and reduce delays, BHS will maintain capacity for timely, field-based screening and housing assessments conducted in shelters, street outreach settings, interim housing sites, hospitals, justice settings, and other community locations. Outcomes will be coordinated with CES to ensure appropriate matching and tracking. Referral documentation, housing status, service engagement, and placement outcomes will be recorded in the Homeless

Management Information System (HMIS), consistent with CoC requirements and BHSA expectations. This coordinated approach ensures clear system alignment with the CoC, reliable referral intake and matching processes, and ongoing accountability for Housing Intervention service delivery throughout the three-year planning period.

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

Local CoC

Orange County Behavioral Health Services (BHS) will implement BHSA Housing Interventions through a coordinated, partner-driven approach that aligns behavioral health, homeless response, and housing system resources. BHS will establish routine structures for collaboration and a clear mechanism for feedback by integrating standing agenda items, documented follow-ups, and continuous communication across partner meetings. This approach ensures that input from individuals with lived experience, providers, and system leaders informs planning, implementation, and mid-course adjustments over the three-year period.

In partnership with the local Continuum of Care (CoC), BHS will engage in regular coordination beginning in January 2026 to align priorities, review performance trends, and coordinate housing investments for FY 2026/27 through FY 2028/29. BHS will participate in Coordinated Entry System (CES) provider meetings to strengthen referral pathways, improve warm handoffs, and support timely placement into Permanent Supportive Housing (PSH) and other housing interventions for individuals with complex behavioral health needs. The County will also participate in the Housing Opportunity Workgroup on a quarterly basis to coordinate with Public Housing Agencies, PSH developers and providers, and other housing partners regarding project pipelines, unit targeting, and service design.

To support sustainability and improved outcomes, BHS will collaborate closely with Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) providers, and Community Supports housing providers to align eligibility workflows, outreach and engagement strategies, tenancy-sustaining services, and care coordination. These partnerships will support braided and complementary funding approaches, reduce duplication across systems, and strengthen continuity of care for high-acuity individuals served through BHSA Housing Interventions.

Through these structured collaborations with the CoC, Public Housing Agencies, Medi-Cal partners, ECM and Community Supports providers, and both existing and prospective PSH developers and service providers, BHS will strengthen system integration, accelerate access to housing, and promote long-term housing stability and recovery-oriented outcomes consistent with BHSA, CalAIM, and Housing First principles.

Public Housing Agency

For FY 2026/27 through FY 2028/29, Orange County Behavioral Health Services (BHS) will maintain a structured and ongoing partnership with local Public Housing Agencies (PHAs) to support implementation of BHSA Housing Interventions, including Permanent Supportive Housing (PSH) and Project-Based Voucher (PBV) opportunities. BHS routinely collaborates with the PHAs serving Orange County, including the Orange County Housing Authority, Santa Ana Housing Authority, Anaheim Housing Authority, and Garden Grove Housing Authority as opportunities arise, to align housing resources with the needs of individuals experiencing homelessness and significant behavioral health conditions.

The County will continue regular coordination with PHAs regarding PBV-related activities, including unit pipeline updates, referral alignment, tenant selection planning, and lease-up readiness. BHS also partners with PHAs to support Continuum of Care (CoC) funding strategies, including collaboration on CoC grant efforts where the County provides supportive service match contributions to strengthen housing-linked service capacity.

PHAs will remain key participants in cross-system coordination meetings to align eligibility requirements, referral processes, and program rules across housing and behavioral health service systems. For new supportive housing developments funded through County behavioral health resources, BHS will convene joint planning with developers, the relevant PHA, CoC partners, and County housing staff to coordinate project timelines, permitting and development milestones, and occupancy planning to support timely placement and stabilization.

To strengthen implementation and problem-solving, the County will continue leveraging technical assistance and best-practice supports to facilitate cross-system coordination, address barriers, and identify opportunities for collaboration. In partnership with PHAs, BHS will also support ongoing compliance and housing stability activities, including completion of required tenant certifications to ensure continued eligibility for rental subsidies and long-term housing retention.

Through these coordinated partnerships with PHAs, BHS will strengthen the availability and sustainability of supportive housing resources and promote stable, recovery-oriented housing outcomes consistent with BHSA, Housing First principles, and local housing system priorities.

MCPs

For FY 2026/27 through FY 2028/29, Orange County Behavioral Health Services (BHS) will collaborate closely with Medi-Cal managed care plans (MCPs) to implement BHSA Housing Interventions by aligning referral pathways, eligibility verification, and financing workflows across Enhanced Care Management (ECM) and Community Supports. This coordination will strengthen continuity between behavioral health housing supports and Medi-Cal–funded housing-related services for individuals experiencing homelessness or housing instability.

BHS will work with MCPs and Community Supports provider networks to expand access to the core housing-related services available through Medi-Cal, including housing navigation,

housing deposits, and tenancy-sustaining services. The County will leverage a newly designated Community Supports provider to improve capacity, responsiveness, and geographic coverage. Shared referral processes will clarify screening responsibilities, authorization steps, documentation exchange, and procedures for requesting and issuing allowable housing-related payments, ensuring timely access to services and reducing administrative barriers for high-acuity individuals.

Beginning January 1, 2026, BHS will coordinate with MCPs on implementation of transitional rent supports, including standardized referral criteria, timely approvals, and clear payment procedures to prevent housing loss and reduce gaps between interim assistance and long-term stabilization. The County will also use DHCS-required screening and transition tools to identify individuals who require higher levels of support and ensure appropriate routing to ECM and/or Community Supports, with structured warm handoffs to behavioral health services when clinically indicated.

To sustain accountability and continuous improvement, BHS will participate in regular MCP-facing coordination meetings focused on transitional rent operations, performance monitoring, and barrier resolution. Outreach and Engagement teams, including street-based partners, will also participate in ongoing cross-system meetings to strengthen field-based identification, referral completion, and

follow-through for members with significant behavioral health needs who are experiencing homelessness or at risk of housing instability.

Through these structured partnerships with MCPs, ECM providers, and Community Supports networks, BHS will strengthen system integration, maximize braided housing resources, and promote long-term housing stability and recovery outcomes consistent with BHSA and CalAIM goals.

ECM and Community Supports Providers

For FY 2026/27 through FY 2028/29, Orange County Behavioral Health Services (BHS) will collaborate with Enhanced Care Management (ECM) and Community Supports providers through routine, structured coordination to streamline implementation of Housing Interventions, reduce duplication, and ensure Medi-Cal members receive the appropriate mix of housing and behavioral health services.

The County will maintain standing coordination meetings with ECM and housing-related providers, including regular on-site collaboration at MHSA/BHSA-funded permanent supportive housing locations. At several sites, external ECM providers meet weekly alongside County mental health staff and, in some cases, housing service partners. This “in-reach” model supports engagement, real-time problem-solving, and rapid linkage to care and tenancy supports, and the County will expand this approach to scattered-site housing settings as needed.

For transitional rent and other housing-related supports, BHS will coordinate closely with ECM and Community Supports providers to confirm eligibility, align documentation, and ensure timely referral follow-through. During lease-up and move-in, ECM and Community Supports providers will proactively connect with members to initiate care coordination, reinforce engagement, and deliver tenancy-sustaining services that promote housing stability and reduce returns to homelessness.

To ensure appropriate and sustainable use of resources, the County will work with Community Supports providers to verify that Medi-Cal housing benefits have been accessed where applicable prior to the use of BHSA-funded housing supports. Clear workflows and shared procedures will support timely verification, service initiation, and coordinated funding strategies.

In addition, BHS will provide targeted cross-system training and technical assistance focused on high-acuity populations, including individuals with serious mental illness and co-occurring substance use conditions. These efforts will strengthen provider understanding of behavioral health access pathways, improve coordination across systems, and increase successful linkage to both treatment services and housing stabilization supports.

Through these collaborative structures, BHS will strengthen integration with ECM and Community Supports networks and ensure Housing Interventions are implemented in a coordinated, person-centered manner consistent with BHSA and CalAIM goals.

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

In addition to collaboration with the Continuum of Care, Public Housing Agencies, Medi-Cal managed care plans, and ECM/Community Supports providers, Orange County Behavioral Health Services (BHS) will partner with a broader network of local housing and system stakeholders to support implementation of BHSA Housing Interventions.

BHS will continue to coordinate closely with Orange County Community Resources (OCCR) and the County's Housing Finance Trust to align behavioral health housing investments with the local permanent supportive housing (PSH) development pipeline. Through these established partnerships, the County works collaboratively with existing and prospective PSH developers and providers to identify project opportunities, structure service commitments, and support long-term sustainability. Requests for Applications and Notices of Funding Availability (NOFAs) are developed through coordinated countywide planning processes to ensure alignment across housing, homelessness response, and behavioral health priorities.

BHS will also strengthen partnerships with family- and youth-serving systems, including CalWORKs/TANF-connected housing programs and child welfare housing initiatives, to support BHSA-eligible households with children and transition-age youth. The County has developed targeted housing pathways for youth exiting or at risk of exiting the child welfare system, including dedicated transitional and supportive housing units for non-minor dependents and other transition-age youth populations. These efforts are implemented in coordination with

internal Children and Youth Behavioral Health teams and child-serving system partners to ensure developmentally appropriate, trauma-informed, and family-centered housing stabilization supports.

Through these cross-system collaborations, BHS will leverage local housing infrastructure, developer partnerships, and specialized youth and family housing pathways to expand access to stable housing opportunities and ensure BHSA Housing Interventions are implemented in a coordinated, equitable, and community-responsive manner.

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?

For FY 2026/27 through FY 2028/29, the Orange County Health Care Agency (HCA) Behavioral Health

Services (BHS) will coordinate closely with Homekey+ and supportive housing sites to ensure BHSA-eligible individuals are prioritized for appropriate housing opportunities, connected to voluntary services, and supported to achieve long-term housing stability.

Although Orange County has not applied for Homekey+ funding to date, HCA will continue to monitor Homekey+ opportunities and collaborate with county and community housing partners to identify and support feasible projects as they emerge. In parallel, HCA will continue advancing MHSA/BHSA-funded supportive housing efforts by aligning service models, referral pathways, and operational planning to ensure new and existing housing sites are prepared for successful implementation and occupancy.

HCA provides supportive services at all MHSA/BHSA-funded Permanent Supportive Housing (PSH) sites using Housing First principles. Services are voluntary, flexible, individualized, and delivered through a client-centered, recovery-oriented approach. BHS has implemented Housing First–oriented supportive housing service models for more than a decade and will continue to emphasize participant choice, engagement, and access to wraparound supports that promote well-being, including social, recreational, educational, occupational, and vocational activities. Staff will be trained to proactively outreach and engage tenants, offer both group and individualized supports, and promote meaningful community integration.

To strengthen tenant engagement and site-level coordination, HCA will support Resident Advisory Councils facilitated by on-site BHS staff, meeting quarterly or as needed to elevate resident priorities and inform continuous service and operational improvements. HCA will also coordinate with property management to convene resident meetings at least quarterly, or more frequently as requested, to address tenancy needs, community-building activities, and housing stabilization supports.

For referrals and unit filling, HCA—working in partnership with OC Community Resources—will continue a standardized application and certification process for MHSA/BHSA-assisted units, with the BHS Housing Program serving as the central point of certification. The County remains committed to utilizing the Continuum of Care’s Coordinated Entry System (CES) to fill units,

prioritize individuals with the highest needs and barriers, and ensure equitable, system-wide coordination consistent with state and federal requirements.

Through these coordinated efforts, BHS will ensure supportive housing resources—including future Homekey+ opportunities and existing PSH investments—are effectively leveraged to house and stabilize BHSA-eligible individuals across Orange County.

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)

Is the county providing this intervention?
Yes

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

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
For FY 2026/27 through FY 2028/29, the County Behavioral Health System estimates that approximately <11*,760 individuals annually will be supported through BHSA Housing Intervention rental subsidies, contingent upon final budget allocations, housing inventory, and market conditions. This estimate reflects an expansion from the approximately <11*,024 individuals previously supported under MHSA-funded housing programs and incorporates both existing permanent supportive housing commitments and new BHSA-funded rental assistance strategies.

