KERN COUNTY BEHAVIORAL HEALTH PLAN

BEHAVIORAL HEALTH SERVICES ACT (BHSA) INTEGRATED PLAN (2026-2029)



KERN BEHAVIORAL HEALTH & RECOVERY SERVICES

2001 28TH STREET, BAKERSFIELD, CA 93301

(DHCS FINAL APPROVED ON 07/01/2026)

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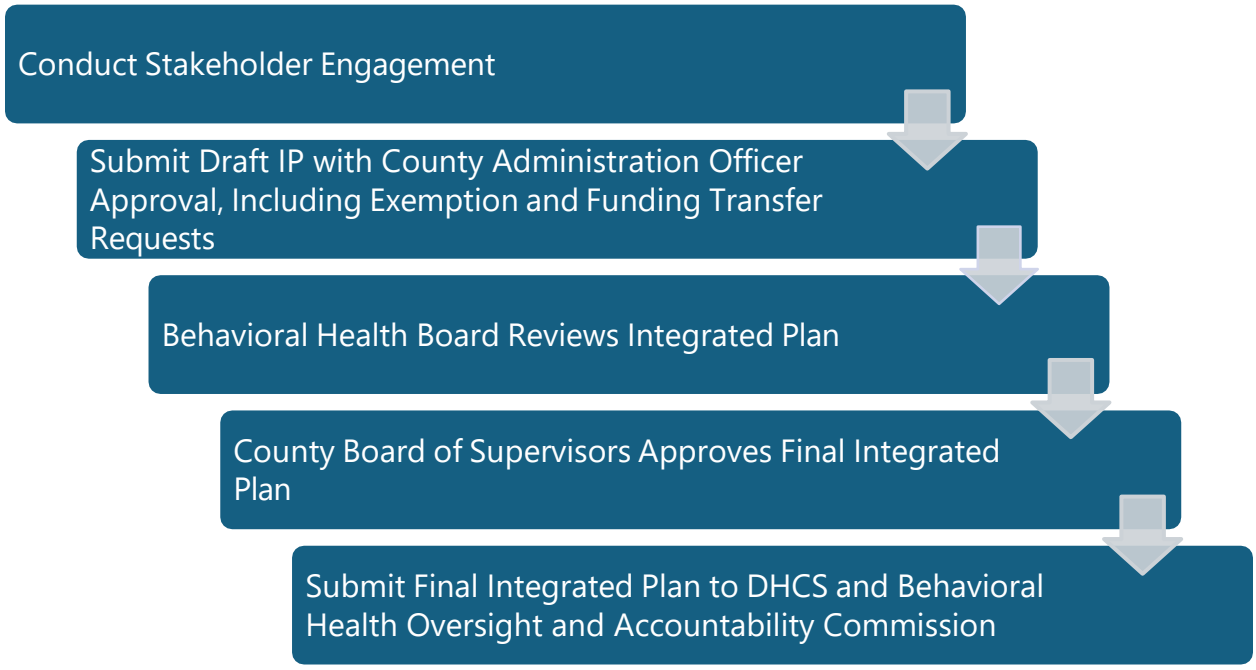
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Introduction

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

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



General Information

1. County, City, Joint Powers, or Joint Submission [checkbox]

   ☒ County

   ☐ City

   ☐ Joint Powers

   ☐ Joint Submission

2. Entity Name (county, city, joint powers, or other): **Kern County**
3. Behavioral Health Agency: **Kern Behavioral Health & Recovery Services**
4. Behavioral Health Agency Mailing Address: **P. O. Box 1000 Bakersfield, CA 93302**
5. Primary Mental Health Contact:
   a. Name: **Mark Kimmel**
   b. Email: **MKimmel@kernbhrs.org**
   c. Phone: **(661) 868-6681**
6. Secondary Mental Health Contact:
   a. Name: **Belinda Vieyra**
   b. Email: **BVieyra@kernbhrs.org**
   c. Phone: **(661) 868-8316**
7. Primary Substance Use Disorder Contact:
   a. Name: **Ana Olvera**
   b. Email: **AOlvera@kernbhrs.org**
   c. Phone: **(661) 868-6117**
8. Secondary Substance Use Disorder Contact:
   a. Name: **Belinda Vieyra**
   b. Email: **BVieyra@kernbhrs.org**
   c. Phone: **(661) 868-8316**
9. Primary Housing Interventions Contact:

a. Name: **Michele Timmerman**

b. Email: **MTimmerman@Kern BHRS.org**

c. Phone: **(661) 868-6660**

10. Compliance Officer for Specialty Mental Health Services (SMHS):

    a. Name: **Liz Brown**

    b. Email: **EBrown@kernbhrs.org**

11. Compliance Officer for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services:

    a. Name: **Liz Brown**

    b. Email: **EBrown@kernbhrs.org**

12. Behavioral Health Services Act (BHSA) Coordinator:

Name	Email Address
Mark Kimmel	**MKimmel@kernbhrs.org**

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

Name	Email Address
Michelle Culy	**MCuly@kernbhrs.org**

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

Name	Email Address
Lesleigh Davis	**LDavis@kernbhrs.org**

15. Medical Director:

Name	Email Address
Garth Olango, MD, PHD	**GOlango@kernbhrs.org**

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).

Populations Served by County Behavioral Health System

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

Children and Youth

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

Table 5. Number of Children and Youth Served

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	**12,324**
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	**8**

Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	**353**
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	**240**
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	**2**
Were chronically homeless or experiencing homelessness or at risk of homelessness	**154**
Were in the juvenile justice system	**2,025**
Have reentered the community from a youth correctional facility	**1,943**

Criteria	Number of Children and Youth Under Age 21
Were served by the Mental Health Plan and had an open child welfare case	**1,472**
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	**15**
Have received acute psychiatric care	**993**

Adults and Older Adults

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

Table 6. Adults and Older Adults Served

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	**2,192**
Received Medi-Cal SMHS	**12,924**
Received DMC or DMC-ODS services	**5,204**
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	**2,270**
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	**591**
Experienced unsheltered homelessness	**289**
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	**80**
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	**24**

Criteria	Number of Adults and Older Adults
Were in the justice system (on parole or probation and not currently incarcerated)	**156**
Were incarcerated (including state prison and jail)	**208**
Reentered the community from state prison or county jail	**58**
Received acute psychiatric services	**2,543**

2. Input the number of people in designated and approved facilities who were
   a. Admitted or detained for 72-hour evaluation and treatment rate: **7,622**
   b. Admitted 14-day and 30-day periods of intensive treatment: **2,509**
   c. Admitted for 180-day post certification intensive treatment: **7**

3. Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs: **5**
4. Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs): **16**
5. Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding? **No**
6. Please describe the local data used during the planning process:

   Data for this project was sourced from multiple internal systems within Kern County's Behavioral Health Plan (BHP) to ensure comprehensive coverage and accuracy.

   The primary data sources included:

   - **SmartCare (Electronic Health Record): Utilized to extract data related to service types, client demographics, insurance pay sources, and the number of clients served.**
   - **FSP-DCR PLD Database: This internal database provided key metrics related to juvenile justice involvement, homelessness, and justice system interactions.**
   - **Departmental Reporting Logs: Collaborations with select Kern BHRS Kern County BHP teams enabled access to Excel-based reporting logs, which were used to supplement and validate data not captured in the primary systems.**

   This multi-source approach ensured a robust dataset that supports accurate reporting and informed decision-making.
7. If desired, provide documentation on the local data used during the planning process [optional file upload] **N/A**

Local CARE ACT Implementation

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

   Kern County BHP is committed to providing comprehensive, client-centered care for individuals participating in the CARE program. Our Assertive Community Treatment (ACT) teams serve as the primary point of support, ensuring that participants receive a wide range of services tailored to their unique needs. These services include housing assistance, individual placement support, case management, evidence-based individual and group therapy, psychiatric care, and certified peer support.

To promote continuity of care and facilitate recovery, we have established fluid step-down processes within the behavioral health continuum. This allows CARE participants to transition to lower-level service teams, with interim support provided by our Intensive Case Management team to ensure a smooth transfer and ongoing recovery. Additionally, through Behavioral Health Bridge Housing funding, the ACT programs have secured 39 priority housing placements exclusively for CARE participants, supplementing the broader resources available through our housing team.

To ensure CARE participants receive timely and appropriate support, the BHP will provide priority access and specialized coordination across the full behavioral health continuum. This includes streamlined entry into indicated levels of care, enhanced clinical communication between ACT, Intensive Case Management, and outpatient teams, and expedited linkage to housing and supportive services when criteria are met. Consistent with BHSA goals and allowable activities, the BHP will utilize BHSA resources to reinforce these coordination pathways and, when appropriate, prioritize access to housing and stabilization supports for individuals participating in CARE. These processes are designed to promote continuity, reduce service disruptions, and support sustained recovery outcomes.

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

Kern County BHP integrates CARE referral pathways into existing referral and service processes by ensuring seamless collaboration across all behavioral health service providers. Referrals to the CARE Court team are accepted from community members, behavioral health providers, and first responders using established channels such as email and telephone. Kern BHP provides comprehensive education about CARE procedures through regular presentations, staff training, and by maintaining up-to-date information on the Kern BHRS public website.

CARE referrals received from the courts for individuals not eligible for LPS conservatorship, MIST, FIST, mental health diversion, or AOT are processed via email. The County's Aging and Adult Services, which oversees the Conservator's Office, directly works with the CARE Court program to coordinate step-downs for clients who no longer meet conservatorship criteria. This integrated approach ensures that all referrals are managed efficiently within the county's behavioral health system, enhancing service accessibility and continuity for those served.

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

   Kern County BHP's Care Court program collaborates closely with community behavioral health providers to identify individuals who may benefit from voluntary services without the need for a formal petition. When a potential respondent chooses to engage in voluntary outpatient treatment during the outreach and engagement phase, the CARE program conducts a warm hand off to the appropriate provider and ensures the individual is connected to services that meet their clinical needs.

   To confirm successful linkage, the CARE program maintains active coordination with the provider, the individual, and identified support for up to 90 days following the transition. During this period, the team monitors engagement, verifies service participation, and addresses any emerging barriers to care. All linkage and follow up activities are documented and reviewed through established CARE program data collection processes, which are evaluated on a weekly basis to ensure continuity and service connection outside of the CARE Court process.

County Behavioral Health Technical Infrastructure

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

1. Does the county behavioral health system use an Electronic Health Record (EHR)? **Yes**
   a. Please select which of the following EHRs the county uses: **SmartCare**
2. Does the county behavioral health system participate in a Qualified Health Information Organization (QHIO)? **Yes**
   a. Please select which QHIO the county participates in: **Connex**

Application Programming Interface Information

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

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

1. Please provide the link to the county's API endpoint on the county behavioral health plan's website: **https://www.calmhsa.org/interoperability-api/**
2. Does the county wish to disclose any implementation challenges or concerns with these requirements? **No**
3. Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056, 23-057, and 24-016. Does the county wish to disclose any implementation challenges or concerns with these requirements? **Yes**
    a. Please describe these challenges and concerns:

    Kern County faces significant challenges with implementing Health Information Exchange (HIE) due to the presence of three Managed Care Plans (MCPs), each utilizing their own (HIE) platform and exchange strategies. This diversity creates difficulties as the county must navigate multiple solutions. A single, unified solution is preferable to avoid the complications of managing various platforms and strategies.

    Each MCP has its own technology platforms or HIE solutions, creating several operational challenges. Firstly, building out interfaces for each unique platform incurs significant financial costs, adding to overall operational expenses. Additionally, the process is extremely time-consuming. Ensuring compatibility between these different systems requires substantial effort. While the state's flexibility is appreciated, it adds layers of complexity when each organization prefers distinct approaches.

County Behavioral Health System Service Delivery Landscape

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

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

1. Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period? **Yes**
    a. Please select all services the county behavioral health system plans to provide under the PATH grant [multi-select list]:

    ☒ **Alcohol or Drug Treatment Services**

☒ **Case Management Services**

☒ **Community Mental Health Services**

☒ **Habilitation and Rehabilitation Services**

☒ **Outreach Services**

☒ **Referrals for Primary Health Care, Job Training, Educational Services, and Housing Services**

☒ **Screening and Diagnostic Treatment Services**

☒ **Staff Training, including the training of individuals who work in shelters, mental health clinics, substance use disorder programs, and other sites where homeless individuals require services**

☒ **Supportive and Supervisory Services in Residential Settings**

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

    a. Please describe these challenges or concerns:

    1. **Lack of affordable housing and/or beds, especially for the individuals with criminal records**
    2. **Individuals' willingness to accept housing available**
    3. **Limited availability of facilities equipped with staff trained in integrated mental health and substance use disorder (MH/SUD) care, including trauma-informed and forensic-responsive approaches.**
    4. **Staff retention**

Community Mental Health Services Block Grant (MHBG)

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

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

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

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

1. Will the county behavioral health system participate in any SUBG set asides during

the Integrated Plan period? **Yes**

a. Please select all set-asides that the county behavioral health system participates in under SUBG [multi-select list]:

☒ **Adolescent/Youth Set-Aside**

☒ **Discretionary**

☒ **Perinatal Set-Aside**

☒ **Primary Prevention Set-Aside**

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

a. Please describe these challenges or concerns:

No challenges on the programmatic side of Adolescent and/or Perinatal – Adolescent Best Practices guidelines and the Perinatal Practice Guidelines have been updated. Kern BHRS is currently in the process of updating programing based on these changes.

For SUBG discretionary programming, outreach to individuals with IV Drug Use is challenging. The SUD Access Line, which is SUBG funded, conducts screenings and referrals into the DMC-ODS system. When an individual is identified to use substances intravenously, they are provided with an appointment within 7 days to expedite treatment. Support calls are made to them ahead of their appointment to continue to encourage them to access SUD treatment. At times, contact cannot be made with IV drug users due to contact information not being accurate or their phone number being disconnected.

Primary Prevention set-aside has not produced challenges, but Friday Night Live funding and changes by the California Friday Night Live Partnership have been difficult to navigate. For example, when the CA FNL partnership required county staff to register attendees to an event, this was difficult since registration payment was also expected at the time of registration. Kern county staff are not authorized to purchase goods and services for non-county staff, so additional local coordination was required to meet registration deadlines.

Opioid Settlement Funds (OSF)

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

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

☒ **Address The Needs of Criminal Justice-Involved Persons**

☒ **Connect People Who Need Help to The Help They Need (Connections to Care)**

☒ **Leadership, Planning, and Coordination**

☒ **Prevent Overdose Deaths and Other Harms (Harm Reduction)**

☒ **Support People in Treatment and Recovery**

☒ **Treat Opioid Use Disorder (OUD)**

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

Bronzan-McCorquodale Act

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

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

1. In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds: [multi-select list]:
    - **Other Programs and Services: Hospitalization**
    a. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **No**

Public Safety Realignment (2011 Realignment)

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

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

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

Medi-Cal Specialty Mental Health Services (SMHS)

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

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

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

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

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

q. Multisystemic Therapy for individuals under the age of 21

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

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

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

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

1. Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026? [multi-select list]:
    - ACT
    - CSC for FEP
    - FACT
    - IPS Supported Employment
    - Peer Support Services
2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **Yes**

    a. Please describe these challenges or concerns:

    Kern County BHP has experienced challenges with the significant time required for staff training, delaying new staff in providing services. In addition, we had trouble in ensuring timely linkage of individuals to services due to extensive requirements within the EBPs model.

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

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

    ☐ DMC Program

    ☒ DMC-ODS Program [if selected, populate DMC-ODS questions]

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

l. Early Intervention for individuals under age 21]

1. Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below as of June 30, 2026?
    - **Inpatient Services (ASAM Levels 3.7 & 4.0)**
    - **Peer Support Services**
    - **Recovery Incentives Program (Contingency Management)**
2. Does the county wish to disclose any implementation challenges or concerns with the requirements under this program? **No**

Other Programs and Services

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

Prevention—Kern County BHP has a team of staff that facilitate SUD Prevention services across Kern County. They support Friday Night Live chapters in various high schools and middle schools, participate in leadership and outreach activities. This team also facilitates Naloxone training and distribution to local entities like schools, behavioral health staff, parent resource centers, community organizations and any others that request this education. The Prevention team also facilitates a coalition called Drug Free Kern that brings partners together to develop strategies to reduce drug use and overdose in the county. Social media channels are managed by this team to provide information to the community about overdose prevention and drug trends.

CalWORKS- The BHP has a Memorandum of Understanding (MOU) with the Kern County Department of Human Services (DHS) to provide behavioral health treatment to CalWORKS Welfare to Work program participants in order to help them remove barriers to employment. The Plan provides behavioral health services to clients in three county operated teams and with two contracted providers in outlying areas of Kern County. This program is designed to be brief in nature (about 6 months) and then connect individuals either to non-specialty mental health services (NSMHS) or specialty mental health services (SMHS) as covered by Medi-Cal.

Recovery Station—The Kern BHP has a Recovery Station program modeled after sobering centers. This program was developed as an MHSA Innovation project that launched in June of 2020. The Recovery Station includes a peer workforce that screens individuals that are intoxicated that need a safe environment to allow those effects to pass. Individuals eligible for this program are referred by network providers and community entities that work directly with the plan and must not meet certain medical criteria and have no acute mental health presentation. Individuals stay for an average of 4 to 10 hours and are then discharged with connections into both behavioral health and SUD treatment as well as housing.

Changes in SUD Case Management – It is expected that case management service provision will shift slightly in response to implementation of SB43 as of 1/1/26. County operated teams will serve higher acuity populations in order to provide support to hospitals that see an increase of 5150 holds, especially those with grave disability due to a severe SUD.

Care Transitions

1. Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services (Adult and Youth)? **Yes**
2. Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition? **No**

Statewide Behavioral Health Goals

Population-Level Behavioral Health Measures

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

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

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

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

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

Priority Statewide Behavioral Health Goals for Improvement

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

Access To Care

Primary Measures

Specialty Mental Health Services (SMHS) Penetration Rates for Adults and

Children & Youth (DHCS), FY 2023

1. How does your county status compare to the statewide rate?
    a. For adults/older adults: **Above**
    b. For children/youth: **Above**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]

    ☒ **Age**

    ☐ Gender

    ☒ **Race or Ethnicity**

    ☐ Sex

    ☐ Spoken Language

    ☐ None Identified

    ☐ No Disparities Data Available

    ☐ Other [narrative box]

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

1. How does your county status compare to the statewide rate?
    a. For adults/older adults: **Above**
    b. For children/youth: **Below**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

    ☒ **Age**

    ☐ Gender

    ☒ **Race or Ethnicity**

    ☒ **Sex**

    ☒ **Spoken Language**

    ☐ None Identified

    ☐ No Disparities Data Available

    ☒ **Other: No data provided for Gender.**

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

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

    a. For adults/older adults: **Not Applicable**

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

2. What disparities did you identify across demographic groups or special populations? [Multi-select]

    ☐ Age

    ☐ Gender

    ☐ Race or Ethnicity

    ☐ Sex

    ☐ Spoken Language

    ☐ None Identified

    ☐ No Disparities Data Available

    ☒ **Other: N/A**

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

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

    a. For adults/older adults: **Below**

    b. For children/youth: **Below**

2. What disparities did you identify across demographic groups or special populations? [Multi-select]

    ☒ **Age**

    ☐ Gender

    ☒ **Race or Ethnicity**

    ☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other

Supplemental Measures

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

1. How does your county status compare to the statewide rate? **Above**
2. What disparities did you identify across demographic groups or special populations?

☐ Age

☐ Gender

☐ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☒ **No Disparities Data Available**

☐ Other

Disparities Analysis

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

   Kern reviewed FY 2021-22 penetration rate data from the DHCS data workbook. The adult SMHS rates are comparable to the statewide mean and the youth SMHS rates exceed it; however, racial disparities exist. Specifically, Hispanic (2.7% adult, 3.8% youth) and Asian or Pacific Islander (1.4% adult, 1.6% youth) beneficiary SMHS penetration rates are below the County rate (3.5% adult, 4.7% youth).

Cross-Measure Questions

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

   Kern County BHP is expanding and strengthening partnerships to enhance access to DMC-ODS services for Kern County beneficiaries. Residential treatment capacity will increase with the addition of two (2) new adult residential SUD providers serving metropolitan Bakersfield and Ridgecrest.

   Completing a data analysis utilizing the California Overdose Surveillance Dashboard Kern BHRS identified East Kern as an underserved area for residential services. The county is currently in discussions with a provider to establish residential treatment in this region, which would improve access for residents in remote areas and support Native American communities in East Kern.

   Additionally, Kern County BHP is formalizing a new single case agreement with Tarzana Treatment Centers to provide youth withdrawal management services within the county.

   These strategic partnerships and service expansions aim to reduce barriers and improve access to DMC-ODS services across Kern County.

2. Please identify the category or categories of funding that the county is using to address the access to care goal [multi-select dropdown]:
   - ☐ BHSA Behavioral Health Services and Supports (BHSS)
   - ☐ BHSA Full Services Partnership (FSP)
   - ☒ **BHSA Housing Interventions**
   - ☒ **1991 Realignment**
   - ☒ **2011 Realignment**
   - ☐ State General Fund
   - ☐ Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized
   - ☐ Delivery System (DMC/DMC-ODS)
   - ☐ Substance Abuse and Mental Health Services Administration (SAMHSA)

☐ Projects for Assistance in Transition from Homelessness (PATH)

☐ Community Mental Health Block Grant (MHBG)

☐ Substance Use Block Grant (SUBG)

☒ **Other: Behavioral Health Bridge Housing (BHBH) Grant, Prop 47 Cohort 5, Felony to Stand Trial (FIST) Diversion Program, Conditional Release Program (ConRep), Opioid Settlement Funds, Community Care Expansion and Preservation Funding (CCE).**

Homelessness

Primary Measures

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

1. How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region? **Below**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]

☒ **Age**

☒ **Gender**

☒ **Race or Ethnicity**

☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other:

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

1. How does your county status compare to the statewide rate? **Below**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

☐ Age

☐ Gender

☒ **Race or Ethnicity**

☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other:

Supplemental Measures

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

1. How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region? **Below**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]

☐ Age

☐ Gender

☐ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☒ **No Disparities Data Available**

☐ Other:

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

1. How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region? **Below**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

☐ Age

☐ Gender

☐ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☒ **No Disparities Data Available**

☐ Other:

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

1. How does your local CoC's rate compare to the average rate across all CoCs?
   Above
2. What disparities did you identify across demographic groups or special populations? [Multi-select]

   ☒ **Age**

   ☐ Gender

   ☒ **Race or Ethnicity**

   ☐ Sex

   ☐ Spoken Language

   ☐ None Identified

   ☐ No Disparities Data Available

   ☐ Other:

Disparities Analysis

1. For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis:
   The 2024 Point-in-Time Count report indicates a 36% increase in people experiencing homelessness in Kern County in comparison to the 2023 Point-in-Time Count. The 2024 report reflects a disparity within the areas of age, gender and race. In particular, the report indicates that more individuals who are ages 35-44, are male, or African American are

experiencing homelessness in Kern County. These disparities do not necessarily represent the population of homeless individuals who are experiencing severe mental illness, severe SUD, or co-occurring conditions.

Though Kern County falls below the Statewide Rate in this category, there is a noted increase in this category amongst the African American race. This disparity is consistent with the overall population experiencing homelessness based upon race.

Kern is above the Statewide Rate in this category, and the 2024 Point-in-Time Count reflects that more services were accessed by individuals who are African American and are between the ages of 25-64. This disparity is consistent with the overall population experiencing homelessness based upon age and race. It is also reflective that the highest population experiencing homelessness accesses available services through the Continuum of Care.

Cross-Measure Questions

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

   The Plan will expand its ROEM program to include assertive, field-based substance use disorder (SUD) services aimed at reducing homelessness among individuals with severe SUD, mental illness, or co-occurring conditions. This initiative is informed by local Public Health data, which highlights a subset of individuals experiencing repeated overdoses and poor engagement with traditional treatment pathway, particularly in the metro Bakersfield area.

   Key components of the initiative include the following:

   - **Data-Driven Outreach: The SUD Access team will conduct proactive**

follow-up based on Public Health data, including outreach calls and chart reviews. When individuals are unreachable, outreach materials will be mailed to their last known address to maintain contact and offer services.

- **Targeted Field-Based Interventions: When data indicates high acuity, such as serial overdoses or urgent behavioral health needs, the SUD Access team will refer individuals to ROEM for in-person, field-based engagement. This approach prioritizes rapid response and personalized outreach to those at elevated risk of homelessness or disengagement from care.**
- **Linkage to MAT: ROEM staff will ensure warm handoffs to MAT services through the county's MAT clinic which ensures timely access to evidence-based treatment for opioid and other substance use disorders.**

The Plan will assume operations over a new 65 (sixty-five) bed Adult SUD Residential Facility in partnership with the City of Bakersfield, who received a Bond BHCIP Round 1 award. The new campus model facility will expand access to services and will offer substance use, mental health, and medical treatment services to men, women, perinatal, and families. The only measure where Kern's status is above the statewide average is People Experiencing Homelessness Who Accessed Services from a Continuum of Care. This status demonstrates that a higher number of individuals experiencing homelessness are utilizing the services available in our Continuum of Care.

2. Please identify the category or categories of funding that the county is using to address the homelessness goal [multi-select dropdown]:

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

☐ SUBG

☒ **Other: Prop 47, BEHAVIORAL HEALTH BRIDGE HOUSING (BHBH), Opioid Settlement Funds, Conditional Release Program (ConRep), Felony to Stand Trial (FIST) Diversion Program, and COMMUNITY CARE EXPANSION AND PRESERVATION FUNDING.**

Institutionalization

[Context text: 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.

Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

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

    a. For adults/older adults: **Not Applicable**

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

2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

    ☐ Age

    ☐ Gender

    ☐ Race or Ethnicity

    ☐ Sex

    ☐ Spoken Language

    ☐ None Identified

    ☒ **No Disparities Data Available**

    ☐ Other:

Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

    a. 14-day involuntary detention rates per 10,000: **Below**
    b. 30-day involuntary detention rates per 10,000: **Not Applicable**
    c. 180-day post-certification involuntary detention rates per 10,000: **Same**

2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

    ☐ Age

    ☐ Gender

    ☐ Race or Ethnicity

    ☐ Sex

    ☐ Spoken Language

    ☐ None Identified

    ☒ **No Disparities Data Available**

    ☐ Other:

Supplemental Measure: Conservatorships, FY 2021 - 2022

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

    a. Temporary Conservatorships: **Below**
    b. Permanent Conservatorships: **Below**

2. What disparities did you identify across demographic groups or special populations? [Multi-select]

    ☐ Age

    ☐ Gender

    ☐ Race or Ethnicity

    ☐ Sex

☐ Spoken Language

☐ None Identified

☒ **No Disparities Data Available**

☐ Other:

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

[Context text: Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities.]

1. How does your county status compare to the statewide rate/average?
    a. Crisis Intervention
        i. For adults/older adults: **Below**
        ii. For children/youth: **Below**
    b. Crisis Residential Treatment Services
        i. For adults/older adults: **Below**
        ii. For children/youth: **Below**
    c. Crisis Stabilization
        i. For adults/older adults: **Below**
        ii. For children/youth: **Below**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

    ☒ **Age**

    ☐ Gender

    ☒ **Race or Ethnicity**

    ☐ Sex

    ☐ Spoken Language

    ☐ None Identified

    ☐ No Disparities Data Available

    ☐ Other:

Disparities Analysis

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

For all measures, disparity data were extracted from the CalMHSA Institutionalization PowerBI Dashboards. CalMHSA assigns the direction of improvement for each measure. Measures without a direction of improvement do not have a clear directionality toward the primary goal.

(1a) Inpatient administrative days (DHCS) rate [Adults] – There are no disparity data available for adult inpatient administrative days.

(1b) Inpatient administrative days (DHCS) rate [Youth] – There are no disparity data available for youth inpatient administrative days.

(2a) Involuntary detention rates [14-day] – There are no disparity data available for 14-day involuntary detention rates.

(2b) Involuntary detention rates [30-day] – There are no disparity data available for 30-day involuntary detention rates.

(2c) Involuntary detention rates [180-day post certification] – There are no disparity data available for 180-day post certification involuntary detention rates.

(3a) Conservatorships [Temporary] – There are no disparity data available for temporary conservatorships.

(3b) Conservatorships [Permanent] – There are no disparity data available for permanent conservatorships.

(4a) SMHS Crisis Utilization, Crisis Intervention (DHCS), FY 2023 – CalMHSA did not assign a direction of improvement for this measure. Kern County's overall crisis intervention service utilization rate (in minutes) for adults is 154.5, which is below the statewide rate of 240.1 minutes. Higher rates (in minutes) of crisis intervention service utilization exists for certain groups in Kern County: adults age 21 – 32 (164.4), 33 – 44 (156.9), and 45 – 56 (178.1); Black (183.3), Hispanic (154.8), White (161.4), and a race other (225.1) than Alaskan Native or American Indian, Asian or Pacific Islander, Black, Hispanic, or White; females (156.8), males (166.6), and individuals whose primary written language is English (162.3). Lower rates (in minutes) of crisis intervention service utilization also exist for certain demographic groups in Kern County: adults age 57 – 68 (147.3) and 69+ (140.1); Asian or Pacific Islander (119.9); and individuals whose primary written language is Spanish (147.8).

Kern County's overall crisis intervention service utilization rate (in minutes) for youth is 161.0, which is below the statewide rate (in minutes) of 266.8. Higher rates of crisis intervention service utilization exist for certain youth groups in Kern County: youth aged

18 – 20 (169.5) and youth who identified as Black (176.8), White (173.4), and male (166.4). Lower rates of crisis intervention service utilization also exist for certain youth demographic groups in Kern County: youth aged 6 – 11 (138.6), and 12 – 17 (150.3); youth who identified as Hispanic (144.4); female (146.5); and youth whose primary written language is English (158.1) or Spanish (135.8).

For this measure, there was no disparity data available for gender or spoken language. For this measure, some data was suppressed. Adult Alaskan Native or American Indian residents and adult residents whose primary written language is Mandarin had the rate suppressed for the county. Youth age 3 – 5, Alaskan Native or American Indian, Asian or Pacific Islander, and youth whose race is a race other than Alaskan Native or American Indian, Asian or Pacific Islander, Black, Hispanic, or White, as well as youth whose written language is Arabic, Vietnamese, or another non-English language other than Spanish had the rate suppressed for the county.

(4b) SMHS Crisis Utilization, Crisis Residential (DHCS), FY 2023 – CalMHSA did not assign a direction of improvement for this measure. The Kern County crisis residential treatment service utilization rate (in days) for adults is below (12.9) the statewide rate (22.8). Within the County, rates of adult residents utilizing crisis residential treatment services are higher than the County (12.9) among: 21 – 32 (14.4), 33 – 44 (15.1), 45 – 56 (17.4), and 57 – 68 (15.4) year olds; adults who identify as Black (13.4), Hispanic (14.8), and White (15.0); female (13.8), male (16.6), and adults whose primary written language is English (15.0).

The Kern County crisis residential treatment service utilization rate (in days) for youth is below (13.0) the statewide rate (21.6). Within the County, rates of youth residents utilizing crisis residential treatment services are lower than the County (13.0) among youth aged 18 – 20 (12.0) and youth whose primary written language is English (12.0).

For this measure, there was no disparity data available for gender or spoken language. Rates of adult residents utilizing crisis residential treatment services are suppressed for the following demographic groups: Asian or Pacific Islander (0.1), adults that identify as a race other than Asian or Pacific Islander, Black, Hispanic, and White, and adults whose primary written language is Spanish (0.1). All youth race/ethnicity and sex data are suppressed.

(4c) SMHS Crisis Utilization, Crisis Stabilization (DHCS), FY 2023 – CalMHSA did not assign a direction of improvement for this measure. Kern County's crisis stabilization service utilization rate (in hours) for adults is 19.1 – below the statewide rate of 24.0. Higher rates of crisis stabilization service utilization exists for certain adult demographic groups in Kern County: adults aged 33 – 44 (21.4), 45 – 56 (19.7), 57 – 68 (19.6), as well as adults who identify as Black (20.6), White (19.5), or a race/ethnicity other (24.7) than Alaskan Native or American Indian, Asian or Pacific Islander, Black, Hispanic, or White, as well as male (20.2) and adult residents whose primary written language is English (19.5).