Consistent with BHSA requirements and Housing First principles, rental subsidies will be

provided in permanent settings for as long as needed, or until an individual transitions to another permanent housing option or alternative rental subsidy source. The County's approach emphasizes voluntary, client-centered services that promote housing stability without preconditions related to treatment participation, while ensuring appropriate linkage to behavioral health and supportive services.

Of the projected annual total, the County estimates that up to 700 households may receive Transitional Rent assistance. Transitional Rent is intended to prevent homelessness, support exits from interim or institutional settings, and bridge individuals to longer-term permanent housing opportunities. Because Transitional Rent operates within a dynamic housing market, the County acknowledges that precise projections regarding the number of households that will transition to permanent housing versus remain in interim or time-limited arrangements cannot be determined with certainty at this time. Outcomes will depend on broader system factors, including local rental market conditions, unit availability, lease-up timelines, and coordination with Public Housing Agencies and Permanent Supportive Housing (PSH) developers.

The County recognizes that long-term stabilization is closely tied to expansion of affordable housing inventory, including PSH and Project-Based Voucher opportunities. Absent significant increases in permanent housing supply, overall system throughput may remain constrained despite effective rental assistance and tenancy support strategies. As such, the County will continue to coordinate with the Continuum of Care (CoC), Public Housing Agencies, Medi-Cal Managed Care Plans (MCPs), and housing developers to maximize unit pipeline development, prioritize BHSA-eligible individuals through Coordinated Entry, and braid funding sources where appropriate.

The projected service levels represent the County's best estimate based on current fiscal modeling and known housing assets. The County will monitor utilization, retention, and transitions on a quarterly basis and adjust projections as additional performance data becomes available, including trends related to Transitional Rent outcomes, PSH lease-up rates, and housing retention.

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
1760

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
1000

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?
The County estimates the total number of rental subsidies and individuals served annually using a blended, throughput-based methodology that reflects differences between interim and permanent

housing interventions. Annual housing intervention funding is first categorized by housing setting, including interim or time-limited housing (e.g., short-term rental assistance, bridge housing, recovery-oriented housing) and permanent housing (e.g., permanent supportive housing, project-based or master-leased units).

For interim housing interventions, the County applies average per-episode subsidy costs and typical lengths of stay to estimate annual throughput, recognizing that interim housing subsidies turn over multiple times per year. Based on average lengths of stay of approximately four to six months, interim housing subsidies may serve two or more households annually.

For permanent housing interventions, the County assumes full-year occupancy with limited turnover and estimates households served based on average annual subsidy costs per household.

Using historical expenditure data, market conditions, and program design assumptions, the County estimates that approximately 1,760 households may be supported annually across all housing intervention types, including approximately 1,000 households served in interim settings through rental subsidies and other time-limited housing interventions. These estimates are updated annually to reflect funding levels, utilization trends, and housing market conditions.

For which setting types will the county provide rental subsidies?

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

Will this Housing Intervention accommodate family housing?
Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding:
Orange County's BHSA Housing Interventions will provide rental subsidies and housing stabilization supports for BHSA-eligible individuals and households who are enrolled in County behavioral health services and who are experiencing homelessness or at risk of homelessness. Eligible participants include individuals with serious mental illness and/or moderate-to-severe substance use disorders who meet BHSA program criteria.

BHSA Housing Intervention funding will be used to provide rental assistance in permanent housing settings for as long as needed, or until an individual transitions to another permanent housing arrangement or rental subsidy source. In addition, the County will utilize interim and time-limited rental supports, including Transitional Rent, to prevent housing loss, facilitate discharge from institutional or crisis settings, and serve as a bridge to permanent housing when immediate permanent options are not available.

Housing subsidies will be paired with voluntary, recovery-oriented tenancy supports and care coordination services, including field-based engagement, benefits linkage, housing navigation, and connection to behavioral health and community-based services. The County will coordinate implementation through the Continuum of Care's Coordinated Entry System (CES), the Homeless Management Information System (HMIS), and partnerships with Public Housing Agencies, Medi-Cal managed care plans, Enhanced Care Management (ECM) and Community Supports providers, and supportive housing operators to ensure timely referrals, appropriate placement matching, and sustained housing stability.

Through this coordinated and eligibility-driven approach, BHSA Housing Interventions will support housing access and stabilization for individuals who are clinically eligible, engaged in behavioral health services, and experiencing or at risk of homelessness, while maintaining alignment with BHSA statutory requirements and Housing First principles.

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

- Project-based
- Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in:
For FY 2026/27–FY 2028/29, Orange County Behavioral Health Services (BHS) will identify and

maintain a diversified portfolio of housing units for BHSA-eligible individuals through long-standing partnerships with Orange County Community Resources (OCCR), the Orange County Housing Authority and local Public Housing Agencies (PHAs), the Continuum of Care (CoC), and affordable housing developers. This portfolio approach is designed to ensure a steady pipeline of permanent and interim housing opportunities aligned with BHSA eligibility requirements and local housing market realities.

BHS works in close coordination with OCCR, which oversees housing development strategy and affordable housing investments across the County. Through this partnership, BHS participates in project planning, service design, and unit targeting discussions for both existing and prospective permanent supportive housing (PSH) developments. The County also leverages its established housing trust and prior MHSA-funded housing developments—now transitioning to BHSA Housing Interventions—to maintain a stable base of dedicated supportive housing units while exploring opportunities to expand inventory through new development, project-based vouchers, and capital financing strategies.

In collaboration with the CoC and PHAs, BHS aligns unit identification and referral processes through the Coordinated Entry System (CES) and standardized certification workflows. This ensures that BHSA-eligible individuals experiencing or at risk of homelessness are prioritized appropriately and matched to available units in a consistent and transparent manner.

To increase flexibility and responsiveness to market conditions, the County will also utilize flex pool strategies where appropriate, including master leasing and risk mitigation approaches, to secure units in the private rental market. These strategies allow the County to negotiate blocks of units, reduce barriers for landlords, and expedite placement for high-acuity individuals who may otherwise face screening challenges. Master leasing and similar mechanisms will be deployed in coordination with housing partners and property management entities to expand access in scattered-site settings and reduce reliance on a limited number of fixed-site developments. BHS will use data from HMIS, CES, Access Line trends, and behavioral health utilization data to inform portfolio management decisions, identify geographic gaps, and adjust unit targeting to address disparities among priority populations. Quarterly cross-system coordination meetings with OCCR, PHAs, and housing partners will support monitoring of pipeline development, lease-up progress, retention rates, and placement outcomes.

Through these collaborative efforts, the County will maintain a dynamic and data-informed housing portfolio that integrates dedicated supportive housing units, project-based vouchers, private market placements, and flexible leasing strategies to ensure BHSA-eligible individuals have access to stable housing aligned with Housing First principles and BHSA requirements.

Total number of units funded with BHSA Housing Interventions per year

900

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:

Work with CalAIM housing naviagtors that help us identify opportunities for BHSA eligible individuals that help us find market rate affordable housing. Anyone that is moving our of our interim settings - if not going stratight in to a BHSA unit, we need ot find a place for them.

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
1820

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding:
The County Behavioral Health System will use BHSA Housing Interventions funding in FY 2026/27–FY 2028/29 to support operational subsidies for permanent and interim housing settings that serve BHSA-eligible individuals with significant behavioral health needs. These investments are intended to ensure the availability, stability, and sustainability of housing resources that provide structured, supportive environments for individuals transitioning from homelessness, institutional settings, or higher levels of care.

Operational subsidies will be used to support the ongoing operation of licensed residential care settings, including Adult Residential Facilities (ARFs) and other interim or supportive housing environments, where service intensity and staffing requirements exceed what can be supported through resident income or other funding sources alone. These subsidies help maintain program viability, ensure appropriate staffing and service delivery, and preserve critical housing capacity within the behavioral health continuum of care.

BHSA Housing Interventions funding will also support Interim Placement Funding (IPF), which provides time-limited financial support to residential providers to sustain placements for individuals who are in the process of establishing Supplemental Security Income (SSI) eligibility. IPF is structured to support provider operations and maintain placement capacity during periods when individuals do not yet have established income, rather than functioning as a traditional tenant-based rental subsidy. IPF payments are not structured as ongoing rental assistance tied to an individual lease; instead, they function as short-term operational support to residential providers to maintain placement availability, prevent discharge to homelessness, and support continuity of care.

These operational subsidies enable providers to maintain placements for high-need individuals, support stabilization and engagement in services, and ensure that critical residential resources remain available as part of the County's broader housing and behavioral health system. Together, these interventions strengthen the continuum of care by supporting both access to and sustainability of housing environments that serve BHSA priority populations.

For which setting types will the county provide operating subsidies?

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

Will this be a scattered site initiative?

Yes

Will this Housing Intervention accommodate family housing?

No

Total number of units funded with BHSA Housing Interventions per year

60

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:

For FY 2026/27–FY 2028/29, the County anticipates using BHSA Housing Interventions to fund operating subsidies that are linked to eligible individuals rather than tied to a fixed, project-based number of units, particularly for interim, bridge, and supportive residential placements.

This approach is applicable to Interim Placement Funding (IPF), Homeless Bridge placements, and similar assisted living or subsidy models in which the County provides a time-limited subsidy on behalf of a BHSA-eligible individual placed in an Adult Residential Facility (ARF), interim housing setting, or other clinically appropriate placement. Under the Homeless Bridge model, BHSA funds may be used to stabilize individuals exiting higher levels of care, custody, hospitals, or crisis settings, or those experiencing unsheltered homelessness, by covering short-term housing costs while longer-term housing arrangements are secured. These subsidies follow the individual rather than being restricted to a predefined inventory of dedicated units.

Operating subsidies are used to address affordability gaps while individuals stabilize, engage in treatment and recovery supports, and establish or reinstate income and benefits (e.g., SSI/SSDI,

employment income, or other ongoing subsidy sources). Because these subsidies are individual-linked, the County retains flexibility to respond to real-time placement needs, clinical appropriateness, and available settings.

This individualized subsidy approach supports timely discharge planning, prevents returns to homelessness or institutional settings, reduces unnecessary system cycling, and ensures continuity of housing and services while individuals transition to permanent housing or alternative long-term subsidy sources consistent with BHSA and Housing First principles.

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
300

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Landlord Outreach and Mitigation Funds will be utilized to expand housing access for BHSA-eligible individuals by reducing financial risk to property owners and encouraging participation in both interim and permanent housing placements. These funds will support landlord engagement efforts and provide a financial backstop for damages or loss-related costs attributable to BHSA-eligible tenants, beyond normal wear and tear and not otherwise covered by security deposits.

Funding will be administered through the County's Behavioral Health Housing and Supportive Services provider supporting MHSA/BHSA-funded permanent supportive housing. In permanent settings, mitigation funds may be used to offset unit damages, vacancy loss, or other allowable costs associated with leasing to individuals with significant behavioral health needs. In interim and time-limited settings, mitigation funding will similarly be available to incentivize property managers and operators to accept referrals of BHSA-eligible individuals, particularly those with limited rental history, prior evictions, justice involvement, or other barriers to housing.

This intervention supports Housing First principles by removing structural barriers to housing access, strengthening landlord partnerships, expanding the pool of available units, and promoting equitable placement opportunities for individuals experiencing or at risk of homelessness. By proactively addressing landlord concerns and mitigating financial risk, the

County aims to increase placement success, reduce delays in housing access, and support long-term housing stability for BHSA-eligible households.

Total number of units funded with BHSA Housing Interventions per year
100

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:
Orange County Behavioral Health Services (BHS) will provide Landlord Outreach and Mitigation Funds under BHSA Housing Interventions in a manner that is not tied to a fixed or project-based number of units. Instead, these funds will be deployed flexibly based on individual placement needs, available housing opportunities, and real-time market conditions to expand access to both interim and permanent housing settings.

These resources will be used primarily to support implementation of the County's Homeless Bridge program and Housing First–aligned placements by reducing barriers to landlord participation and strengthening housing retention for BHSA-eligible individuals. Mitigation funds may be used to address unit-related costs that exceed typical security deposits, such as repairs for damages beyond normal wear and tear, limited vacancy loss associated with tenancy disruptions, or other allowable remediation necessary to secure or maintain a housing placement.

In addition, the County will utilize these funds to support proactive landlord outreach and engagement activities, including recruitment of new housing partners, relationship-building with property managers, and education regarding the supportive services and tenancy-sustaining resources available through the behavioral health system.