Lower rates of crisis stabilization service utilization exists for certain adult demographic groups in Kern County: adults aged 21 – 32 (17.8) and 69+ (17.2), as well as adults who identify as Asian or Pacific Islander (18.2), Hispanic (18.6), female (18.5), and adult Kern County residents whose primary written language is Spanish (16.2).

Kern County's crisis stabilization service utilization rate (in hours) for youth is 18.1 – below the statewide rate of 18.6. Higher rates of crisis stabilization service utilization exist for Black (21.9) youth. Lower rates of crisis stabilization service utilization exists for certain youth demographic groups in Kern County: youth aged 6 – 11 (11.0), 12 – 17 (16.2) 18 – 20 (16.0), as well as youth who identify as Asian or Pacific Islander (16.9), Hispanic (13.7), or White (17.5), as well as female (16.3) and male (15.0), and youth Kern County residents whose primary written language is English (16.1), and Spanish (14.2).

For this measure, there was no disparity data available for gender or spoken language. Rates of adult residents utilizing crisis stabilization treatment services are suppressed for the following demographic groups: Alaskan Native or American Indian and those whose primary written language is Mandarin and Tagalog. Rates of youth residents utilizing crisis stabilization treatment services are suppressed for the following demographic groups: Alaskan Native or American Indian, residents who identify as a race other than Black, White, Asian or Pacific Islander, Hispanic, Alaskan Native or American Indian, and residents whose primary written language is Arabic.

Cross-Measure Questions

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

   Kern County's Behavioral Health Plan (BHP) maintains data on the utilization and length of stay for Mental Health Rehabilitation Centers (MHRC), acute inpatient psychiatric hospitals, and crisis residentials. In addition, the county tracks the number of individuals on involuntary holds admitted to Kern County designated facilities.

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

demonstrates they have poorer outcomes:

Kern County Behavioral Health Plan (BHP) is implementing enhanced crisis response teams beginning fiscal year 26/27, to reduce institutionalization rates by improving diversion from inpatient and emergency department (ED) settings. These teams will serve both youth and adults presenting in hospital emergency rooms with behavioral health crises and will provide rapid assessment, crisis stabilization, and care coordination to ensure timely linkage to the least restrictive and most appropriate level of care.

The BHP utilizes a wide range of data to guide decisions regarding program design, service delivery, and system-level partnerships. Data referenced for the new crisis response teams includes ED utilization patterns, psychiatric inpatient admission rates, crisis stabilization needs, response times, demographic trends, and outcomes from existing crisis services.

The BHP analyzes these data elements to identify gaps in the current crisis system, understand drivers of unnecessary inpatient hospitalization, and determine where targeted interventions can improve outcomes. This information supports decisions about staffing models, geographic deployment, hours of operation, and coordination strategies with local hospitals.

By comparing Kern County's performance to statewide averages or medians (e.g., rates of involuntary holds resulting in inpatient admission, timeliness of transfers, follow up outpatient services, etc.), the BHP can evaluate where the county is outperforming, meeting, or falling below state benchmarks. These comparisons help clarify areas where enhanced crisis intervention could reduce disparities, improve treatment timeliness, and align Kern County with statewide best practices.

Ultimately, these data-driven insights ensure that the crisis response teams are strategically designed to:

- **Reduce preventable hospitalizations**
- **Shorten ED length of stay for behavioral health crises**
- **Increase rapid access to the appropriate level of care**
- **Improve care coordination and continuity of services**
- **Strengthen countywide crisis system performance relative to state outcomes**

Performance will be monitored through ongoing analysis of key indicators, including ED length of stay, timeliness of transfer, 7- and 30-day outpatient follow-up rates, and repeat crisis encounters. These metrics will be compared

against statewide benchmarks to assess progress and guide continuous quality improvement efforts.

Through this data-informed approach, Kern County BHP is aligning resource allocation and service delivery strategies to directly address areas of underperformance and reduce reliance on institutional care.

3. Please identify the category or categories of funding that the county is using to address the institutionalization goal [multi-select dropdown]

   ☒ **BHSA BHSS**
   ☒ **BHSA FSP**
   ☒ **1991 Realignment**
   ☒ **2011 Realignment**
   ☒ **State General Fund**
   ☒ **Federal Financial Participation (SMHS, DMC/DMC-ODS)**
   ☐ SAMHSA PATH
   ☐ MHBG
   ☐ SUBG
   ☐ Other [narrative box]

Justice-Involvement

Primary Measures

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

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

   a. For adults/older adults: **Above**
   b. For juveniles: **Above**

2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

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

☐ Other:

Supplemental Measures

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

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

2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

   ☐ Age

   ☐ Gender

   ☒ **Race or Ethnicity**

   ☐ Sex

   ☐ Spoken Language

   ☐ None Identified

   ☐ No Disparities Data Available

   ☐ Other:

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

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

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

2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

☐ Age

☐ Gender

☐ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☒ **No Disparities Data Available**

☐ Other:

Disparities Analysis

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

   Juveniles: In 2023, Kern County showed elevated juvenile arrest rates compared to the state, with disparities by race and gender. CalMHSA reports Kern's youth arrest rate at 424 per 100,000, higher than the state rate of 372. Although CalMHSA combines youth and adult racial data, Kidsdata provides youth-specific information showing Kern's overall juvenile arrest rate at 5.3 per 1,000, above the state rate of 3.8.

   Racial disparities are significant: African American youth in Kern experience arrest rates of 28.1 per 1,000, notably higher than the state rate of 18.5. Gender disparities are also present, with Kern males at 8.4 per 1,000 and females at 2.1 per 1000, compared to state rates of 6.1 (males) and 1.5 (females). These figures indicate disproportionate system contact for African American youth and males. While arrest does not equal conviction, early police contact is linked to long-term justice involvement. Kern County recognizes this concern and continues to implement early intervention strategies to support at-risk youth and reduce justice system involvement.

   Adults: Data from the California Department of Corrections and Rehabilitation (CDCR) show racial disparities among adults in Kern County as well. The Supplemental Measures Adult Recidivism Conviction Rate (FY 2019–2020) indicates Black/African American individuals have the highest recidivism rate at 54.4% among all racial/ethnic groups. Despite being one

of the smallest racial populations in the county, this group is disproportionately impacted by reoffending and reconviction.

Summary: Across both youth and adult populations, racial disparities—particularly affecting Black/African American residents—are evident in Kern County justice involvement data. Gender disparities also persist among juveniles. These findings highlight a continued need for targeted, culturally responsive prevention, diversion, and reentry support services.

Cross-Measure Questions

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

Juvenile Justice-Involved Population

Kern County BHP will expand prevention and early intervention services to address disparities among justice involved youth through:

1. **Culturally Responsive Engagement & Equity Partnerships: Strengthened outreach through the Cultural Competence Resource Committee (CCRC) African American/Black Subcommittee and the Kern Health Equity Partnership to improve access for underserved youth.**
2. **Workforce Development: Increased training in cultural humility, implicit bias reduction, and trauma-informed care for staff serving youth in justice settings.**
3. **Cross-System Collaboration: The Special Multi-Agency Resource Team (SMART) will continue coordinated case planning with Probation and Child Welfare to stabilize youth and prevent re-incarceration.**
4. **Early Identification and Care Continuity: Behavioral health screening (MAYSI-2), integrated treatment, and 90-day pre-release planning will be expanded through the Future Focus Team to increase successful community linkage.**

Adult Justice-Involved Population

To reduce adult recidivism, Kern County BHP will:

1. **Continuing equity-focused outreach partnerships with NAACP, Project Rebound, Wendale Davis Foundation, and trusted faith-based organizations.**
2. **Expand behavioral health services in custody through Correctional Behavioral Health and Integrated Care Teams, including crisis intervention, psychiatric care, and coordinated discharge planning.**
3. **Strengthen Substance Use Disorder (SUD) services, including Medication-Assisted Treatment (MAT) and reentry case management funded by Opioid Settlement Funds.**
4. **Expand diversion programs offering treatment as an alternative to incarceration.**
5. **Implement the Proposition 47 Kern New Beginnings Program to provide behavioral health treatment, housing linkage, and reentry support.**

These strategies align with CalAIM's Justice-Involved Initiative and the BHSA's goals of reducing disparities, improving continuity of care, and advancing behavioral health equity.

2. Please identify the category or categories of funding that the county is using to address the justice-involvement goal [multi-select dropdown]:

☒ BHSA BHSS
☒ BHSA FSP
☒ BHSA Housing Interventions
☒ 1991 Realignment
☒ 2011 Realignment
☒ State General Fund
☒ Federal Financial Participation (SMHS, DMC/DMC-ODS)
☐ SAMHSA PATH
☐ MHBG
☐ SUBG
☒ Other: STOP Grant (youth), Opioid Settlement funds (ADULT), PATH ROUND 3 (youth and ADULTS) , AB109 funds (Adults), Prop 47 (Round 3 and 5)(Adults), general county funds (Adults).

Removal Of Children from Home

Primary Measures

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

1. How does your county status compare to the statewide rate? **Above**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

   ☒ **Age**

   ☐ Gender

   ☐ Race or Ethnicity

   ☐ Sex

   ☐ Spoken Language

   ☐ None Identified

   ☐ No Disparities Data Available

   ☐ Other:

Supplemental Measures

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

1. How does your county status compare to the statewide rate? **Above**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]:

   ☒ **Age**

   ☐ Gender

   ☐ Race or Ethnicity

   ☐ Sex

   ☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other:

Child Maltreatment Substantiations (CWIP), 2022

1. How does your county status compare to the statewide rate? **Above**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]

☒ Age

☐ Gender

☒ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other:

Disparities Analysis

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

Disparities in Child Removal Rates:

According to CalMHSA 2025 data, the statewide rate of child removal is 525 per 110K, while Kern has a higher rate at 679 per 110K, a difference of 154 children.

- **Age: The 2025 CalMHSA PIT count for Kern shows that children under 2 years old have higher removal rates, with 1012 children under 1 year and 911 children aged 1-2 being removed.**
- **Penetration rate: Kern exceeded the state penetration rate in 2022, with 44.2% compared to the state rate of 43%. The most recent demographic data from 2021 shows a disparity in age penetration rates, with 35.7% for youth aged 3-5 and 7.6% for children aged 0-2.**

- **Disparities for Child Maltreatment Substantiation: According to CalMHSA 2022 data (per 1000), Kern's rate for child maltreatment substantiation is 10.1, compared to the state rate of 6.2.**

- **Age: 2024 data show disparities by age in Kern. Per 1000 children, the rates are 29.8 for under 1 year, 14 for ages 1-2, and 11.7 for ages 3-5.**
- **Race or Ethnicity: 2024 data show disparities by race/ethnicity. Per 1,000 children, the rates are 31.7 for Black children, 22.1 for Native American children, and 10.8 for White children, compared to the state rate of 9.8.**

Cross-Measure Questions

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

   To address Kern County's local needs and improve their standing on measures below statewide averages, the following strategies will be implemented:

   - **Data Monitoring and Cross-System Coordination: The BHP will continue regular data sharing with Child Welfare Services to monitor referral trends, improve coordination, and early identification. In addition, The Foster Care Coordination Meeting provides shared strategies to increase referrals and engagement for young children entering the system.**
   - **Increased Access to Early Assessments: The BHP currently provides behavioral health assessments, including the Ages and Stages Questionnaire–Social Emotional (ASQ-SE) starting at 16 months. To promote early intervention, the assessment age will be lowered to 6 months, ensuring infants at risk of trauma exposure are screened earlier. Additionally, children who don't initially meet SMHS criteria will now be re-screened within 3 months to prevent care gaps and ensure early behavioral health needs are not missed.**
   - **Strengthened Care Coordination: Assessment results will continue to guide**

referrals to pediatric care, Regional Center, developmental services, or parent SUD/behavioral health treatment as needed. Care coordination with social workers will ensure follow-through on recommendations.

- **Training and System Support: Kern County BHP will expand training for social workers on recognizing early developmental and emotional concerns in infants and toddlers. A liaison will remain onsite to streamline referrals through a dedicated phone line and secure drop box.**
- **These strategies align with Kern's priority to safely maintain children in their homes whenever possible by addressing behavioral health needs early and preventing system escalation.**

- **Attached files:**
  - **Removal of Children from Home – Cross Measure Questions.pdf**
  - **Integrated Plan Foster Care Referrals_0 to 5.pdf**

2. Please identify the category or categories of funding that the county is using to address the removal of children from home goal [multi-select dropdown]:

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

Untreated Behavioral Health Conditions

Primary Measures

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

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

   a. For the full population measured: **Below**

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

☐ Age

☐ Gender

☐ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☒ **No Disparities Data Available**

☐ Other:

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

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured: **Below**
2. What disparities did you identify across demographic groups or special populations? [Multi-select]

☐ Age

☐ Gender

☐ Race or Ethnicity

☐ Sex

☐ Spoken Language

☐ None Identified

☒ **No Disparities Data Available**

☐ Other:

Supplemental Measures

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

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

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

☒ **Age**

☐ Gender

☒ **Race or Ethnicity**

☒ **Sex**

☐ Spoken Language

☐ None Identified

☐ No Disparities Data Available

☐ Other:

Disparities Analysis

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

Kern BHP reviewed MY*2022 DHCS data for FUA, FUM*** and CHIS**** (MY2023) data for Adults that Needed Help for Emotional /Mental Health Problem or Use of Alcohol/Drugs and Had No Visits in Past Year. No equity data was available for FUA or FUM. However, for Adults Needing Help With No Visits in the Past Year, there were noticeable disparities in age, race/ethnicity, and race/sex. Adults 18-24 are more than 20% above the county average in this measure (73.37% vs. 52.8%), which means they are less likely to have a visit for a mental/drug/alcohol issue. Asians and Latinos are also above the standard (65.1% and 68.0%, respectively). Supporting that trend, male and female Latinos and Asian females were also less likely to have a visit for mental/drug/alcohol issues with each grouping over 10% the countywide rate of 52.8%.**

Notes:

- **MY refers to Measurement Year in health plans.*
- ***FUA refers to Follow-Up After Emergency Department Visit for Substance Use.*
- ****FUM refers to Follow-Up After Emergency Department Visit for Mental Illness*
- *****CHIS refers to California Health Interview Survey.*

Cross-Measure Questions

1. Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026, that may decrease 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 county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes):

   Following a review of MY2023 HEDIS FUA/FUM results, which highlighted emergency department utilization patterns across Kern County, the Plan elected to strengthen partnerships with emergency departments and Managed Care Plans (MCPs) in an effort to decrease the county's residents with untreated behavioral health conditions.

   Beginning the first quarter of FY 26/27 Kern BHP will be implementing Crisis Hospital response services to support individuals experiencing a behavioral health crisis and in and Kern County Emergency Department. This will help in care coordination and timely access to urgent appointments.

   As a result of Kern County BHP receiving daily FUA/FUM data from the MCP's, Kern County BHP is working on enhancing data sharing with the three Managed Care Plans, receiving real time FUA/ FUM data to support coordinated care and provide supportive services to Medi-Cal beneficiaries. Upon receiving the real time FUA/FUM data, the identified network provider will be alerted to the unique beneficiary need to support coordination of care.

2. Please identify the category or categories of funding that the county is using to address the untreated behavioral health condition's goal [multi-select dropdown]:

   ☒ **BHSA BHSS**
   ☐ BHSA FSP
   ☐ BHSA Housing Interventions
   ☒ **1991 Realignment**

☒ **2011 Realignment**
☒ **State General Fund**
☒ **Federal Financial Participation (SMHS, DMC/DMC-ODS)**
☐ SAMHSA PATH
☐ MHBG
☐ SUBG
☐ Other:

Additional Statewide Behavioral Health Goals for Improvement

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

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

Care Experience

Primary Measures

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

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

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

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

Engagement In School

Primary Measures

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

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

Supplemental Measures

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

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

Student Chronic Absenteeism Rate (Data Quest), 2022

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

Engagement In Work

Primary Measures

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

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

Supplemental Measures

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

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

Overdoses

Primary Measures

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

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

Supplemental Measures

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

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

Prevention And Treatment of Co-Occurring Physical Health Conditions

Primary Measures

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

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

Supplemental Measures

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

1. How does your county status compare to the statewide rate/average?
    a. For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications) **Below**
    b. For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing) **Above**

Quality Of Life

Primary Measures

Perception of Functioning Domain Score (CPS), 2024

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured **Not Applicable**
    b. For adults/older adults **Not Applicable**
    c. For children/youth **Not Applicable**

Supplemental Measures

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

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

Social Connection

Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured **Not Applicable**
    b. For adults/older adults **Not Applicable**
    c. For children/youth **Not Applicable**

Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides

Primary Measures

Suicide Deaths, 2022

1. How does your county status compare to the statewide rate/average?
    a. For the full population measured **Not Applicable**

Supplemental Measures

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

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

    a. For the full population measured **Above**
    b. For adults/older adults **Below**
    c. For children/youth **Above**

County-Selected Statewide Population Behavioral Health Goals

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. [multi-select dropdown of statewide goals for improvement and reduction, excluding statewide priority goals]

1. **Goal #1: Overdoses**

    a. Please describe why this goal was selected:

    Kern County's rate of overdose deaths has been climbing since Kern County BHP began monitoring the CA Opioid Dashboard in 2018. Although efforts have been made to make Naloxone available through various entities, and informational presentations on the dangers of opioids and counterfeit pills are available, overdose deaths and emergency department visits continue to rise. In 2016, Kern had 54 opioid overdose deaths, and that number climbed to 321 in 2023. Kern began conversations with multiple agencies and community partner partners to discuss strategies to address the opioid crisis locally. The strategies involved increasing awareness of the dangers of opioid use, reducing prescription medication availability, preventing overdose deaths by increasing availability of naloxone, expanding SUD treatment options, and reducing opioid misuse. Progress has been made in each of these strategies, including expansion of buprenorphine prescription rates – in 2017 this rate was above 7 per 1000 residents, and in 2023, this was 16.24 per 1000. Making this medication more widely available in specialty clinics, primary care and street medicine clinics increases access to options for treatment, helping to prevent overdose deaths.

    b. 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.

Kern County California Opioid Dashboard reports for years 2019 through 2023 indicates that the Native American/Alaskan Native population consistently experienced the highest rates of opioid overdose in the county for the years 2019, 2021, and 2022. However, in 2023, this trend shifted, with Black/African American residents reporting the highest opioid overdose rate among all racial and ethnic groups.

c. 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 [selected goal] 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)

Kern County BHP will collaborate with the Kern County Public Health Department to obtain data from Emergency Medical Services (EMS) that involves a response to an overdose. This can include opioids only or multiple substances in one event. This data will be reviewed and processes established in order to receive this patient information on an ongoing basis in order to deploy staff to engage the person that had an overdose into SUD treatment. The BHP would approach the individual and family members to explain services that are available, provide naloxone education and education on the dangers of opioid misuse. Another strategy that will be implemented is to approach communities that have higher rates of overdose events in order to offer educational sessions and Naloxone training. This will prepare families and community members to potentially save someone's life if they experience an overdose.

Expanding Kern County BHP's Outpatient Medications for Addiction Treatment (MAT) clinic to provide telehealth services in rural areas of the county could help address the limited access to care outside of Bakersfield.

Obtaining data from Medi-Cal Managed Care Plans that capture emergency department visits due to overdose can help identify individuals at risk. Kern County BHP staff working in Emergency Departments can

then initiate engagement and offer treatment options, including specialty substance use disorder services and medications for MAT.

d. Please identify the category or categories of funding that the county is using to address this goal [multi-select dropdown]:

☒ **BHSA BHSS**
☐ BHSA FSP
☐ BHSA Housing Interventions
☒ **1991 Realignment**
☒ **2011 Realignment**
☒ **State General Fund**
☒ **Federal Financial Participation (SMHS, DMC/DMC-ODS)**
☐ SAMHSA PATH
☒ **MHBG**
☒ **SUBG**
☒ **Other: Opioid Settlement Funding, MHBG Dual Diagnosis Set Aside**

Community Planning Process

Stakeholder Engagement

1. Please indicate the type of engagement used to obtain input on the planning process [multi-select check boxes; display those selected with ability to choose from options below]

   A. ☒ County outreach through social media
   B. ☒ County outreach through townhall meetings
   C. ☒ County outreach through traditional media (e.g., television, radio, newspaper)
   D. ☒ Focus group discussions
   E. ☒ Key informant interviews with subject matter experts
   F. ☐ Meeting(s) with county
   G. ☐ Provided data to county
   H. ☐ Public e-mail inbox submission
   I. ☒ Survey participation
   J. ☐ Training, education, and outreach related to community planning
   K. ☒ Workgroups and committee meetings
   L. ☐ Other:

2. Include date(s) of stakeholder engagement for each type of engagement [question repeats for each type of engagement selected above]:

   A. County outreach through social media – 09/10/25 (see attachment for additional dates)
   B. County outreach through townhall meetings – 08/13/25 (see attachment for additional dates)
   D. Focus group discussions – 07/14/25(see attachment for additional dates)
   E. Key informant interviews with subject matter experts – 10/27/25 (see attachment for additional dates)
   I. Survey participation – 09/17/25 (see attachment for additional dates)
   K. Workgroups and committee meetings – 10/27/25 (see attachment for additional dates)

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

   - **Action Family Counseling**
   - **American Health Associates Inc**

- **Anthem**
- **Bakersfield American Indian Health Project (BAIHP)**
- **Bakersfield Behavioral Healthcare Hospital**
- **Bakersfield Burrito Project**
- **Bakersfield City**
- **Bakersfield College**
- **Bakersfield Police Department**
- **Bakersfield-Kern Regional Homeless Collaborative**
- **California Veterans Assistance Foundation**
- **California Victim Compensation Board**
- **Charlie's Health: Virtual provider (MH & SUD)**
- **Children's Behavioral Health Initiative (CBHI)**
- **Clarvida**
- **Clinica Sierra Vista**
- **Community Action Partnership of Kern (CAPK)**
- **Dolores Huerta Foundation**
- **Elevance Health**
- **Greater Bakersfield Legal Assistance (GBLA)**
- **Innovative Integrated Health**
- **Jason's Retreat**
- **Kaiser Permanente**
- **Kern County Public Health**
- **Kern Health Systems**
- **Kern High School District**
- **Kern Medical Center**
- **La Vida Nueva**
- **Mercy House**
- **River Sage Revival**
- **Rowi Counseling**
- **STEPS Inc**
- **Sunshine Behavioral Health Services**
- **Teen Challenge**
- **Telecare**
- **WestCare Bakersfield**

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

Cities, Counties, and the State)

	City Name
1	Bakersfield City
2	Delano City
3	Ridgecrest City
4	Wasco City
5	Shafter City

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

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

   - **County social services and child welfare agencies**
     - **Attempted but did not receive a response**
   - **Disability insurers**
     - **Other: Based on the definition that was provided for Disability Insurers [A commercial disability insurer that covers hospital, medical, or surgical benefits as defined in Insurance Code section 106(b)], Kern County BHP was unable to identify a group or individual under this category.**
   - **Early childhood organizations**
     - **Attempted but did not receive a response**
   - **Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+) communities**
     - **Attempted but did not receive a response**

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

   The CPP Stakeholder Feedback report synthesizes input gathered through multiple listening sessions and engagement activities conducted between July and December 2025 to inform the Kern BHRS Integrated Plan. Across sessions, stakeholders consistently identified housing as the most urgent behavioral health priority, citing its foundational role in stability, overdose prevention, and compliance with state mandates. Other high-priority themes included addressing the needs of vulnerable

and underserved populations (particularly individuals experiencing homelessness, rural residents, and children and families), improving system integration between mental health and substance use disorder services, responding to the overdose crisis, and ensuring system sustainability through adequate staffing, billing structures, and workforce capacity. Stakeholders strongly supported whole-person care and MH/SUD integration but emphasized that success depends on sufficient funding, staff training, and removal of systemic and legal barriers such as fragmented electronic health records and confidentiality constraints.

The feedback further highlighted persistent gaps in access driven by stigma, poverty, transportation challenges, cultural and language barriers, and service fragmentation. Affordable and supportive housing, particularly for individuals with co-occurring disorders, youth/TAY, veterans, and adults with complex needs, was repeatedly identified as a critical system gap. Ranking exercises conducted in August and September 2025 reinforced these findings, with stakeholders prioritizing reducing suicides and overdoses, increasing prevention and treatment of co-occurring public health conditions, and improving quality of life. Ultimately, "Reduce Overdoses" was selected as the additional goal for the Integrated Plan, reflecting both stakeholder input and supporting CalMHSA data. The report underscores the need for coordinated equity-driven strategies that integrate housing, prevention, treatment, and community engagement to strengthen Kern County's behavioral health system.

Attachments:

- **A. 2025 CPP Stakeholder Feedback**
- **B. CPP Stakeholder Engagement (stakeholder types - activity types by date)**
- **C. 2025 CPP Meeting Minutes**
- **D. Emails: Attempting to Engage Stakeholder Groups**

Groups that Kern was Unable to Engage in the Planning Process
Kern County Behavioral Health was not able to fully engage all required stakeholders during the Community Planning Process (CPP). Despite multiple outreach attempts, the County was unable to secure participation from disability insurers, early childhood organizations, county social services and child welfare agencies, and LGBTQ+ communities. Outreach efforts included direct email invitations, distribution of public notices, and inclusion in stakeholder forum announcements; however, these efforts did not result in active participation from these groups.

Although direct consultation was limited, Kern County incorporated the needs of these populations through alternative data-informed and collaborative approaches. Specifically, the County utilized secondary data sources, including service utilization data, demographic trends, and needs assessment findings, to identify disparities and

service gaps impacting these populations. For example, child welfare–involved youth and young children were considered through analysis of Medi-Cal claims, EPSDT utilization patterns, and existing cross-system referral data.

Additionally, the County relied on input gathered from adjacent and overlapping stakeholder groups that serve or represent these populations. This included feedback from school partners, healthcare providers, community-based organizations, and family advocates who regularly interact with early childhood populations, child welfare–involved families, and LGBTQ+ individuals. Internal collaboration with county departments and program staff who have subject matter expertise in these areas also informed planning discussions.

Furthermore, Kern County reviewed prior CPP input, existing program evaluations, and statewide guidance to ensure that historically underserved and underrepresented populations—including LGBTQ+ communities and individuals involved in the child welfare system—were reflected in program planning priorities and funding decisions.

The County recognizes the importance of direct engagement and will strengthen targeted outreach strategies in future CPP cycles. Planned improvements include developing formal partnerships, leveraging trusted community-based organizations to facilitate introductions, and implementing more tailored engagement approaches to increase participation from these specific stakeholder groups.

Local Health Jurisdiction (LHJ)

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

1. Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP)? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.
   - ☒ **Yes. [Populate question 2 and 3, if selected]**
   - ☐ No. The LHJ is not currently working on and/or did not develop a recent CHA and/or CHIP.
   - ☐ Other
2. Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP:
   Kern County BHP Cultural Competence Team met with Crescendo, an organization that was hired to conduct focus groups for the Kern County CHA. The Cultural Competence Team provided input on the different

populations that are underserved in behavioral health and substance use services, such as Hispanic/Latinx, Punjabi American, African American, Native American, and 2SLGBTQ+ communities. It was shared that stigma for behavioral health and substance use was prevalent in those communities, making outreach difficult. A survey being conducted for the CHA was also completed by the Cultural Competence Team. The Plan meets with Kern County Public Health quarterly to go over the behavioral health goals in the CHIP.

3. Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?
   - ☐ Yes
   - ☒ **No**

Collaboration

1. Please select how the county collaborated with the LHJ [multi-select list]
   - ☒ **Attended key CHA and CHIP meetings as requested.**
   - ☐ Served on CHA and CHIP governance structures and/or subcommittees as requested.
   - ☐ Other.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

1. Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP [multi-select list]:
   - ☒ **Access to Care**
   - ☒ **Care Experience**
   - ☒ **Engagement in School**
   - ☐ Engagement in Work
   - ☐ Homelessness
   - ☐ Institutionalization
   - ☐ Justice Involvement
   - ☐ Overdoses
   - ☐ Prevention of Co-Occurring Physical Health Conditions
   - ☐ Quality of Life
   - ☐ Removal of Children from Home
   - ☐ Social Connection

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

2. Was data shared? **No**

Data-Sharing from MCPS and LHJs to Support IP development

1. Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development [multi-select list]
   - ☐ Access to Care
   - ☐ Care Experience
   - ☐ Engagement in School
   - ☐ Engagement in Work
   - ☐ Homelessness
   - ☐ Institutionalization
   - ☐ Justice Involvement
   - ☐ Overdoses
   - ☐ Prevention of Co-Occurring Physical Health Conditions
   - ☐ Quality of Life
   - ☐ Removal of Children from Home
   - ☐ Social Connection
   - ☐ Suicides
   - ☐ Untreated BH Conditions (e.g., substance use disorder, depression, maternal and child behavioral disorders, other adult mental health conditions)
   - ☒ **Other: MCP's are attending Kern County BHP's community forums. Standing agenda item of the community forums is discussing the IP plan and we collect their feedback and suggestions.**
2. Was data shared? **No**

Stakeholder Activities

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

IP and CHA/CHIP process.

☒ **Collaborated on joint surveys, focus groups, and/or interviews that can be used to inform both the IP and CHA/CHIP.**

☐ Co-hosted community sessions, listening tours, and/ or other community events that can be used to strengthen stakeholder engagement for both the IP and CHA/CHIP.

☐ Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.

☐ Other

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

1. Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3 [Yes/No radio buttons]

   ☒ **Yes**

   i. Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP:
   Kern County BHP holds ongoing quarterly meetings with Kern County Public Health to review behavioral health goals outlined in the CHIP. These meetings have also served as a forum for discussing the Integrated Plan and broader Behavioral Health Transformation efforts, allowing for valuable feedback. In addition, overdose trends and response strategies have been a recurring topic of discussion, helping to align public health and behavioral health efforts in addressing the opioid crisis across the county.

   ☐ No

   ii. Please explain why the county did not consider the LHJ's CHA/CHIP or strategic plan when preparing its

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

1. Please list the Managed Care Plans (MCP) the county worked with to inform the

MCPs' respective community reinvestment planning and decision-making processes

We are currently reaching out to our Managed Care Plans (MCPs) to understand their activities related to Community Reinvestment planning.

Below is a summary of the information we have received to date:

a. Kern Health Systems (KHS): KHS reported a net profit of zero (0) for 2024 and indicated during our meeting on 9/26/25 that they would not be participating.

b. Anthem: We have contacted this managed care plan but have not yet received a response.

c. Kaiser Permanente (KP): KP has reported a net income of zero (0).

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

a. Kern Health Systems (KHS): KHS is not participating due to zero (0) net profit margin.

b. Anthem: Unknown.

c. Kaiser Permanente (KP): KP is not participating due to zero (0) net profit margin.

Comment Period and Public Hearing

1. Date the draft Integrated Plan (IP) was released for stakeholder comment: **01/12/2026**
2. Date the stakeholder comment period closed: **02/11/2026**
3. Date of behavioral health board public hearing on draft IP: **01/26/2026**
    a. Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality Link

Attachment F: https://www.kernbhrs.org/about-us/mental-health-services-act

4. [Optional] If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page: **N/A**
5. Please select the process by which the draft plan was circulated to stakeholders [multi-select list]:
    ☒ **Public posting**
    ☒ **Email outreach [if selected, attach email (no file type restrictions)]**
    ☒ **Other [logic: if selected, populate question 6 below]**
6. Please specify the other process the draft plan was circulated to stakeholders:

    Kern BHRS shared the draft plan at our BHSA Community Forums in English, Spanish, and virtually, in addition to email outreach, social media, media release, and Kern BHRS public website postings. Details are included in the attached document titled "30-Day Public Comment Stakeholder Data - BHSA Integrated Plan (FINAL)"

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

Table 7. Stakeholder Input

Stakeholder group that provided feedback	Summarize the substantive revisions recommended this stakeholder during the comment period
Organization with Experience in Underserved Populations	**Recommended explicitly incorporating a stronger rural and geographically isolated community framework throughout planning, implementation, innovation, and evaluation activities. Suggested enhancing mobile and field-based services, leveraging place-based**

	and relationship-driven approaches, and strengthening rural workforce development and retention strategies to ensure equitable regional impact.
Individuals/Clients	**Requested clearer communication regarding what the Integrated Plan means for the average resident and taxpayer, including improved explanation of community-level benefits, fiscal accountability, and measurable outcomes.**
Health Care & Hospitals	**Raised questions regarding transportation access within the BEST program, equitable ER referral access across all regions (not only Metro Bakersfield), and whether reliance on historical referral data accurately reflects First Episode Psychosis (FEP) need. Recommended strengthening provider outreach and referral pathway awareness countywide.**
Public Safety	**Urged that crisis services be treated as core behavioral health infrastructure and more fully integrated across 988, mobile crisis teams, hospitals, inpatient and residential care, outpatient providers, law enforcement diversion efforts, and CARE Act implementation. Emphasized reducing system cycling between emergency rooms, incarceration, and homelessness.**
Community-Based Organization (CBO) & Tribal Organization	**Recommended incorporating a stronger racial equity lens across funding allocations, outreach, service delivery, workforce development, and system communication. Emphasized culturally and linguistically responsive services, community-defined evidence practices, promotor/community health worker investment, and sustainability planning for immigrant, refugee, American Indian/Alaska Native, and limited-English-proficiency populations.**
Mental Health Provider	**Identified inconsistencies in program numbering, system-of-care labeling (FSP, EI, System of Care), formatting, and terminology. Requested clarification between First Episode Psychosis (FEP) and Early Psychosis Intervention Plus (EPI Plus), and correction of typographical errors to improve clarity and**

	internal consistency.

8. Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A. [narrative response, with unlimited option to add new entries]

   Requested clarification regarding how feedback received during the 30-Day Public Comment period would be reviewed, documented, and incorporated into revisions or future implementation planning.

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

Cities submitting their Integrated Plan independently from their counties do not have to complete the Medi-Cal Quality Improvement Plan questions or Question 1 under All BHSA Provider Locations.

Medi-Cal Quality Improvement Plans

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

   Attachment G: Kern County FY25-26 Work Plan.FINAL.pdf

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

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

   Attachment G: Kern County FY25-26 Work Plan.FINAL.pdf

Contracted BHSA Provider Locations

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

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

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

Services Provided	Number of Contracted BHSA Provider Locations
Mental Health (MH) services only	6
Substance Use Disorder (SUD) services only	1
Both MH and SUD services	6

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

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

Services Provided	Number of Contracted BHSA Provider Locations
SMHS only	6
DMC/DMC-ODS only	1
Both SMHS and DMC/DMC-ODS systems	6

All BHSA Provider Locations

1. Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS *Note: DHCS will provide each county with a list of their SMHS providers that also contract with MCPs. Counties will then calculate a final percentage after excluding SMHS providers that do not offer any services that may be covered as NSMHS.* [logic: if estimate is <60 percent, populate question a below]: **67%**

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

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

    a. Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening;
    b. Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and
    c. Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding.
        i. Does the county wish to describe implementation challenges or concerns with these requirements? **No**

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

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

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

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS)

General

1. Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan [multi-select list]

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

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

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 additional program" button.

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

1. Please select the service types provided under Program One [multi-select list]:

   ☒ **Mental health services**
   ☒ **Supportive services**
   ☒ **Substance Use Disorder treatment services**

2. Please describe the specific services provided:

   Kern County BHP's Youth Crisis Engagement Team provides intensified services for youth at risk of hospitalization, who meet criteria for Pathway to Well Being services and/or Therapeutic Behavioral Services, or are in frequent need of crisis intervention. This team is partially co-located at the Psychiatric Evaluation Center (PEC) and the Mary K. Shell and Kern Medical (KM) Emergency and Pediatrics. Youth are engaged after self/family-referrals, from schools, the Probation Department, Department of Human Services, Mobile Evaluation Team, Psychiatric Evaluation Center, SMART Committee, local hospitals, and inpatient facilities. Staff are available after hours, weekends, and during holidays to ensure engagement occurs as close to presenting need as possible. Treatment planning is developed in a child and family centric trauma informed focused approach to meet specific needs of the youth and family. The treatment team involves the whole client, support system, and treatment team, including therapist, recovery specialists, schools, and other child-serving agencies.

Menu of Services include:

- **Intensified treatment services**
- **Individual and family therapy**
- **Group therapy**
- **Co-occurring coordinated services**
- **Psychiatric services**
- **Medication Management**
- **Therapeutic Behavioral Services (TBS)**
- **Cognitive Behavioral Therapy (CBT)**
- **Trauma-focused CBT**
- **Motivational Interviewing**
- **Dialectical Behavior Therapy (DBT)**
- **Pathways to Well-Being services**

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**1038**
FY 2027 – 2028	**1088**
FY 2028 – 2029	**1138**

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

Non-scientific cursory evaluation of the last three years, 2023, 2024, and January 2025 to present to extrapolate potential patterns. For instance, from 2024 to present there was an increase of 50 clients, etc. For 2025 approximately 1065 referrals, 2024 approximately 1015 referrals, and for 2023 approximately 1279 referrals.

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

1. Please select the service types provided under Program One [multi-select list]:

☒ **Mental health services**
☐ Supportive services
☐ Substance Use Disorder treatment services

2. Please describe the specific services provided:

   The Youth MIST Program delivers intensive, multidisciplinary behavioral health interventions for youth ages 12–21 experiencing serious emotional disturbances, placement instability, or juvenile justice involvement. Grounded in the Treatment Foster Care Oregon (TFCO) model, MIST promotes stabilization in the least restrictive, most family-like environment possible. The program provides caregivers with coaching in contingency behavior management and strengths-based strategies to improve family relationships and reduce high-risk behaviors. Youth MIST serves youth who might otherwise require residential placement, psychiatric hospitalization, or prolonged probation supervision. Integration of the TFCO model ensures structured, data-informed treatment within certified resource family homes or the youth's home of origin. Services emphasize consistent routines, positive reinforcement, and intensive support for foster/resource parents and biological families. Care coordination is collaborative, engaging probation, child welfare, education, and health partners to ensure continuity of care. Individualized treatment plans are guided by data from the Parent Daily Report (PDR), Child and Adolescent Needs and Strengths (CANS), Pediatric Symptom Checklist-35, and ongoing family meetings and coaching sessions. The Team Lead maintains fidelity to the model through supervision, data review, and parent coaching. Comprehensive services include TFCO, Dialectical Behavioral Therapy (DBT), Aggression Replacement Training (ART), Trauma-Informed Cognitive Behavioral Therapy (CBT), Solution-Focused Brief Therapy (SFBT), and Motivational Interviewing. Additional supports include co-occurring services, medication management, crisis intervention, 24/7 on-call response, case management, family reunification, and recruitment and certification of resource families for adolescents ages 12–18. Youth MIST promotes long-term stability, resilience, and successful reintegration within the community.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**336**
FY 2027 – 2028	**336**
FY 2028 – 2029	**336**

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

   Gathered unduplicated client count from FY 24/25 projected number of clients to be served with one therapist position filled in August of 2025, and one extra help recovery specialist position expiring in February of 2026.

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

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 additional program" button.

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

1. Please select the service type provided under Program One [multi-select list

   ☒ **Mental health services**
   ☒ **Supportive services**
   ☒ **Substance Use Disorder treatment services**

2. Please describe the specific services provided:

   The WISE Team delivers comprehensive mental health services to older adults in the community who are living with serious mental illness. The team addresses the complex needs of this population through individualized, field-based care. Referrals to the WISE Team are received from any specialty or non-specialty mental health treatment providers, as well as, through a variety of community agencies. To reduce barriers that often prevent clients from accessing office-based services, the WISE Team operates primarily in the field. The multidisciplinary team includes a Gero psychiatrist, licensed Therapists, Recovery Specialists, and Support Staff, all working collaboratively to meet client needs.

   Services provided include mental health screenings, comprehensive evaluations, therapy, individual rehabilitation, and case management.

   The Geropsychiatric also offers integrated care for co-occurring physical and mental health concerns, with referrals to appropriate medical providers as needed.

   Menu of Services include:

   - **Cognitive Behavioral Therapy (CBT) is a structured, goal-oriented talk therapy that helps people identify and change unhelpful thinking patterns and behaviors, improving mood and coping.**

- **Dialectical Behavioral Therapy (DBT) is a structured therapy, an adaptation of Cognitive Behavioral Therapy (CBT), that teaches skills in Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness to manage intense emotions and build a more fulfilling life**
- **Solution Focused Therapy (SFT) is a brief, goal-oriented therapy focusing on building solutions and the future, not dwelling on problems, by identifying client strengths and resources to create small, practical steps toward desired outcomes.**
- **Problem Solving Therapy (PST) is a brief, goal-oriented therapy focusing on building solutions and the future, not dwelling on problems, by identifying client strengths and resources to create small, practical steps toward desired outcomes.**
- **Individual rehabilitation and skill building strategies**
- **PEARLS Behavior Activation: Program to Encourage Active, Rewarding Lives (PEARLS) is an evidence-based behavioral health program for older adults (60+) to manage depression and improve quality of life through in-home or virtual coaching, focusing on problem-solving, activity planning, and connecting to community resources, adapting techniques like Behavioral Activation.**
- **Geropsychiatry Neurocognitive impairment screenings use brief, simple tasks to check mental functions like memory, attention, and language**
- **Psychiatric nursing interventions are actions nurses take to promote mental health, prevent illness, and manage psychiatric conditions, focusing on safety, stabilization, and recovery through strategies like creating a safe milieu, de-escalation, teaching coping skills (e.g., relaxation, problem-solving), milieu therapy, therapeutic communication, and providing emotional support.**
- **Targeted Case Management: Refer, linkage and monitoring.**

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

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

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

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

The WISE Team started as a Full-Service Partnership (FSP) Team in FY 2005-06, data and assumptions for the WISE Team considered to project the number of individuals served has been based on:

1. A review of past referrals

2. A review of enrollment numbers

3. Caseload capacity 1:10/15 for a Full Service Partnership (FSP) Program

4. Team composition of service providers

Moving forward as a Non-FSP WISE Team, data and assumptions would include the aforementioned as well as a review of potential referrals within the Adult System of Care, a review of elder population in the larger community, a review of prevalence rates for severe mental illness among older adults as potential clients.

By combining local demographic data, prevalence rates of serious mental illness in older adults, expected referral rates, and program capacity, can provide a realistic projection of the number of older adults that the WISE Team can serve. This approach enables strategic planning for staffing, funding, and outreach efforts to meet the needs of the older-adult population effectively.

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

1. Please select the service type provided under Program One [multi-select list

☒ **Mental health services**
☒ **Supportive services**
☒ **Substance Use Disorder treatment services**

2. Please describe the specific services provided:

The Assisted Outpatient Treatment (AOT) Program provides structured, individualized behavioral health services designed to help individuals achieve goals related to psychological stability, social functioning, self-esteem, and community integration. Services are tailored to each person's needs and may include therapy, case management, psychiatric support, and family engagement. Referrals may be submitted by family members, roommates, community partners, peace officers, hospital or agency directors, or licensed therapists.

Following referral, AOT staff conduct screening and outreach for a minimum of 30 days. The assigned therapist completes a comprehensive evaluation in accordance with the Kern County BHP System of Care Policy and petitions the court if all AOT criteria are met. Petitions are based on the individual's clinical acuity and severity

of symptoms.

AOT services may include individual and group therapy, family counseling, psychiatric and nursing support, and psychoeducation. Services are coordinated and flexible in order to address diverse clinical and social needs. Program participation concludes when individuals achieve their treatment goals and are successfully "graduated" as determined by the AOT Team and Court Partners.

Case management emphasizes goal-oriented service coordination, focusing on self-sufficiency through assessment, planning, linkage, advocacy, and monitoring. Supportive counseling and crisis intervention are integral components. Qualified service coordinators work collaboratively with clients and external partners to ensure integrated care. With client consent, staff engage family members, probation officers, court representatives, and social workers to promote continuity of care. Consistent with Kern County BHP's family inclusion framework, the AOT Program aims for at least 10% of total services to involve family or natural support, strengthening recovery and long-term stability within the community.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**150**
FY 2027 – 2028	**165**
FY 2028 – 2029	**181**

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

Assumptions:

1. **Changes to 5150 holds (Medical and SUD)- Increased need for engagement and delivery of services**
2. **Historical numbers of Individuals served (10% increment per year)**
3. **Increased number of referrals from court and outpatient teams/ Community.**

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

1. Please select the service type provided under Program One [multi-select list

   ☒ **Mental health services**
   ☒ **Supportive services**
   ☒ **Substance Use Disorder treatment services**

2. Please describe the specific services provided:

   Behavioral Emergency Support Team (BEST) delivers a range of supportive services, including behavioral health and substance use education, therapeutic skills and interventions, discharge planning, linkage to ongoing behavioral health treatment and/or substance use treatment, and linkage to additional crisis services such as inpatient hospitalization and substance detoxification. Through timely assessment, engagement, and coordination of care, BEST facilitates prompt connection to appropriate services and reduces the amount of time individuals spend in local emergency departments awaiting behavioral health treatment.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**1906**
FY 2027 – 2028	**2021**
FY 2028 – 2029	**2143**

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

   Projections were developed using existing data compiled from multiple teams and reflect the volume of individuals referred from medical hospitals to the Psychiatric Evaluation Center. Historical data from prior fiscal years demonstrate an average annual growth rate of six (6) percent, which was applied to estimate the projected number of clients to be served during the requested fiscal years. These projections do not incorporate the potential impact of significant systemic changes, including Senate Bill 43 and Assembly Bill 416, both of which are anticipated to increase referrals and service demand from medical hospitals.

Early Intervention (EI) Programs

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 additional program" button.

Early Intervention (EI) Program #1

1. Program or service name: **First Episode Psychosis**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:

   ☒ **Outreach**

   ☒ **Access and Linkage: Screenings**

   ☐ Access and Linkage: Assessments

   ☐ Access and Linkage: Referrals

   ☐ Access and Linkage: Other

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

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

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

   ☐ Treatment Services and Supports: Other
   [Logic: Populate if e is selected above] Please specify "other" type of Access and Linkage [narrative box]
   [Logic: Populate if i is selected above] Please specify "other" type of Treatment Services and Supports [narrative box]

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

a. List the EBPs and CDEPs that apply:

- **Cognitive Behavioral Therapy (CBT) for Psychosis**
- **Coordinated Specialty Care Model (CSC)**
- **Adapted Mini-SIPS version of the Structured Interview for Psychosis-Risk Syndromes (SIP)**
- **Columbia-Suicide Severity Rating Scale-CSSRS**
- **Global Functioning: Social and Role Scales**

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

First Episode Psychosis is an MHSA Innovation Plan that will end on 5/26/27, The plan for program sustainability and continued achievement of program outcomes is to move the program under BHSA BHSS EI.

The following are the intended outcomes of the program:

- **Individuals experiencing first episode psychosis to receive treatment as early as possible to prevent decline in functioning that can occur with illness onset, to empower individuals and their social supports to be able to progress in their personal, social, and occupational goals.**
- **The team delivers and adheres to the Coordinated Specialty Care Model (CSC) for service users with a First Episode of Schizophrenia Spectrum Disorder.**

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

a. Additional priority name [narrative box]: **N/A**

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**35**
FY 2027 – 2028	**55**
FY 2028 – 2029	**90**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Data based on the number of referrals received in the last two years was used to project the number of individuals to be served in the coming years.

Early Intervention (EI) Programs #2

1. Program or service name: **Crisis Hotline**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:

   ☒ **Outreach**

   ☒ **Access and Linkage: Screenings**

   ☐ Access and Linkage: Assessments

   ☒ **Access and Linkage: Referrals**

   ☐ Access and Linkage: Other

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

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

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

   ☐ Treatment Services and Supports: Other
   [Logic: Populate if e is selected above] Please specify "other" type of Access and Linkage [narrative box]
   [Logic: Populate if i is selected above] Please specify "other" type of Treatment Services and Supports [narrative box]

3. Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs:
   No
4. Please describe intended outcomes of the program or service:
   1. **Outreach and Engagement: Activities designed to increase community awareness and utilization of the 988 Crisis Hotline. This effort focuses on delivering accessible, developmentally responsive information about 24/7 crisis support to youth, families,**

and community partners across Bakersfield and surrounding areas. Special emphasis is placed on reaching populations at elevated risk of behavioral health crises, including school aged youth, justice involved youth, foster youth, LGBTQ+ youth, and young people experiencing or at risk of homelessness. Activities include school based presentations, community pop ups, culturally responsive engagement events, youth centered informational materials, and partnerships with local education, justice, and social service agencies. The goal is to strengthen early connection to crisis services, improve community awareness of 988, and reduce barriers to immediate help seeking for vulnerable youth and their caregivers.

2. **The 988 Crisis Hotline: Kern BHP's 988 Crisis Hotline is a uniquely integrated and essential component of the county's 24/7 crisis continuum. Unlike many counties whose 988 operations function as standalone suicide prevention hotline, Kern's 988 team is fully integrated into the county's crisis continuum, allowing crisis counselors to access treatment records, coordinate directly with existing providers, schedule follow up appointments, and initiate Mobile Crisis Response when appropriate. This integrated model ensures timely access to services, prevents crises from escalating, and delivers proactive engagement for individuals, including youth and other vulnerable populations at the earliest point of need. The BHSA Early Intervention funds supplement the 988 state's funds which are essential in sustaining Kern's comprehensive 24/7 crisis response to ensure continuity, coordination, and early connection to treatment.988 Hotline: To maintain a quick and accessible pathway for individuals to receive acute behavioral health care when needed through timely interventions, de-escalation, and connection to additional resources.**

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2: **No**
    a. Additional priority name [narrative box]: **N/A**
    b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**16,493**
FY 2027 – 2028	**17,751**
FY 2028 – 2029	**19,219**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Data reflects the projected growth pattern for the next three fiscal years based on the average increase over the last three fiscal years. These projections do not account for an increase in advertising and outreach in the upcoming years and are based on our historical data.

Early Intervention (EI) Programs #3

1. Program or service name: **The Center for Sexuality and Gender Diversity**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:

   ☒ **Outreach**

   ☒ **Access and Linkage: Screenings**

   ☐ Access and Linkage: Assessments

   ☐ Access and Linkage: Referrals

   ☐ Access and Linkage: Other

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

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

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

   ☒ **Treatment Services and Supports: Other: Culturally responsive, trauma-informed outreach, engagement, navigation, and support services.**

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

   3a. Please provide the name of the EBPs and CDEPs that apply:

   - **Culture as Treatment**
   - **Reducing Isolation through Support Empowerment (RISE)**

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

   The Center for Sexuality and Gender Diversity introduced the CDEP Reducing Isolation through Support and Empowerment (RISE) program. Using community feedback as a guide, The Center has instituted the following components: 1) one on one (1:1) advocacy services, 2) a series of seven-week support workshops, 3) provision of cultural competency training to outside agencies, 4) connecting individuals with existing affirming and non-judgmental medical and mental health providers, and 5) supporting LGBTQ individuals with educational and social connections through Center events and activities. The purpose of the program is to offer prevention and early intervention techniques, teach healthy coping skills, increase support through groups and 1:1 interventions, and decrease negative responses to environmental stressors.

   The Center is an easy access hub providing safe, supportive spaces and services to the Gay, Lesbian, Bisexual and Transgender, Queer/Questioning (LGBTQ+) community, and serving as a bridge to the greater community in Kern County. (from https://cultureishealth.org/implementation-pilot-projects-ipp/lgbtq/the-center-forsexuality-and-gender-diversity/)

   By providing health and wellness services that nurture, access to mental health services that heal, community education that enlightens and advocacy that strengthens, The Center aims to ensure 2SLGBTQIA+ persons in Kern County have the opportunity to lead healthy, fulfilled, and respected lives. (from https://www.thecenterbak.org/the-center.html)

   Prioritizing the well-being and safety of our community, staff, and volunteers is paramount. The Center advocates for environments that are physically safe and promote mental and emotional health in spaces where individuals can thrive, feel secure, and are supported in their journey towards healing and resilience. (from https://www.thecenterbak.org/thecenter.html)

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

   a. Additional priority name [narrative box]: **N/A**

   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**197**
FY 2027 – 2028	**212**
FY 2028 – 2029	**227**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projections were based on unduplicated individuals served in FY 2022-2023 through 2024-2025 as reported by The Center while taking into account the population of Kern County and the hours of operation and/or accessibility of The Center by members of the community.

Early Intervention (EI) Programs #4

1. Program or service name: **Consumer Family Learning Center – Clarvida Tehachapi Learning Center**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:

☐ Outreach

☐ Access and Linkage: Screenings

☐ Access and Linkage: Assessments

☒ **Access and Linkage: Referrals**

☒ **Access and Linkage: Other - Peer Support Services**

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

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

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

☐ Treatment Services and Supports: Other

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

   3a. Please provide the name of the EBPs and CDEPs that apply:

   - **The Recovery Model**
   - **Culture as Treatment**

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

   The Clarvida Tehachapi Learning Center provides a welcoming environment for those who have lived experience in behavioral health recovery, either as consumers of behavioral health services, or as family members/loved ones. The goals of the Learning Center include supporting members in identifying their own goals for their lives; empowering members through connectedness and active participation to achieve their goals; and showing by example that people do recover. The Learning Center provides members with social and educational skills building activities that promote wellness, inspire hope, and enrich their lives. It provides virtual and in-person groups, activities and classes, including in Spanish. Many of the staff have lived experience in behavioral health recovery and share their own recovery experiences with members.

   The Learning Center provides groups, activities and classes including but not limited to:

   - **Skills-based groups such as Seeking Safety, DBT, and 12-Step Groups**
   - **Physical activity**
   - **Art for the Soul**
   - **Support groups**
   - **Arts and crafts**
   - **Music**
   - **Field trips**
   - **Health classes**
   - **Movie nights**
   - **NAMI events (e.g., NAMI Walks)**
   - **Outreach to community-based organizations**

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

   a. Additional priority name [narrative box]: **N/A**

   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**

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

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

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

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projections were based on unduplicated individuals served in FY 2022-2023 through 2024-2025 as reported by the Learning Center while taking into account the population of Kern County and the hours of operation and/or accessibility of The Center by members of the community.

Early Intervention (EI) Programs #5

1. Program or service name: **Consumer Family Learning Center – Clarvida Ridgecrest Hope Center**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:

☐ Outreach

☐ Access and Linkage: Screenings

☐ Access and Linkage: Assessments

☐ Access and Linkage: Referrals

☒ **Access and Linkage: Other - Peer Support linkage to services as needed**

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

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

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

☒ **Treatment Services and Supports: Other: Peer support Services**

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

   3a. Please provide the name of the EBPs and CDEPs that apply:

   - **The Recovery Model**
   - **Culture as Treatment**

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

   The Clarvida Ridgecrest Hope Center provides a welcoming environment for those who have lived experience in behavioral health recovery, either as consumers of behavioral health services, or as family members/loved ones. The goals of the Hope Center include supporting members in identifying their own goals for their lives; empowering members through connectedness and active participation to achieve their goals; and showing by example that people do recover. The Hope Center provides members with social and educational skills building activities that promote wellness, inspire hope, and enrich their lives. It provides virtual and in-person groups, activities and classes, including in Spanish. Many of the staff have lived experience in behavioral health recovery and share their own recovery experiences with members.

   The Hope Center provides groups, activities and classes including but not limited to:

   - **Skills-based groups such as Seeking Safety, DBT, and 12-Step Groups**
   - **Physical activity**
   - **Art for the Soul**
   - **Support groups**
   - **Arts and crafts**
   - **Music**
   - **Field trips**
   - **Health classes**
   - **Movie nights**
   - **NAMI events (e.g., NAMI Walks)**
   - **Outreach to community-based organizations**

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

   a. Additional priority name [narrative box]: **N/A**

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**

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

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

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

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
The projected numbers of unduplicated individuals served are based on minimal population growth in the areas served.

Early Intervention (EI) Programs #6

1. Program or service name: **Consumer Family Learning Center (CFLC) – Bakersfield**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:

☐ Outreach

☐ Access and Linkage: Screenings

☐ Access and Linkage: Assessments

☐ Access and Linkage: Referrals

☒ **Access and Linkage: Other - Peer Support linkage to services as needed**

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

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

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

☒ **Treatment Services and Supports: Other: Culturally responsive, trauma informed outreach, engagement, navigation, and support services.**

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

   3a. Please provide the name of the EBPs and CDEPs that apply:

   - **The Recovery Model**
   - **Culture as Treatment**

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

   The Bakersfield CFLC provides a welcoming environment for those who have lived experience in behavioral health recovery, either as consumers of behavioral health services, or as family members/loved ones. The goals of the Center include supporting members in identifying their own goals for their lives; empowering members through connectedness and active participation to achieve their goals; and showing by example that people do recover. The Centers provide members with social and educational skills, building activities that promote wellness, inspire hope, and enrich their lives. The Centers provide virtual and in-person groups, activities and classes, including in Spanish at the CFLC. Many of the staff have lived experience in behavioral health recovery and share their own recovery experiences with members.

   The Center provides groups, activities and classes including but not limited to:

   - **Skills-based groups such as Seeking Safety, DBT, and 12-Step Groups**
   - **Physical activity**
   - **Art for the Soul**
   - **Support groups**
   - **Arts and crafts**
   - **Music**
   - **Field trips**
   - **Health classes**
   - **Movie nights**
   - **NAMI events (e.g., NAMI Walks)**
   - **Outreach to community-based organizations**

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

   a. Additional priority name [narrative box]: **N/A**

   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**

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

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

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

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
The projected numbers of unduplicated individuals served are based on minimal population growth in the areas served.

Early Intervention (EI) Programs #7

1. Program or service name: **Continuum of Care Reform (CCR)**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:

☐ Outreach

☐ Access and Linkage: Screenings

☒ **Access and Linkage: Assessments**

☐ Access and Linkage: Referrals

☐ Access and Linkage: Other - Peer Support linkage to services as needed

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

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

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

☐ Treatment Services and Supports: Other

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

3a. Please provide the name of the EBPs and CDEPs that apply:

- **Trauma Focused Cognitive Behavioral Therapy (TF-CBT)**
- **Eye Movement Desensitization and Reprocessing (EMDR)**
- **Dialectical Behavior Therapy (DBT)**
- **Seeking Safety (SS)**

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

Outcomes of the program include:

- **System support of continuum of care providers specifically STRTP Provider support, tracks and actively participates in both in and out of county CFT meetings and coordination.**
- **The program utilizes validated tools such as the Pediatric Symptom Checklist-35 (PSC-35) and CANS to assess behavioral health needs. These evidence-based assessments guide service recommendations and promote early intervention through trauma-informed, strengths-based practice and ensure the right level of services are provided.**
- **Ensure youth are connected to appropriate mental health, educational, and community-based services that support stabilization and well-being.**
- **Reduce symptoms related to trauma, anxiety, depression, or behavioral challenges through coordinated care planning.**
- **Promote youth voice and family engagement in treatment planning and service decisions.**
- **Increase service linkage efficiency through QI assessments and coordination with providers.**
- **Prevent unnecessary placement disruptions and promote permanency in the least restrictive setting.**
- **Monitor and track progress to ensure alignment with youth's evolving goals for living a meaningful and self-directed life through attending ICC/CTM meetings.**

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

   a. Additional priority name [narrative box]: **N/A**

   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**233**
FY 2027 – 2028	**246**
FY 2028 – 2029	**257**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Since 2020, the Continuum of Care Reform (CCR) program, implemented under the Mental Health Services Act (MHSA), has been guided by the core principle that children should not have to change placements in order to access the services and supports they need. With the transition to Proposition 1 and the Behavioral Health Services Act (BHSA), Kern County will sustain and build upon this framework by continuing to deliver comprehensive, high-acuity services to children and youth across the continuum of care.
Based on historical utilization trends and the average number of individuals served over the past five fiscal years, the Estimated Number of Individuals Served presented in Table 12 reflects a projected annual growth rate of approximately 5 percent for FY 2026–27, FY 2027–28, and FY 2028–29, respectively.

Early Intervention (EI) Programs #8

1. Program or service name: **Foster Care Engagement**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:

☒ **Outreach**

☒ **Access and Linkage: Screenings**

☐ Access and Linkage: Assessments

☐ Access and Linkage: Referrals

☐ Access and Linkage: Other - Peer Support linkage to services as needed

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

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

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

☐ Treatment Services and Supports: Other

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

3a. Please provide the name of the EBPs and CDEPs that apply:

- **Integrated The Core Practice Model (ICPM)**
- **Cognitive Behavioral Therapy (CBT) for Psychosis**
- **Solution-Focused Brief Therapy (SFBT)**

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

The Foster Care Engagement Team utilizes evidence-based practices (EBPs) that are responsive to the unique needs of youth navigating the challenges of foster care. Integrated The Core Practice Model (ICPM) is utilized to ensure cross-system coordination, allowing for a streamlined process in developing integrated plans for youth in the foster care system. As part of this approach, the team provides Intensive Care Coordination (ICC) services to help develop and implement individualized, strength-based plans for youth with complex Behavioral health needs. Motivational Interviewing (MI) approaches are used to enhance engagement by meeting families and youth where they are emotionally and developmentally, supporting their autonomy, and fostering motivation for change, especially during times of transition. Cognitive Behavioral Therapy (CBT) provides a structured, short-term approach that helps youth process trauma, build problem-solving skills, and regain a sense of hope and control. Solution-Focused Brief Therapy (SFBT) is also widely used to support goal setting and build on existing strengths, helping youth and families adapt to new environments while maintaining stability. These interventions are delivered in collaboration with caregivers, social workers, and families, and are tailored to each youth's unique situation.

The Foster Care Engagement Team provides immediate support during this transition by connecting youth to behavioral health services as soon as they enter foster care. Staff collaborate with caregivers, social workers, and families to determine appropriate services and ensure timely access. The program aims to stabilize placements, prevent hospitalizations, and support youth as they adjust to new environments. It also promotes family involvement, strengthens community connections, and offers flexible, individualized care, including crisis services, intensive care coordination, and in-home visits. Treatment goals are developed during the assessment process and reviewed regularly to ensure progress and responsiveness to each youth's evolving needs.

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2: **No**
    a. Additional priority name [narrative box]: **N/A**
    b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**752**
FY 2027 – 2028	**790**
FY 2028 – 2029	**830**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Utilized FY 24/25 unduplicated data which included 596 individuals served Children (0-15) and 120 individuals served TAY (16-25); and added 5% increase to each fiscal year listed for the projected numbers.

Early Intervention (EI) Programs #9

1. Program or service name: **Justice Involved Future Focused Team**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:
    ☐ Outreach
    ☐ Access and Linkage: Screenings
    ☒ **Access and Linkage: Assessments**
    ☒ **Access and Linkage: Referrals**
    ☐ Access and Linkage: Other - Peer Support linkage to services as needed
    ☐ Treatment Services and Supports: Services to address first episode psychosis (FEP)

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

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

☒ **Treatment Services and Supports: Other- Services to address justice involved youth to reduce recidivism rates**

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

   3a. Please provide the name of the EBPs and CDEPs that apply:

   - **Motivational Enhancement Therapy (MET) Motivational Interviewing**
   - **Solution-Focused Brief Therapy (SFBT)**

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

   The Justice Involved Future Focused Team is designed to engage those youth and families who have been involved in the juvenile justice system, with a dedicated focus on breaking through the stigma often associated with both justice involvement and behavioral health challenges. This is accomplished by providing culturally sensitive outreach and fostering a supportive, nonjudgemental environment.

   The Justice Involved Future Focused Team emphasizes early engagement and treatment to increase participation in behavioral health services and to reduce recidivism rates. The team works closely with youth and their families to help them understand the behavioral health system and provides support in navigating and connecting with their geographic provider.