By maintaining mitigation funding that is not restricted to a predefined unit inventory, BHS will retain the flexibility to respond quickly to emerging placement opportunities, stabilize tenancies, and prevent returns to homelessness. This approach is consistent with BHSA requirements and Housing First principles by expanding the pool of available units, reducing structural barriers to housing access, and promoting long-term housing stability for individuals with significant behavioral health needs.

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year

100

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

Participant Assistance Funds will be utilized under BHSA Housing Interventions to help BHSA-eligible individuals eliminate practical and financial barriers to securing and maintaining housing, consistent with Housing First principles and the goal of promoting long-term housing stability. These flexible supports are intended to address immediate needs that may otherwise prevent an individual from moving into housing or successfully sustaining tenancy.

Participant Assistance Funds will be available for use in both interim and permanent housing settings. In interim or bridge housing placements, these funds will primarily support individuals in removing barriers to obtaining permanent housing, such as costs associated with preparing for lease-up, completing documentation requirements, or addressing urgent needs that support housing readiness and transition. In permanent housing settings, participant assistance may be used on a limited basis to support tenancy stabilization and prevent housing disruption when other resources are not available.

These funds will be administered through the County's Behavioral Health Housing and Supportive Services provider supporting MHSA/BHSA-funded Permanent Supportive Housing units. Participant Assistance Funds will also support individuals served through BHSA-funded Homeless Bridge programs as they work toward transitioning into permanent housing and establishing the supports necessary for ongoing stability.

By providing individualized, barrier-reducing assistance, the County aims to increase housing access, improve successful transitions from interim to permanent settings, and strengthen long-term housing retention for BHSA-eligible individuals experiencing or at risk of homelessness.

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

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

Is the county providing this intervention?

Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

Anticipated number of individuals served per year
100

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Housing Transition Navigation and Tenancy Sustaining Services will be provided through BHSA Housing
Interventions to support BHSA-eligible individuals in accessing housing, successfully transitioning from interim settings, and maintaining long-term housing stability. These services are core components of the County's Housing First–aligned approach and are designed to reduce barriers to housing entry, promote engagement in voluntary supports, and prevent returns to homelessness.

These services will be available to all individuals served through County-funded Homeless Bridge programs, bridge housing placements, and shelter-based housing intervention programs. Housing Transition Navigation activities may include individualized housing search support, assistance with completing housing applications and documentation, coordination with landlords and housing providers, and facilitation of warm handoffs from interim settings into permanent housing opportunities.

Tenancy Sustaining Services will provide ongoing, person-centered supports once an individual is housed, including tenant education, support with lease compliance, connection to behavioral health and recovery services, coordination with property management, and early intervention when housing instability or tenancy challenges arise. Services will be delivered in a flexible, field-based manner and tailored to the needs of individuals with significant behavioral health conditions.

By pairing housing navigation with tenancy sustaining supports, the County aims to strengthen transitions from homelessness to housing, improve retention in permanent settings, and ensure that BHSA-eligible individuals receive the level of stabilization and support needed to maintain housing and advance recovery in the community.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
13000

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Housing Outreach and Engagement services will be implemented through an interagency agreement with
the Office of Care Coordination to support field-based identification and engagement of individuals experiencing homelessness who may be BHSA-eligible. This intervention is designed to proactively connect individuals with significant behavioral health needs to housing opportunities and the broader behavioral health system of care.

Multidisciplinary outreach teams will conduct street-based outreach, encampment engagement, and community-based engagement activities in coordination with local partners, including shelters, hospitals, law enforcement, housing providers, and other community stakeholders. Outreach efforts will prioritize individuals experiencing unsheltered homelessness and those with complex behavioral health needs who face barriers to accessing traditional service entry points.

BHSA Housing Interventions funding will support assertive engagement, housing-focused care coordination, screening for BHSA eligibility, and facilitation of warm handoffs to interim housing, Homeless Bridge placements, permanent supportive housing, Full Service Partnership (FSP) programs, and other appropriate behavioral health treatment and recovery services. Services will be delivered in a flexible,
field-based manner consistent with Housing First principles, emphasizing voluntary engagement, person-centered planning, and rapid connection to housing resources.

This intervention is intended to reduce barriers to care, strengthen continuity of engagement, and increase timely access to both interim and permanent housing options for individuals with serious mental illness and/or moderate-to-severe substance use disorders who are experiencing or at risk of homelessness.

Capital Development Projects (Chapter 7, Section C.10)

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
Yes

Is the county providing this intervention to chronically homeless individuals?

Yes

How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?
6

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

Name of Project
Orange County Behavioral Health Services (BHS) anticipates funding the following capital development projects under BHSA Housing Interventions:
Mercury Senior Apartments (Brea)
Lampson Workforce Housing (Los Alamitos) TBD Project (San Juan Capistrano)
TBD Project (Anaheim Hills) TBD Project (Buena Park) TBD Project (Fountain Valley)

What setting types will the capital development project include?
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)
65

Will this project braid funding with non-BHSA funding source(s)?
Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources
416

Total number of units funded with Housing Interventions funds only
56

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
The County's Health Care Agency (HCA) partners with OC Community Resources (OCCR) to administer
funding available for the development of permanent supportive housing (PSH) through an ongoing Notice of Funding Availability (NOFA). Through this NOFA process, the County has completed the development of 476 units of MHSA housing since June 2018 with another 196 MHSA units in the pipeline. The County has an overarching goal of developing 2,396 units of PSH by 2029 and MHSA/BHSA is a critical catalyst fund to support the County's efforts. With each BHSA dollar used to support capital development of a project, an additional $5.50 is leveraged. Along with the MHSA units that are in the pipeline, the MHSA funds used to finance these developments also helped support the development of over 2,600 additional supportive and affordable housing units. The process for developing affordable housing is complex and utilizes multiple funding sources, including tax credits, that often require commitment of County funding in order to proceed. However, the County can only make enforceable funding commitments using funding that the County has in hand. As such, HCA typically allocates funding to OCCR through a Three-Year Spending Plan to make funding available through a future NOFA.

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)
1/1/2028

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
208000

Have you utilized the "by right" provisions of state law in your project?
Yes

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention:
In addition to the Housing Interventions described above, the County may utilize BHSA Housing Interventions funding to provide limited ongoing utility assistance and renter's insurance support for BHSA-eligible individuals when these costs are not otherwise covered through Medi-Cal managed care plan (MCP) Community Supports or other funding sources.

Ongoing utility assistance may be provided beyond the initial month of tenancy when necessary to prevent housing loss and stabilize individuals transitioning from homelessness or interim placements into permanent housing. Similarly, renter's insurance support may be provided when required as a condition of tenancy and when individuals lack the financial means to secure coverage independently.

These supports will be provided on a time-limited and individualized basis, consistent with Housing First principles and BHSA requirements, to address affordability gaps that could otherwise jeopardize housing stability. By addressing essential housing-related expenses not covered by MCPs, the County aims to reduce returns to homelessness, strengthen tenancy retention, and promote long-term stabilization for BHSA-eligible households.

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

Anticipated number of individuals served per year
500

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing):
For FY 2026/27–FY 2028/29, BHSA Housing Interventions funding may be used to continue and stabilize existing housing and interim services that are approaching the end of their current funding terms, to avoid service disruption for BHSA-eligible individuals.

- Behavioral Health Bridge Housing: The County anticipates one additional year of Bridge Housing operations, fully funded through the existing Bridge Housing grant, with a projected completion/term end of June 2027. BHSA Housing Interventions may be used to support continuation of Bridge Housing as an interim setting beyond that grant period, as feasible and consistent with local planning and procurement timelines.
- Homeless Bridge Housing (HBH): This program will be renewed for an additional year and is eligible to be supported by Housing Interventions. HBH has been successful in assisting BHSA eligible participants get matched to permanent supportive housing.
- Year Round Shelter Program: This program requires renewal and is projected to expire in June 2027. BHSA Housing Interventions may be considered to help sustain this interim shelter capacity and associated engagement/referral pathways for BHSA-eligible participants.
- Residential Rehabilitation Program: BHSA Housing Interventions may support the continuation of this program to maintain critical treatment-linked housing options for adults with behavioral health needs.
- Recovery Residences and Perinatal SUD housing supports: The County anticipates continued program

- development and/or renewal activities in these areas; projected annual service volumes will be finalized with program leadership during the planning cycle.
- In addition to direct housing program continuation, the County will maintain system capacity-building supports, including the contract with CSH Corporation for Supportive Housing (MOU/technical assistance) in coordination with OC Community Resources (OCCR) to support project development and provide consultation as housing initiatives move from planning into full operations.

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

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

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

- Housing Transition Navigation Services
- Housing Deposits Transitional Rent
- Housing Tenancy and Sustaining Services

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

Housing Transition Navigation Services: Yes

When does the county behavioral health system plan to become an MCP-contracted provider? 1/1/2026

Housing Deposits: Yes

When does the county behavioral health system plan to become an MCP-contracted provider? 1/1/2026

Housing Tenancy and Sustaining Services: Yes

When does the county behavioral health system plan to become an MCP-contracted provider? 1/1/2026

Short-Term Post-Hospitalization Housing: No

Recuperative Care: No

Day Habilitation: No

Transitional Rent: Yes

When does the county behavioral health system plan to become an MCP-contracted provider? 1/1/2026

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)?
For FY 2026/27–FY 2028/29, the County Behavioral Health System will identify, confirm eligibility, and refer Medi-Cal members to MCP-funded housing-related Community Supports (including Transitional Rent) through standardized screening, verification, and coordinated referral workflows integrated across clinics, outreach, and housing programs.

Identify members: At intake and ongoing care contacts, Behavioral Health providers (including PSH-based housing support staff) will screen for homelessness/housing instability and Medi-Cal status. Telecare Home First, as the County's housing support provider, will serve as a primary pathway for identifying members who may benefit from MCP Community Supports.

Confirm eligibility: With member consent, County staff and Telecare Home First will verify (1) active Medi-Cal coverage and MCP assignment, and (2) applicable Community Supports eligibility criteria (e.g., homelessness or risk of homelessness, service need). Individuals served by Telecare will generally be Medi-Cal eligible; eligibility confirmation will be completed prior to referral submission. As ECM/FSP program models evolve, the County will align eligibility checks with ECM enrollment processes and will coordinate with FSP providers as they expand to Community Supports, as applicable.

Refer and coordinate services: Referrals will be made via warm handoffs to Telecare Home First and/or MCP-designated Community Supports providers, using MCP-required documentation and authorization processes. For members in Permanent Supportive Housing, on-site housing support providers will coordinate directly with Telecare and MCPs to ensure timely service initiation and continuity.

Relationship to BHSA Housing Interventions: The County will implement "payer-of-first-resort" sequencing by exhausting MCP-covered Community Supports (including Transitional Rent) whenever available before using BHSA Housing Interventions funding to fill remaining gaps. The County will develop shared tracking and feedback loops with MCPs and providers to monitor approvals, denials, timelines, and outcomes, and to reduce delays in Transitional Rent access.

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:
For FY 2026/27–FY 2028/29, the County Behavioral Health System will ensure that the contracted provider network for BHSA Housing Interventions is clearly known, shared, and operationally

aligned with Medi-Cal managed care plans (MCPs) serving Orange County through structured coordination and ongoing joint implementation processes. The County is standing up an interagency Housing Interventions implementation workgroup that includes representatives from the Continuum of Care (CoC), OC Community Resources (OCCR), housing and service providers, MCP partners, and individuals with lived experience to support a coordinated and transparent system of care.

The County will maintain routine communication with MCPs, including weekly coordination meetings focused on referral workflows, eligibility alignment, service authorization processes, and real-time problem-solving as Housing Interventions are implemented. In parallel, the County will continue active engagement with CoC provider networks, many of whom also contract with MCPs to deliver Community Supports housing services, ensuring consistent understanding of roles, access points, and available resources across systems.