   Engagement begins pre-release, with a focus on developing individualized return-to-community plans. The Justice Involved Future Focused Team ensures that youth and families are equipped with necessary resources and supports to facilitate service linkage, promote stability, and reduce recidivism rates.

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

   a. Additional priority name [narrative box]: **N/A**

b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**900**
FY 2027 – 2028	**945**
FY 2028 – 2029	**992**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projections for upcoming years were developed using service data from June to September 2025 as a representative baseline, projecting a 5% increase each year.

Early Intervention (EI) Programs #10

1. Program or service name: **Recovery Station**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:

☐ Outreach

☐ Access and Linkage: Screenings

☐ Access and Linkage: Assessments

☐ Access and Linkage: Referrals

☐ Access and Linkage: Other - Peer Support linkage to services as needed

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

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

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

☒ **Treatment Services and Supports: Other- The Recovery Station is staffed by clinicians, substance use specialists, and peers with lived experience who collaboratively facilitate access to and linkage with appropriate mental health and substance use treatment services.**

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

   The Recovery Station in Bakersfield operates 24 hours per day, seven days per week for adults who are currently experiencing a substance use or alcohol-related crisis. Individuals may also have a co-occurring behavioral health disorder. Individuals served may be referred to or transported by law enforcement and other designated community partners. Services are voluntary and provided in a safe, sober environment for individuals to reduce intoxication. The Recovery Station is staffed by clinicians, substance use specialists, and peers with lived experience who seek to provide guests with access and linkage to appropriate mental health and substance use care. Individuals receive substance use screenings, brief clinical interventions, obtain resources, and are connected to ongoing services in the community. The typical length of stay is approximately four to ten hours.

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2: **No**
   a. Additional priority name [narrative box]: **N/A**
   b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**3,608**
FY 2027 – 2028	**4,108**
FY 2028 – 2029	**4,608**

a. Please describe any data or assumptions the county used to project the number of individuals served through EI programs:
Projections were derived from historical service data, with adjustments reflecting percentage increases in the total number of clients served.

Early Intervention (EI) Programs #11

1. Program or service name: **Crisis Walk in Clinic (CWIC)**
2. Please select which of the three EI components are included as part of the program or service [multi-select list]:

☐ Outreach

☒ **Access and Linkage: Screenings**

☒ **Access and Linkage: Assessments**

☒ **Access and Linkage: Referrals**

☐ Access and Linkage: Other - Peer Support linkage to services as needed

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

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

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

☐ Treatment Services and Supports: Other

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

3a. Please provide the name of the EBPs and CDEPs that apply:

- **Dialectical Behavioral Therapy (DBT)**
- **Cognitive Behavioral Therapy (CBT)**
- **Applied Suicide Intervention Skills Training (ASIST)**

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

The CWIC operates 24 hours a day, seven days per week for adults who are currently experiencing a behavioral health crisis. Individuals receive

immediate crisis intervention and support, access to urgent follow up care (outpatient services, medication management, SUD treatment) and appropriate referrals and resources based on individual's current needs to ensure seamless care across the behavioral health system.

The Crisis Walk-in Clinic (CWIC) is a core Early Intervention program designed to reduce the duration of untreated behavioral health conditions by providing immediate, clinically informed care at the earliest point of need. Operating 24/7, the CWIC delivers rapid crisis intervention for adults experiencing behavioral health crises and ensures timely access to follow-up treatment, including outpatient services, medication management, substance use treatment, and other urgent supports. Embedded within the Kern County BHP continuum of care, the CWIC offers comprehensive screening, assessment, stabilization, and coordinated referrals tailored to each individual's unique needs. Intended outcomes for the program include providing immediate crisis support, ensuring urgent linkage to appropriate services, facilitating seamless care transitions across the behavioral health system, and preventing crises from escalating into more severe or disabling conditions, all fundamental goals of Early Intervention.

5. Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2: **No**
    a. Additional priority name [narrative box]: **N/A**
    b. Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program: **N/A**
6. Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY) in the table below

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**6,324**
FY 2027 – 2028	**6,400**
FY 2028 – 2029	**6,600**

    a. Please describe any data or assumptions the county used to project the

number of individuals served through EI programs:
The data used was previous fiscal year 2022-2023, 2023-2024, and 2024-2025. From 2022-2025 there was an average increase in 450 clients per year, TAY clients decreased by 3% per year, Adults Increased by 4% per year, and Older Adults decreased >1% per year. Using this information and assuming potential limitations, the calculations assumed an increase of 200 Clients per year, TAY reduction at 2% per year, 3% increase for adults per year, and 1% reduction for Older Adults per year. Children remain unchanged as the population served is 18 and older.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

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

    a. CSC program name: **Early Psychosis Intervention on Plus (EPI Plus)**
    b. CSC program description: **The Early Psychosis Program (EPP) provides specialty care for individuals and their families who are experiencing their first episode of psychotic symptoms, as well as those who may be showing early warnings signs of these symptoms. The program utilizes Gold-Standard clinical and functional assessment measures to identify at-risk individuals early in their illness and provide comprehensive, evidence-based interventions throughout the client's treatment. EPP employs a family-oriented approach to provide education and support to each client's family network. We strive to provide treatment as early as possible to prevent a decline in functioning that can occur with illness onset. We work to empower individuals and family members to become active participants in their treatment and progress toward their personal, social and occupational goals while being supported by a "team" of individuals, not just a clinician or doctor.**

[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.]

2. Please review the total estimated number of individuals who may be eligible for

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

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

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**199**
Number of Uninsured Individuals	**19**
CSC Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	**26**
Number of Teams Needed to Serve Total Eligible Population	**6**

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

Table 14. Total Number of CSC Practitioners and Teams

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

4. Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)? **Yes**
    a. Please list the other funding source(s): **Medi-Cal**

Outreach and Engagement (O&E)

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 additional program" button.

Outreach and Engagement (O&E) Program #1

1. Program or activity name: **Relational Outreach and Engagement Model (ROEM)**
2. Please describe the program or activity:

   The Kern Relational Outreach and Engagement Model (ROEM) program is a behavioral health outreach program serving individuals experiencing homelessness with mental illness and/or substance use disorders. As an expansion of the Homeless Adult Team, ROEM deploys interdisciplinary field teams to provide outreach, engagement, and treatment services directly in the community.

   Using the Relational Outreach and Engagement Model, to engage and serve individuals. The program prioritizes engagement with individuals who are treatment-resistant or have experienced repeated treatment failures. The program builds trust with vulnerable populations—including youth, adults, and older adults—to connect them with behavioral health care. Outreach units are interdisciplinary and include psychiatric services, mental health and substance use treatment, case management, and safety assessments. ROEM staff work alongside other community outreach partners, including faith-based organizations, healthcare agencies, and other social services.

   ROEM provides Mobile services include, but are not limited to, intake/screening, assessment, case management, individual rehabilitation, behavioral health and substance use counseling, treatment planning (ISSP), psychoeducation, medical triage including refills, intramuscular injections, and Narcan distribution.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**78**
FY 2027 – 2028	**83**
FY 2028 – 2029	**88**

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

Using ROEM's census from FY 2024-2025, the above projections for the future assume continued success in the team's ability to build rapport through engagement and make their presence known as a resource to individuals in the communities. The projections account for a 5% increase each year.

Outreach and Engagement (O&E) Program #2

1. Program or activity name: **Mobile Clinic with Street Psychiatry**
2. Please describe the program or activity:

   Mobile Clinic with Street Psychiatry (MCSP) program is a MHSA Innovation Plan ending on 3/24/2028. For sustainability of the program and the valuable service they provide to the vulnerable population, the MCSP program will continue under BHSA BHSS Other Outreach &Engagement Plan. The Mobile Clinic with Street Psychiatry (MCSP) program is designed to reduce barriers to psychiatric and behavioral health care services faced by the community we serve. By deploying both a Motor home unit and a sprinter van outfitted as Mobile clinics, this initiative ensures critical services are readily available when and where our unsheltered clients need them most. MCSP provides psychiatric support and medical services to individuals facing homelessness. Based on their needs, MCSP offers a variety of service modalities designed to provide mental health support for clients working to improve their social functioning and coping abilities.

   Mobile services include, but are not limited to, street outreach, intake/screening, assessment, case management, individual rehabilitation, behavioral health and substance use counseling, treatment planning (ISSP), psychoeducation, medical triage including refills, intramuscular injections, and Narcan distribution. Kern County BHP offers comprehensive, coordinated, and defined services that vary in level of intensity and address a variety of needs, including but not limited to situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, and/or addictions.

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	**148**
FY 2027 – 2028	**157**
FY 2028 – 2029	**166**

4. Please describe any data or assumptions the county used to project the number of individuals served through O&E programs:
   The projections above are based on the individuals served in FY 2024-2025, where 6 TAY, 108 Adult, and 25 Older Adults were served by ROEM. The program is expecting to expand it services and continue to successfully engage and build rapport with individuals in the community as their presence becomes more established in certain communities. Each year, the team is projected to reach/engage approximately 5% more individuals than the previous year, which is reflected on the table.

County Workforce, Education, and Training (WET)

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 additional program" button.

County WET Program #1

1. Program or activity name: **Professional Development and Clinical Internship Program**
2. Please select which of the following categories the activity falls under [single-select dropdown]
   - ☐ Continuing Education
   - ☐ Internship and Apprenticeship Programs

☐ Loan Repayment
☐ Professional Licensing and/or Certification Testing and Fees
☐ Retention Incentives and Stipends
☒ **Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program**
☐ Workforce Recruitment, Development, Training, and Retention
☐ Other [narrative box]

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

Kern County BHP's Professional Development and Clinical Internship Program include targeted strategies to address disparities in the behavioral health workforce, with a focus on increasing racial, ethnic, linguistic, and geographic diversity.

To strengthen workforce diversity, the BHP prioritizes recruitment and training of interns and residents who reflect the communities served, particularly individuals from underrepresented racial and ethnic backgrounds and those with bilingual (e.g., Spanish-speaking) capabilities. Partnerships have been established with regional universities, including programs serving first-generation and historically underrepresented students, to create structured internship pipelines into public behavioral health careers.

To address geographic disparities, the program prepares interns to serve clients throughout the count, including rural and underserved regions, by providing training on the unique behavioral health challenges affecting these areas. Interns learn about service barriers, cultural considerations, social determinants of health, and treatment engagement needs specific to geographically isolated communities. While interns are primarily placed in centralized clinical settings, the program strengthens the future workforce pipeline by equipping graduates with the competencies needed to work effectively countywide. Many program graduates go on to serve in public-sector positions within Kern County BHP, supporting workforce availability across all regions of the county.

The program also reduces structural barriers to workforce entry by offering paid internship opportunities where feasible, flexible scheduling for working students, and coordination with academic institutions to align practicum requirements with Kern County BHP's service needs. These efforts are intended to increase access for individuals who may otherwise face financial or logistical

barriers to entering the behavioral health field.

Program effectiveness is monitored through workforce and internship data, including demographic characteristics of trainees, placement locations, and post-internship employment outcomes within the County system. These data are used to assess progress toward increasing workforce diversity and to inform continuous quality improvement efforts.

Through these strategies, the Kern County BHP is advancing a more representative, culturally responsive workforce aligned with community needs and state policy expectations.

County WET Program #2

1. Program or activity name: **Psychology Internship Program**
2. Please select which of the following categories the activity falls under [single-select dropdown]
   - ☐ Continuing Education
   - ☒ **Internship and Apprenticeship Programs**
   - ☐ Loan Repayment
   - ☐ Professional Licensing and/or Certification Testing and Fees
   - ☐ Retention Incentives and Stipends
   - ☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program
   - ☐ Workforce Recruitment, Development, Training, and Retention
   - ☐ Other [narrative box]

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

   Kern County BHP's Psychology Internship Program implements targeted strategies to reduce disparities in the behavioral health workforce by expanding racial, ethnic, linguistic, and geographic diversity among doctoral level clinicians. Recruitment efforts intentionally focus on attracting interns from underrepresented racial and ethnic groups, as well as applicants with bilingual and bicultural competencies, particularly Spanish-speaking candidates who reflect the communities served in Kern County.

   To address geographic disparities, the program provides services to individuals who reside in rural and underserved areas of the county. The County further supports workforce development and continuity by offering permanent

positions to select highly qualified graduates. The program has successfully retained many former interns as postdoctoral and clinical staff, strengthening long term workforce stability.

The internship curriculum provides structured training in culturally responsive care, health equity, and evidence based practices for working with diverse populations. Supervision emphasizes culturally and linguistically appropriate services (CLAS) and builds competencies for serving priority groups, including Latino communities, LGBTQ+ individuals, and children and families involved with public systems such as child welfare and juvenile justice.

Program effectiveness is monitored through demographic tracking of applicants and interns, completion rates, and post internship employment within the Kern County BHP or other public sector agencies. This data informs ongoing recruitment strategies and guides continuous improvement in advancing workforce diversity.

Through these integrated efforts, the Psychology Internship Program actively contributes to a more representative, culturally competent, and geographically accessible behavioral health workforce that aligns with both community needs and state policy priorities.

County WET Program #3

1. Program or activity name: **Workforce Enhancement and Wellness Initiative**
2. Please select which of the following categories the activity falls under [single-select dropdown]
   - ☐ Continuing Education
   - ☐ Internship and Apprenticeship Programs
   - ☐ Loan Repayment
   - ☐ Professional Licensing and/or Certification Testing and Fees
   - ☐ Retention Incentives and Stipends
   - ☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program
   - ☐ Workforce Recruitment, Development, Training, and Retention
   - ☒ **Other: A Kern BHRS program designed to improve staff health, wellness, and engagement through activities that promote well-being and workforce stability.**

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

Kern County BHP's Workforce Enhancement & Wellness Initiative supports efforts to reduce disparities within the Behavioral Health workforce by strengthening staff wellbeing, increasing retention, and promoting equitable access to wellness resources across all worksites. While the initiative is not a recruitment pipeline, it plays a critical role in reducing workforce inequities by ensuring that all employees, regardless of racial, ethnic, or linguistic background, have access to consistent, supportive, and health promoting resources.

The initiative provides wellness equipment, healthy food options, meditation resources, and structured self-care activities at multiple Kern County BHP locations. By ensuring access to these resources across all sites, the department promotes fairness and equity in the workplace and helps eliminate disparities in staff support. This consistent availability of wellness opportunities helps retain a diverse workforce by fostering a supportive environment where staff feel valued, healthy, and able to maintain wellbeing while performing demanding behavioral health roles.

Kern County BHP is also a Blue Zone Certified department, which strengthens the initiative by embedding evidence based practices that promote longevity, wellbeing, connection, and workplace satisfaction. Through these strategies, the Workforce Enhancement & Wellness Initiative contributes to reducing disparities by improving workplace conditions, supporting staff from all backgrounds, and promoting long term retention within the behavioral health system. This approach strengthens Kern County BHP's capacity to maintain a resilient, diverse, and effective workforce capable of meeting the needs of the community.

County WET Program #4

1. Program or activity name: **Workforce Training Enhancement Program**
2. Please select which of the following categories the activity falls under [single-select dropdown]
   - ☒ **Continuing Education**
   - ☐ Internship and Apprenticeship Programs
   - ☐ Loan Repayment
   - ☐ Professional Licensing and/or Certification Testing and Fees
   - ☐ Retention Incentives and Stipends
   - ☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency

program
☐ Workforce Recruitment, Development, Training, and Retention
☐ Other [narrative box]

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

Kern County BHP's Workforce Training Enhancement Program (Continuing Education) incorporates targeted strategies to address disparities in the behavioral health workforce by strengthening the skills, cultural responsiveness, and retention of a diverse workforce.

The program prioritizes continuing education opportunities that enhance culturally and linguistically appropriate services (CLAS), with required and elective trainings focused on health equity, implicit bias, and effective engagement with diverse populations, including Latino communities, LGBTQ+ individuals, and individuals involved in public systems such as child welfare and justice settings. These trainings are designed to improve workforce competency and support equitable service delivery across populations disproportionately impacted by behavioral health disparities.

To support racial and ethnic diversity, the program ensures equitable access to continuing education for all staff, including those in entry-level and paraprofessional roles who may face barriers to professional advancement. Training opportunities are structured to support career progression (e.g., licensure preparation, clinical skill development), thereby strengthening internal workforce pipelines and promoting upward mobility among staff from underrepresented backgrounds.

The program also addresses linguistic disparities by offering training opportunities that support bilingual staff in developing advanced clinical and professional skills, including specialized training for providing services in Spanish and other threshold languages. These efforts enhance the County's capacity to deliver services in a culturally and linguistically responsive manner.

To reduce geographic disparities, continuing education is delivered through flexible modalities, including virtual and hybrid formats, ensuring that staff in rural and underserved areas have equal access to training and professional development opportunities. This approach helps mitigate barriers related to travel, time, and resource constraints, while supporting workforce retention in outlying regions.

Additionally, the program aligns training investments with workforce data,

including staff demographics, service delivery needs, and identified gaps in culturally responsive care. Data are used to prioritize training topics, allocate resources, and evaluate participation across different staff groups and locations to ensure equitable access and impact.

Through these strategies, the Workforce Training Enhancement Program strengthens a more diverse, culturally competent, and geographically distributed workforce, while supporting career advancement and retention in alignment with state policy expectations and local community needs.

County WET Program #5

1. Program or activity name: **Cultural Competency Enhancement Program**
2. Please select which of the following categories the activity falls under [single-select dropdown]
   - ☐ Continuing Education
   - ☐ Internship and Apprenticeship Programs
   - ☐ Loan Repayment
   - ☐ Professional Licensing and/or Certification Testing and Fees
   - ☐ Retention Incentives and Stipends
   - ☐ Staff time spent supervising interns and/or residents who are providing direct county behavioral health services through an internship or residency program
   - ☐ Workforce Recruitment, Development, Training, and Retention
   - ☒ **Other: The Cultural Competency Enhancement Program addresses disparities in the Behavioral Health workforce. The program oversees (CCRC) Cultural Competence Resource Committee, providing representatives and key stakeholders input on the department's efforts to address health disparities, workforce training, and cultural competence efforts.**

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

   The Cultural Competency Enhancement Program is a BHP system-level workforce and organizational development initiative that strengthens culturally and linguistically and promotes equity throughout Kern County. Central to this work is the Cultural Competence Resource Committee (CCRC), which brings together staff, leadership, and community-informed perspectives to guide policy, training priorities, and service improvements related to cultural responsiveness and health equity.

   The program addresses behavioral health workforce disparities by advancing

racial, ethnic, and linguistic diversity and enhancing culturally responsive practice across the organization. The CCRC reviews workforce and service delivery data to identify disparities in representation, access, and outcomes, using these findings to recommend targeted recruitment, retention, and professional development strategies. The committee also advises on equitable hiring and workforce development practices that strengthen representation of staff reflecting the communities served.

To support diversity, the program collaborates with workforce development and training efforts to align with equity goals, including outreach to underrepresented populations and integration of equity-focused competencies into staff training. Linguistic capacity is enhanced through initiatives that support bilingual staff, recognize bilingual skills, and embed CLAS standards into supervision and practice expectations.

Culturally responsive practice is further strengthened through ongoing training in cultural competence and humility, focusing on reducing implicit bias, improving cross cultural communication, and supporting engagement with diverse populations, including Latino communities, LGBTQ+ individuals, and others historically underserved by behavioral health systems.

The program also incorporates community and stakeholder input into workforce planning, ensuring strategies remain responsive to community needs and support meaningful disparity reduction. Continuous monitoring of workforce demographics, training participation, and equity-related outcomes guides improvement efforts and reinforces Kern County BHP's commitment to building a representative, culturally competent workforce.

Capital Facilities and Technological Needs (CFTN)

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 additional project" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5.

CFTN Program #1

1. Project name: **Kern PEC Expansion (BHCIP Grant application match)**
2. Please select the type of project [single-select]:
   - ☒ **Capital facilities project**
   - ☐ Technological needs project

   a. If capital facilities project, please indicate which of the following

categories the project falls under [single-select]:

- ☐ Acquiring, renovating, or constructing buildings that are or will be county-owned. *The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.*
- ☐ Acquiring facilities not secured to a foundation that is permanently affixed to the ground
- ☐ Establishing a capitalized repair or replacement reserve
- ☒ **Meeting match requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award**
- ☐ Renovating or constructing buildings that are privately owned

3. Please describe the project:

BHCIP Application

Kern County BHP submitted a Behavioral Health Continuum Infrastructure Program (BHCIP) application in Round 2 of the BHCIP Bond project and is awaiting award determination from the Department of Health Care Services (DHCS). The Plan intends to use CFTN dollars to meet the required project match.

Project Location

The Kern Psychiatric Emergency Center (PEC) project will be located at the Mary K. Shell Building, 2151 College Avenue, Bakersfield, California. The building is owned by Kern County and serves as the headquarters for Kern County BHP's Crisis Services. It is a single-story concrete block structure with four wings. Rehabilitation will be limited to the C wing, allowing other crisis operations to continue uninterrupted. The site is adjacent to Kern Medical (KM) Hospital and is publicly accessible.

Rehabilitation Details

The project includes rehabilitation of approximately 2,200 square feet to create 12 additional treatment slots, two private rooms, an updated medication room, an additional nursing station, a restroom, and a new entry and intake area. The layout will include a day room and private spaces for individuals requiring a quieter environment. The design emphasizes a recovery-oriented setting with natural light, calming colors, and open space to support engagement and treatment.

Onsite Improvements

- **Interior reconfiguration, including demolition of non-load-bearing walls and installation of new partitions, finishes, and ceilings**
- **Mechanical, electrical, and plumbing upgrades, including HVAC modifications and plumbing for a new restroom**
- **ADA accessibility improvements, including entrances, restrooms, ramps, and signage**
- **Fire and life-safety upgrades, including sprinkler, alarm, and emergency lighting modifications**
- **Interior finish upgrades with durable, service-appropriate flooring, casework, and counters**

Offsite Improvements

- **Public right-of-way improvements for ADA parking or drop-off areas**
- **Limited construction staging due to site constraints**

CFTN Program #2

1. Project name: **Ridgecrest CSU improvements**
2. Please select the type of project [single-select]:
   - ☒ **Capital facilities project**
   - ☐ Technological needs project

   a. If capital facilities project, please indicate which of the following categories the project falls under [single-select]:
      - ☒ **Acquiring, renovating, or constructing buildings that are or will be county-owned. *The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.***
      - ☐ Acquiring facilities not secured to a foundation that is permanently affixed to the ground
      - ☐ Establishing a capitalized repair or replacement reserve
      - ☐ Meeting match requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award
      - ☐ Renovating or constructing buildings that are privately owned

   b. Please indicate if the project involves leasing or renting to own a building: **No**

3. Please describe the project:

Project Overview

The Kern County BHP Capital Facilities project for the Ridgecrest Crisis Stabilization Unit (CSU) encompasses repair and restoration efforts for a county-owned building. This facility hosts the adult and youth crisis operations for Eastern Kern County and is located at 1141 Chelsea Street, Ridgecrest, CA.

Project Focus

The primary focus of the project is to replace the existing roof covering, spanning 3,493 square feet, due to wear, tear, and storm damage. Despite several years of pursuing insurance claims to cover some of the repair costs, most of the repairs are not covered.

Scope of Work:

- **The scope of work includes the following tasks:**
- **Remove and dispose of the existing roof membrane.**
- **Inspect, remove, dispose of, and repair any damaged roof flashing.**
- **Inspect, remove, dispose of, and repair any damaged decking.**
- **Inspect, remove, dispose of, and repair any damaged parapet frames and roof membrane.**

- **Install a new non-reinforced white EPDM membrane.**
- **Weather-proof all roof intrusions.**
- **Weather-proof all HVAC unit roof curbing and mechanical roof connections.**
- **Weather-proof all roof jacks.**

CFTN Program #3

1. Project name: **Youth CSU FRC BHCIP Project construction enhancements**
2. Please select the type of project [single-select]:
   - ☒ **Capital facilities project**
   - ☐ Technological needs project

   a. If capital facilities project, please indicate which of the following categories the project falls under [single-select]:
      - ☒ **Acquiring, renovating, or constructing buildings that are or will be county-owned. *The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.***
      - ☐ Acquiring facilities not secured to a foundation that is permanently affixed to the ground
      - ☐ Establishing a capitalized repair or replacement reserve
      - ☐ Meeting match requirements for Behavioral Health Continuum Infrastructure Program (Bond BHCIP) award
      - ☐ Renovating or constructing buildings that are privately owned

   b. Please indicate if the project involves leasing or renting to own a building: **No**

3. Please describe the project:

Kern County BHP was awarded a Behavioral Health Continuum Infrastructure Program (BHCIP) grant in Round 5 to support construction of a new Youth Crisis Stabilization Unit (CSU) and Family Resource Center (FRC). Together, these facilities will operate as a mental health urgent care center for youth in Kern County.

<u>Construction Enhancements Using CFTN Funds</u>

CFTN funds will support construction enhancements that improve safety, continuity of operations, and the therapeutic environment. Planned upgrades include specialty secure artwork; a large emergency generator with a masonry security wall; an on-site security camera and access control system; roof modifications to increase ceiling height in treatment areas; upgraded ceiling panels for improved acoustics; artificial turf in outdoor courtyards; an additional pony wall in the CSU to enhance privacy near restrooms; and wall protection in designated utility rooms. The total CFTN funding request is $554,506.

<u>Building Specifications</u>

The project includes a 16,500-square-foot mixed-use building on Workman Street with a secured Youth CSU and an outpatient FRC with clinical services. The building

will include a public front lobby and a secure rear entrance for after-hours access by law enforcement and the Mobile Evaluation Team. All CSU exits will be locked, as the site will operate as a 5150-designated treatment facility.

Youth Crisis Stabilization Unit (CSU)

The Youth CSU will serve voluntary and involuntary youth experiencing behavioral health crises and will operate 24/7, providing immediate, in-person crisis intervention and stabilization for stays of less than 23 hours.

Family Resource Center (FRC)

The FRC will provide a welcoming, family-centered setting offering trauma-informed and culturally responsive services designed to address behavioral health crises and reduce future risk for youth and families.

CFTN Program #4

4. Project name: **Finance Technology Enhancement**
5. Please select the type of project [single-select]:
   - ☐ Capital facilities project
   - ☒ **Technological needs project**

   a. If Technological Needs Project, please select the focus area(s) of the project:
      - ☐ Data exchange and interoperability
      - ☐ Data security and privacy
      - ☐ Data warehouse
      - ☐ Electronic health record system
      - ☐ Individual/family access to computing resources
      - ☐ Imaging/paper conversion
      - ☐ Monitoring
      - ☐ Online information resources for individuals/families
      - ☐ Personal health record system
      - ☐ Resources to support web content and mobile app accessibility
      - ☐ System maintenance costs
      - ☐ Telemedicine
      - ☒ **Other: Finance software needs to update and expand due to BHSA Fiscal reporting requirements.**
6. Please describe the project:

California's Proposition 1 and Senate Bill 326 added fiscal reporting requirements for the County BHP Integrated Plan and changed the format of the fiscal reporting now called the BHOATR. Due to the new requirements and changes to The County BHPs existing fiscal reporting systems, Allocap, the plan's cost allocation software managed by Public Consulting Group, must be updated. The County BHP will update and expand the fiscal management software and programming from Public Consulting Group to comply with new BHSA fiscal reporting requirements.

Full Service Partnership Program

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

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

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

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**3,959**
Number of Uninsured Individuals	**499**
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	**1,698**

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

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

Table 17. Estimated Number of Individuals Eligible for ACT

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**593**
Number of Uninsured Individuals	**75**

Table 18. Estimated Number of Individuals Eligible for FACT

FACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**297**
Number of Uninsured Individuals	**37**

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

ACT and FACT Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**110**
Number of Teams Needed to Serve Total Eligible Population	**11**

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

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**64**	**80**	**100**
Total Number of Teams	**8**	**10**	**10**

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

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

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

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**3,069**
Number of Uninsured Individuals	**387**

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**140**
Number of Teams Needed to Serve Total Eligible Population	**28**

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

Table 22. Total Number of FSP ICM Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**50**	**60**	**70**
Total Number of Teams	**3**	**5**	**5**

High Fidelity Wraparound (HFW) Eligible Population

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

Note: HFW guidance is forthcoming; DHCS will provide these estimates in accordance with HFW guidance

Table 23. Estimated Number of Individuals Eligible for HFW and Estimated Number of Teams Needed to Serve Total Eligible Population

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**1973**
Number of Uninsured Individuals	**222**

HFW Practitioners and Teams Needed	*Estimates*
Number of Practitioners Needed to Serve Total Eligible Population	**740**
Number of Teams Needed to Serve Total Eligible Population	**15**

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

Table 24. Total Number of HFW Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**14**	**28**	**28**
Total Number of Teams	**2**	**4**	**4**

Individual Placement and Support (IPS) Eligible Population

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

Table 25. Estimated Number of Individuals Eligible for IPS and Estimated Number of Teams Needed to Serve Total Eligible Population

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	**5,726**

Number of Uninsured Individuals	**731**

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	**405**
Number of Teams Needed to Serve Total Eligible Population	**162**

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

Table 26. Total Number of IPS Practitioners and Teams

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	**10**	**14**	**14**
Total Number of Teams	**5**	**7**	**7**

Full Service Partnership (FSP) Program Overview

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

1. Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP? **Yes**
    a. Please describe how the estimated practitioners will provide more than one EBP:

    During FY 2027–2028, Kern County BHP will establish a structured process to expand Full Service Partnership (FSP) programs in both Eastern and Western Kern County. In urban areas of Kern County, the intent is for evidence-based practices (EBPs) to be delivered by practitioners on an individual, program-specific basis. In contrast, rural areas of Kern County have a significantly smaller number of beneficiaries eligible for FSP services.

To ensure equitable access to EBPs across all regions, practitioners serving rural areas will deliver multiple EBPs on designated days that align with beneficiary needs and service demand. EBPs will be offered on alternating days or through scheduled service blocks to ensure consistent availability, maintain fidelity to each model, and maximize access to services for rural populations.

During FY 2027–2028, Kern County BHP intends to implement multifaceted programs in Eastern and Western Kern County. Each rural program will integrate the following evidence-based practices: Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), Individual Placement and Support (IPS), and High-Fidelity Wraparound (HFW).

Given the relatively small number of beneficiaries in these regions who are expected to utilize these services, the Plan will evaluate the most efficient and sustainable service delivery models to ensure program effectiveness, resource optimization, and continued adherence to EBP fidelity standards.

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

A Whole Person, Trauma-Informed Approach:

Kern County FSPs utilize a whole person, trauma-informed approach that recognizes the widespread impact of trauma on an individual's behavioral health. Providing a safe environment by implementing principles such as personal choice and empowerment, and by moving away from judgment-based language. This approach integrates knowledge about trauma into policies and practices to support recovery and prevent re-traumatization.

Key Principles and Practices:

a. **Recognize the prevalence of trauma: Understand that many people have experienced trauma that affects their health and behavior.**
b. **Ensure staff are trained in trauma informed care.**
c. **Identify the signs: Be aware of the signs and symptoms of trauma in individuals and staff.**
d. **Prioritize safety: Create a physical and emotional environment where people feel safe and can build trust.**

e. **Empowerment and choice: Give individuals more control over their care and decisions, recognizing their inherent strengths and resilience.**
f. **Prevent re-traumatization: Actively work to avoid practices that may trigger past traumatic experiences.**
g. **Address the whole person: Consider the non-medical factors influencing a person's health, such as their life experiences, culture, and history.**
h. **Include (with consent) the individual's natural support system and identified family.**

Benefits of This Approach:

a. **Improved patient engagement: Individuals are more likely to engage with services when they feel safe and respected.**
b. **Better health outcomes: This approach leads to improved health outcomes and a greater sense of well-being.**
c. **Stronger relationships: It helps build trusting, collaborative relationships between providers and those they are helping.**

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

Kern County BHP's FSPs are committed to reducing healthcare disparities among our FSP clients through comprehensive strategies that include outreach and engagement, workforce development, policy reforms, and data-driven initiatives. These efforts aim to ensure timely access to FSP level services, provide field-based outreach services, offer peer support, integrate substance use disorder services, conduct cultural competency training, and utilize data to address specific behavioral health needs effectively.

4. Select which goals the county is hoping to support based on the county's allocation of FSP funding [multi-select dropdown; logic: statewide priority goals and county goals selected from the Plans, Goals, and Objective section]:

☒ **Access to care**
☒ **Homelessness**
☒ **Institutionalization**
☒ **Justice involvement**
☐ Removal of children from home
☐ Untreated behavioral health conditions
☐ Care experience
☐ Engagement in work

☒ **Overdoses**
☐ Prevention of co-occurring physical health conditions
☐ Quality of life
☐ Social connection
☐ Suicides

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

   Kern County BHP strategically outreaches to clients and potential clients strategically using a client-centered, wholistic approach incorporating stage-matched interventions to gain engagement. These are field-based services/interventions that attempt to involve family/supports if allowed by the client. Administratively, data is tracked to monitor ongoing attempts to engage are occurring consistently.

   a. (Optional) 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: **N/A**

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

   Kern County BHP currently utilizes an internally developed set of criteria and a referral tool to identify individuals who may benefit from ACT services. This tool considers several clinical and functional indicators, including:

   a. A primary diagnosis of schizophrenia or another psychotic disorder
   b. Severity of symptoms and level of functional impairment
   c. Difficulty engaging in or benefiting from traditional outpatient services
   d. Frequent utilization of crisis services and/or inpatient psychiatric hospitalization
   e. Referrals to ACT may be initiated by any program within the system. Upon receipt, the ACT team supervisor reviews the referral along with the client's health record to determine eligibility and appropriateness for admission.

   To enhance consistency and clinical decision-making, Kern County BHP is

currently exploring the adoption of a standardized assessment tool, such as the Level of Care Utilization System (LOCUS). Implementing LOCUS would provide a structured, evidence-based framework to support more objective identification of individuals whose needs align with the ACT model of care.

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

   Yes. Kern County BHP - FSP programs will include the following:

   a. Primary substance use disorder (SUD) FSPs: **Yes**

      i. If Y, please describe:

         All Kern County BHP FSPs will be able to provide SUD services and referrals to community level SUD services if needed. The county will prioritize individuals who are at high risk of institutionalization, homelessness, or justice-involvement, consistent with FSP eligibility criteria, with a primary diagnosis of substance use disorder, including those with co-occurring mental health conditions. The BHP will also offer intensive wraparound services such as case management, housing support, medication-assisted treatment (MAT), and peer recovery services.

         As part of SB 43 and BHSA, Kern County FSP providers will be equipped to:

         a. Conduct SUD screenings and assessments as part of the intake and ongoing care planning process.

         b. Deliver integrated behavioral health services, including relapse prevention, harm reduction, and recovery planning.

         c. Refer and coordinate with community-based SUD providers for residential treatment, detoxification, outpatient care, and specialty services when needed.

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

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

         Kern County BHP FSPs provide outreach activities including street outreach and weekly targeted outreach events at local

parks in the community to build rapport with individuals who experience homelessness or are at risk for homelessness with behavioral health needs. The weekly outreach events rotate throughout the community park areas and additional street outreach occurs on regular basis in other field-based settings including encampments and rural areas. Clinicians and psychiatric medical staff determine the behavioral health needs of individuals through rapport building, engagement, and targeted outreach services to enroll clients into an FSP team. FSP teams have a significant presence in carceral settings, both for adults and juveniles that are not currently open to mental health services before incarceration but would benefit from services once released. The purpose of these outreach services is to build a therapeutic rapport with these individuals while incarcerated, to determine individuals needs once released and ensure an effective transition plan from incarceration. FSP teams are also active on acute psychiatric units to ensure that individuals that will need FSP level services once discharged are appropriately linked at that time.

c. Other recovery-oriented services: **Yes**

   i. Please describe the other recovery-oriented services of the county's FSP program will include:
   The Plan's FSP teams will be inclusive of peer support services, support for housing stability, and Evidence-Based Practices such as IPS, DBT, Motivational Interviewing, EMDR, CBT-SP, among others.

8. If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams. If no additional FSP services, use "N/A": **N/A**

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

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

   Kern BHRS closely engages with the Kern County Probation Department to provide cross-system coordination for shared youth, offering preventive interventions and intensified services for those meeting FSP criteria. Services are delivered in all Kern detention centers, aiming to prevent the need for

higher levels of care. The SMART Committee, including Kern BHRS, Probation, DHS, and community mental health providers, develops proactive plans to support youth and families transitioning from detention facilities back to the community.

Kern County BHP collaborates with probation to support placement youth, targeting them for Wraparound services as they transition to lower care levels. Regular stepdown meetings identify strategies to leverage resources, facilitating youth return to families or family-like environments. Kern BHRS coordinates care for out-of-county placements, ensuring a strong plan to welcome youth back when they are ready to step down from higher care levels.

Bridges Academy is a specialized school program for youth exiting juvenile justice facilities. Kern BHRS, Kern Probation, and KCSOS collaborate at Bridges Academy to identify and support youth needing intensive services. These include SMHS, psychiatric appointments, substance use services, and frequent partner consultations. Additional supports include vocational training and mentoring.

Kern County BHP also collaborates with probation and partner agencies to assist transition-age youth in moving from traditional to extended foster care, addressing mental health and criminogenic needs, reducing homelessness risk, and ensuring a successful transition to adulthood.

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

Kern County BHP has established a Memorandum of Understanding (MOU) with the Center for Sexuality and Gender Diversity, creating a vital partnership that enhances support for LGBTQ+ youth. Frequently, our Transition Age Youth (TAY) team utilizes this collaboration to provide additional resources and services to LGBTQ+ individuals. In recent months the Center delivered a comprehensive training session titled "Understanding the LGBTQ+ Community and Transgender, Gender Diverse, Intersex (TGI) Populations," aimed at increasing our staff's sensitivity and competency in delivering care to these youth. Kern County BHP is committed to supporting youth with accessing gendering affirming care, using their preferred pronouns, using a nonjudgemental approach, and honoring their right to self-determination.

Kern County BHP is also focused on targeted recruiting for resource parents through the TFCO program, specifically seeking those interested in being licensed to welcome LGBTQ foster youth into their homes. This additional protective measure will provide a safe and supportive environment, ensuring stability for these youth as they transition through different phases.

Kern County BHP supports the LGBTQ+ youth through advocacy and educating partners on how to best support shared clients through collaborative service implementation.

c. In the child welfare system:

Kern County BHP is embedded at Jamison Children Center and provides immediate intervention for youth that are brough into protective custody. All children are provided with a mental health assessment. Youth that need a higher level of care are provided with an Intensive Care Coordination meeting with Child Welfare staff to begin to proactively plan. Youth that are deemed higher risk are reviewed in our SMART committee to provide expedited services to youth to assist in minimizing trauma and providing care for our children.

Kern County BHP regularly meets with DHS and Probation to strategize system development for identifying youth who can be transitioned from higher-level care to family or family-like environments.

Kern County BHP CSOC in partnership with CDSS has recently provided training to placing agencies about the Qualified Individual Program, presenting training to help streamline referrals and coordination of these youth that are at risk of higher level of care. Additionally, Kern BHRS emphasized the importance of ongoing interagency collaboration, particularly focusing on supporting children transitioning from or to higher level care settings such as STRTPs. This continued partnering helps to promote best practices as we care for some of our most vulnerable children.

Kern County BHP collaborates with DHS, probation, and other partner agencies using Intensive Care Coordination to create and implement intervention plans using the CANS tool, aiming to support youth in improving mental health, strengthening connections, achieving permanency, and thriving. These intensive care coordination teams consist of important support persons both informal and formal support such as school staff, advocates, and mentors in addition to family members.

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

a. Older adults:

In developing FSP programs, Kern County BHP took several targeted actions to address the unique needs of older adults. These efforts reflect a comprehensive and inclusive planning process:

Stakeholder Engagement: Kern County BHP collaborates with local organizations such as Aging & Adult Services and community-based groups that serve seniors. These partnerships helped identify service gaps and tailor supports for older adults experiencing serious mental illness.

Needs Assessment & Data Review: The county reviews demographic and service utilization data to understand the prevalence of mental health issues among

older adults, including those at risk of homelessness, institutionalization, or social isolation. This informs the prioritization of services like housing support, in-home care coordination, and transportation assistance.

Program Design with Flexibility: Kern County BHP's FSP programming includes wraparound services that are flexible and responsive to the needs of older adults. These include outreach, peer support, and linkages to Medicare and long-term care resources.

Cultural Competency & Accessibility: Services were designed to be linguistically and culturally appropriate, with attention to mobility, cognitive decline, and other age-related barriers.

These efforts reflect Kern County's commitment to the "whatever it takes" philosophy of FSPs, ensuring that older adults receive individualized, community-based care that supports recovery and dignity.

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

Kern County BHP took intentional steps to address the unique needs of LGBTQ+ adults. These efforts aimed to ensure culturally responsive, inclusive, and affirming mental health services.

Community-Based Partnerships: Kern County BHP collaborates with local LGBTQ+ organizations such as Diversity, the Center for Sexuality & Gender Diversity, a nonprofit that provides peer support, advocacy, and safe spaces for LGBTQIA2S2SLGBTQIA+ individuals in Kern County. These partnerships informed service design and outreach strategies.

Stakeholder Engagement & Listening Sessions: LGBTQ+ individuals and advocacy groups were invited to participate in stakeholder meetings and planning forums. These sessions surfaced key concerns such as stigma, discrimination in care settings, and the need for trauma-informed services.

Cultural Competency Training: Kern County BHP emphasized training for staff and providers to ensure services were inclusive of diverse sexual orientations and gender identities. This included education on pronoun use, gender-affirming care, and the intersectionality of mental health and identity.

Safe & Affirming Environments: Kern County BHP FSP programs were designed to create welcoming spaces for LGBTQ+ clients, with attention to privacy, respect, and representation.

Data-Informed Planning: The county has reviewed national and local data on mental health disparities among LGBTQ+ populations—, such as higher rates of depression, anxiety, and suicide risk—, to guide program priorities and resource allocation.

Integrated Services: Recognizing the unique challenges faced by LGBTQ+

individuals—such as (housing instability, family rejection, and barriers to employment—), FSPs have incorporated wraparound supports including that include housing assistance, legal aid, and linkage to affirming primary care., and employment assistance.

Ongoing Evaluation & Feedback: Kern County BHP has maintained open channels for feedback from LGBTQ+ clients and community partners to continuously improve services and address emerging needs.

c. In, or are at risk of being in, the justice system:
Kern County BHP has implemented a range of strategic activities to address the unique needs of adults involved in, or at risk of entering, the justice system. These efforts were grounded in inclusive planning, data-informed decision-making, and cross-sector collaboration.

Kern County BHP ensures that service providers maintain close coordination with local civil and criminal courts in delivering a comprehensive array of behavioral health interventions. These include Mental Health Diversion, Misdemeanor Incompetent to Stand Trial (MIST), Specialized Probation Options/Forensic Intensive Support Teams (SPO/FIST), Assisted Outpatient Treatment (AOT), and CARE Court services. This collaborative approach strengthens the continuum of care and supports individuals with complex behavioral health needs as they navigate both treatment and the justice system. Data Review & Needs Assessment: The county has analyzed local justice and behavioral health data to identify trends in arrests, incarcerations, and psychiatric hospitalizations among adults with serious mental illness (SMI). This includes reviewing recidivism and crisis intervention data to target high-risk populations for intensive support.

<u>Interagency Collaboration:</u> Kern County BHP regularly collaborates with law enforcement, probation, public defenders, and courts to understand systemic barriers and service needs. The county partners with the Kern County Sheriff's Office (KCSO), probation, and the courts to coordinate care and diversion strategies. The county also works closely with housing and substance use providers to support re-entry and reduce recidivism.

Kern County's approach ensures that justice-involved adults receive comprehensive, person-centered services that promote recovery and community integration, reflecting the county's "whatever it takes" philosophy.

Assertive Field-Based Substance Use Disorder (SUD) Questions

1. Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment

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

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach:

1. Existing programs (name): **SUD Access Line**
2. Program descriptions:

   SUD counselors that work at the SUD Access Line (centralized screening and referral team for DMC-ODS) contact people seeking SUD care via phone to conduct a brief screening to determine the most appropriate level of SUD care within the DMC-ODS network.

   Reminder calls are made to increase attendance of new upcoming appointments and follow-up calls are made to provide support and assist the individual to reschedule an appointment or find transportation to SUD services.

   The Kern ROEM Program is a behavioral health field outreach unit consisting of teams of professional and paraprofessional staff dedicated to addressing the needs of the homeless with behavioral health challenges. The mission of Kern ROEM is to provide field-based outreach, engagement and treatment services to unserved or underserved individuals who are homeless and have mental illness and/or substance use disorders. The program aims to serve the most vulnerable on the streets, including youth, adults, and older adults.

3. Current funding source:

   1. **SUD Access Line is funded by SUBG Discretionary funds and Medi-Cal FFP**
   2. **HAT is currently funded by MHSA, FFP, State General Fund, PATH Grant and the START Team is funded by Medi-Cal FFP.**

4. BHSA changes to existing programs to meet BHSA requirements:

   Kern County Behavioral Health and Recovery Services (BHP) in partnership with

Kern County Department of Public Health is creating an overdose surveillance and response system for Kern County.

Kern County BHP will email information from Emergency Medical Services (EMS) and the Kern County BHP Care Coordination Unit, where the referral will be followed up by an SUD provider network through the SUD Access Line. SUD Access line staff will provide rapid response outreach. This effort aims to ensure that individuals who have recently experienced a non-fatal overdose receive appropriate follow-up care. These efforts will engage individuals in substance use disorder (SUD) treatment, offer overdose prevention education, and provide short-term follow-up support.

If an Individual Identified is unhoused and needs targeted outreach from a specialty team, ROEM will receive the referral information from the SUD Access Line to provide additional outreach and engagement. This information is provided to an identified outreach staff on ROEM to ensure a rapid response to the individual and facilitate connection to appropriate treatment and referrals.

To support the additional calls and response, one (1) additional Substance Use Disorder Specialist will be added to the Access Line funded by BHSA. To support ROEM's additional response and targeted outreach, two (2) Recovery Specialists will be added to the team.

5. Expected timeline of operation: **July 1, 2026**

Mobile-field based programs:

1. Existing programs (name): **ROEM Team**
2. Program descriptions:

The Kern ROEM Program is a behavioral health field outreach unit consisting of teams of professional and paraprofessional staff dedicated to addressing the needs of the homeless with behavioral health challenges. The mission of Kern ROEM is to provide field-based outreach, engagement and treatment services to unserved or underserved individuals who are homeless and have mental illness and/or substance use disorders. The program aims to serve the most vulnerable on the streets, including youth, adults, and older adults.

The program involves a heavy outreach and engagement component along with field-based prevention and treatment strategies. Outreach units are interdisciplinary, including peer services, psychiatric services, mental health

and substance use treatment, case management, and safety assessments. Kern ROEM staff work alongside other community outreach partners, including faith-based organizations, healthcare agencies, and other social services.

Current funding source: **MHSA, FFP, State General Fund**

3. BHSA changes to existing programs to meet BHSA requirements:

Kern County BHP is expanding MAT services to the unhoused through the ROEM program. Adding 1 FTE of Psychiatry staffing to offer telehealth MAT services to our ROEM outreach team, offering MAT services to those most vulnerable and highest need. The program will allow telepsychiatry services multiple days per week.

4. Expected timeline of operation: **January 2026**

Open-access clinics:

1. Existing programs (name): **DMC-ODS NTP providers**
2. Program descriptions:

Kern County BHP contracts with two NTP providers to serve the county of Kern. Clinics are available in Bakersfield, Delano, Ridgecrest and Palmdale. NTP clinics offer methadone, buprenorphine, disulfiram, and naltrexone. Services are available on a walk in basis to those needing access care.

3. Current funding source:

NTP clinics are currently funded by Medi-Cal FFP.

4. BHSA changes to existing programs to meet BHSA requirements:

None at this time.

5. Expected timeline of operation: **NTPs are currently in operation in Kern County.**

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach:

1. New programs (name): **No new programs at this time.**
2. Program descriptions:

N/A

3. Planned funding:

   N/A

4. Planned operations:

   N/A

5. Expected timeline of implementation: **N/A**

Mobile-field based programs:

1. New programs (name): **No new programs at this time.**
2. Program descriptions:

   N/A

3. Planned funding:

   N/A

4. Planned operations:

   N/A

5. Expected timeline of implementation: **N/A**

Open-access clinics:

1. New programs (name): **No new programs at this time.**
2. Program descriptions:

   N/A

3. Planned funding:

   N/A

4. Planned operations:

   N/A

5. Expected timeline of implementation: **N/A**

Medications for Addiction Treatment (MAT) Details

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

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

   Currently there are a variety of MAT clinics that offer same-day access to MAT treatment during the week. However, a noticeable gap exists in weekend availability. Several hospitals in Kern County participate in the CA Bridge Program, which provides MAT through Emergency Departments with future follow up for ongoing SUD treatment services. If individuals request access to MAT on the weekends, they are referred to hospitals that continue to offer this service. Although this allows for service accessibility on the weekends, it is not the most convenient way for clients to access this care. To address this gap, the county is actively exploring opportunities to expand weekend access, either by enhancing existing services or partnering with additional agencies. This review process will inform strategic planning efforts to ensure that by July 1, 2029 clients can reliably access same-day MAT services every day of the week.

   ADDITIONAL INFORMATION:

   Kern County BHP will assess the gaps between current MAT resources and population needs by reviewing various data sets, including current electronic health record data to identify those within our BHP network that have diagnoses of alcohol use disorder and opioid use disorder. Kern BHRS will also utilize claim data available from Medi-Cal Connect in order to identify individuals that may be in need of this treatment modality in Kern County, as this dataset will include Medi-Cal members that may not be within the Kern BHRS network. Additional data will be obtained from partnerships with the Kern County Public Health department on overdoses which are managed in the field and do not necessarily have a hospital admission.

   Using these combined data sources, Kern County BHP will evaluate whether additional MAT capacity is required, including consideration of new contracted providers or county-operated MAT clinics. Findings will inform efforts to develop a comprehensive, accessible MAT network capable of meeting the needs of both current and previously unserved or underserved individuals in Kern County.

2. Select the following practices the county will implement to ensure same day access to MAT [multi-select list]:
   - ☒ **Contract directly with MAT providers in the county**
   - ☒ **Operate MAT clinics directly**
   - ☐ Enter into referral agreements with other MAT providers including providers whose services are covered by Medi-Cal MCPs and/or Fee-For-Service (FFS)
   - ☐ Medi-Cal
   - ☒ **Leverage telehealth model(s)**
   - ☐ Partner with neighboring counties [Yes/No radio buttons; logic: if Y, populate below

question]

Please provide the names of the neighboring counties [narrative box]

☐ Contract with MAT providers in other counties [Yes/No radio buttons; logic: if Y, populate below question]

Please provide the names of neighboring counties [narrative box]

☐ Other strategy [narrative box]

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

☒ **Buprenorphine**

☐ Methadone

☐ Naltrexone

☐ Other

Housing Interventions

Planning

System Gaps

1. Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does 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. [For each, counties select from dropdown: no gap, small gap, medium gap, large gap.]
   a. Supportive housing: **Large gap**
   b. Apartments, including master-lease apartments: **Not applicable**
   c. Single and multi-family homes: **Not applicable**
   d. Housing in mobile home communities: **Not applicable**
   e. (Permanent) Single room occupancy units: **Not applicable**
   f. (Interim) Single room occupancy units: **Not applicable**
   g. Accessory dwelling units, including junior accessory dwelling units: **Not applicable**
   h. (Permanent) Tiny homes**: Medium gap**
   i. Shared housing: **No gap**
   j. (Permanent) Recovery/sober living housing, including recovery-oriented housing:

Small gap

k. (Interim) Recovery/sober living housing, including recovery-oriented housing**: Medium gap**
l. Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)**: Large gap**
m. License-exempt room and board: **No gap**
n. Hotel and Motel stays: **No gap**
o. Non-congregate interim housing models: **Not applicable**
p. Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings): **No gap**
q. Recuperative Care: **Medium gap**
r. Short-Term Post-Hospitalization housing: **Medium gap**
s. (Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units: **Not applicable**
t. Peer Respite: **Small gap**
u. Permanent rental subsidies: **Not applicable**
v. Housing supportive services: **Small gap**

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

- **Behavioral Health Bridge Housing**
- **Prop 47 funding**
- **CalAIM Community Supports (Housing Trio, Transitional Rent)**
- **AB109**
- **Realignment**
- **ConRep**
- **SPO**
- **PATH JI**

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

Additional resources and funding sources will enhance and expand housing support available to BHSA eligible individuals, based on the specific criteria and eligibility requirements of each funding source. For instance, Transitional Rent will offer up to six months of rental assistance for individuals enrolled in a Medi-Cal Managed Care Plan. PATH JI, Prop 47, AB109, and Con-Rep funds will provide further services tailored to specific populations, such as those involved in the justice system or under Prop 36.

4. What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?
   Kern County BHP provides funding to cover rental subsidies for thirty-nine permanent supportive housing units (PSH) through our Behavioral Health Bridge Housing grant. Kern County BHP participates weekly with the Coordinated Entry System Committee to match clients to PSH. Kern County BHP received funding through five rounds of No Place Like Home (NPLH) funding, leveraging 166 new PSH units in Kern County. In addition to NPLH, Kern County BHP also provides supportive services at other PSH sites. We have also committed future BHSA Housing Interventions funding to support a Homekey+ applicant. Our Housing Service program also works to identify and recruit supportive housing facilities, and monitors housing providers to established quality standards.

5. What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?
   Kern County BHP provides funding to cover rental subsidies for thirty-nine permanent supportive housing units (PSH) through our Behavioral Health Bridge Housing grant. Our agency participates weekly with the Coordinated Entry System Committee to match clients to PSH. Our agency received funding through five rounds of No Place Like Home (NPLH) funding, leveraging 166 new PSH units in Kern County. In addition to NPLH, Kern County BHP also provides supportive services at other PSH sites. We have also committed future BHSA Housing Interventions funding to support a Homekey+ applicant. Our Housing Service Team also works to identify and recruit supportive housing facilities, and monitors housing providers to established quality standards.

6. Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services:
   Kern County BHP will provide clinical and supportive behavioral health care and housing related services to individuals who are open to our system of care directly or through a Kern County BHP contracted provider. Services may be provided at various locations including on-site at housing projects, at behavioral health offices, or via telehealth, depending on the client's preference and level of functioning.

Eligible Populations

1. Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions:
   The Kern County BHP Housing Services Team (HST) collaborates with treatment teams to retain housing for clients and assists in the coordination of housing-focused services such as HI assistance for those at high-risk of homelessness. Additionally, the HST serves as a liaison within the system of care and community-based organizations, providers, and partner agencies for support and assist with consumer placement into safe, stable, and recovery-oriented housing.
   Housing referrals are initiated through the Kern County BHP Housing Provider list which is updated monthly and placed on the Kern County BHP public website. The department, agencies, and the public can refer to the list for housing needs and placement. To identify appropriate housing for each client, housing referrals are coordinated with the case manager.

2. Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only? **Yes**

3. What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:
   a. In, or at-risk of being in, the juvenile justice system:
      Kern County BHP's Children's System of Care (CSOC) coordinates closely with the county Probation Department and other appropriate agencies through ongoing meetings, (SMART, Step Down Meetings, SOCIT, Foster Care Meetings) to closely monitor and consider the needs of children and youth who are in, or at-risk of being in the Kern County juvenile justice system. In addition, the department does cross system coordination under the Integrated Core Practice Model with frequent Child Family CFT and Intensive Care Coordination (ICC) Meetings to coordinate care.

   b. Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+):
      The Plan provides all specialty mental health services to LBGTQ+ youth, expanding and incorporating additional resources and support specific to the individual needs of each youth. The department will continue to outreach within our local community to expand available resources for this population.

   c. In the child welfare system:
      Kern County BHP's CSOC coordinates closely with the County Probation Department and other appropriate agencies through ongoing meetings, (SMART, Step Down Meetings, SOCIT, Foster Care Meetings) to closely monitor and consider the needs of children and

youth within the Kern County child welfare system. In addition, the department does cross system coordination under the Integrated Core Practice Model with frequent Child Family CFT (CTF) and Intensive Care Coordination (ICC) Meetings to coordinate care.

4. What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:
   a. Older adults:
      Kern County BHP holds monthly MHSA Stakeholder meetings to share updates on MHSA funding and programs as well as receive feedback on these matters. Our department works closely with Kern County Aging and Adult Services and Kern County Public Health to help determine gaps and needs for this population. Existing data available through our teams dedicated to serving older adults and our Housing Services Team is also utilized to help inform the needs of our older adults.
   b. In, or are at risk of being in, the justice system:
      Kern County BHP utilizes existing data available through our SUD and Correctional Behavioral Health staff to help inform the needs of this population. Additionally, the department holds ongoing stakeholder meetings in our local communities to keep the residents informed and to receive feedback as to the needs of each community. As legislative changes occur, the department actively engages with other agencies and the public to keep them informed of these changes, such as with CARE Court, SB43 and PATH JI.
   c. In underserved communities:
      Kern County BHP utilizes existing data available through our treatment and housing teams to determine the needs of our underserved communities. The department holds ongoing stakeholder meetings in our local communities to keep the residents informed and to receive feedback as to the needs of each community.

Local Housing System Engagement

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

   Kern County BHP participates weekly with the Coordinated Entry System (CES) Committee to match clients to housing related services offered through our agency. Clients enrolled in the CES who are eligible for housing services offered by Kern County BHP will be referred through this process. All referrals received through the CES are evaluated by our Housing Services Team to verify eligibility.

2. Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as

other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

a. Local CoC:

Kern County BHP is actively involved with our local CoC. Staff serve on the Executive Board, Governing Board, and various subcommittees of our CoC to continuously address the most critical housing and homeless service needs in Kern. Kern County BHP staff also work closely with the Coordinated Entry System (CES) and Homeless Management Information System (HMIS) lead agencies within the CoC.

b. Public Housing Agency:

Kern County BHP has clients who reside in various housing sites operated by the Housing Authority of the County of Kern and has partnered with them to provide funding for both capital and rental assistance for dedicated units within some of these sites. This partnership will continue forward as we implement Housing Interventions through the BHSA.

c. MCPs:

Kern County BHP is actively engaged with our three MCPs. The county intends to contract with all three MCPs to be a provider for the housing related Community Supports. We intend to continue to work closely with them to coordinate a seamless transition from the Transitional Rent benefit to longer-term BHSA housing support. Kern County BHP will also be developing a Flex Pool model for Kern County, through partnership with our MCPs and other housing partners.

d. ECM and Community Supports Providers:

Kern County BHP will work with ECM and Community Supports Providers to receive referrals for individuals with unmet behavioral health needs and to conversely refer/connect eligible Kern County BHP clients to providers for appropriate ECM and Community Supports.

e. Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
The Housing Authority of the County of Kern is the predominant developer of PSH in Kern County, often times in partnership with local non-profits and other public agencies including the City of Bakersfield and Kern County BHP, as funding is available. The department also collaborates with Kern County Human Services as it relates to child welfare housing programs.

3. How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA

eligible individuals?

Kern County BHP provides services to tenants residing in supportive housing sites, who are open to the BHP or a contracted provider. Services may be provided at various locations including on-site at housing projects, at behavioral health offices, or via telehealth, depending on the client's preference and level of functioning.

Kern County BHP is aware of one Homekey+ application being submitted. If an award is received by the applicant, we have committed to providing supportive services to tenants in the manner stated above. We have also committed to providing annual funding to support the rental cost of ten (10) units within the project.

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

BHSA Housing Interventions Implementation

[Context text: The following questions are specific to BHSA Housing Interventions funding (no action needed)]

Rental Subsidies (Chapter 7. Section C.9.1)

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

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

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

3. How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
   Kern County BHP anticipates very few if any, rental subsidies will be funded under BHSA Housing Interventions in year 1 (26-27), as the majority of rental subsidies are currently funded with BHBH funding, which is scheduled to end June 30, 2027. In addition, the Transitional Rent Community Support is scheduled to become effective January 1, 2026, which must be used for new clients prior to accessing BHSA Housing Interventions, further reducing the utilization of BHSA Housing Interventions for rental assistance. Kern County BHP has seen about a 45% increase in the number of unduplicated clients being housed since 2023/24. If the increase continues at the same rate, we would anticipate providing rental assistance to 1,557 clients in year 2 (27-28), and 2,258 in year 3 (28-29).

- How many of these individuals will receive rental subsidies for permanent housing on an annual basis? **49**

- How many of these individuals will receive rental subsidies for interim housing on an annual basis? **3,717**

4. What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?
Kern BHRS' has estimated total rental subsidies and number of individuals to be served based upon the number of unduplicated clients served in FY 23/24, 24/25 and 25/26 and the expectation that the average annual increase will continue. Kern County BHP will continuously monitor rental subsidies and the rental market and adjust as warranted.

5. For which setting types will the county provide rental subsidies? [multi-select dropdown of allowable settings included in the BHSA Policy Manual Housing Interventions Chapter (Chapter 7, Section C.9.3 Allowable Settings)]

☒ **Non-Time-Limited Permanent Settings: Supportive housing**

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

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

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

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

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

☒ **Non-Time-Limited Permanent Settings: Tiny Homes**

☐ Non-Time-Limited Permanent Settings: Shared housing

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

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

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

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

☒ **Time Limited Interim Settings: Hotel and motel stay**

☒ **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) (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: Peer respite
- ☐ Time Limited Interim Settings: Other settings identified under the Transitional Rent benefit

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

7. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding:
   This intervention will provide up to two years of rental subsidies per individual. The goal is to ensure that individuals are placed in a setting that is appropriate for their needs as they progress through their recovery journey. This intervention will include both interim and permanent settings. BHSA funds will be leveraged alongside other funding to maximize the impact while ensuring individuals have the housing and supports necessary for long-term stability.

8. Will the county behavioral health system provide rental assistance through project- based (tied to a particular unit) or tenant-based (tied to the individual) subsidies? [multi-select check box]
   - ☒ **Project-based**
   - ☒ **Tenant-based**
9. How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in:
   Kern County BHP's Housing Services Team maintains a network of housing providers who have qualified under its Quality Standards Program. The team continuously works to identify and recruit supportive housing facilities, and monitors housing providers to established quality standards. The (future) Flex Pool Operator will also be responsible for identifying available units through landlord engagements.

10. Total number of units funded with BHSA Housing Interventions per year: **1,214**

11. [Optional question] 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 [narrative box]: **N/A**

Operating Subsidies (Chapter 7, Section C.9.2)

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

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

3. Anticipated number of individuals served per year: **750**

4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding:
   Operating Subsidies, under the BHSA Housing Interventions, will fund the operating costs for new or existing housing listed below. These costs include utilities (internet included), maintenance, repairs, marketing, leasing, taxes, insurance, property management, supplies, legal and accounting services, security, cleaning fees, and housing essentials like appliances, water heaters, transportation, furnishings, food, and hygiene products.

5. For which setting types will the county provide operating subsidies? [multi-select dropdown of allowable settings included in the BHSA Policy Manual Housing Interventions Chapter (Chapter 7, SectionC.9.3 Allowable Settings)]

   ☐ **Non-Time-Limited Permanent Settings: Supportive housing**

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

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

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

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

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

   ☒ **Non-Time-Limited Permanent Settings: Tiny Homes**

   ☐ Non-Time-Limited Permanent Settings: Shared housing

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

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

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

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

☐ Time Limited Interim Settings: Hotel and motel stay

☐ 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) (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: Peer respite

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

6. Will this be a scattered site initiative? **Yes**
7. Will this Housing Intervention accommodate family housing? **Yes**
8. Total number of units funded with BHSA Housing Interventions per year: **1214**
9. [Optional question] 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 [narrative box]: **N/A**

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

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

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

3. Anticipated number of individuals served per year: **750**

4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding:
   Kern County BHP will utilize Landlord Outreach and Mitigation Funds to enhance engagement with landlords and property owners as a critical component of its Housing Interventions. These funds will support the creation and dissemination of targeted outreach materials, presentations, and public awareness campaigns designed to educate and encourage property owners to participate in housing programs for eligible individuals.