To strengthen shared implementation, the County will develop aligned policies and procedures (P&Ps) in collaboration with MCPs and housing partners to address operational challenges, including areas where federal, state, and Medi-Cal requirements may not fully align. These efforts will support clear referral pathways, coordinated care planning, and timely handoffs between behavioral health, housing, and managed care partners. Through these ongoing processes, the County will prioritize continuity, reduce fragmentation, and ensure BHSA-eligible individuals do not fall through the cracks as they access housing and supportive services.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?
No

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?
To prevent gaps in housing stability and supportive services when Medi-Cal managed care plan (MCP) housing benefits are exhausted, the County Behavioral Health System is developing structured, collaborative workflows and aligned policies and procedures (P&Ps) that prioritize continuity of housing and care for individuals with significant behavioral health conditions.

The County is working closely with MCP partners to design coordinated transition protocols that identify members approaching the end of time-limited benefits, including transitional rent, and proactively assess continued housing risk and BHSA eligibility. Through these efforts, the County is establishing internal screening, referral, and funding workflows to ensure that, to the extent resources are available, individuals do not return to homelessness or experience service disruption when MCP-funded housing supports conclude.

As the designated transitional rent provider for CalOptima Health at this time, the County is intentionally aligning implementation timelines to ensure readiness prior to July 1, 2026,

when the initial six-month transitional rent obligation for early approved members is expected to end. Policies, contracts, and operational processes are being structured to allow for timely transition to BHSA Housing Interventions funding where appropriate, including bridge support, rental subsidies, tenancy sustaining services, and care coordination.

These processes are grounded in a shared commitment with MCPs and housing partners to reduce fragmentation, prevent avoidable housing loss, and ensure individuals with serious mental illness and/or moderate-to-severe substance use disorders experience seamless transitions between funding streams. Through proactive planning, coordinated monitoring, and clear handoffs, the County aims to ensure Medi-Cal members do not fall through the cracks when MCP housing services are exhausted, consistent with Housing First principles and BHSA requirements.

Flexible Housing Subsidy Pools

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

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools .

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
No

Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?
No

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above:
Although the County is not implementing a Flex Pool during this initial year, the County Behavioral Health
System will take several roles to support future launch and scaling. These functions include establishing internal governance and cross-department coordination; developing program policies, eligibility criteria, and standard operating procedures aligned with BHSA Housing Interventions requirements;

building fiscal infrastructure for subsidy payments and internal controls; and preparing procurement and contracting materials, including scopes of work, reporting requirements, and performance standards.

In addition, the County is working with system and community partners to develop collaborative and aligned policies and procedures to ensure coordinated implementation across the local continuum of care. To support this effort, the County has convened an ad hoc workgroup comprised of County departments and external partners to jointly identify operational needs, clarify roles and responsibilities, align referral pathways, and promote consistent program implementation and documentation standards.

The County will also develop data collection and reporting processes to support monitoring and evaluation, including measures for timeliness of subsidy deployment, housing placement outcomes, and housing retention. These actions will build the administrative and operational foundation needed to implement a Flex Pool model in a future year, which would be reflected in a subsequent amendment or update to the Integrated Plan.

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

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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:

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

Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.

The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.

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

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

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
16

Upload any data source(s) used to determine vacancy rate: n/a

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

- Medi-Cal Certified Peer Support Specialist
- Licensed Psychologist Psychiatrist
- Community Health Workers (CHW) defined in the Enhanced Community Health Workers Services benefit Licensed Clinical Social Worker

Please describe any other key workforce gaps in the county:
In addition to the positions identified through the statewide dropdown selections, Orange County Behavioral Health Services (BHS) has identified several key workforce gaps based on local classification structures, vacancy data, and service delivery needs under Behavioral Health Transformation and BH-CONNECT.

BHS utilizes broader, consolidated classifications for many clinical roles. For example, licensed clinical staff such as Licensed Clinical Social Workers (LCSWs), Licensed Marriage and Family Therapists (LMFTs), and licensed psychologists are grouped under a single Behavioral Health Clinician classification. As a result, vacancy rates for individual licensed disciplines may appear lower when viewed independently but represent a higher combined vacancy rate when aggregated within this classification. This consolidated structure reflects service delivery flexibility but also masks discipline-specific shortages, particularly among licensed clinicians required to meet increasing demand for specialty mental health services.

BHS continues to experience workforce challenges in recruiting and retaining psychiatrists and licensed psychologists, particularly for specialty mental health settings serving high-acuity populations. These shortages impact access to timely assessments, medication management, and evidence-based treatment and are compounded by regional labor market competition and rising demand under expanded eligibility and service requirements.

Certified peer support specialists represent another critical workforce gap. While peer roles are

increasingly central to BH-CONNECT and recovery-oriented care models, BHS is currently working to embed certification requirements across programs to ensure consistency, quality, and sustainability. This transition has temporarily constrained the available peer workforce and requires ongoing investment in training, certification pathways, and supervision capacity.

Community Health Workers (CHWs) were identified as a high-vacancy role through the dropdown selection; however, BHS does not currently employ Enhanced Community Health Workers specifically within the specialty behavioral health system. This reflects a strategic gap rather than attrition and represents an area of planned workforce development aligned with BH-CONNECT's emphasis on community-based engagement, navigation, and culturally responsive care.

In addition to direct service roles, BHS has identified significant recruitment challenges for clinic-level supervisory and management positions, referred to locally as Service Chiefs. These positions require advanced clinical expertise, leadership competencies, and administrative responsibility and are increasingly difficult to fill due to workload demands, competition with non-supervisory clinical roles, and limited leadership pipeline capacity. Strengthening leadership development and succession planning has therefore been identified as a critical workforce priority.

Collectively, these workforce gaps underscore the need for continued investment in pipeline development, certification and training pathways, leadership advancement, and innovative recruitment and retention strategies. Addressing these gaps is essential to supporting BH-CONNECT implementation, delivering evidence-based practices under Behavioral Health Transformation, and ensuring equitable access to specialty behavioral health services across the county.

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, Orange County Behavioral Health Services (BHS) anticipates a significant shift in workforce needs to support implementation of Behavioral Health Transformation (BHT) and the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT). These changes reflect a transition toward more integrated, community-based, and equity-focused models of care that emphasize multidisciplinary teams, evidence-based practices, and strengthened partnerships across systems. As BHS expands implementation of new and emerging evidence-based practices under BHT and BH-CONNECT, there will be increased demand for staff who can deliver services in community settings, support care coordination, and engage individuals with complex behavioral health needs. To meet these needs, BHS will invest in the development of Enhanced Community Health Workers, who will play a critical role in outreach, engagement, navigation, and connection to services, particularly for populations experiencing disparities in access and outcomes. These roles align with BH-CONNECT's emphasis on trusted, community-based providers and culturally responsive care.

BHS will also expand the number of certified peer support specialists integrated across the

continuum of care and invest in health and wellness coaches to strengthen integrated, whole-person care delivery within multidisciplinary teams. These workforce roles support engagement, recovery, and continuity of care and are central to the delivery of transformed behavioral health models.

To support long-term workforce sustainability, BHS will strengthen local pipelines and career pathways that support a "grow our own" workforce strategy. This includes expanding internship and practicum opportunities for second-year Marriage and Family Therapists (MFTs), Master of Social Work (MSW) students, and psychologists, piloting apprenticeship programs to create alternative entry points into the behavioral health workforce, and intentionally linking internship pathways to longer-term employment opportunities within the system.

In addition, BHS will invest in leadership development and succession planning to make supervisory and management roles more accessible and attractive to existing staff. These efforts are intended to support internal advancement, retain institutional knowledge, and ensure continuity of leadership as the system transforms. Leadership development initiatives will focus on building competencies in integrated care, supervision of multidisciplinary teams, equity-centered practice, and implementation of evidence-based models under BH-CONNECT and BHT.

Retention strategies will include leveraging loan repayment opportunities and continuing to offer free continuing education (CE) opportunities to support professional development, licensure, and workforce readiness. Together, these strategies support workforce stability, advancement, and capacity to meet evolving service delivery expectations.

Through these combined investments, BHS expects its workforce to evolve over the next three fiscal years toward a more diverse, multidisciplinary, community-embedded, and leadership-ready model. These efforts will ensure the workforce is prepared to support BH-CONNECT implementation, deliver evidence-based practices under BHT, and meet the behavioral health needs of the community in an equitable and sustainable manner.

Address Workforce Gaps

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

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

Please explain any actions or activities the county is engaging in to leverage the program:

Orange County Behavioral Health Services (BHS) is leveraging the BH-CONNECT workforce initiative by actively supporting and promoting participation in the Behavioral Health Scholarship Program as part of its broader workforce pipeline and sustainability strategy. While individual students and trainees apply directly to the state-administered scholarship program, BHS supports participation by serving as an eligible public behavioral health employer and incorporating scholarship opportunities into recruitment, outreach, and workforce development activities.

BHS is engaging in targeted outreach to students, interns, and trainees in behavioral health disciplines that align with priority service areas, including Full Service Partnerships (FSP) and Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP). This includes promoting scholarship opportunities through internship and practicum placements, partnerships with academic institutions, and communication with training programs serving Marriage and Family Therapists, Master of Social Work students, psychologists, and other behavioral health professionals.

BHS also leverages existing workforce pathways by connecting scholarship recipients and applicants to field-based, team-oriented service models consistent with BH-CONNECT, including FSP and CSC for FEP programs. These efforts support early exposure to public behavioral health practice, encourage service commitments in high-need areas, and strengthen the local pipeline of clinicians prepared to deliver evidence-based, community-based care.

In addition, BHS provides administrative support, employment verification, and information-sharing to facilitate participation in the Behavioral Health Scholarship Program and aligns scholarship promotion with complementary workforce strategies, such as internships, apprenticeships, peer certification pathways, and leadership development. Through these coordinated actions, BHS aims to strengthen recruitment and retention of a workforce capable of supporting BH-CONNECT implementation and addressing workforce gaps across specialty behavioral health services.

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

Yes

Please explain any actions or activities the county is engaging in to leverage the program:

Yes. Orange County Behavioral Health Services (BHS) plans to leverage the BH-CONNECT workforce initiative by actively supporting staff participation in the Behavioral Health Student Loan Payment Program. While individual eligible staff apply directly to the state-administered program, BHS will serve as an eligible public employer and promote loan repayment opportunities as part of its recruitment, onboarding, and retention strategies. BHS will provide required employment verification and administrative support to facilitate staff participation and will integrate student loan repayment opportunities into broader workforce development efforts aligned with Behavioral Health Transformation and BH-CONNECT goals.

In addition to state-administered loan repayment opportunities, BHS plans to enhance workforce recruitment and retention through a locally administered student loan repayment strategy utilizing Behavioral Health Services Act (BHSA) funds. Workforce Development funding may be used to support ongoing loan repayment incentives for priority behavioral health classifications and hard-to-recruit positions. In parallel, Innovation funding may be leveraged, when appropriate, to pilot or test novel loan repayment models or eligibility approaches designed to address local workforce gaps, promote equity, or support emerging roles consistent with BH-CONNECT service delivery models. Together, these approaches may operate independently or in coordination with state-funded programs to maximize workforce impact and support a sustainable, community-based behavioral health workforce.

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

Please explain any actions or activities the county is engaging in to leverage the program:
Orange County Behavioral Health Services (BHS) plans to leverage the BH-CONNECT workforce initiative by applying for and participating in the Behavioral Health Recruitment and Retention Program to address workforce gaps and support staffing stability across specialty behavioral health services, including Full Service Partnerships (FSP) and Coordinated Specialty Care for First Episode Psychosis (CSC-FEP).

As part of this effort, BHS will implement targeted recruitment and pipeline strategies designed to strengthen workforce capacity in high-need and hard-to-fill service areas. These strategies include incentivizing internship and training placements that focus on delivery of co-occurring mental health and substance use services, services for very young children, and programs serving individuals with high acuity behavioral health needs. By prioritizing these placements, BHS aims to build a workforce with early exposure to complex service environments and increase the likelihood of long-term employment in specialty behavioral health settings.

BHS will also continue to strengthen multidisciplinary, team-based care models aligned with BH-CONNECT, including teams that incorporate roles funded through Medi-Cal Managed Care Plans. These integrated teams may include a mix of licensed clinicians, certified peer support specialists, community-based roles, and other non-traditional workforce classifications that support engagement, care coordination, and whole-person care. Establishing and sustaining these team structures supports recruitment and retention by expanding career pathways, reducing provider burden, and improving workforce sustainability, while also supporting delivery of evidence-based, community-based services.

Participation in the Behavioral Health Recruitment and Retention Program will complement other workforce initiatives, including scholarship and loan repayment programs, workforce training and technical assistance through Centers of Excellence, leadership development efforts, and local pipeline and apprenticeship strategies. Together, these coordinated

approaches will support a stable, skilled, and multidisciplinary workforce capable of meeting BH-CONNECT service delivery requirements and addressing the behavioral health needs of the community.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
No

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training:
In addition to the workforce strategies described above under Behavioral Health Services Act Workforce, Education, and Training, Orange County Behavioral Health Services (BHS) is pursuing broader, system-level efforts to address workforce gaps and strengthen long-term workforce sustainability.

BHS is in the early stages of establishing a countywide behavioral health workforce collaborative that brings together internal program leadership, County Human Resources partners, labor representatives, academic institutions, and community-based providers. The purpose of this collaborative is to align workforce planning across systems, identify shared recruitment and retention challenges, and coordinate strategies that support pipeline development, career advancement, and workforce stability across the behavioral health continuum. This collaborative approach is intended to reduce silos, improve coordination, and support consistent implementation of workforce strategies aligned with Behavioral Health Transformation and BH-CONNECT.

In partnership with County Human Resources, BHS is also exploring the feasibility of piloting an Employee 20/20 program as part of its “grow our own” workforce strategy. This concept would support employees in balancing work and education or training commitments, with the goal of expanding internal career pathways and advancing staff into hard-to-fill clinical, supervisory, and leadership roles over time.

Implementation of such a pilot would require coordination with labor representatives and approval by the County Board of Supervisors; however, BHS views this as a promising long-term strategy to strengthen recruitment, retention, and succession planning within the behavioral health workforce.

Together, these efforts reflect BHS’s commitment to addressing workforce gaps not only through individual programs or incentives, but also through coordinated, structural

approaches that support career progression, leadership development, and long-term system capacity. These initiatives are intended to complement existing BHSA workforce investments and further support a sustainable, skilled, and community-responsive behavioral health workforce.

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 .

Budget and Prudent Reserve

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

Behavioral Health Services and Supports (BHSS): N/A

Full Service Partnership (FSP): N/A

Housing Interventions: N/A

Enter date of last prudent reserve assessment: 1/13/2026

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

BHSS: N/A

FSP: N/A

Housing Interventions: N/A

Behavioral Health Care Continuum Projected Expenditures

A	B	C	D	E	F	G	H	I	J	K
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/TAY
25	**Substance Use Disorder (SUD) Services**									
26	Primary Prevention Services	☑	$7,352,213	$7,499,257	$7,649,242	$816,913	$833,251	$849,916	5598	11,253
27	Early Intervention Services	☑	$5,259,904	$5,365,102	$5,472,404	$584,434	$596,122	$608,045	2700	300
28	Outpatient Services	☑	$49,744,290	$50,739,175	$51,753,959	$5,527,143	$5,637,686	$5,750,440	8607	285
29	Intensive Outpatient Services	☑	$18,509,192	$18,879,376	$19,256,963	$2,056,576	$2,097,709	$2,139,663	1896	184
30	Crisis and Field-Based Services	☑	$495,000	$504,900	$514,998	$55,000	$56,100	$57,222	832	16
31	Residential Treatment Services	☑	$31,986,000	$32,625,720	$33,278,234	$3,554,000	$3,625,080	$3,697,582	1183	52
32	Inpatient Services	☑	$675,000	$688,500	$702,270	$75,000	$76,500	$78,030	20	2
33	**Mental Health (MH) Services**									
34	Primary Prevention Services	☑	$734,294	$748,980	$763,960	$109,722	$111,916	$114,155	200	30
35	Early Intervention Services	☑	$33,448,853	$32,861,813	$32,263,032	$29,352,013	$29,939,054	$30,537,834	14,965	22,530

Behavioral Health Care Continuum Projected Expenditures

A	B	C	D	E	F	G	H	I	J	K
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/TAY
	Mental Health (MH) Services									
36	Outpatient and Intensive Outpatient Services	☑	$84,840,326	$86,537,132	$88,267,873	$118,728,192	$121,102,756	$123,524,811	25,440	23,054
37	Crisis Services	☑	$51,041,871	$52,062,708	$53,103,963	$29,230,837	$29,815,454	$30,411,763	32,019	8,715
38	Residential Treatment Services	☑	$2,907,225	$2,965,370	$3,024,677	$3,523,588	$3,594,060	$3,665,941	183	392
39	Hospital and Acute Services	☑	$2,876,999	$2,934,539	$2,993,230	$719,250	$733,635	$748,307	6,940	1,780
40	Subacute and Long-Term Care Services	☑	$114,870,065	$117,167,466	$119,510,816				500	0
41	**Housing Services (MH + SUD)**									
42	Housing Services	☑	$72,765,000	$72,913,500	$73,064,970	$735,000	$736,500	$738,030	2,829	35
43	**Total Projected Expenditures and Individuals Served**									
44	Total Projected Expenditures and Individuals Served (auto-populated)		$477,506,232	$484,493,538	$491,620,591	$195,067,668	198,955,823	$202,921,739	10,3912	68,628

Behavioral Health Care Continuum Projected Expenditures

Instructions

Counties shall report their planned expenditures for all behavioral health funding sources, not limited to only BHSA, along the Behavioral Health Care Continuum in Tab One.

For Annual Updates, counties should review and make updates only to the next fiscal year. For Intermittent Updates, counties should review and make updates to the current fiscal year.

Column C: counties shall indicate whether they provide each category of services using the check box.

Columns D through I: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs by each Behavioral Health Care Continuum category. Counties should consider children/youth as 21 and under for Columns G - I.

Columns J and K: counties shall input their estimated total count of all individuals served through the county behavioral health system across all funding sources/programs.

These counts may be duplicated. Counties should consider eligible children/youth as 21 and under for Column K.

Row 38: the total projected expenditures in columns D through I and total projected individuals served annually in columns J and K will be auto-populated from rows 20 through 36.

Note: For a list of all funding streams that should be included in the projected expenditures calculation for each BH Care Continuum Category, please see the Behavioral Health Services Act (BHSA) County Policy Manual Chapter 3, Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance.

These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Other County Expenditures

A	B	C	D	E
16	**Table Two: Other County Expenditures**			
17	**Other Expenditures**	**Total Projected Expenditures**		
18		**Year One**	**Year Two**	**Year Three**
19	Capital Infrastructure Activities	$32,399,439	$35,399,439	$38,399,438
20	Workforce Investment Activities	$12,344,519	$12,591,410	$12,843,238
21	Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$63,915,966	$62,842,274	$61,807,109
22	Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs	$18,734,095	$19,108,777	$19,490,953
23	**Total Projected Expenditures**			
24	Total Projected Expenditures (auto-populated)	$127,394,019	$129,941,900	$132,540,738

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activites, other than those that are part of the Behavioral Health Care Continuum in Table Two.

Rows 19 through 22: 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 Table One, "BH CoC Expenditures."

Row 24: total projected expenditures will be auto-populated from rows 19 through 22.

Note: 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.

3. Total County Behavioral Health Expenditures

34A	B	C	D	E
16	**Table Three: Projected Annual Expenditures by County BH Funding Source**			
17		**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
18	BHSA	$304,164,673	$310,247,966	$316,452,926
19	1991 Realignment (Bronzan-McCorquodale Act)	$59,694,674	$60,888,567	$62,106,338
20	2011 Realignment (Public Safety Realignment)	$93,714,672	$95,588,966	$97,500,745
21	State General Fund	$13,424,000	$13,692,480	$13,966,329
22	FFP (SMHS, DMC/DMC-ODS, NSMHS)	$232,450,722	$236,430,526	$240,489,926
23	Projects for Assistance in Transition from Homelessness (PATH)	$564,842	$564,842	$564,842
24	Community Mental Health Block Grant (MHBG)	$3,942,031	$3,942,031	$3,942,031
25	Substance Use Block Grant (SUBG)	$19,306,499	$19,306,499	$19,306,499
26	Commercial Insurance	$1,178,859	$1,202,437	$1,226,485
27	County General Fund	$3,550,301	$3,550,301	$3,550,301
28	Opioid Settlement Funds	$15,538,699	$15,538,699	$15,538,699
29	**Other Funding Sources**	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
30	Other federal grants	$4,700,000	$4,700,000	$4,700,000
31	Other state funding (including DSH funding)	$41,650,627	$41,650,627	$41,650,627
32	Other county mental health or SUD funding	$6,087,320	$6,087,320	$6,087,320
33	Other foundation funding	$	$	$

3. Total County Behavioral Health Expenditures

A	B	C	D	E
Table Three: Projected Annual Expenditures by County BH Funding Source				
	Summary	**Total Annual Projection (Year One)**	**Total Annual Projection (Year Two)**	**Total Annual Projection (Year Three)**
35	**Total projected expenditures (all BH funding streams/ programs) (auto-populated)**	**$799,967,919**	**$813,391,261**	**$827,083,068**
36	**Total projected unspent BHSA funds**	**$-**	**$-**	**$-**
37	**Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures**	**$672,573,900**	**$683,449,361**	**$694,542,330**
38	**Auto-validation: Table 2: Other County Expenditures**	**$127,394,019**	**$129,941,900**	**$132,540,738**

Instructions

CountiCounties 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.

BHSA Transfers

A	B	C	D	E	F
36	**Table Four: BHSA Transfers**				
37		**Housing Intervention**	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
38	Year 1 Component Allocation (dollars)	$73,500,000	$85,750,000	$85,750,000	$245,000,000
39	Year 2 Component Allocation (dollars)	$73,500,000	$85,750,000	$85,750,000	$245,000,000
40	Year 3 Component Allocation (dollars)	$73,500,000	$85,750,000	$85,750,000	$245,000,000

A	B	C	D	E	F
41	**BHSA Transfers**				
42		**Housing Intervention**	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
	Year One Summary (Auto-Populated)				
43	Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	29%	41%	100%
44	Projected Component Allocation (Based on Adjusted Allocation Percentages)	$73,500,000	$71,050,000	$100,450,000	$245,000,000
45	Unspent Mental Health Services Act (MHSA) to BHSA	$-	$3,600,000	$334,812,821.57	$338,412,821.57
46	Excess Prudent Reserve (PR) to BHSA	$-	$-	$-	$-

BHSA Transfers

A	B	C	D	E	F
41	**BHSA Transfers**				
42		**Housing Intervention**	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
47	**Year two Summary (Auto-Populated)**				
49	Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	29%	41%	100%
50	Projected Component Allocation (Based on Adjusted Allocation Percentages)	$73,500,000	$71,050,000	$100,450,000	$245,000,000
51	**Year three Summary (Auto-Populated)**				
53	Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	29%	41%	100%
54	Projected Component Allocation (Based on Adjusted Allocation Percentages)	$73,500,000	$71,050,000	$100,450,000	$245,000,000

A	B	C	D
55	**Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)**		
57	**Base Component**	**Housing Intervention Component Percentage**	**Housing Intervention Funds**
58	Base Percentage and Funding	30%	$73,500,000
59	Percentage Reduced	0%	$
60	Percentage Added	0%	$
61	New Housing Interventions Base Percentage (auto-populated)	30%	$73,500,000

BHSA Transfers

A	B	C	D
55	**Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)**		
62	**Transferred To/From**	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
63	Base Percentage and Funding	35%	$85,750,000
64	Percentage Reduced	0%	$0
65	Percentage Added	0%	$0
66	New FSP Base Percentage (auto-populated)	35%	$85,750,000
67	**Transferred To/From**	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
68	Base Percentage and Funding	35%	$85,750,000
69	Percentage Reduced	0%	$0
70	Percentage Added	0%	$0
71	New BHSS Base Percentage (auto-populated)	35%	$85,750,000

A	B	C	D	E	F
72	**Funding Transfers (Year One)**				
73		**Housing Intervention (1)**	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
74	Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
75	Amount Transferring Out	0%	-6%	0%	Row Does Not Exceed 14%
76	Amount Transferring In	0%	0%	6%	Transfers Out and In Equal
77	New Base Percentage after Funding Transfer Request (auto-populated)	30%	29%	41%	Row Equals 100%