5. Total number of units funded with BHSA Housing Interventions per year: **1214**
6. [Optional question] 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 [narrative box]: **N/A**

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

1. Is the county providing this intervention? **Yes**
2. Is the county providing this intervention to chronically homeless individuals? **Yes**
3. Anticipated number of individuals served per year: **750**
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding:
   Kern County BHP will use BHSA Housing Interventions funding to create a Participant Assistance Fund that helps individuals overcome immediate barriers to housing. Support is tailored to each person's unique needs and may include:
   - **Vital Documents: Fees for government-issued IDs and other essential paperwork**
   - **Application Costs: Housing application fees and credit report charges**
   - **Deposits: Security, utility, and pet deposits**
   - **Storage: Temporary storage fees for personal belongings**
   - **Move-In Support: Transportation, food, hygiene items, and basic furnishings (e.g., bed, table, chairs, cleaning supplies)**
   - **Housing Stability: Payment of past-due rent or utility bills to secure or maintain housing**
   - **This flexible fund ensures people can access the resources they need to move into and remain in stable housing. Funds will be used in coordination with BHBH funded activities.**

5. Total number of units funded with BHSA Housing Interventions per year: **1214**

6. [Optional question] 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 [narrative box]: **N/A**

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

[Context text: Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who

are not eligible to receive the services through their Medi-Cal MCP (no action needed)].

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

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

3. Anticipated number of individuals served per year: **375**

4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding:
   This intervention will assist individuals with various activities associated with finding, applying for, and obtaining housing. Services will be provided to individuals who are not eligible for services through a Medi-Cal Managed Care Plan and in accordance with the BHSA Policy Manual.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

1. Is the county providing this intervention? **Yes**
2. Is the county providing this intervention to chronically homeless individuals? **Yes**
3. Anticipated number of individuals served per year: **375**
4. Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding:
   This intervention will support engaging unserved individuals who are experiencing homelessness in the Kern County BHP system so that they may receive appropriate services. Peer outreach and engagement will be provided by individuals with lived experience who work to engage and build trust with individuals experiencing homelessness and who may have a serious mental illness and/or substance use disorder.

Capital Development Projects (Chapter 7, Section C.10)

1. Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects? **Yes**

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

3. How many capital development projects will the county behavioral health system fund

with BHSA Housing Interventions? **2**

Capital Development Project Specific Information

Capital Development Project #1

Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions [logic: allow for multiple entries]

1. Name of Project: **Rural Permanent Supportive Housing Project**
2. What setting types will the capital development project include? [multi-select dropdown of allowable settings included in the BHSA Policy Manual Housing Interventions Chapter (Chapter 7, Section C.9.3 Allowable Settings)]

   ☐ Non-Time-Limited Permanent Settings: Supportive housing
   ☐ Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
   ☒ **Non-Time-Limited Permanent Settings: Single and multi-family homes**

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

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

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

   ☐ Non-Time-Limited Permanent Settings: Tiny Homes

   ☐ Non-Time-Limited Permanent Settings: Shared housing

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

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

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

   ☐ Time Limited Interim Settings: Hotel and motel stay

   ☐ 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) (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: Peer respite

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

3. Capacity (Anticipated number of individuals housed at a given time): **20**
4. Will this project braid funding with non-BHSA funding source(s)? **No**
5. Total number of units in project, inclusive of BHSA and non-BHSA funding sources: **10**
6. Total number of units funded with Housing Interventions funds only: **10**
7. [Optional question] 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 [narrative box]: **N/A**
8. Anticipated date of unit availability: **06/30/2029**
9. Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000): **$450,000**
10. Have you utilized the "by right" provisions of state law in your project? **No**
    a. If you have not incorporated use of the "by right" provisions into your project, please explain why [narrative box]: **Does not apply**

Other Housing Intervention

1. If the county is providing another type of Housing Interventions not listed above, please describe the intervention (optional): **N/A**
2. Is the county providing this intervention to chronically homeless individuals (optional)
3. Anticipated number of individuals served per year (optional): **N/A**

Continuation of Existing Housing Programs

1. Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing):

   Housing programs and services offered through our BHBH grant will shift to BHSA upon expiration of the funding, including rental assistance, participant assistance, and housing navigation.

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

1. Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of? [multi-select list]
   - ☒ **Housing Transition Navigation Services**
   - ☒ **Housing Deposits**
   - ☒ **Housing Tenancy and Sustaining Services**
   - ☐ Short-Term Post-Hospitalization Housing
   - ☐ Recuperative Care
   - ☐ Day Habilitation
   - ☒ **Transitional Rent**
   - ☐ None of the Above
2. For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?
   - ☒ Housing Transition Navigation Services: **Yes**
     When does the county behavioral health system plan to become an MCP-contracted provider? **01/01/2026**
   - ☒ Housing Deposits: **Yes**
     When does the county behavioral health system plan to become an MCP-contracted provider? **01/01/2026**
   - ☒ Housing Tenancy and Sustaining Services: **Yes**
     When does the county behavioral health system plan to become an MCP-contracted provider? **01/01/2026**
   - ☒ Transitional Rent: **Yes**
     When does the county behavioral health system plan to become an MCP-contracted provider? **01/01/2026**
3. How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)?
   Kern County BHP will identify Medi-Cal members within our system of care who may be eligible for housing-related Community Supports, and referrals will be made in accordance with the CalAIM required referral processes. As Kern County BHP is going to be a contracted provider for community supports services, clients will be referred from their case managers to the housing services team for assistance. The housing services team will complete the necessary screening forms to confirm eligibility of these services and then send the request directly to the

managed care plans through Kern County BHP care coordination unit for authorization. As this process is currently being worked through with the three MCP's, it is anticipated that changes will be made over the next year as this benefit becomes live next year.

4. Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county:
   Kern County BHP shares our Housing Provider Directory established through our Quality Standards Program with our Medi-Cal Managed Care Plans. As Kern County BHP is also contracted for community supports services and will be transitional rent provider, these network providers will be known through that contractual relationship as well.

5. Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)? **No**

6. What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?
   Many individuals with significant behavioral health conditions are already connected to the Kern County BHP through an FSP or treatment team. The county is also working closely with our MCPs to develop these procedures, to ensure seamless transition from MCP housing services to BHSA Housing Interventions.

ADDITIONAL INFORMATION:

Kern BHRS has had a Housing Services Team (HST) in place for more than ten (10) years and as such, has a very streamlined process in place. The process of housing placement starts with the FSP/treatment team working with the client to identify, among other things, housing goals and appropriate housing placement. The treatment team submits a request for housing placement to the HST, who then coordinates with the Housing Provider and facilitates timely payment for services going forward.

Kern BHRS opted to become MCP-contracted to provide Housing Trio and Transitional Rent Community Supports for clients who are open to our system of care to mitigate service gaps once MCP housing services have been exhausted. As an MCP-contracted provider, our process will operate very much the same as described above, with some slight variations. Upon receipt of a request for housing, the HST will verify

if the client is enrolled with an MCP. If the client is enrolled with an MCP the HST will submit a referral for Transitional Rent and any other housing related services the client is eligible for to the appropriate MCP, in accordance with each MCP's requirements. A secondary funding source will be identified at the time of placement, which will be intended to cover any expenses not covered by MCP housing services and to cover the full cost of housing expenses in the event the referral is denied or at such time the member has exhausted MCP housing services.
Kern BHRS will submit invoicing or a reimbursement request for all MCP covered services, in accordance with each MCP's requirements. The goal of Kern BHRS is to house our clients as quickly as possible, and in many cases our existing process allows us to do so in 24-48 hours. Maintaining this existing process while incorporating the identification of eligibility for MCP housing services and submission of timely referrals to the appropriate MCP, ensures that the client does not experience gaps in service.

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.

1. Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)? **No**
2. Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county? **Yes**
    a. What role does the county behavioral health system plan to have in the Flex Pool? [multi-select list; logic: if 'Operator' is not selected, populate question 2.b]
        ☒ **Lead Entity**
        ☐ Operator
        ☒ **Funder**
        ☒ **Housing Supportive Services Provider**
    b. Have you identified an Operator of the Flex Pool? **No**

c. What organization will serve as the Operator? [narrative box]: **N/A**
d. Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool? **Yes**
e. Which Housing Interventions does the county plan to administer through or in coordination with a Flex Pool? [multi-select list of BHSA Housing Interventions (Chapter 7, Section C.9)]:
   - ☒ **Rental Subsidies**
   - ☒ **Operating Subsidies**
   - ☒ **Landlord Outreach and Mitigation Funds**
   - ☐ Participant Assistance Funds
   - ☒ **Housing Transition Navigation Services and Tenancy and Sustaining Services**
   - ☐ Outreach and Engagement (up to 7 percent)
   - ☐ Capital Development Projects

3. Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above:
   Kern County BHP is participating in the DHCS sponsored Flex Pool TA Academy and also received a Flex Pool Planning Grant. We have applied for additional funding that will support the implementation and start-up costs for the Flex Pool. We anticipate having identified a Flex Pool Operator through a competitive process by the end of April 2026.

4. 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:
   Kern County BHP is participating in the DHCS sponsored Flex Pool TA Academy and also received a Flex Pool Planning Grant. We have applied for additional funding that will support the implementation and start-up costs for the Flex Pool. We anticipate having identified a Flex Pool Operator through a competitive process by the end of April 2026.

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.

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

Workforce Strategy

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

1. Maintains and monitors a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and

2. Meets federal and state standards for timely access to care and services, considering the urgency of the need for services.

3. The county must ensure that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual. Does the county intend to adopt this recommended approach for BHSA-funded providers that
    a. Does the county intend to adopt this recommended approach for BHSA-funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System? **Yes**

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

Build Workforce to Address Statewide Behavioral Health Goals

Assess Workforce Gaps

1. What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)? **9%**
2. Upload any data source(s) used to determine vacancy rate [optional file upload]: **N/A**
3. For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates [multi-select dropdown]

   ☐ Advanced Emergency Medical Technicians
   ☐ Certified Nurse Specialist
   ☐ Community Health Workers (CHW) defined in the Enhanced Community ☐ Health Workers Services benefit
   ☐ Community Paramedics
   ☐ Emergency Medical Technicians
   ☒ **Licensed Clinical Social Worker**
   ☒ **Licensed Marriage and Family Therapist**
   ☐ Licensed Professional Clinical Counselor
   ☐ Licensed Psychologist
   ☒ **Licensed Vocational Nurse**
   ☐ Medical assistant
   ☐ Medi-Cal Certified Peer Support Specialist
   ☐ Mental Health Rehabilitation Specialist
   ☐ Nurse practitioner
   ☐ Occupational Therapist
   ☐ Pharmacist
   ☐ Physician
   ☐ Physician assistant
   ☐ Psychiatric Technician (PT)
   ☐ Psychiatrist
   ☐ Registered nurse
   ☒ **Substance Use Disorder Counselor**
   ☒ **Other qualified provider**

4. Please describe any other key workforce gaps in the county:
   Our most significant workforce gap is among Therapists working in high-acuity environments—such as correctional behavioral health and crisis services—that require shift-based coverage.
5. How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based

practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?

Kern County BHP anticipates increasing workforce demands in the next three years as it implements new evidence-based practices aligned with BHT. Key Workforce changes include the following:

Focus to the most vulnerable of the SMI and SUD populations:

- **The BHP will expand evidence based practices including trauma-informed care, early psychosis treatment, and culturally responsive services, which require specialized training of staff.**
- **Optimizing Workforce: Reallocation of existing staff to key workforce gaps such as correctional behavioral health and crisis services.**
- **Focus on Diversity and Language Access: To better serve Kern's diverse communities, the county is prioritizing bilingual and bicultural staff, especially Spanish-speaking professionals.**
- **Recruitment and Retention: Recognizing the challenges of shift work and high-acuity settings, the BHP is exploring employee support measures to retain staff, especially in crisis and correctional roles.**

Address Workforce Gaps

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

1. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program? **Yes**
    a. Please explain any actions or activities the county is engaging in to leverage the program:
    Kern County BHP is a Community Mental Health Center that continues to provide services to Medicaid and/or uninsured population. When the application dates open, we will provide the information to our employees so they may apply. Currently work in collaboration with HCAI to provide qualifying information to our staff.

2. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program? **Yes**
    a. Please explain any actions or activities the county is engaging in to leverage the program:

    Our county BHP has joined webinars to learn more about HCAI BH-Comment MBH-SLRP in order to provide information to our employees along with providing notice department-wide via email when enrollment opens.
3. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program? **No**
4. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program? **Yes**

    a. Please explain any actions or activities the county is engaging in to leverage the program:

    Kern County BHP is a Community Mental Health Center that continues to provide services to Medicaid and/or uninsured population. The applications date starts in first quarter of 2026.

    ADDITIONAL INFORMATION:

    To promote these opportunities to eligible individuals, the County will implement targeted outreach to current staff, interns, and prospective workforce candidates. This includes direct communication campaigns such as internal email announcements, informational webinars, and presentations during staff meetings and supervision sessions to ensure that eligible employees—particularly those in hard-to-fill classifications and underserved program areas such as Full-Service Partnerships (FSP) and Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)—are aware of scholarship and training opportunities.

    The County will also collaborate with local and regional academic institutions (e.g., CSU Bakersfield, community colleges, and partnering graduate programs) to promote BH-CONNECT opportunities to students pursuing degrees in behavioral health fields. Outreach strategies include participation in career fairs, classroom presentations, and coordination with university program directors and field placement coordinators to share program information directly with eligible students, including those from underrepresented backgrounds.

    Additionally, Kern County will partner with contracted community-based organizations (CBOs) and providers to encourage participation in the Community-Based Provider Training Program. This includes distributing program materials, hosting technical assistance sessions to support application readiness, and incorporating BH-CONNECT opportunities into regular provider meetings and contract communications.

    To further expand access, the County will prioritize outreach to bilingual and culturally diverse candidates, as well as individuals with lived experience, to support workforce diversity goals. Recruitment materials will be culturally and linguistically appropriate, and outreach efforts will include community-based channels to reach individuals who may not be connected to traditional academic pathways.

The County will also align these efforts with existing "grow-your-own" workforce strategies by encouraging current paraprofessional staff and interns to apply for scholarship opportunities that support advancement into licensed or hard-to-fill clinical roles.

Through these coordinated actions, including internal engagement, academic partnerships, provider collaboration, and targeted outreach, the Kern County BHP will actively promote BH-CONNECT workforce programs and expand participation among eligible individuals, with the goal of strengthening workforce capacity in high-need service areas.

5. Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program? **No**
6. Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training:

   Kern County BHP promotes Employee Wellness and has worked hard to become Blue Zone certified in the Winter of 2024. This initiative has allowed us to focus on creating an environment to assist in improving the well-being of our employees. We provide details and reminder emails for the NHSC loan forgiveness program, Public Service Loan Forgiveness Program, CalSWEC, SCRP, and MBH-SLRT to ensure our employees are aware.

Budget And Prudent Reserve

1. Please upload the completed budget template: **Budget attached to this document.**
2. Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template
    a. Behavioral Health Services and Supports (BHSS): **No excess prudent reserve.**
    b. Full Service Partnership (FSP): **No excess prudent reserve.**
    c. Housing Interventions: **No excess prudent reserve.**
3. Enter date of last prudent reserve assessment: **09/04/2024**
4. Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan
    a. BHSS: **No excess prudent reserve.**
    b. FSP: **No excess prudent reserve.**
    c. Housing Interventions: **No excess prudent reserve.**

Plan Approval and Compliance

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

Behavioral health director certification

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

Please upload the completed Behavioral health director certification template

Attachment H - Behavioral Health Director Certification signed 3-24-26.pdf

County administrator or designee certification

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

Please upload the completed County administrator or designee certification template

Attachment I - Signed CAO form.pdf

Board of supervisor certification

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

Please upload the completed Board of supervisor certification template

Attachment J – Board of Supervisor Certification.pdf

Requests

- Funding Transfer Request: **None**
- Behavioral Health Services and Supports Transfers: **None**
- Full Service Partnership Transfers: **None**
- Housing Interventions Transfers: **None**
- Supporting Information and Data: **None**

Approved Budget

Attachment K - Approved Budget (FY 2026 – 2029)

Attachments

Attachments	Title
A	2025 CPP Stakeholder Feedback (pages 166-172)
B	CPPP Stakeholder Engagement (stakeholder types - activity types by date) (pages 173-175)
C	2025 CPP Meeting Minutes (pages 176-228)
D	Emails: Attempting to Engage Stakeholder Groups (pages 229-238)
E	30-Day Public Comment Stakeholder Data - BHSA Integrated Plan (FINAL) (pages 239-255)
F	Proof of Public Posting.pdf (page 256)
G	Kern County FY25-26 Work Plan.FINAL.pdf (pages 257-280)
H	Behavioral Health Director Certification signed 3-24-26.pdf (pages 281-283)
I	Signed CAO form.pdf (pages 284-285)
J	Board of Supervisor Certification.pdf (pages 286-287)
K	Approved Budget (FY 2026 – 2029) (pages 288-314)

CY 2025 – CPP Stakeholder Feedback

#	Date	Listening Session:
1	07/14/25	Listening Session: Q: What do you see as the priorities for the BH Plan?

Overview:
Stakeholder input revealed recurring themes for the Behavioral Health Plan. Priorities were grouped into six thematic areas.

Key Findings:

- Housing (7 mentions): Most urgent priority; tied to stability, overdose prevention, and state mandates.
- Vulnerable Populations & Equity (6 mentions): Focus on the most at-risk groups, including homeless and overdose-affected individuals.
- System Integration & Structure (6 mentions): Need for coordinated, holistic, and streamlined care with stronger plan oversight.
- SUD & Overdose (5 mentions): Addressing overdose crisis and capacity gaps in SUD inpatient treatment.
- System Sustainability (4 mentions): Ensuring billing, staffing, and efficiency for long-term viability.
- Compliance (2 mentioned): Meeting state contract requirements as a foundation for other priorities.

Interpretation:
Stakeholders strongly agree that housing is the top priority, followed closely by equity-driven services, overdose response, and system integration. Fiscal sustainability and compliance remain crucial for developing a robust behavioral health system.

2	07/14/25	Listening Session: Q: What are your thoughts on the MH & SUD services working together towards whole-person care?

Overview:
The majority of stakeholders supported integration, while some noted challenges related to funding, access, and system barriers.

Key Findings:

- Support for Integration / Holistic Care (13 mentions): Strong agreement that MH and SUD must work together. Responses emphasized holistic care, breaking down silos, and making integration the norm.
- Need for Tailored / Staff Support (3 mentions): Emphasis on individualized care and staff training to successfully implement integration.
- Equity / Access Issues (3 mentions): Concerns that residents without insurance or adequate support are left out, highlighting the need for equity in integration efforts.
- Concerns about Funding / Resources (2 mentions): Stakeholders noted that funding has not matched the scale of integration and expressed concern about MH resources being diverted.
- Systemic Challenges / Legal Limits (2 mentioned): Legal and systemic barriers were noted as significant obstacles, even if integration is widely supported.

Interpretation:
Stakeholders largely see integration as essential and overdue, describing MH and SUD as inherently connected. However, they caution that without adequate funding, staff support,

	and solutions for systemic/legal barriers, integration may fall short of its promise of true whole-person care.	
3	**07/14/25**	**Listening Session: Q: What does this look like?**
	Overview: Stakeholders' responses highlight the need for timely access, integrated services, and removal of systemic barriers that prevent coordinated care. **Key Findings:** • Integration / Collaboration / Teamwork (11 mentions): The most common theme. Stakeholders envision seamless collaboration across providers and systems, including cross-training, shared caseloads, and one-stop access to both MH and SUD services. • Barriers / System Challenges (3 mentions): Stakeholders noted obstacles such as privacy/confidentiality laws, separate electronic health records (EHRs), and siloed operations that hinder integration. • Follow-up / Continuity of Care (2 mentions): Concerns about poor follow-up after crisis interventions, with calls for consistent mental health support after initial engagement. • Timely Access / Immediate Services (1 mention): Urgency in reducing long waiting times, emphasizing services should be available immediately or as soon as possible. • Equity / Access (1 mention): Special concerns about access for youth, rural residents, and those without reliable transportation. **Interpretation:** Stakeholders broadly envision whole-person care as a seamless, collaborative system with fewer silos and greater integration across MH and SUD services. However, to fully realize this vision, barriers such as long wait times, regulatory hurdles, and inequitable access must be addressed.	
4	**07/14/25**	**Listening Session: Q: What do you see as the unserved or underserved population with the most pressing behavioral health needs in our community?**
	Overview: Responses consistently pointed to homelessness, rural access issues, and vulnerable children and families as priority areas. **Key Findings:** • Rural Populations / Transportation Barriers (10 mentions): Transportation challenges and lack of access in rural areas outside Bakersfield were noted repeatedly as barriers to care. • Homeless Populations (7 mentions): The most frequently identified group. Stakeholders cited homelessness as highly visible, pressing, and often overlapping with other behavioral health needs. • Children / Youth / Families (7 mentions): Multiple responses highlighted children, youth, and families, particularly those with MH/SUD needs, as underserved groups requiring early intervention and greater access. • Stigma / Awareness Issues (2 mentions): Stigma about behavioral health and lack of knowledge within families remain barriers to care.	

	• Judicial System-Involved (1 mention): The need for treatment within custody and post-release support was noted. • Developmental Delays (1 mention): Adults and children with developmental delays were identified as underserved. • Veterans (1 mention): Veterans with behavioral health needs were specifically mentioned. **Interpretation:** Stakeholders view homelessness, rural access, and children/youth as the most urgent areas of unmet need. Transportation barriers and stigma further compound inequities, while specialized groups such as veterans, justice-involved individuals, and those with developmental delays also require targeted interventions.	
5	**07/14/25**	**Listening Session: Q: Are there specific populations (i.e., youth, older adults, homeless individuals) that face barriers in accessing behavioral health care?**
	Overview: Stakeholders identified several populations who face significant barriers to accessing behavioral health care. Recurring themes include socioeconomic disadvantages, stigma, cultural barriers, and logistical obstacles such as transportation. **Key Findings:** • Stigma / Generational Gaps / Navigation Issues (9 mentions): The most common barrier. Respondents emphasized stigma, lack of knowledge on how to navigate systems, and generational gaps in understanding behavioral health. • Low Socioeconomic Status / Poverty (5 mentions): Poverty and economic hardship were frequently cited as barriers to accessing timely care. • Youth (4 mentions): Youth were highlighted due to stigma, generational disconnect with parents, and difficulty navigating services. • Cultural / Language Barriers (3 mentions): Latino communities, farmworkers, monolingual Spanish speakers, and LGBTQ+ individuals were noted as facing additional cultural and language-related challenges. • Rural Populations / Transportation Barriers (3 mentions): Transportation issues, rural isolation, and lack of infrastructure were highlighted. • Homeless Populations (2 mentions): Homeless and emancipated youth, in particular, were noted as highly vulnerable groups. • Older Adults (2 mentions): Barriers include discomfort seeking services alongside younger adults and cultural stigma. • Veterans (1 mention): Veterans were specifically identified as facing access barriers, particularly related to wait times. **Interpretation:** Stakeholders view barriers as multifaceted, rooted in stigma, poverty, cultural challenges, and systemic issues such as transportation and navigation. Addressing these barriers will require targeted outreach, culturally responsive care, and improved system navigation support for vulnerable populations.	

6	**07/14/25**	**Listening Session – Q: Where do you see gaps in how behavioral health treatment is provided in our community?**
	Overview: Stakeholders' responses highlighted needs around housing, mobile crisis services, workforce shortages, and navigation challenges. **Key Findings:** • Housing / MET / Crisis Services (4 mentions): Stakeholders stressed the need for more housing, mobile evaluation/treatment (MET) units, and crisis response capacity. • Navigation / System Fragmentation (4 mentions): Multiple respondents noted that people fall through the cracks between hospitals, managed care providers, and specialty systems (e.g., MH vs. SUD). • Stigma / Outreach / Engagement (3 mentions): Continued need to reduce stigma and increase engagement, especially by targeting youth and diverse populations. • Staffing / Workforce Capacity (2 mentions): Concerns about insufficient staff meeting demand and providing intensive, consistent care. • Youth / Family Engagement (2 mentions): Early education for youth and family-centered supports were emphasized. • Bilingual / Culturally Responsive Services (2 mentions): Calls for more bilingual providers and services tailored to diverse groups. • Court-Ordered Treatment / BH Beds (1 mention): Gaps noted in mandated treatment capacity and inpatient availability. • Older Adults / Age-Related Decline (1 mention): Aging populations with behavioral health needs were noted as underserved. • No Gaps Seen (1 mention): A minority perspective suggested services exist but need expansion and engagement. Interpretation: Stakeholders broadly identified housing, crisis response, navigation, and workforce shortages as the most pressing treatment gaps. While some view the system as improving, persistent barriers—particularly around staffing, culturally responsive services, and system fragmentation—continue to limit access and effectiveness. **Interpretation:** Stakeholders broadly identified housing, crisis response, navigation, and workforce shortages as the most pressing treatment gaps. While some view the system as improving, persistent barriers—particularly around staffing, culturally responsive services, and system fragmentation—continue to limit access and effectiveness.	
7	**07/14/25**	**Listening Session – Q: What types of housing options do you think are missing or limited in Kern County?**
	Overview: Responses highlighted affordability, supportive housing, and specialized housing needs for vulnerable populations. **Key Findings**:	

- Affordable Housing (7 mentions): The most common theme. Stakeholders emphasized high costs, lack of affordable units, and limited options for individuals transitioning from supportive housing.
- Supportive Housing (6 mentions): Strong need for housing with integrated support services for individuals with mental health or substance use disorders, as well as transitional and ongoing supportive models.
- Veteran Housing (1 mention): Affordable housing dedicated to veterans was specifically noted as missing.
- Youth / TAY / Family Housing (1 mention): Stakeholders called for safe, family-like placements for foster youth and transitional age youth.
- Long-Term Housing (1 mention): The need for permanent, stable housing options beyond transitional programs was mentioned.
- Adult Residential Housing (1 mention): Residential options for adults with behavioral health needs were highlighted.
- SUD Inpatient / Recovery Housing (1 mention): Inpatient housing options for substance use disorder recovery were identified as lacking.
- Skills / Education for Housing Stability (1 mention): Educational support to help individuals gain and maintain housing was suggested.
- Outreach / Awareness (1 mention): Suggestions included stronger media campaigns targeted to youth about housing resources.

Interpretation:
Stakeholders see affordable and supportive housing as the most pressing gap. Specialized housing for veterans, youth, individuals in recovery, and adults with complex needs is also missing. Addressing these gaps will require both building affordable housing stock and embedding behavioral health support into housing options.

8	**07/14/25**	**Listening Session: (Q): What would Kern BHRS prioritize?**

A. Increase Care Experience
B. Reduce Overdoses
C. Increase Prevention/Treatment of Co-occurring Public Health Conditions
D. Increase Quality of Life
E. Increase Social Connection
F. Hospitalizations
G. Homelessness
H. Other

Key Findings:
1. (C) Increase Prevention/Treatment of Co-occurring Public Health Conditions (17%)
2. (G) Homelessness (15%)
3. (A) Increase in Care Experience (13%)
4. (D) Increase Quality of Life (13%)

5. (B) Reduce Overdoses (13%)
6. (F) Hospitalizations (13%)
7. (G) Increases Social Connection (9%)
8. (H) Other: (Youth knowledge, Housing, Care Integration and Coordination, Distribution of Services to Rural Areas, Correction Involvement, Transportation Needs, Lockdown Treatment, and Other Holistic care) (8%)

9 | **07/14/25** | **Listening Session: (Q): Do you have any questions or concerns?**

Key Findings:
1. Starting with youth. Think outside the box in catching their attention.
2. Think outside the box to engage the community.
3. Evaluate and potentially leverage the "Housing First" initiative.

10 | **August 2025** | **During the month of August 2025, we ask stakeholders (including Spanish Speaking stakeholders) to rank the following additional goals for the Kern BHRS Integrated Plan (2026-2029).**

Top 3 Results**: Reduce Suicides (86), Reduce Overdoses (85), and Increase Prevention/ Treatment of Co-occurring Public Health Conditions (68).

Additional Goals	Total
Increase Care Experience	62
Increase Engagement in School	64
Increase Engagement in Work	59
Reduce Overdoses	85
Increase Prevention/Treatment of Co-occurring Public Health Conditions	68
Increase Quality of Life	67
Increase Social Connection	58
Reduce Suicides	86

***NOTE: In August, stakeholders were instructed to rate from 1 to 8 with #1 (lowest) and #8 (highest). Therefore, the priorities with the highest numbers were selected.*

11 | **September 2025** | **During the month of September 2025, we asked stakeholders (including Spanish Speaking stakeholders) to rank the following additional goals for the Kern BHRS Integrated Plan (2026-2029).**

Top 3 Results:** Increase Quality of Life (94), Reduce Overdoses (96), and Increase Quality of Life (102).