BHSA Transfers

A	B	C	D
78	**Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)**		
79	**Base Component**	**Housing Intervention Component Percentage**	**Housing Intervention Funds**
80	Base Percentage and Funding	30%	$73,500,000
81	Percentage Reduced	0%	$
82	Percentage Added	0%	$
83	New Housing Interventions Base Percentage (auto-populated)	30%	$73,500,000
84	**Transferred To/From**	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
85	Base Percentage and Funding	35%	$85,750,000
86	Percentage Reduced	0%	$
87	Percentage Added	0%	$
88	New FSP Base Percentage (auto-populated)	35%	$85,750,000
89	**Transferred To/From**	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
90	Base Percentage and Funding	35%	$85,750,000
91	Percentage Reduced	0%	$-
92	Percentage Added	0%	$-
93	New BHSS Base Percentage (auto-populated)	35%	$85,750,000

BHSA Transfers

A	B	C	D	E	F
94	**Funding Transfers (Year Two)**				
95		**Housing Intervention (1)**	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
96	Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
97	Amount Transferring Out	0%	-6%	0%	Row Does Not Exceed 14%
98	Amount Transferring In	0%	0%	-6%	Transfers Out and In Equal
99	New Base Percentage after Funding Transfer Request (auto-populated)	30%	29%	41%	Row Equals 100%

A	B	C	D
100	**Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)**		
101	**Base Component**	**Housing Intervention Component Percentage**	**Housing Intervention Funds**
102	Base Percentage and Funding	30%	$73,500,000
103	Percentage Reduced	0%	$
104	Percentage Added	0%	$
105	New Housing Interventions Base Percentage (auto-populated)	30%	$73,500,000
106	**Transferred To/From**	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
107	Base Percentage and Funding	35%	$85,750,000
108	Percentage Reduced	0%	$
109	Percentage Added	0%	$
110	New FSP Base Percentage (auto-populated)	35%	$85,750,000

BHSA Transfers

A	B	C	D
100	**Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)**		
111	**Transferred To/From**	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
112	Base Percentage and Funding	35%	$85,750,000
113	Percentage Reduced	0%	$
114	Percentage Added	0%	$
115	New BHSS Base Percentage (auto-populated)	35%	$85,750,000

A	B	C	D	E	F
116	**Funding Transfers (Year Three)**				
117		**Housing Intervention (1)**	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Validation**
118	Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
119	Amount Transferring Out	0%	-6%	0%	Row Does Not Exceed 14%
120	Amount Transferring In	0%	0%	-6%	Transfers Out and In Equal
121	New Base Percentage after Funding Transfer Request (auto-populated)	30%	29%	41%	Row Equals 100%

BHSA Transfers

A	B	C	D	E	F
122	**MHSA Transfers to BHSA**				
123	**MHSA Component**	**Available Unspent BHSA Funds**	**Transferred to Housing Intervention Component**	**Transferred to Full-Service Partnership**	**Transferred to Behavioral Health Services and Support**
124	CSS	$226,900,869.58	$-	$3,000,000.00	$61,612,971.16
125	PEI	$17,129,184.25	$-	$-	$17,129,184.25
126	Encumbered INN	$53,158,489.16	$-	$600,000.00	$52,558,489.16
127	Unencumbered INN	$-	$-	$-	$-
128	WET	$3,524,746.96			$27,410,385.00
129	CFTN	$37,699,531.62			$176,101,792.00
130	Total (auto-populated)	$338,412,821.57	$-	$3,600,000.00	$334,812,821.57

A	B	C
131	**Excess Prudent Reserve to BHSA Components**	
132	**Transfer from Prudent Reserve to BHSA Component Allocation**	**Amount**
133	Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$33,258,769.00
134	Local Prudent Reserve Maximum (2)	$50,416,182.77
135	Excess Prudent Reserve Funding that must be transferred	$(17,157,413.77)
136	Housing Intervention (3)	$
137	FSP	$
138	BHSS (4)	$
139	Total Transferred Excess Prudent Reserve (auto-populated)	$

References

1. 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.

BHSA Transfers

Instructions

Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. All counties must complete this sheet.

Rows 38-40: input your county's base BHSA funding allocation by component and year.

Rows 43-54: this section will be auto-populated from the sections below it.

Rows 43, 49, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.

Rows 44, 50, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Row 45: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.

Row 46: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.

Rows 58, 80, and 102: the base funding amount for Housing Interventions will auto-populate from Column C, rows 38-40.

Rows 59, 81, and 103: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value.

It will automatically display as a negative value in the cell.

Rows 60, 82, and 104: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions.

Enter this percentage as a positive value.

Rows 63, 85, 107: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 38-40.

Rows 68, 90, 112: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 38-40.

Rows 64, 69, 86, 91, 108, and 113: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.

Rows 65, 70, 87, 92, 109, and 114: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.

Rows 74, 96, 118: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."

Rows 75, 97, 119: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."

Rows 76, 98, 120: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."

Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 75) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.

Rows 77, 99, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."

Rows 124-130: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information.

Row 130: the total dollar amount of MHSA Transfers to BHSA is

BHSA Transfers

Instructions (continue)

auto-populated.

Row 133: enter the dollar amount of prior year prudent reserve ending balance

Row 134: enter the prudent reserve maximum for your county.

Row 135: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. Negative values indicate no transfer is necessary.

Rows 136-138: enter the amount of excess prudent reserve funds allocated to each component.

Row 139: the total transferred excess prudent reserve is auto-populated.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy

Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to

bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance.

These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Housing Interventions

A	B	C	D	E	F
37	**Table Five: BHSA Components**				
38	**Total Housing Interventions Funding (1)**				
		Year 1	**Year 2**	**Year 3**	
39	Total Estimated Housing Intervention Funding Received (BHSA Funds)"	$73,500,000	$73,500,000	$73,500,000	
40	Transfers into Housing Intervention component from Local Prudent Reserve	$0	$0	$0	
41	Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$0	$0	$0	
42	**Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)**	$73,500,000	$73,500,000	$73,500,000	

A	B	C	D	E	F	G	H
43	**Housing Interventions Category**						
44	**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**
45	**Housing Interventions Component Programs/Services**						
46	Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
47	Rental Subsidies	14,000,000	$14,000,000	14,000,000	$3,000,000	$3,000,000	$3,000,000
48	Operating Subsidies	$6,787,829	$6,787,829	$6,787,829	$-	$-	$-
49	Bundled Rental and Operating Subsidies	$2,100,000	$2,100,000	$2,100,000	$500,000	$500,000	$500,000
50	% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%

Housing Interventions

A	B	C	D	E	F	G	H
		Housing Interventions Category					
		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**
51	Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
52	Rental Subsidies	$10,020,254	$10,020,254	$10,020,254	$3,000,000	$3,000,000	$3,000,000
53	Operating Subsidies	$4,982,424	$4,982,424	$4,982,424	$3,500,000	$3,500,000	$3,500,000
54	Bundled Rental and Operating Subsidies	$1,500,000	$1,500,000	$1,500,000	$-	$-	$-
55	% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
56	**Other Housing Interventions**						
57	Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$1,000,000	$1,000,000	$1,000,000	$	$	$
58	Other Housing Supports: Participant Assistant Funds (2)	$2,250,000	$2,250,000	$2,250,000	$	$	$
59	Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$750,000	$750,000	$750,000	$	$	$
60	Other Housing Supports: Outreach and Engagement (2)	$3,600,000	$3,600,000	$3,600,000	$	$	$
61	Capital Development Projects	$18,375,000	$18,375,000	$18,375,000	$990,508	$990,508	$990,508
62	Housing Flex Pool Expenditures (start-up expenditures)	$	$	$	$	$	$
63	BHSA Innovative Housing Intervention Pilots and Projects	$	$	$	$	$	$
64	MHSA INN Projects	$	$	$	$	$	$
65	**Subtotal (auto-populated)**	$65,365,507	$65,365,507	$65,365,507	$10,990,508	$10,990,508	$10,990,508

Housing Interventions

A	B	C	D	E
66	**Housing Interventions Transfer Information**	**Year 1**	**Year 2**	**Year 3**
67	Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$	$	$
68	**Housing Interventions Component Administrative Information**	**Year 1**	**Year 2**	**Year 3**
69	Housing Interventions Component Admin Expenses	$7,500,000	$7,650,000	$7,803,000
70	**Total Housing Interventions Expenditures (auto-populated)**	$72,865,507	$73,015,507	$73,168,507
71	**Housing Interventions Populations to be Served**	**Year 1**	**Year 2**	**Year 3**
72	Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$36,750,000	$36,750,000	$36,750,000
73	Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$8,240,995	$8,240,995	$8,240,995
74	**Housing Interventions Component Funds Validation (auto-populated based on inputs above)**	**Year 1**	**Year 2**	**Year 3**
75	Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	25.0%	25.0%	25.0%
76	Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	50.0%	5,0.0%	50.0%
77	Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	4.9%	4.9%	4.9%
78	**Projected Individuals to be Served (Unduplicated)**	**Year 1**	**Year 2**	**Year 3**
79	Eligible Children/TAY (25 years and younger)	84	86	88
80	Eligible Adults/Older Adults	2,800	2,829	2,886
81	**Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)**	**Year 1**	**Year 2**	**Year 3**
82	MHSA "Encumbered" INN	$	$	$

Housing Interventions

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 for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Table Five.

Rows 35-37: input the estimated total Housing Intervention component allocation received for each year. Row 35 will include projected BHSA funding received. Row 36 will include unspent MHSA dollars carried over. Row 37 will auto-populate the sum of Rows 35-36 to account for total funding.

Rows 42-57: input the projected expenditures and projected slots for each Housing Intervention component service category or program for each year.

Row 41: 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 46: 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, E, and G. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns I - K.

Row 58: the sub-total of rows 42 - 57 will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

Row 60: input the projected expenditures for Housing Interventions

Housing Interventions

Instructions (Continue)

component's administration for each year (see Policy Manual Chapter 6, Section B.8. Cost Principals).

Row 61: the overall total of Housing Intervention expenditures will be auto-populated from rows 58 and 60.

Row 63: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. allocations. This amount should equal 50% of Housing Interventions component

Row 64: input the total dollar amount for Housing Intervention components 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 63.

Row 66: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable.

Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 69: the proportion of funds dedicated to capital development funds will be auto-populated from rows 55 and 37.

Row 70: the proportion of funds dedicated to the chronically homeless population will be auto-populated from rows 63 and 37.

Rows 72 and 73: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

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.

Full Service Partnership

A	B	C	D	E	F
22	**Table Six: BHSA Components**				
23	**Total Full Service Partnership (FSP) Funding**				
		Year 1	**Year 2**	**Year 3**	
25	"Total Estimated Full Service Partnership Funding Received (BHSA Funds)"	$71,050,000	71,050,000	71,050,000	
26	Transfers into Full Service Partnership component from Local Prudent Reserve	$-	$-	$-	
27	"Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)"	$1,200,000	$1,200,000	$1,200,000	
28	"Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)"	$72,250,000	$72,250,000	$72,250,000	

A	B	C	D	E	F	G	H	I	J	K
	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**
30	**FSP Programs/Services**									
31	Assertive Community Treatment (ACT)(2)	$13,536,000	$14,400,000	$14,147,200	$6,030,000	$8,620,000	$8,880,000	$	$	$
32	Forensic Assertive Community Treatment (FACT) Fidelity (2)	$7,614,000	$8,100,000	$8,250,300	$3,390,000	$4,850,000	$5,000,000	$	$	$
33	FSP Intensive Case Management	$9,541,000	$9,317,700	$9,398,453.40	$7,170,000	$10,250,000	10,560,000	$	$	$

Full Service Partnership

A	B	C	D	E	F	G	H	I	J	K
	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									
34	High Fidelity Wraparound	$16,083,400	$16,109,000	$16,126,200	$11,400,000	$12,670,000	$13,050,000	$	$	$
35	Individual Placement and Support (IPS) Model of Supported Employment (2)	$3,384,000	$3,600,000	$3,666,800	$930,000	$1,330,000	$1,370,000	$	$	$
36	Assertive Field-Based Initiation for SUD Treatment Services	$2,284,200	$2,430,000	$2,474,200	$1,620,000	$1,800,000	$1,850,000	$	$	$
37	Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$8,884,500	$8,884,500	$8,884,500	$200,000	$200,000	$200,000	$	$	$
38	Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$-	$-	$-	$-	$-	$-	$-	$-	$-
39	BHSA Innovative FSP Pilots and Projects	$-	$-	$-	$-	$-	$-	$-	$-	$-
40	MHSA INN Projects	$200,000	$200,000	$200,000	$-	$-	$-	$-	$-	$-
41	**Subtotal (auto-populated)**	$61,527,100	$63,041,200	$63,147,653.40	30,740,000	$39,720,000	40,910,000	$-	$-	$-

Full Service Partnership

A	B	C	D	E
42	**FSP Transfer Information**	**Year 1**	**Year 2**	**Year 3**
43	Transfers out of FSP component into Local Prudent Reserve	$	$	$
44	**FSP Administrative Information**	**Year 1**	**Year 2**	**Year 3**
45	FSP Component Admin Expenses	$9,400,000.00	$9,180,000.00	$9,259,560.00
46	**Total Full Service Partnership Expenditures (auto-populated)**	$70,927,100.00	$72,221,200.00	$72,407,213.40
47	**Projected Individuals to be Served (Unduplicated)**	**Year 1**	**Year 2**	**Year 3**
48	Eligible Children/TAY (25 years and younger)	2,300	2,346	2,393
49	Eligible Adults/Older Adults	3,720	3,794	3,870
50	**Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)**	**Year 1**	**Year 2**	**Year 3**
51	MHSA "Encumbered" INN	$600,000	$400,000	$200,000

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 Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Table Six.