Additional Goals	Total
Increase Care Experience	112
Increase Engagement in School	120

		Increase Engagement in Work	148
		Reduce Overdoses	96
		Increase Prevention/Treatment of Co-occurring Public Health Conditions	94
		Increase Quality of Life	102
		Increase Social Connection	118
		Reduce Suicides	71
		***NOTE: In September, stakeholders were instructed to rate from 1 to 8 with #1 (highest) and #8 (lowest). Therefore, the priorities with the lowest numbers were selected.*	
12	**October 2025**	**During the month of October 2025, we provided the results of the *Additional Goal* selection.**	
	Key Findings: • The *Additional Goal* selected **"Reduce Overdoses".** • The Reduce Overdoses additional goal was selected by combining the results of priorities ranked by the stakeholders who attended the *August and September Meaningful Engagement Activities* and the data received from CalMHSA.		
13	**November 2025**	**During the month of November 2025, we experienced a drop in stakeholder attendance due to weather conditions.**	
	Key Findings: • N/A		
14	**December 2025**	**During the month of December 2025, we continued to experience a drop in stakeholder attendance due to weather conditions and holidays.**	
	Key Findings: • N/A		

COMMUNITY PLANNING PROCESS

(January 2025 – January 2026)

STATEHOLDER ENGAGEMENT: A. County Outreach through social media

Date	Engagement Type/Stakeholder Type	No. of Views
2025-26	A. County outreach through social media	Views
01/08/25	Instagram	358
01/13/25	Instagram	701
01/13/25	Facebook	1,023
03/12/25	Instagram	258
04/09/25	Instagram	355
04/16/25	Instagram	289
08/13/25	Instagram	355
09/10/25	Instagram	331
	Total Views	**3,026**

STATEHOLDER ENGAGEMENT: B. County Outreach through townhall meetings

Date	Engagement Type/Stakeholder Type	No. of Participants
2025-26	B. County outreach through townhall meetings	No. of Participants
01/08/25	Stakeholder Types: 1,3, 5, 7, 8, 9, 15, 16, 18, 19, and 30.	28
01/15/25	Stakeholder Types: 1,2, 3, and 5.	18
02/12/25	Stakeholder Types: 1,3, 5,15, 16 and 29.	14
02/19/25	Stakeholder Types: 2, 3, and 5.	8
03/12/25	Stakeholder Types: 3, 5,16 and 19.	14
03/19/25	Stakeholder Types: 1, 2, 3, and 5.	8
03/26/25	Stakeholder Types: 1, 3, 5, 16, and 18.	9
04/09/25	Stakeholder Types: 1, 3, 5, 16, 18 and 24.	14
04/16/25	Stakeholder Types: 1, 2, 3, and 5.	12
05/14/25	Stakeholder Types: 3, 5, 16, and 24.	8
05/21/25	Stakeholder Types: 1, 2, 3, and 5.	8
06/11/25	Stakeholder Types: 3, 5, 16, 18, 19, 24, 28, and 30.	13
06/18/25	Stakeholder Types: 1, 2, 3, and 5.	6
07/09/25	Stakeholder Types: 1, 3, 5, and 16.	10
07/16/25	Stakeholder Types: 1, 2, and 5.	5
08/13/25	Stakeholder Types: 2, 3, 5, 14, and 18.	8
08/20/25	Stakeholder Types: 1, 2, 3, and 5.	9
09/10/25	Stakeholder Types: 3, 4, 5, 11, and 16.	6
09/17/25	Stakeholder Types: 1, 2, 4, 22 and 30.	3
10/08/25	Stakeholder Types: 3, 5, 16, 18, 24, and 26.	10
10/15/25	Stakeholder Types: 1 and 2.	3
11/12/25	Stakeholder Types: 3, 5, 6,16, 18, and 24.	8

COMMUNITY PLANNING PROCESS

(January 2025 – January 2026)

11/19/25	Stakeholder Types: 1 and 2.	3
12/10/25	Stakeholder Types: 1, 3, 5, 6, 11, 16, 18, 26, and 30.	14
12/17/25	Stakeholder Types: 1 and 2.	3
01/14/26	Stakeholder Types: 1, 3, 5, 6, 11, 13, 15, 16, 18, 23, 24, 26, and 30.	26
01/21/26	Stakeholder Types: 2 and 5.	3
	Total Participants	**271**

STATEHOLDER ENGAGEMENT: D. Focus group discussions

Date	Engagement Type/Stakeholder Type	No. of Participants
2025	**D. Focus group discussions**	**No. of Participants**
07/14/25	Stakeholder Types: 2, 3, 5, 6, 7, 8, 14, and 30.	22
09/30/25	Stakeholder Types: 6, 9, 16, and 26.	12
	Total Participants	**34**

STATEHOLDER ENGAGEMENT: E. Key Informant interviews with subject matter experts

Date	Engagement Type/Stakeholder Type	No. of Participants
2025	**E. Key informant interviews with subject matter experts**	**No. of Participants**
10/27/25	Stakeholder Types: 18.	3
	Total Participants	**3**

STATEHOLDER ENGAGEMENT: I. Survey Participation

Date	Engagement Type/Stakeholder Type	No. of Participants
2025	**I. Survey Participation**	**No. of Participants**
09/17/25	Stakeholder Types: 5 and 30.	6
	Total Participants	6

STATEHOLDER ENGAGEMENT: K. Workgroups and committee meetings

Date	Engagement Type/Stakeholder Type	No. of Participants
2025	**K. Workgroups and committee meetings**	**No. of Participants**
10/27/25	Stakeholder Types: 6, 18, 26 and 29.	46
01/26/26	Stakeholder Types: 5 and 6.	32
	Total Participants	**78**

COMMUNITY PLANNING PROCESS

(January 2025 – January 2026)

STATEHOLDER ENGAGEMENT: L. Other: Public Hearing

Date	Engagement Type/Stakeholder Type	No. of Participants
2026	**L. Other: Public Hearing**	**No. of Participants**
01/26/26	Stakeholder Types: 3, 4, 5, 7, 8, 9, 14, 18, 26, and 30.	18
	Total Participants	**18**

Attachment C

2025 CPP Meeting Minutes

CPPP – Community Forum Minutes

July 9, 2025

12:00 PM – 2:00 PM

Westchester Training Room

Number of stakeholders in attendance:

- **In Person: 7 (3 clients, 1 peer/fam, 1 higher ed., 1MCP, 1 Declined)**
- **Virtual: 3 (2 MH Providers & 1 Declined)**

MHSA Team members in attendance:

Camden Trapp	**Estela Padilla**	**Mark Kimmel**
Cassie Deras-Coker	**Leydi Garcia De Luna**	**Sara Palmer**

Facilitator: Mark Kimmel **Scribe: Sara Palmer**

Other presenters: n/a

Minutes

I. **Welcome and Land Acknowledgement by Sara Palmer**

II. **Announcements by Sara Palmer**
   a. **Kern County Child Support Annual Ready-Set Back 2 School – July 18th – August 7th**
   b. **Friendship House Backpack Giveaway – August 2nd**
   c. **Kern County Public Works – Needle disposal boxes (Ongoing)**
   d. **Cultural Competence Resource Committee – Invitation to join (Ongoing)**
   e. **KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing)**
   f. **Prepare U – FREE Access to mental health education (Ongoing)**
   g. **KernBHRS – MHSA is bringing back the CPPP incentive program – We want your feedback**

III. **MHSA Education by Camden Trapp**

IV. **Behavioral Health Services Act Transformation Update by Camden Trapp**

a. **Local-Level Stakeholder changes and updates**
b. **What we know**
    i. **Full-Service Partnerships (FSP)**
    ii. **BHSS**

V. **BHSA Integrated Plan by Mark Kimmel**
a. **Questions & Comments from the Audience after the presentation:**
    i. **(Q)What is MHSA? (A)(Mark) It stands for the Mental Health Services Act**
    ii. **(Q)Does it help pay for disability? (A)(Mark) No. This is a little different kind of service to folks with different needs.**
    iii. **(Q)Does it come from the taxes we pay? (A)(Mark) Technically, yes. The funding comes from the taxes paid by the millionaires in California.**
    iv. **(Q) How do the homeless receive services? (A)(Mark) We have teams that go out in the community and provide services to those who need that kind of assistance.**
    v. **(Q) Will the Early Psychosis Program be under Early Intervention? (A)(Camden) We are currently funding Early Psychosis through a different grant. Once that grant ends, we will look to where it better fits in because Early Psychosis is a requirement to have, but we don't know just yet where it will fall under.**
    vi. **(Q)I am so glad to hear that you have people providing services at the room and board facilities! (A)(Mark) Thank you for saying that! I am sure they would appreciate hearing that.**

VI. **Innovation Projects Update by Mark Kimmel**
a. **CalMHSA – Quality Assurance/Quality Improvement QA/QI**
b. **Population Health Management**
c. **Questions & Comments from the Audience after the presentation:**
    i. **(Q) What data are you collecting for plans? (A)(Mark) We collect all types of things like homelessness rates, substance abuse, suicide rates, and much more.**

VII. **Listening Session by Camden Trapp**

VIII. **Next meetings:**
a. **CPPP Spanish Community Forum on Wednesday, July 16th, here at the Westchester Training Room from 12 to 2 PM**
b. **CPPP English Community Forum on Wednesday, August 13th, here at the Westchester Training Room from 12 to 2 PM**

IX. **Numbers to Know by Camden Trapp**
X. **End of meeting**

Meaningful Engagement Event Report

Date:	Activity Type:	Name of Event:	Location:
07/14/2025	Listening Session	Listening Session with Behavioral Health Board	Kern BHRS Westchester Training Room

Purpose of Event:	**Listening session with Behavioral Health Board (BHB) members and Kern BHRS Admin to obtain feedback on the development and planning of the Three-Year Integrated Plan.**
Attendance:	**18**
MHSA Team:	**Mark Kimmel, MHSA Coordinador**
Agenda:	**Attached**

KERN COUNTY BEHAVIORAL HEALTH BOARD

https://www.kernbhrs.org/about-us/behavioral-health-board

Behavioral Health & Recovery Services

Location: 2001 28th Street – 1st Floor Training Room

July 14, 2025

STRATEGIC PLANNING AGENDA

5:30 p.m.	1. Dinner (Self-Serve) & Networking (10 Mins)
5:40 p.m.	2. BHB Introductions – Alison Burrowes (10 Mins)
5:50 p.m.	3. BHSA Stakeholder Presentation – Mark Kimmel (25 Mins)
6:15 p.m.	4. Behavioral Health Plan Activity – Robin Taylor and Jessica Armstrong (35 Mins)
6:50 p.m.	5. KernBHRS Strategic Plan Activity – Heather Hornibrook (35 Mins)
7.25 p.m.	6. Wrap Up – Alison Burrowes (5 Mins)

CPPP – Community Forum Minutes (Spanish in Person & Virtual)

July 16, 2025

12:00 PM – 2:00 PM

Westchester Training Room

Foro Comunitario en Persona (español en Persona y Virtual)

16 de julio del 2025

Sala de Entrenamiento de Westchester

Number of stakeholders in attendance/Total de Asistencia:

- **In Person: 6 (1 client, 2 family members, 2 MH providers, 1 CBO)**
  En Persona: 6 (1 cliente, 2 familias, 2 proveedores de salud mental, 1 de organización basada en la comunidad)
- **Virtual/Virtual: 0**

MHSA Team members in attendance/Miembros del Equipo MHSA Presentes:

- **Estela Padilla**
- **Cassie Deras-Coker**
- **Leydi Garcia De Luna**
- **Camden Trapp**
- **Sara Palmer**

Facilitator/Facilitadora: Leydi Garcia De Luna

Minutes/Minutos

I. **Welcome and Land Acknowledgement by Leydi Garcia De Luna**
Bienvenida y Reconocimiento de la Tierra presentado por Leydi García De Luna

II. **Announcements by Leydi Garcia De Luna**
Anuncios por Leydi García de Luna
   a. **16th Annual Ready-Set Back 2 School – multiple dates and locations. See flyer for more details.**
   16º Evento Anual de Mochilas Gratis – múltiples fechas y lugares. Consulte el folleto para obtener más detalles.

b. **Friendship House Community Center School Backpack Giveaway & more! On Saturday, August 2nd.**
¡Regalos de mochilas escolares por parte del Centro Comunitario Friendship House! Sábado, 2 de agosto.
c. **Kern County Public Works – FREE containers and disposal for used needles.**
Obras Públicas del Condado de Kern: contenedores GRATUITOS y eliminación de agujas usadas.
d. **Cultural Competence Resource Committee – Invitation to join (Ongoing).**
Comité de recursos de Competencia Cultural – Invitación continua para unirse
e. **KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing).**
Voluntarios para la Línea de Crisis de KernBHRS – Reclutamiento continuo.
f. **Prepare U – FREE Access to mental health education (Ongoing).**
Prepárese usted - Acceso GRATUITO a educación para la salud mental continuo.
g. **Community Forum Incentive Program July 2025 to June 2026.**
Programa de Incentivos para Foros Comunitarios julio 2025 a junio 2026.

III. **MHSA Education by Leydi Garcia De Luna**
Educación de MHSA por Leydi García de Luna
a. **Questions and Comments from the audience after the Presentation**
Preguntas y Comentarios por parte de la audiencia después de la presentación:
i. **None**
Ninguna

IV. **Behavioral Health Services Act Transformation Update by Leydi Garcia De Luna**
Actualizaciones sobre la Transformación de la Salud Conductual presentadas por Leydi García de Luna
a. **Local-Level Stakeholder changes and updates**
Cambios y actualizaciones de las partes interesadas a nivel local
b. **Changes due to the transition to Behavioral Health Transformation/Prop 1**
Cambios en el programa MHSA debido a la transición a la Transformación de Salud Conductual/Propuesta 1
c. **New Integrated Plan to report on all income sources and only BHSA**
Plan integrado de la BHSA reportará todas las fuentes de ingresos y no solo BHSA.
d. **Questions and Comments from the audience after the Presentation**
Preguntas y Comentarios por parte de la audiencia después de la presentación:
i. **None**
Ninguna

V. **Full-Service Association (FSP) presented by Leydi Garcia De Luna**
Asociación de Servicio Completo (FSP)
a. **Questions and Comments from the audience after the presentation**

Preguntas y Comentarios por parte de la audiencia después de la presentación:

i. **None**
Ninguna

VI. **35% Behavioral Health Services and Support**

35% servicios y apoyo de salud conductual (BHSS)

a. **Questions and Comments from the audience after the presentation:**

Preguntas y Comentarios por parte de la audiencia después de la presentación:

i. **None**
Ninguna

VII. **Innovation Projects Update by Leydi Garcia De Luna**
Actualización sobre los Proyectos de Innovación presentado por Leydi Garcia De Luna

a. **EHR/CalMHSA: Kern County Board of Supervisors approved the Innovation proposal on July 15th. We are waiting for the appointment to present before the Oversight and Accountability Committee.**
EHR / CalMHSA: La Junta de Supervisores del Condado de Kern aprobó la propuesta de innovación el 15 de julio. Estamos a la espera de la cita para presentar ante el Comité de Fiscalía y Rendición de Cuentas.
b. **Population Health Management is in the development stage. We have to design the program and prepare it for the 30-Day Circulation and Public comment period.**
La Gestión de la Salud de la Población está en etapa de desarrollo. Tenemos que diseñar el programa y prepararlo para el periodo de 30 días de circulación y comentarios públicos.

c. **Questions and Comments from the audience after the presentation:**

Preguntas y Comentarios por parte de la audiencia después de la presentación:

i. **None**
Ninguna

VIII. **Behavioral Health Transition Population Health Strategy**
Transformación de Salud Conductual: Estrategia de Salud Poblacional
a. **Priority Goals**
Objetivos Prioritarios
b. **Additional Goals**
Objetivos Adicionales

IX. **Survey/Encuesta**
a. **Questions/Preguntas:**
i. **Q: ¿Tengo que poner mi nombre en la encuesta? / Do I have to write my name on the survey?**
A: No, no necesita poner su nombre en la encuesta. / No, you do not need to write your name on the surveys.
ii. **Q: ¿Qué pongo donde dice ubicación?**
A: No se preocupe, nosotros podemos completar esa sección.

iii. **Andrea Chávez de CAPK proporcionó información sobre los servicios gratuitos de VITA y sobre el Taller en Colaboración acerca de ITINs.**
Andrea Chavez from CAPK provided information about VITA's free services and the ITIN Collaborative Workshop.

X. **Listening Session by Leydi Garcia De Luna**
Sesión de Escucha presentada por Leydi Garcia De Luna

a. **Questions and Comments from the audience after the presentation:**

Preguntas y Comentarios por parte de la audiencia después de la presentación:

i. **None**
Ninguna

XI. **Next meetings:**
Siguientes juntas:

a. **CPPP English Community Forum on Wednesday, August 13th, here at the Westchester Training Room from 12 to 2 PM**
CPPP Foro Comunitario en inglés el miércoles, 13 de agosto, aquí en el Cuarto de Entrenamiento Westchester de 12 a 2 PM.
b. **CPPP Spanish Community Forum on Wednesday, August 20th, here at the Westchester Training Room from 12 to 2 PM**
CPPP Foro Comunitario en Ingles el miércoles, 20 de agosto, aquí en el Cuarto de Entrenamiento Westchester de 12 a 2 PM

XII. **Numbers to Know by Leydi Garcia De Luna**
Números para Saber presentado por Leydi Garcia De Luna

XIII. **End of meeting**
Final de la junta

CPPP – Community Forum Minutes

August 13, 2025

12:00 PM – 2:00 PM

Westchester Training Room

Number of stakeholders in attendance:

In Person: 8 (3 Peers/Fam., 1 Native American, 4 MH Providers) **Virtual: 0**

MHSA Team members in attendance:

Camden Trapp **Tia Flores** **Mark Kimmel**

Cassie Deras-Coker **Leydi Garcia De Luna**

Facilitator: Mark Kimmel **Scribe: Tia Flores**

Other presenters: Jennie Sill

Minutes

I. **Welcome and Land Acknowledgement by Tia Flores**

II. **Announcements by Tia Flores**
   a. **Kern BHRS September Calendar of Events**
   b. **Puentes-Bridges Kern-Coordinated Family Supports 8/19/2025 & 8/26/2025**
   c. **Project Food Box- Invitation to enroll (Ongoing)**
   d. **KERN S.A.F.E Spay & Neuter Program (Ongoing)**
   e. **Cultural Competence Resource Committee – Invitation to join (Ongoing)**
   f. **KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing)**
   g. **Prepare U – FREE Access to mental health education (Ongoing)**
   h. **KernBHRS – MHSA is bringing back the CPPP incentive program – We want your feedback**

III. **MHSA Education by Tia Flores**

IV. **Local-Level Stakeholder changes and updates by Tia Flores**

V. **Youth Juvenile Justice Engagement: Future Focused by Jennie Sill**

VI. Behavioral Health Services Act Transformation Update by Mark Kimmel

- **a. What we know**
  - **i. Housing Allocation**
  - **ii. Full-Service Partnerships (FSP)**
  - **iii. BHSS**
- **b. Questions & Comments from the Audience after the presentation:**
  - **i. (Q) Will residential treatment centers come under the housing or BHSS bucket?**
    (A) (Mark) When you say residential treatment, what are you referring to when you say that? For substance?
    (Q) Yes, along with the substance use, but also for adolescent residential treatment centers
    (A) (Mark). So, that could be under the substance abuse side, which would necessarily be here; But under BHSS, but under the new rules under housing, it could include some of those. Depending on the type of programming facility, it could fall under the BHSS or housing bucket. I hope that answers.
    (A) Yes, because I have been going through the website page, and some of those come under housing, substance abuse, and other sections.
  - **ii. (Q) On the housing, do you happen to know the rates for the rental subsidies and confirm that those will support long-term housing and not just transitional?**
    (A) (Mark) They will do permanent; I don't have those rates with me now. I think they have kind of given us an idea of what those rates will look like. I am not certain what that looks like.
  - **iii. (Q) Are you aware of teams for services for people that have been through a lot of training in therapeutic activities over a long period of time, but might still qualify, if not need some exposure or inclusion in whatever program that involves seniors?**
    (A) (Mark) Yes, the WISE team currently does that.

VII. BHSA Integrated Plan by Mark Kimmel

- **a. Questions & Comments from the Audience after the presentation:**
  (none)

VIII. Innovation Projects Update by Mark Kimmel

- **a. CalMHSA – Quality Assurance/Quality Improvement QA/QI**
- **b. Population Health Management:**
  - **i. Reflection on Population Health Management**
    1. **Does this definition of PHM resonate with you? When I mention "population health management," we mention the idea of collecting related that. What does that tell you?**
       (Q) How is the data interpreted and used?

(A) What if I were to tell you that the information is going to be used to better serve our community?
(A) If that information is used to better serve our community, I agree with the data collection.
(A) Collecting data from individuals that may help them obtain other services, like applying for social security, or help them become stable.
Data-driven approach of pragmatic design for program modifications.

c. **Population Health Strategy**
Questions & Comments from the Audience after the presentation:
(none)
d. **Population Health Management – Poll cards completed**

IX. Listening Session by Tia Flores

a. **(Comment from Stakeholder) I attended the ADA conference last month and learned about a federal provision that anyone who ever believed or perceived to have had a mental health issue is eligible to be compensated. Has anyone heard about this?**
No, we have not heard about this.

b. **We asked our stakeholders to rank the following additional goals for the KernBHRS Integrated Plan (2026-2029). The top 3 are highlighted in yellow.**

	1	2	3	4	5	6	7	Total
Increase Care Experience	**8**	**2**	**8**	**4**	**5**	**3**	**7**	**37**
Increase Engagement in School	4	8	2	3	2	4	6	**29**
Increase Engagement in Work	2	3	1	8	4	2	4	**24**
Reduce Overdoses	7	6	5	1	1	8	2	**30**
Increase Prevention/Treatment of Co-occurring Public Health Conditions	3	4	4	5	3	5	8	**32**
Increase Quality of Life	**5**	**5**	**7**	**6**	**8**	**6**	**5**	**42**
Increase Social Connection	1	1	6	7	6	1	3	**25**
Reduce Suicides	**6**	**7**	**3**	**2**	**7**	**7**	**1**	**33**

X. Next meetings:

a. **CPPP Spanish Community Forum on Wednesday, August 20th, here at the Westchester Training Room from 12 to 2 PM**
b. **CPPP English Community Forum on Wednesday, September 10th, here at the Westchester Training Room from 12 to 2 PM**

XI. Numbers to Know by Tia Flores

XII. End of meeting

CPPP – Community Forum Minutes (Spanish in Person & Virtual)

August 19th, 2025

12:00 PM – 2:00 PM

Westchester Training Room

Foro Comunitario en Persona (español en Persona y Virtual)

19 de agosto del 2025

Sala de Entrenamiento de Westchester

Number of stakeholders in attendance/Total de Asistencia:

- **In Person: 9 (2 clients, 2 Family, 2 Peers & lived exp., 3 MH Providers)**
  En Persona: 9 (2 clientes, 2 familias, 2 compañeros y experiencia vivida, 3 proveedores de MH)
- **Virtual/Virtual: 0**

MHSA Team members in attendance/Miembros del Equipo MHSA Presentes:

- **Estela Padilla**
- **Cassie Deras-Coker**
- **Leydi Garcia De Luna**
- **Camden Trapp**
- **Mariliea Prado**

Facilitator/Facilitadora: Leydi Garcia De Luna

Scribe/Escriba: Mariliea Prado

Minutes/Minutos

I. **Welcome and Land Acknowledgement by Leydi Garcia De Luna**
   Bienvenida y Reconocimiento de la Tierra presentado por Leydi García De Luna

II. **Announcements by Leydi Garcia De Luna**
   Anuncios por Leydi Garcia De Luna
   a. **September 2025 Calander of Events**
      Calendario de eventos de septiembre de 2025
   b. **Puentes/Bridges Coordinated Family Supports (CFS) 08/19/25 2-3pm, 08/26/25 5-6pm**
      Apoyos Familiares Coordinados 08/19/25 2–3pm, 08/26/25 5-6pm

c. **Kern Safe Spay and Neuter Clinics**
   Kern Safe Clínicas de esterilización y castración
d. **Project Food Box**
   Proyecto Caja de Alimentos
e. **Cultural Competence Resource Committee – Invitation to join (Ongoing)**
   Comité de recursos de Competencia Cultural – Invitación continua para unirse
f. **KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing)**
   Voluntarios para la Línea de Crisis de KernBHRS – Reclutamiento continuo
g. **Prepare U – FREE Access to mental health education (Ongoing)**
   Prepárese Usted – Acceso GRATUITO a educación para la salud mental continuo
h. **Community Forum Incentive Program July 2025 to June 2026**
   Programa de Incentivos para Foros Comunitarios Julio 2025 a junio 2026

III. **MHSA Education by Leydi Garcia De Luna**
Educación de MHSA por Leydi García De Luna

IV. **Behavioral Health Services Act Transformation Update by Leydi Garcia De Luna**
Actualizaciones sobre la Transformación de la Salud Conductual presentadas por Leydi Garcia De Luna
a. **Local-Level Stakeholder changes and updates**
   Cambios y actualizaciones de las partes interesadas a nivel local
b. **Changes due to the transition to Behavioral Health Transformation/Prop 1**
   Cambios en el programa MHSA debido a la transición a la Transformación de Salud Conductual/Propuesta 1

V. **Youth Juvenile Justice Engagement**
Participación de los jóvenes en la justicia juvenil
a. **Future Focus, July 2025 Update Information. Enfoque Futuro, Información de Actualización de julio del 2025**
b. **Children's System of Care, PEI Juvenile Justice Involvement Initiatives, Juvenile Futures Program. Sistema de Atención Infantil/Juveniles, Iniciativas involucradas en la Justicia Juvenil de PEI, Programa de Futuros Juveniles**

VI. **Mental Health Service Act**
La Ley de servicios de salud mental

VII. **Housing Component of the BHSA by Leydi Garcia De Luna**
Componente de Viviendas de la BHSA presentado por Leydi Garcia De Luna
a. **30% going to housing**
   30% se asignará a fondos de viviendas
b. **$6.38 billion bond available**
   Bono de 6.38 billones de dólares disponible
c. **Questions and Comments from the audience after the presentation**

   Preguntas y Comentarios por parte de la audiencia después de la presentación:

   i. **None (Ninguna)**

VIII. **Full-Service Association (FSP) presented by Leydi Garcia De Luna**
Asociación de Servicio Completo (FSP)

a. **Questions and Comments from the audience after the presentation**

Preguntas y Comentarios por parte de la audiencia después de la presentación:

i. **None**
Ninguna

IX. **35% Behavioral Health Services and Support**

35% servicios y apoyo de salud conductual (BHSS)

a. **Questions and Comments from the audience after the presentation**

Preguntas y Comentarios por parte de la audiencia después de la presentación:

i. **None**
Ninguna

X. **Plan Integrado de la BHSA**

a. **Questions and Comments from the audience after the presentation**

Preguntas y Comentarios por parte de la audiencia después de la presentación:

i. **None**
Ninguna

b. **Questions & Comments from the Audience after the presentation:**
Preguntas y Comentarios por parte de la audiencia después de la presentación:
i. **None**
Ninguna

XI. **Innovation Projects Update by Leydi Garcia De Luna**
Actualización sobre los Proyectos de Innovación presentado por Leydi Garcia De Luna

a. **EHR/CalMHSA: Kern County Board of Supervisors approved the Innovation proposal on July 15th. We are waiting for the appointment to present before the Oversight and Accountability**
EHR / CalMHSA: La Junta de Supervisores del Condado de Kern aprobó la propuesta de innovación el 15 de julio. Estamos a la espera de la cita para presentar ante la Fiscalía y Rendición de Cuentas
b. **Population Health Management is in the development stage. We have to design the program and prepare it for the 30-Day Circulation and Public comment period.**
La Gestión de la Salud de la Población está en etapa de desarrollo. Tenemos que diseñar el programa y prepararlo para el periodo de 30 días de circulación y comentarios públicos.

c. **Reflection**
Reflexión

i. **Does this definition resonate with you?**
Yes
¿Puedes entender esa definición?
Si

ii. **What does population health management look like to you?**
¿Como visualiza usted la gestión popular?

XII. Behavioral Health Transition Population Health Strategy
Transformación de Salud Conductual Estrategia de Salud Poblacional

a. **Priority Goals**
Objetivos Prioritarios

b. **Additional Goals**
Objetivos Adicionales

XIII. Survey
Encuesta

XIV. Listening Session by Leydi Garcia De Luna
Sesión de Escucha presentada por Leydi Garcia De Luna

a. **We asked our stakeholders to rank the following additional goals for the KernBHRS Integrated Plan (2026-2029). The top 3 are highlighted in blue.**

8/20/25 SPANISH	1	2	3	4	5	6	7	Total
Increase Care Experience	8	0	0	8	6	1	8	31
Increase Engagement in School	7	0	8	8	5	2	8	38
Increase Engagement in Work	3	8	0	8	7	4	8	38
Reduce Overdoses	4	0	0	8	5	3	8	28
Increase Prevention/Treatment of Co-occurring Public Health Conditions	5	0	0	8	6	5	8	32
Increase Quality of Life	6	0	7	8	8	6	8	43
Increase Social Connection	5	0	0	8	6	7	8	34
Reduce Suicides	8	8	6	8	7	8	8	53

a. Pedimos a nuestras partes interesadas que clasificaran los siguientes objetivos adicionales para el Plan Integrado KernBHRS (2026-2029). Los 3 primeros están resaltados en azul.

20/08/25 ESPAÑOL	1	2	3	4	5	6	7	Total
Aumente la experiencia de atención	8	0	0	8	6	1	8	**31**
Aumentar la participación en la escuela	7	0	8	8	5	2	8	**38**
Aumentar el compromiso en el trabajo	3	8	0	8	7	4	8	**38**
Reducir las sobredosis	4	0	0	8	5	3	8	**28**
Aumentar la prevención / tratamiento de afecciones de salud pública concurrentes	5	0	0	8	6	5	8	**32**
Aumentar la calidad de vida	6	0	7	8	8	6	8	**43**
Aumentar la conexión social	5	0	0	8	6	7	8	**34**
Reducir los suicidios	8	8	6	8	7	8	8	**53**

XV. Next meetings:
Siguientes juntas

a. **CPPP English Community Forum on Wednesday, September 10th , here at the Westchester Training Room from 12 to 2 PM**
CPPP Foro Comunitario en Ingles el Miércoles, 10 de septiembre, aquí en el Cuarto de Entrenamiento Westchester de 12 a 2 PM

b. **CPPP Spanish Community Forum on Wednesday, September 17th , here at the Westchester Training Room from 12 to 2 PM**
CPPP Foro Comunitario en Ingles el Miércoles, 17 de septiembre, aquí en el Cuarto de Entrenamiento Westchester de 12 a 2 PM

XVI. Numbers to Know by Leydi Garcia De Luna
Números para Saber presentado por Leydi Garcia De Luna

XVII. End of meeting
Final de la junta

CPPP – Community Forum Minutes

September 10, 2025

12:00 PM – 12:30 PM

Westchester Training Room

Number of stakeholders in attendance:

In Person: 5 (1 individual [peer&fam], 2 MH Providers, 2 Local PH) **Virtual: 1(1 MCP)**

MHSA Team members in attendance:

Camden Trapp	**Tia Flores**	**Mark Kimmel**
Cassie Deras-Coker	**Leydi Garcia De Luna**	**Mariliea Prado**

Facilitator: Mark Kimmel **Scribe: Mariliea Prado**

Other presenters: Tia Flores

Minutes

I. **Welcome and Land Acknowledgement by Tia Flores**

II. **Announcements by Tia Flores**
   a. **Kern BHRS September Calendar of Events**
   b. **Move with MADD**
   c. **Kickin' It with Behavioral Health CSUB Soccer Game**
   d. **MindDivers MH**
   e. **ROWI Teen & Parent Wellness Center**
   f. **Cultural Competence Resource Committee – Invitation to join (Ongoing)**
   g. **KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing)**
   h. **Prepare U – FREE Access to mental health education (Ongoing)**
   i. **KernBHRS – MHSA is bringing back the CPPP incentive program**

III. **MHSA Education by Tia Flores**

IV. **Local-Level Stakeholder changes and updates by Tia Flores**

V. **Behavioral Health Services Act Transformation Update by Mark Kimmel**
   a. **What we know**
      i. **Housing Allocation**
      ii. **Full-Service Partnerships (FSP)**
      iii. **BHSS**
   b. **Questions & Comments from the Audience after the presentation: None**

VI. **BHSA Integrated Plan by Mark Kimmel**
   a. **Questions & Comments from the Audience after the presentation None**

VII. **Behavioral Health Transition Population Health Strategy**
   a. **Priority Goals**
   b. **1 Additional Goal**
   c. **Questions & comments from the audience after the presentation None**

VIII. **Innovation Projects Update by Mark Kimmel**
   a. **CalMHSA – Quality Assurance/Quality Improvement QA/QI**
   b. **Population Health Management**
   c. **Questions & Comments from the Audience after the presentation: (none)**
   d. **Poll cards completed**

IX. **Listening Session by Tia Flores**
   a. **Maria Herrera- ROWI Rep. Introduced ROWI program, initiated in Bakersfield in February 2025. ROWI is a comprehensive mental healthcare for teens and family therapy. Will be collaborating with BHRS soon and contracting with Kern Family.**

X. **Next meetings:**
   a. **CPPP Spanish Community Forum on Wednesday, September 20th, here at the Westchester Training Room from 12 to 2 PM**
   b. **CPPP English Community Forum on Wednesday, October 8th , here at the Westchester Training Room from 12 to 2 PM**

XI. **Numbers to Know by Tia Flores**

XII. **End of meeting**

CPPP – Community Forum Minutes (Spanish in Person & Virtual)

September 17th, 2025

12:00 PM – 1:00 PM

Westchester Training Room

Foro Comunitario en Persona (español en Persona y Virtual)

17 de septiembre del 2025

Sala de Entrenamiento de Westchester

Number of stakeholders in attendance/Total de Asistencia:

In Person/En Persona: 3 (2 family and 1 client) **Virtual/Virtual: 1 (MH provider)**

MHSA Team members in attendance/Miembros del Equipo MHSA Presentes:

Estela Padilla **Leydi Garcia De Luna**

Cassie Deras-Coker **Camden Trapp** **Mariliea Prado**

Facilitator/Facilitadora: Leydi Garcia De Luna **Scribe/Escriba: Mariliea Prado**

Other presenters: Estela Padilla

Minutes/Minutos

I. **Welcome and Land Acknowledgement by Leydi Garcia De Luna**
Bienvenida y Reconocimiento de la Tierra presentado por Leydi García De Luna