Rows 22-24: input the total estimated FSP component allocation received for each year. Row 22 will include projected BHSA funding received. Row 23 will include unspent MHSA dollars carried over. Row 24 will auto-populate the sum of Rows 22-23 to account for total funding.

Rows 29-37: 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 29 - 34.

Full Service Partnership

Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 35 and 36, accordingly.

Row 38: the subtotal of FSP programs/services will be auto-populated from rows 29 through 37.

Row 40: input the projected expenditures for the FSP component's administration for each year (see Policy Manual Chapter 6, Section B.8 Cost Principals).

Row 41: total projected expenditures for FSP for each year will be auto-populated from rows 38 and 40.

Row 43: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable.

Row 44: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.

Rows 46 and 47: input the estimated unduplicated count of individuals that will be served across all FSP programs.

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.

Behavioral Health Services Suport

A		C	D	E	F
24	**Table Seven: BHSA Components**				
25	**Type of Service**	**Projected Expenditures Unspent MHSA and BHSA Funding Only**			
		Year 1	**Year 2**	**Year 3**	
26	Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$100,450,000	$100,450,000	$100,450,000	
27	Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$-	$-	$-	
28	Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$161,604,274	$92,104,274	$81,104,273	
29	**Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)**	$262,054,274	$192,554,274	$181,554,273	

A	B	C	D	E	F	G	H	I	J	K
	Behavioral Health Services and Supports (BHSS) 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**
32	**BHSS Programs/Servicess**									
33	Children's System of Care-Non FSP (25 years and younger)	$9,500,000	$9,500,000	$9,500,000	$2,850,000	$2,850,000	$2,850,000	0	0	0
34	Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$33,195,987	$33,195,987	$33,195,987	$9,958,796	$9,958,796	$9,958,796	0	0	0

Behavioral Health Services Suport

A	B	C	D	E	F	G	H	I	J	K
	Behavioral Health Services and Supports (BHSS) 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**
32	**BHSS Programs/Servicess**									
35	Early Intervention Expenditures	$62,800,866	$62,800,866	$62,800,866	$16,150,000	$17,665,000	$18,422,500	0	0	0
36	Coordinated Specialty Care for First Episode Psychosis	$2,000,000	$2,000,000	$2,000,000	$1,000,000	$1,000,000	$1,000,000	0	0	0
37	All Other EI Expenditures	$60,800,866	$60,800,866	$60,800,866	$15,150,000	$16,665,000	$17,422,500	0	0	0
38	Outreach and Engagement	$14,600,000	$14,600,000	$14,600,000	$-	$-	$-	0	0	0
39	Workforce Education and Training (WET)	$12,940,257	$12,940,257	$12,940,257	$-	$-	$-	0	0	0
40	Dedicated BHSA WET funds	$-	$-	$-	$-	$-	$-	0	0	0
41	Dedicated MHSA WET funds	$12,940,257	$12,940,257	$12,940,257	$-	$-	$-	0	0	0
42	Capital Facilities and Technological Needs (CFTN)	$60,325,597	$30,325,597	$30,325,597	$-	$-	$-	0	0	0
43	Dedicated BHSA CF/TN funds	$-	$-	$-	$-	$-	$-	0	0	0
44	Dedicated MHSA CF/TN funds	$60,325,597	$30,325,597	$30,325,597	$-	$-	$-	0	0	0
45	BHSA Innovative BHSS Pilots and Projects	$-	$-	$-	$-	$-	$-			
46	MHSA INN Projects	$7,232,869	$1,519,585	$1,526,852	$-	$-	$-	0	0	0
47	**Subtotal (auto-populated)**	$200,595,576	$164,882,292	$164,889,559	$28,958,796	$30,473,796	$31,231,296	0	0	0

Behavioral Health Services Suport

A	B	C	D	E
48	**BHSS Prudent Reserve Transfer Information**	**Year 1**	**Year 2**	**Year 3**
49	Transfers out of BHSS component into Local Prudent Reserve	$-	$-	$-
50	**BHSS Administrative Information**	**Year 1**	**Year 2**	**Year 3**
51	BHSS Component Admin Expenses	$19,542,835.00	$25,456,119.00	$25,652,851.00
52	Total Behavioral Health Services and Supports Expenditures (auto-populated)	$220,138,411.00	$190,338,411.00	$190,542,410.00
53	**Youth-Focused Early Intervention Expenditures**	**Year 1**	**Year 2**	**Year 3**
54	Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$32,028,442.00	$32,028,442.00	$32,028,442.00
55	**Behavioral Health Services and Supports Validation (auto-populated based on inputs above)**	**Year 1**	**Year 2**	**Year 3**
56	BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	1049.5%	369.8%	123.7%
57	Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	51.0%	51.0%	51.0%
58	**Projected Individuals to be Served (Unduplicated)**	**Year 1**	**Year 2**	**Year 3**
59	Eligible Children/TAY (25 years and younger)	24,697	25,191	25,691
60	Eligible Adults/Older Adults	22,798	23,254	23,719
61	**Projected BHSS Funds transferred to WET or CF/TN**	**Year 1**	**Year 2**	**Year 3**
62	BHSS transfer to WET	$-	$-	$-
63	BHSS transfer to CF/TN	$-	$-	$-
64	**Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)**	**Year 1**	**Year 2**	**Year 3**
65	Estimated MHSA WET Funds	$27,410,385.00	$14,470,128.00	$1,529,871.00
66	Estimated MHSA CF/TN Funds	$176,101,792.00	$115,776,195.00	$85,450,598.00
67	MHSA "Encumbered" INN	$52,558,489.16	$45,325,620.16	$43,806,035.16

Behavioral Health Services Suport

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 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 Table Seven.

Row 26-28: input the total estimated BHSS component allocation received for each year. Row 26 will include projected BHSA funding received. Row 27 will include unspent MHSA dollars carried over. Row 28 will auto-populate the sum of Rows 26-27 to account for total funding.

Rows 31-43: input the projected expenditures for each BHSS service category or program for each year.

Row 44: the subtotal for projected expenditures will be auto-populated from rows 31-33, 36, 37, 40, and 43.

Row 46: input the total projected expenditures for BHSS administration for each year (see Policy Manual Chapter 6, Section B.8. Cost Principals).

Row 47: the total for projected BHSS expenditures will be auto-populated from rows 44 and 46.

Row 49: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable).

Row 50: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.

Row 52: the proportion of EI funds will auto-populate from rows 33 and 28. Note: MHSA WET and CF/TN funds in Row 61-62 will be deducted from the revenue.

Row 53: the proportion of Youth-Focused EI funds will auto-populate from rows 33 and 34.

Rows 55 and 56: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.

Rows 58 and 59: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.

Rows 61 and 62: auto-populates projected estimated amount of MHSA WET and CF/TN 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.

BHSA Plan Administration

A		C	D	E	F
25	**Table Eight: BHSA Plan Administration**				
26	**Integrated Plan Administration and Monitoring**	**Year 1**	**Year 2**	**Year 3**	
27	Total Projected Improvement and Monitoring Expenditures	$5,441,979	$5,441,979	$5,441,979	
28	Total Projected County Integrated Plan Annual Planning Expenditures	$13,604,947	$13,604,947	$13,604,947	
29	New and Ongoing Administrative Costs				

Select County Population Size:	More than 200k

A		C	D	E	F
33	**Administrative Information Validation**				
34	Total Projected Annual Revenues of Local Behavioral Health Services Fund	$306,912,049	$308,412,049	$305,412,049	
35	Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	1.8%	1.8%	1.8%	
36	Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	4.4%	4.4%	4.5%	
37	**Admin Spending Overages (in Dollars)**				
38	Improvement & Monitoring	$-	$-	$-	
39	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 projected spending for Behavioral Health Services Act (BHSA) plan administration in Table Eight.

Row 30: the total dollar amounts 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, pro-

Instructions (Continue)

grams 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.

Row 31: the total dollar amount 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.

Row 32: The total dollar amounts for new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 34: the total projected annual revenues of the Local Behavioral Health Services Fund.

Row 35: the proportion of funding used for improvement and monitoring will be auto-populated from rows 30 and 34.

Row 36: the proportion of funding used for planning expenditures will be auto-populated from rows 31 and 34.

Row 37: For counties with a population under 200,000: add any Improvement and Monitoring expenditures that exceed 4% of the total projected annual revenues of the Local Behavioral Health Services Fund, any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund, and any new and ongoing administrative costs to obtain the input for this cell.

For counties with a population over 200,000: add any Improvement and Monitoring expenditures that exceed 2% of the total projected annual revenues of the Local Behavioral Health Services Fund, any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund, and any new and ongoing administrative costs to obtain the input for this cell.

Prudent Reserve Assessment

A	B	C
17	**Table Nine: Estimated Local Prudent Reserve Balance**	
18	Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$33,258,769.00
19	Local Prudent Reserve Maximum (1)	$50,416,182.77
20	Excess Prudent Reserve Funds (auto-populated)	$(17,157,413.77)
21	Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$-
22	Total prudent reserve funds above maximum allocated to Full Service Partnerships	$-
23	Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$-
24	Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$-
25	**Auto-validation: allocation of all excess Prudent Reserve Funds**	**NO EXCESS**
26	Total Contributions Into the Local Prudent Reserve (auto-populated)	$-
27	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 totalfunds distributed to the county Behavioral Health Services Fundover past five years (25% for counties with a population of less than 200,000).

Instructions

Counties shall report their estimated local prudent reserve maximums for each allocation component in Table Nine.

Rows 18 and 19: dollar amounts will be auto-populated from Table 4 rows 91 and 92

Row 20: total excess prudent reserve dollars will be auto-populated from rows 18 and 19.

Rows 21-23: total dollar amounts will be auto-populated from Table 4, rows 94-96.

Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21 through 23.

Row 25: auto-validates from rows 20 and 24 to ensure the dollar amounts match with "equal" or "does not equal" statements.

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations for each plan year will be auto-populated from Table 5 row 65, Table 6 row 42, and Table 7 row 46.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations for each plan year will be auto-populated from Table 5 row 64, Table 6 row 41, and Table 7 row 45.

Funding Summary

	B	C	D	E	F
22	**Table Ten: BHSA Funding Summary**				
23		**Housing Intervention**	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
24	**Year One**				
25	Allocation Percentage, with Transfers	30%	29%	41%	100%
26	Component Allocations	$73,500,000.00	$71,050,000.00	$100,450,000.00	$245,000,000.00
27	**Year Two**				
28	Allocation Percentage, with Transfers	30%	29%	41%	100%
29	Component Allocations	$73,500,000.00	$71,050,000.00	$100,450,000.00	$245,000,000.00
30	**Year Three**				
31	Allocation Percentage, with Transfers	30%	29%	41%	100%
32	Component Allocations	$73,500,000.00	$71,050,000.00	$100,450,000.00	$245,000,000.00
33	**BHSA Funding Summary**	**Housing Interventions**	**Full Service Partnerships**	**Behavioral Health Services and Supports**	**Totals**
34	**Year One**				
35	Estimated Year One Component Allocations (*BHSA Funding Only*)	$73,500,000.00	$71,050,000.00	$100,450,000.00	$245,000,000.00
36	Transfers From PR Into Component	$-	$-	$-	$-
37	Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$-	$200,000.00	$61,712,049.00	$61,912,049.00
38	Estimated Total Available Funding for Year One	$73,500,000.00	$71,250,000.00	$162,162,049.00	$306,912,049.00
39	Transfers from Component Into PR	$-	$-	$-	$-
40	Estimated Total Year One Expenditures	$72,865,507.00	$69,727,100.00	$161,709,950.00	$304,302,557.00

Funding Summary

	B	C	D	E	F
41	**Year Two**				
42	Estimated New Year Two Component Allocations (*BHSA Funding Only*)	$73,500,000.00	$71,050,000.00	$100,450,000.00	$245,000,000.00
43	Transfers From PR Into Component	$-	$-	$-	$-
44	Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$634,493.00	$1,722,900.00	$63,664,148.00	$66,021,541.00
45	Estimated Total Available Funding for Year Two	$74,134,493.00	$72,772,900.00	$164,114,148.00	$311,021,541.00
46	Transfers from Component Into PR	$-	$-	$-	$-
47	Estimated Total Year Two Expenditures	$73,015,507.00	$70,914,925.00	$164,909,950.00	$308,840,382.00
48	**Year Three**				
49	Estimated New Year Three Component Allocations (*BHSA Funding Only*)	$73,500,000.00	$71,050,000.00	$100,450,000.00	$245,000,000.00
50	Transfers From PR Into Component	$-	$-	$-	$-
51	Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$1,118,986.00	$2,057,975.00	$59,416,247.00	$62,593,208.00
52	Estimated Total Available Funding for Year Three	$74,618,986.00	$73,107,975.00	$159,866,247.00	$307,593,208.00
53	Transfers from Component Into PR	$-	$-	$-	$-
54	Estimated Total Year Three Expenditures	$73,168,507.00	$71,241,557.02	$168,113,947.00	$312,524,011.02
55	**BHSA Plan Admin Expenses**				
56	**Plan Admin Category**	**Year One**	**Year Two**	**Year Three**	**Total**
57	Total Projected Improvement and Monitoring Expenditures	$5,441,979.00	$5,441,979.00	$5,441,979.00	$16,325,937.00
58	Total Projected County Integrated Plan Annual Planning Expenditures	$13,604,947.00	$13,604,947.00	$13,604,947.00	$40,814,841.00
59	Total Projected New and Ongoing Administrative Expenditures	$-	$-	$-	$-

Funding Summary

Instructions

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 43, 49, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26.

Rows 36, 44, and 52: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Rows 38, 46, and 54: estimated total available funding will be auto-populated from rows 35-37, 43-45 and 51-53.

Rows 39, 47, and 55: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 67; Tab 6, row 43; and Tab 7, row 49.

Rows 40, 48, and 56: estimated expenditures for each component will be auto-populated from Tab 5, row 70; Tab 6, row 46; and Tab 7, row 52.

Rows 45 and 53: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.

Rows 59-61: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws,

regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual,

including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a

good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services

that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

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

DHCS | County Portal

Behavioral Health Director Certification

Certification

1. I hereby certify that County of Orange 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:

   - ☑ The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
   - ☑ 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
   - ☑ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
   - ☑ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
   - ☑ 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)
   - ☑ 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
   - ◉ No

Page 1 | 3

a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

County Behavioral Health Agency Director contact information

3. County Name

Orange

4. Certification for

- (●) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

4a. Submission type

- (●) Draft
- ( ) Final

5. County Behavioral Health Agency Director name

Ian Kemmer

6. County Behavioral Health Agency Director phone number

(714) 834-2160

7. County Behavioral Health Agency Director email

ikemmer@ochca.com

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

Ian Kemmer

13. Title

Director, Behavioral Health Services

14. Date

03/30/2025

15. Signature

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

17. Title

18. Date

19. Signature

County Administrator or Designee Certification

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

Signature

3. Print name

Michelle Aguirre

4. Date

04/01/2026

5. Signature

Michelle Aguirre Digitally signed by Michelle Aguirre
Date: 2026.04.01 16:21:38 -07'00'

Contact information

6. County Name

County of Orange

7. Certification for

- (●) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) Intermittent Update

7a. Submission type

- (●) Draft

8. County Chief Administration Officer Name

Michelle Aguirre

9. County Chief Administration Officer Phone number

714-834-4304

10. County Chief Administration Officer Email

michelle.aguirre@ocgov.com

County Administrator or Designee Certification

Docusign Envelope ID: DBF36369-21D2-8FD0-82A1-D72103350875

Board of Supervisors Certification

Certification

1. Orange County Board of Supervisors certifies the following:

   ✔ Orange County Board of Supervisors has reviewed and approved this Integrated Plan for the period of 2026-2029

   ✔ County will meet its realignment obligations pursuant to W&I Code section 14197, including but not limited to time or distance standards and appointment time standards set forth in W&I Code section 14197 or other applicable guidance, without utilizing waitlists

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 their realignment obligations (optional)

Signature

3. Printed name

   Doug Chaffee

4. Title

   Board of Supervisors Chair

DHCS | County Portal

5. Date

5/19/26

DS

6. Signature

Doug Chaffee

FACSIMILE SIGNATURE AUTHORIZED PER G.C. SEC. 25103, RESO 79-1535 SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIR OF THE BOARD

ATTEST:

DocuSigned by:

Robin Stieler

FAA99035BC1B2A

ROBIN STIELER

CLERK OF THE BOARD OF SUPERVISORS

ORANGE COUNTY, CALIFORNIA

Requests

Funding Transfer Request

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%)	41	41	41
Full Service Partnership (Base 35%)	29	29	29
Housing Intervention (Base 30%)	25	25	25
Housing Interventions for Outreach and Engagement	5	5	5

Behavioral Health Services and Supports Transfers

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	5145000	5145000	5145000
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

For Behavioral Health Services and Supports, please include a rationale for the funding allocation transfer request Orange County Behavioral Health Services (BHS) is requesting approval to transfer 6% of Full Service Partnership (FSP) funding into the Behavioral Health Services and Supports (BHSS) category to maintain continuity of essential system infrastructure and recovery-oriented supports during the BHSA transition period.

As the County transitions from prior MHSA Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) funding structures into the BHSA framework, BHS is actively updating scopes of work, strengthening Medi-Cal billing expectations, and supporting contracted providers in achieving

specialty behavioral health Medi-Cal certification where appropriate. BHS is also coordinating with Medi-Cal Managed Care Plans (MCPs) and system partners to support long-term sustainability through braided and blended funding approaches.

At the same time, BHS is pursuing maximization of Medi-Cal reimbursement within the FSP service model. Because a significant portion of FSP services are Medi-Cal reimbursable, and in anticipation of potential participation in BH-CONNECT bundled rate structures, the County believes it can maintain—and potentially modestly increase—FSP service utilization through improved billing capture and enhanced financing strategies. This approach supports long-term sustainability of FSP programming without reducing access to intensive services.

However, during this ramp-up period, core BHSS system supports that serve thousands of individuals annually—particularly peer-run Recovery Centers and recovery services, navigation supports, and other community-based engagement programs—remain critical to preventing deterioration, crisis escalation, and unnecessary institutional utilization. These services often include non-billable infrastructure elements that cannot be fully sustained through Medi-Cal reimbursement alone but are essential to maintaining a comprehensive continuum of care. They also function as key engagement and step-down resources for individuals transitioning from higher levels of care, including FSP programs.

The requested transfer will allow BHS to preserve system stability while financial modeling improvements, billing optimization, and BH-CONNECT implementation are fully operationalized. Without this temporary rebalancing, the County risks reductions in foundational recovery-oriented supports, which could increase pressure on crisis services and more restrictive levels of care.

This funding strategy reflects a prudent transition approach that aligns with BHSA and CalAIM goals by maintaining access to services in the least restrictive setting, strengthening sustainable financing models, and ensuring continuity of care across the behavioral health continuum.

Full Service Partnership Transfer

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	0	0	0
Dollars transferred into Behavioral Health Services and Supports	5145000	5145000	5145000
Dollars transferred into Housing Intervention	0	0	0

For Full Service Partnership, please include a rationale for the funding allocation transfer request Orange County Behavioral Health Services (BHS) is requesting approval to transfer 6% of Full Service Partnership (FSP) funding into the Behavioral Health Services and Supports (BHSS) category to maintain continuity of essential system infrastructure and recovery-oriented supports during the BHSA transition period.

As the County transitions from prior MHSA Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) funding structures into the BHSA framework, BHS is actively updating scopes of work, strengthening Medi-Cal billing expectations, and supporting contracted providers in achieving specialty behavioral health Medi-Cal certification where appropriate. BHS is also coordinating with

Medi-Cal Managed Care Plans (MCPs) and system partners to support long-term sustainability through braided and blended funding approaches.

At the same time, BHS is pursuing maximization of Medi-Cal reimbursement within the FSP service model. Because a significant portion of FSP services are Medi-Cal reimbursable, and in anticipation of potential participation in BH-CONNECT bundled rate structures, the County believes it can maintain—and potentially modestly increase—FSP service utilization through improved billing capture and enhanced financing strategies. This approach supports long-term sustainability of FSP programming without reducing access to intensive services.

However, during this ramp-up period, core BHSS system supports that serve thousands of individuals annually—particularly peer-run wellness and recovery services, navigation supports, and other community-based engagement programs—remain critical to preventing deterioration, crisis escalation, and unnecessary institutional utilization. These services often include non-billable infrastructure elements that cannot be fully sustained through Medi-Cal reimbursement alone but are essential to maintaining a comprehensive continuum of care. They also function as key engagement and step-down resources for individuals transitioning from higher levels of care, including FSP programs.

The requested transfer will allow BHS to preserve system stability while financial modeling improvements, billing optimization, and BH-CONNECT implementation are fully operationalized. Without this temporary rebalancing, the County risks reductions in foundational recovery-oriented supports, which could increase pressure on crisis services and more restrictive levels of care.

This funding strategy reflects a prudent transition approach that aligns with BHSA and CalAIM goals by maintaining access to services in the least restrictive setting, strengthening sustainable financing models, and ensuring continuity of care across the behavioral health continuum.

Housing Interventions Transfers

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	0	0	0

For Housing Intervention, please include a rationale for the funding allocation transfer request
We are not requesting any housing intervention transfers. We are dedicating approximately $3.6M toward outreach and engagement that will be implemented by our OC Office of Care Coordination - the entity responsible for implementation of the homeless services continuum of care.

Supporting Information and Data

How does the funding transfer request respond to community needs and input?
This funding request is directly supported by community-identified needs through the Community Planning Process (CPP). Across educational sessions, listening sessions, focus groups, key informant interviews, and community forums, stakeholders consistently emphasized the importance of crisis services, recovery-oriented supports, and accessible community-based engagement programs. Participants across age groups and priority populations identified wellness and recovery services, peer supports, navigation assistance, and timely crisis response as essential components of the behavioral health continuum.

In addition, community members and system partners repeatedly highlighted the value of outreach and ongoing engagement strategies to ensure individuals are connected to care before needs escalate.

Stakeholders also prioritized early intervention approaches—particularly for children, transitional age youth, and individuals experiencing emerging serious mental illness—as well as continued investment in workforce development to expand culturally and linguistically responsive service capacity, including peer providers and trusted community-based roles.

Wellness centers and other recovery-oriented programs were described as trusted entry points that reduce isolation, promote stability, and prevent escalation to crisis-level care. Similarly, crisis services were consistently valued as critical safety-net supports that must remain accessible and responsive across the county.

The requested transfer will help preserve these highly utilized and community-valued services during the BHSA transition period. Maintaining these supports ensures that individuals who may not qualify for FSP—or who are transitioning between levels of care—continue to have access to recovery-oriented, culturally responsive services in the least restrictive setting. This approach reflects the priorities expressed through the CPP and supports system stability while long-term financing and Medi-Cal maximization strategies are fully implemented.

Please include local data supporting the funding transfer request
OC Transfer Analysis_FSP to BHSS_Final.pdf

Data Suppression Notice:
Values marked with "*" have been suppressed per DHCS de-identification standards.
Counts between 1–10 are displayed as "<11*"