II. **Announcements/Anuncios by/por Leydi Garcia De Luna**
   a. **September 2025 Calander of Events**
   Calendario de eventos de septiembre de 2025
   b. **Kickin'It with Behavioral Health CSUB Soccer Game**
   Dándole Patadas a salud conductual 09/17 @7pm
   c. **MindDivers MH**
   MindDivers Salud Mental
   d. **ROWI Teen & Parent Wellness Center**
   Centro de bienestar para padres y adolescentes

e. **Cultural Competence Resource Committee – Invitation to join (Ongoing)**
   Comité de recursos de Competencia Cultural – Invitación continua para unirse
f. **KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing)**
   Voluntarios para la Línea de Crisis de KernBHRS – Reclutamiento continuo
g. **Prepare U – FREE Access to mental health education (Ongoing)**
   Prepárese Usted – Acceso GRATUITO a educación para la salud mental continuo
h. **Kern HBRS-MHSA is bringing back the CPPP incentive program**
   Estará regresando el Programa de Incentivos para Foros Comunitarios

III. **MHSA Education by Leydi Garcia De Luna**
Educación sobre la MHSA presentada por Leydi García De Luna

IV. **Behavioral Health Services Act Transformation Update by Leydi Garcia De Luna**
Actualizaciones sobre la Transformación de la Salud Conductual presentadas por Leydi Garcia De Luna

a. **Local-Level Stakeholder changes and updates**
   Cambios y actualizaciones de las partes interesadas a nivel local
b. **BHSS**
   Servicio y Apoyos de Salud Conductual (BHSS)

V. **Mental Health Service Act**
La Ley de servicios de salud mental

VI. **Housing Component of the BHSA by Leydi Garcia De Luna**
Componente de Viviendas de la BHSA presentado por Leydi Garcia De Luna

a. **30% going to housing**
   30% se asignará a fondos de viviendas
b. **$6.38 billion bond available**
   Bono de 6.38 billones de dólares disponible
c. **Questions and Comments from the a**

VII. **Full-Service Association (FSP) presented by Leydi Garcia De Luna**
Asociación de servicio Completo (FSP)

a. **Questions and Comments from the audience after the presentation**

   Preguntas y Comentarios por parte de la audiencia después de la presentación:

   i. **None**
      Ninguna

VIII. **35% Behavioral Health Services and Support**

35% servicios y apoyo de salud conductual (BHSS)

a. **Questions and Comments from the audience after the presentation**

Preguntas y Comentarios por parte de la audiencia después de la presentación:

i. None
Ninguna

IX. Plan Integrado de la BHSA

a. Questions and Comments from the audience after the presentation

Preguntas y Comentarios por parte de la audiencia después de la presentación:

i. None
Ninguna

b. Questions & Comments from the Audience after the presentation:
Preguntas y Comentarios por parte de la audiencia después de la presentación:

i. None
Ninguna

X. Innovation Projects Update by Leydi Garcia De Luna
Actualización sobre los Proyectos de Innovación presentado por Leydi Garcia De Luna

a. CalMHSA – Quality Assurance/Quality Improvement QA/QI
CalMHSA – Asegureamienot u Mejora de la Calidad (QA/QI

b. Population Health Management is in the development stage. We have to design the program and prepare it for the 30-Day Circulation and Public comment period.
La Gestión de la Salud de la Población está en etapa de desarrollo. Tenemos que diseñar el programa y prepararlo para el periodo de 30 días de circulación y comentarios públicos.

c. Poll Cards completed
Tarjetas electorales completadas

XI. Behavioral Health Transition Population Health Strategy
Transformación de Salud Conductual Estrategia de Salud Poblacional

a. Priority Goals
Objetivos Prioritarios

b. Additional Goals
Objetivos Adicionales

XII. Survey
Encuesta

XIII. Cultural Competence Resource Committee - program will continue. Will be under MHSA/WET
Programa de Competencia Cultural

a. **El programa continuara**
b. **Permanecerá bajo MHSA/WET**

XIV. **Listening Session by Leydi Garcia De Luna**
Sesión de Escucha presentada por Leydi Garcia De Luna

XV. **Next meetings:**
Siguientes juntas

a. **CPPP English Community Forum on Wednesday, October 8th , here at the Westchester Training Room from 12 to 2 PM**
CPPP Foro Comunitario en Ingles el Miércoles, 8 de agosto, aquí en el Cuarto de Entrenamiento Westchester de 12 a 2 PM
b. **CPPP Spanish Community Forum on Wednesday, October 15th , here at the Westchester Training Room from 12 to 2 PM**
CPPP Foro Comunitario en Ingles el Miércoles, 15 de octubre, aquí en el Cuarto de Entrenamiento Westchester de 12 a 2 PM

XVI. **Numbers to Know by Leydi Garcia De Luna**
Números para Saber presentado por Leydi Garcia De Luna

XVII. **End of meeting**
Final de la junta

Meaningful Engagement Event Report

Date:	Activity Type:	Name of Event:	Location:
09/17/25	Survey Participation	Kickin' with Kern BHRS	CSUB Soccer Field

Purpose of Event:	**To outreach hard to reach populations (working parents, college students who live in the dorms, regular students, and soccer clubs) who are available in the evenings.**
Attendance:	**2,012 (children, youth, adults, and older adults)**
MHSA Team:	**6 MHSA team members**
Agenda:	• **Provided 988, mental health, and substance abuse resources.** • **Deputy Director spoke to those attending about behavioral health services.** • **Asked attendees to provide feedback about Behavioral Health Services Act (BHSA) – Integrated Plan additional goals (infographics).**

Meaningful Engagement Event Report

Date:	Activity Type:	Name of Event:	Location:
09/30/2025 10:00am	Targeted Outreach	Homeless Outreach Committee	Bakersfield Kern Regional Homeless Collaborative 2101 Oak St.

Purpose of Event:	**Engage the unhoused population regarding Behavioral Health Transition, Funding and Program Changes and Integrated Plan.**
Attendance:	**12**
MHSA Team:	**Mark Kimmel, Tia Flores**
Agenda:	• **Mental Health Services Act Education** • **Behavioral Health Transition** • **Integrated Plan** • **Additional Goals Poll** • **Q&A Session**
Q&A:	• **For the CSS, what is the SD acronym?** **Mark: System Development, funds different teams like our ROC** • **What about the ROEM team?** **Mark: Currently under FSP, BHSS may fit under there, do not know at this time.** • **For the new housing category 30%, does the department have an idea for capitol?** **Mark: We do not. Not for services, and 50% for chronically homeless.** • **For the chronically homeless 30% is used for housing?** **Mark: Correct** • **Will you be identifying landlords or subsect living?** **Mark: We do not know how it will look yet. Possibly third parties.** • **For 30% housing allocation, I assume county is leveraging CALAIM?** **Mark: I am not sure yet.**

CPPP – Community Forum Minutes

October 8, 2025

12:00 PM – 12:30 PM

Westchester Training Room

Number of stakeholders in attendance:

In Person: **2 individual (peer&fam), 1 MH Provider, 4 MCPs, 2 Tribal, 2 CBO's, and 1 Organization serving the underserved.**

MHSA Team members in attendance:

Camden Trapp	**Leydi Garcia De Luna**	**Estela Padilla**
Cassie Deras-Coker	**Mark Kimmel**	
Tia Flores	**Mariliea Prado**	

Facilitator: Mark Kimmel **Scribe:** Mariliea Prado

Other presenters: Tia Flores

Minutes

I. **Welcome and Land Acknowledgement by Tia Flores**

II. **Announcements by Tia Flores**
   a. **Kern BHRS September Calendar of Events**
   b. **Move with MADD**
   c. **Kickin' It with Behavioral Health CSUB Soccer Game**
   d. **MindDivers MH**
   e. **ROWI Teen & Parent Wellness Center**
   f. **Cultural Competence Resource Committee – Invitation to join (Ongoing)**
   g. **KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing)**
   h. **Prepare U – FREE Access to mental health education (Ongoing)**
   i. **KernBHRS – MHSA is bringing back the CPPP incentive program**

III. **MHSA Education by Tia Flores**

IV. **Local-Level Stakeholder changes and updates by Tia Flores**

V. **Behavioral Health Services Act Transformation Update by Mark Kimmel**
   a. **What we know**
      i. **Housing Allocation**
      ii. **Full-Service Partnerships (FSP)**
      iii. **BHSS**
   b. **Questions & Comments from the Audience after the presentation: None**

VI. **BHSA Integrated Plan by Mark Kimmel**
   a. **Questions & Comments from the Audience after the presentation None**

VII. **Behavioral Health Transition Population Health Strategy**
   a. **Priority Goals**
   b. **1 Additional Goal**
   c. **Questions & comments from the audience after the presentation None**

VIII. **Innovation Projects Update by Mark Kimmel**
   a. **CalMHSA – Quality Assurance/Quality Improvement QA/QI**
   b. **Population Health Management**
   c. **Questions & Comments from the Audience after the presentation: (none)**
   d. **Poll cards completed**

IX. **Listening Session by Tia Flores**
   a. **Maria Herrera- ROWI Rep. Introduced ROWI program, initiated in Bakersfield in February 2025. ROWI is a comprehensive mental healthcare for teens and family therapy. Will be collaborating with BHRS soon and contracting with Kern Family.**

X. **Next meetings:**
   a. **CPPP Spanish Community Forum on Wednesday, September 20th, here at the Westchester Training Room from 12 to 2 PM**
   b. **CPPP English Community Forum on Wednesday, October 8th , here at the Westchester Training Room from 12 to 2 PM**

XI. **Numbers to Know by Tia Flores**

XII. **End of meeting**

CPPP – Community Forum Minutes (Spanish in Person & Virtual)

October 15, 2025

12:00 PM – 1:00 PM

Westchester Training Room

Foro Comunitario en Persona (español en Persona y Virtual)

15 de octubre del 2025

Sala de Entrenamiento de Westchester

Number of stakeholders in attendance/Total de Asistencia:

In Person/En Persona: 3 (2 family and 1 client) **Virtual/Virtual: 0**

MHSA Team members in attendance/Miembros del Equipo MHSA Presentes:

Estela Padilla **Camden Trapp** **Mark Kimmel**

Leydi Garcia De Luna

Facilitator/Facilitadora: Leydi Garcia De Luna **Scribe/Escriba: Estela Padilla**

Other presenters: Estela Padilla

Minutes/Minutos

I. **Welcome and Land Acknowledgement by Leydi Garcia De Luna**
Bienvenida y Reconocimiento de la Tierra presentado por Leydi García De Luna

II. **Announcements/Anuncios by/por Leydi Garcia De Luna**
   a. **4th Annual California Native American Indian Symposium on Intellectual and Developmental Disabilities**
   4º Simposio Anual de Indios Nativos Americanos de California sobre Discapacidades Intelectuales y del Desarrollo
   b. **Health Project – Doula Scholarship Program**
   Proyecto de salud - Programa de becas Doula
   c. **MindDivers – Mental Health providers**
   MindDivers – Proveedores de salud mental

d. **ROWI Teen & Parent Wellness Center**
   Centro de bienestar para padres y adolescentes
e. **Cultural Competence Resource Committee – Invitation to join (Ongoing)**
   Comité de recursos de Competencia Cultural – Invitación continua para unirse
f. **KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing)**
   Voluntarios para la Línea de Crisis de KernBHRS – Reclutamiento continuo
g. **Prepare U – FREE Access to mental health education (Ongoing)**
   Prepárese Usted – Acceso GRATUITO a educación para la salud mental continuo

III. **MHSA Education by Leydi Garcia De Luna**
Educación sobre la MHSA presentada por Leydi García De Luna

IV. **Behavioral Health Services Act Transformation Update by Leydi Garcia De Luna**
Actualizaciones sobre la Transformación de la Salud Conductual presentadas por Leydi Garcia De Luna

a. **Local-Level Stakeholder changes and updates**
   Cambios y actualizaciones de las partes interesadas a nivel local
b. **Full Service Association (FSP)**
   Asociación de Servicios Completo (FSP)
c. **BHSS**
   Servicio y Apoyos de Salud Conductual (BHSS)

V. **What we know / Lo que sabemos**

a. **We have allocated $60K for WET programs**
   Hemos asignado $ 60K para programas WET
b. **Forensic Assertive Community Treatment (FACT)**
   Tratamiento Comunitario Asertivo Forense (FACT)
c. **Substance Use Disorder (SUD) training to comply with SB43.**
   Capacitación sobre trastornos por consumo de sustancias (SUD) para cumplir con la ley SB43.
d. **Creating an Overdose Outreach System through EMS Reporting**
   Creación de un sistema de alcance para la sobredosis a través de informes de EMS
e. **Creation of the new Youth Crisis team to focus on responding to the emergency department, Inpatient Facilities, and Crisis Stabilization Units**
   Creación del nuevo equipo de Crisis Juvenil para enfocarse a responder al departamento de emergencia, Instalaciones para Pacientes Hospitalizados y Unidades para Estabilización de Crisis

    a. **(Stakeholder Comment) Stakeholder shares story of a mother who had loss her son to SUD issues and homelessness. Her friend never lost hope and after several years, her son came back, and he is getting the help he needs. So, she was excited that programs like this will soon exist so parents and youth like her friend don't go through situation like theirs.**
       (Comentario de las partes interesadas) Las partes interesadas comparten la historia de una madre que perdió a su hijo por problemas de SUD y falta de vivienda. Su amiga nunca perdió la esperanza y después de varios años, su hijo regresó y está recibiendo la ayuda que necesita. Así que estaba

emocionada de que pronto existieran programas como este para que los padres y los jóvenes como su amiga no pasen por una situación como la de ellos.

f. **Creation of the Adult Crisis Response Team to support medical hospitals and emergency departments in Kern County with behavioral health needs in crisis.**
Creación del equipo de respuesta de adultos en crisis para apoyar a hospitales médicos y departamentos de emergencia en el condado de Kern con necesidades de salud conductual en crisis.

g. **We were able to maintain the Cultural Competency team; therefore, it did not sunset on June 30th as previously reported.**
Pudimos mantener el equipo de Competencia Cultural; por lo tanto, no se extinguió el 30 de junio como se informó anteriormente.

VI. **BHSA Integrated Plan (IP)presented by Leydi Garcia De Luna**

a. **IP Priority goals and 1 additional goal**
   i. **The additional goal selected was "Reduce Overdoses"**
   ii. **This selection was supported with data received from the state and feedback from our stakeholders.**

b. **IP Priority Goals and 1 Additional Goal The additional goal selected was "Reduce Overdoses" This selection was supported with data received from the state and feedback from our stakeholders.**

c. **Integrated Plan Explanation: Analyze and understand the information provided by the state to identify disparities in the county.**

Plan Integrado (IP) BHSA presentado por Leydi García De Luna

a. **Objetivos prioritarios de PI y 1 objetivo adicional**
   i. **El objetivo adicional seleccionado fue el de "Reducir las sobredosis"**
   ii. **Esta selección fue respaldada con datos recibidos del estado y comentarios de nuestras partes interesadas.**

b. **Objetivos prioritarios de IP y 1 objetivo adicional El objetivo adicional seleccionado fue "Reducir las sobredosis" Esta selección fue respaldada con datos recibidos del estado y comentarios de nuestras partes interesadas.**

c. **Explicación del Plan Integrado: Analizar y entender la información que proveo el estado para identificar las disparidades que hay en el condado.**

VII. **Preguntas y Comentarios por parte de la audiencia después de la presentación:**
   i. **None**
   Ninguna

VIII. **Listening Session by Leydi Garcia De Luna**
Sesión de Escucha presentada por Leydi Garcia De Luna

IX. **Next meetings:**
Siguientes juntas

a. **CPPP English Community Forum on Wednesday, November 12th , here at the Westchester Training Room from 12 to 2 PM**
   CPPP Foro Comunitario en Ingles el miércoles 12 de noviembre, aquí en la Sala de Capacitación de Westchester de 12 a 2 PM
b. **CPPP Spanish Community Forum on Wednesday, November 19th , here at the Westchester Training Room from 12 to 2 PM**
   CPPP Foro Comunitario en Ingles el miércoles 19 de noviembre, aquí en la Sala de Capacitación de Westchester de 12 a 2 PM

X. **Numbers to Know by Leydi Garcia De Luna**
Números para Saber presentado por Leydi Garcia De Luna

XI. **End of meeting**
Final de la junta

Meaningful Engagement Event Report

Date:	Activity Type:	Name of Event:	Location:
10/27/2025	Targeted Outreach	SUD Treatment Provider Meeting	Westchester Training Room 2001 28th St.

Purpose of Event:	**Collaborate and educate countywide SUD Providers of Kern BHRS updates, provide updates for themselves and introduce new providers.**
Attendance:	**46**
MHSA Team:	**Mark Kimmel, Tia Flores**
Agenda:	• **Mental Health Services Act to Behavioral Health Services Transition, funding allocations and 3-year Integrated Plan.** • **Brief questionnaire regarding SUD inclusion into Behavioral Health Services.**

Key Informant Interview Event Report

Date:	Activity Type:	Name of Event:	Location:
10/27/2025 12:00pm	Key Informant Interviews	Bakersfield American Indian Health Project Interviews	Bakersfield American Indian Health Project 501 40th St.

Purpose of Event:	**Interviewed Vice Chair Board Member, the Tribal Liaison and Grants Program Director regarding improvements in services to their consumers and collaborating with Kern BHRS.**
Attendance:	**3**
MHSA Team:	**Tia Flores**
Agenda:	• **Q&A Session**
Q&A:	1. **What is your agency currently doing in collaboration with Kern BHRS?** 2. **What are the mental health and substance use needs in your community?** 3. **How is BAIHP currently working to meet those needs?** 4. **What gaps in service has BAIHP identified?** 5. **What opportunities does BAIHP have to collaborate with Kern BHRS? What does that look like to you?**

Responses:

1. Partnership, currently. Go both ways on referrals to make sure client needs are being met.
2. Tribal medicines and ceremonies are now billable in CA. Going forward now it is good for both sides (provider/client) to receive traditional cultural treatment that is holistic. Tribe supports them along the way. Generational trauma. On the Western medicine side, agencies can be representative of their heritage with pictures, resources etc., to make them feel comfortable and included. They are not just a checkbox.
3. Partnerships with other agencies throughout Kern County and the state. Billable through IHSS.
4. MOU's, Billable insurance, increase partnerships in kern and statewide. Becoming more than just an urban health center. Tribal centered, all tribes.
5. Women's Facility: treatment home, emergency refuge, rehab, DV/SA, cultural self-care. Centralized safe haven for Indigenous woman in CA.

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1. I participate in CCRC and AINA committees. I know we have an MOU, as far as I am concerned, we have not received any referrals for that.
2. Traditional care and culturally relevant work. Native Americans, we really want to see ourselves in these programs, especially those who come to a city from a reservation, there is a huge cultural shock. Working with reservation natives is going to be different than working with urban natives. It is important to have staff that are trained holistically, not so culturally competent but have cultural humility. Those are the biggest components in our community and that is why they come here; they feel a sense of home here. Even the natives that are not from the reservation, it's ingrained in them and us as urban natives. You feel that. I always encourage organizations that ask, "How do they become more culturally competent?". I do trainings on that, it can be something simple as artwork around, smudge bowl just something that represents indigenous cultural. And there are about 24,000 Native Americans in Kern County, that's a high number.
3. We provide traditional healing services. We recognize all tribes and where they come from. We offer smudging classes that are culturally relevant and really focus on giving that care in a holistic way. If we can we hire native staff. We teach staff about important things going on within our community and we train a lot of cultural competencies here for those who do not know.
4. Our biggest one is that we do not offer primary care right now. We are working on it though. But as you said with all the changes, it has kind of set us back as well. We were set in June to launch that, so that is one of our biggest gaps. I would also say our lack of visibility. When I was working with KHS, there are about 1000 Native Americans that are either self-identified within their system and only 3 of those clients within that system have a connection to BAIHP. That is a lot, and for native American's, this should be their place of care. We know about intergenerational trauma, the trauma we have with healthcare and government, even if we don't feel like we do, it's ingrained. A lot of history isn't

even history you know. Even in the 90's they were doing sterilization and things like that on Native women. We have a lack of visibility but especially in Kern County, because I have worked all over the nation with Native American's. I moved here from South Dakota and there is a lot of Native Americans in South Dakota, large number and most of them are going to be from the reservation coming into the city, you get a different culture there. Here I have noticed that a lot of the Native Americans here are urban and they are trying to reconnect with their culture and that is even a bigger gap, because they are not going to be aware of urban Indian healthcare, they don't know what urban Indian healthcare can do for them, they are unaware and l a lot of them are not enrolled and think they can't even get enrolled. We help with those services, it is important if a person says they are Native American, to say to them, "Hey, have you heard about BAIHP and their services?" Even if they say they are not even enrolled or whatever, they still should come here. We really want to help them with their indigenous roots. We offer services for those who are enrolled as well. Under the Indian Health Services, they do require that you be enrolled Native American in one of the recognized tribes to get certain services. We still offer services to those who are not enrolled or self-identified because the issue we find in this county is that there's a tribe Tubatulabal they are not federally recognized but they are still a tribe and it unfair and doesn't give them justice to not allow those services. For members like that we still welcome them in, and they get the services we are allowed to give them under IHS regulation.

5. When I was told, I was going to have this interview, I looked at what we already do, it doesn't seem to be too much. I investigated your organization; you guys offer a lot of important services that we lack here and likewise. These are the best combinations, that is where we get the whole person's care. Help each other out where we both have gaps in service, what I think is best is to get someone there to train your staff on cultural humility and to give the indigenous population here visibility. The visibility of the native population is very little, and it affects them very much. I don't have the data on it, when the Trump administration cut out the DEI it wiped a lot of data, the data that was on the government website is not there anymore. So, we lost a lot of our data but training, not a 10-minute presentation, getting into the depths of indigenous healthcare and statistics of indigenous people and things that lead up to us having an extremely high rate of SUD's and mental health problems. That might even be underwhelming, the number maybe actually be a lot higher than what I am giving. The violence that natives' faces is very high, sexually and physically. One out of two women have faced it in a form of extreme and one out of four men faced extreme violence. That training is important and compelling to get people to listen and understand. A lot of time people will just look at natives when they see they are Native American and just move on. It is important to pinpoint that. If your provider or therapist or anyone in your

organization has this training, they can connect with this person because that is how you build trust and that strong kind of connection as a non-native then they will open because they see you care. I would suggest targeted outreach and a way to identify Native Americans with a specific check box, not "other" or API. I have seen that component in client forms missing or here in Bakersfield specifically, they will label themselves as "Hispanic". Historically here there was issues with identifying as Native American so a lot of them grew up in a Hispanic culture and have completely lost the native side. Identifying them is going to take some leg work though going through the Hispanic population. What I am doing with KHS right now is a member outreach service in rewriting their questionnaire, how they are talking to people and see how people are identifying as native American. That is a big component that is lost, and it is never bad to double check that. Data exchange would be awesome, seeing how many natives you have identified in your system so we can collaborate on outreach and getting those clients over here as well. We are great support system for these people; we treat all people as if they are most important members. A lot of people here have a big passion for helping indigenous people. Learning about each other's programs so we can see how we can best help each other.

1. These current interviews. I also try to attend the monthly stakeholder meetings. We are looking to get contracted for traditional services and were getting the contract ready for MediCare/MediCal licensing to come through. We recently applied for the SUD outpatient services RFA. That's basically it right now, I do see a lot of opportunities to collaborate and open those discussions with KBHRS, but we would need some support behind it.
2. Statistically, Native American's have a high rate of mental health and substance abuse. The Native American has higher rates then other ethnicities. Generally, in the community mental health and substance use is not something that is talked about but there is a need for those services. In Kern we do know that substance use overdose rates are highest in the Kern River Valley area according to Kern Public Health Community Health Assessment 2023. There is a lack of services in that area, including culturally appropriate services. It is difficult for Native Americans in general to seek services and in times when they do, they feel judged. They don't feel like the services meet their needs. Are approach being a holistic approach, mental, physical and spiritual aspect of it. When you treat all three aspects you achieve whole person's wellness. There is a high need, especially MAT services, they have a cultural relevance. Unfortunately, we have limited funding for services and don't currently offer MAT. Mental health and substance use services we offer are primarily meant for HIS contract and grants and don't truly meet the needs of our clients.

3. We offer primary mental, behavioral and substance use services. We recently recruited 2 psychologists for diagnosis of serious mental illness and substance use disorder as well. We have established telehealth services. IHS offers free psychiatric services with the psychiatric nurse practitioner for those needing medication for serious mental illness. We are looking to establish those services in the KRV area once we identify funding for the staff. KDAC right now called, First Primary Substance Use Services, right now we refer out to MAT. We are building a bridge housing/transitional housing unit which are going to be those who are experiencing homelessness or are at risk of homelessness and are experiencing SMR or SUD. Recently awarded bond grant as well, this will be a mental health urgent care which will also provide outpatient substance use and mental health treatment. The idea is for these programs to work in coordination with each other if someone is coming for crisis and is homeless or at risk and are believed to have those conditions, they will be referred to there. We were also awarded adult re-entry grant which will offer housing supportive services for those formally incarcerated. With a recent award for CDSS for IHS staff funding, it will be those who may be eligible for SSI disability. Those with chronic substance use disorder generally have chronic health conditions that may be eligible for SS disability. With the housing supportive services, we have an ability to support them with getting the benefits. With our Beecham 5 grant, we will be able to build urgent mental health care, which will offer wellness center services and that will include job development, day program, traditional services and cultural services, that will help address the spiritual aspect of healing. We have mental health, substance use and spiritual, with that we will have a primary care clinic by that time. We are going through the process of licensing through MediCal as well. By the time it is all said in done, we will be able to offer whole person care.
4. We are not primary care yet for medical. We are not licensed through MediCAL/MediCare. Even though we have primary care providers, the manage care plans will not recognize referrals l issued for our clients because they are not registered with them as primary care providers so that creates a gap, we end up absorbing the whole cost of services for them and they are rather expensive. Funding in general creates gaps in services as well because then you have limited staff available to support them. We are pretty fortunate that we are not scheduled weeks out in advance but its not to the level of care that we would like to be able to offer to our clients. Not having a peer respite program and the urgent care services as of right now. Also being able to offer our clients fully what they need, although we are working towards it, we are not there yet. Still trying to figure out how we are going to fund the programs after construction completed. There is also a lack of housing available.
5. Lots of collaboration. Primarily it is going to tie to funding. The county received funding for the Opioid Settlement funds and although it

conducts several stakeholder meetings throughout the county, I for one have not seen an official report nor have I seen how this county has really put the funds out there. I haven't seen any RFA to support it, I know the intention of it is to reduce overdose in the community yet, I haven't seen anything done by KBHRS in the KRV area where the highest rates of overdose exist. For funding received, we should prioritize those populations that are most underserved. I don't see the funding really going there and that offers the potential for collaboration with BAIHP. Whereas if KBHRS would be interested in funding one of our programs we can definitely offer services out there. We are open to reimbursement for SUD, outpatient, we are not ready for inpatient yet, however we are looking to build a plan for our peer respite program and urgent care and sobering center. What we have heard in the KRV area is that there is a lack of services available and the services that are available are usually scheduled weeks to months out, there is a limited number of providers there. Being able to fund a program and prioritize their indigenous population and offer the services they need for one of the most underserved populations, on top of the area being rural. Looking at housing, I know there is a change from MHSA to BHSA, housing is a big priority for us right now, it is where a lot of the push is going into, the services and expanding services, not to just the transitional housing but also looking into peer respite and urgent care because all that ties together. If you are able to intervene earlier, you can prevent somebody from escalating and hence the idea of an urgent care and sobering center and tying that to the peer respite program you can prevent someone from potentially going full 51/50. Then you're able to address those needs before they spiral out of control. People go through things in life where they need help, they need someone to talk to, they need to become recentered and grounded but there is a lack of services that exist in that nature, where it is either they are not there yet or that at the complete extreme where they need to be in an inpatient program and that is what we are trying to prevent. Those of course have substantial cost for one and it's a financial burden on the funding streams that are usually already tied up as they are. Additionally, here in Bakersfield, we are going to have our traditional housing units. We are looking to have those launch in probably April/May 2026, however we lack funding currently to fully staff the facility, so although we will have 56 beds available, we are going to have a limit due to the staffing capacity. We are also expanding services here for our clinic. We are constantly applying and looking for funding to support it, but the thing about grants is that it is temporary funding not long term which is helpful to jump start these so we can get to reimbursement.

CPPP – Community Forum Minutes

November 12, 2025

12:00 PM – 2:00 PM

Westchester Training Room

Number of stakeholders in attendance:

In Person: 4 (1 Tribal, 1 MH Provider, 1 Individual [peer & fam] 1 Org serving underserved)

Virtual: 4 (1 CBO, 1 MH Provider, 1, MC Provider, 1 New)

MHSA Team members in attendance:

Camden Trapp | Leydi Garcia De Luna | Mariliea Prado

Tia Flores | Mark Kimmel

Facilitator: Mark Kimmel

Scribe: Mariliea Prado

Other presenters: Tia Flores

Minutes

I. Welcome and Land Acknowledgement by Tia Flores

II. Announcements by Tia Flores
- CAPK EBT Food Distribution
- AMVETS Golden State Tour
- BAIHP "A Celebration of Indigenous Culture"
- VET FEST
- Cultural Competence Resource Committee – Invitation to join (Ongoing)
- KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing)
- Prepare U – FREE Access to mental health education (Ongoing)

III. MHSA Education by Tia Flores

IV. Behavioral Health Services Act Transformation June 2026

- Local-Level Stakeholder changes and updates by Tia Flores

V. Behavioral Health Services Act Transformation Update by Mark Kimmel
  - Funding Breakdown
    - Housing Allocation
    - Full-Service Partnerships (FSP)
    - BHSS
  - Questions & Comments from the Audience after the presentation:

VI. Upcoming Changes to Programs by Mark Kimmel
  - PEI Homeless Outreach team with Flood ended June 30th, 2025
  - New PEI program with flood Ministries July 16, 2025
  - WET training
  - FACT
  - SUD training for SB43
  - Creation of overdose outreach through EMS. Creation of Adult Crisis Response Team
  - New Youth Crisis team
  - Cultural Competence is not sunsetting

VII. BHSA Integrated Plan by Mark Kimmel
  - Questions & Comments from the Audience after the presentation

VIII. Behavioral Health Transition Population Health Strategy
  - Priority Goals
  - 1 Additional Goal
  - Substance Use Disorder reporting requirements for IP
  - Questions & comments from the audience after the presentation
    Q: What areas are a priority in Kern Conty?
    A: It hasn't been decided yet. We've set the goal and are now deciding what areas to focus on, outskirts areas have been discussed.

IX. Incentive Drawing by Tia Flores

X. Listening Session by Tia Flores

XI. Next meetings:
  - CPPP Spanish Community Forum on Wednesday, December 10, at the Westchester Training Room from 12 to 2 PM
  - CPPP English Community Forum on Wednesday, December 17, at the Westchester Training Room from 12 to 2 PM

XII. Numbers to Know by Tia Flores

XIII. End of meeting

CPPP – Community Forum Minutes (Spanish in Person & Virtual)

November 19, 2025

12:00 PM – 2:00 PM

Westchester Training Room

Foro Comunitario en Persona (español en Persona y Virtual)

19 de noviembre del 2025

Sala de Entrenamiento de Westchester

Number of stakeholders in attendance/Total de Asistencia:

In Person/En Persona: 3 (3 family and 1 client) **Virtual/Virtual: 0**

MHSA Team members in attendance/Miembros del Equipo MHSA Presentes:

Estella Padilla	Camden Trapp	Mari Prado
Cassie Deras-Coker	Tia Flores	Leydi Garcia De Luna

Facilitator/Facilitadora: Leydi Garcia De Luna **Scribe/Escriba: Estela Padilla**

Other presenters: n/a

Minutes/Minutos

I. **Welcome and Land Acknowledgement by Leydi Garcia De Luna**
Bienvenida y Reconocimiento de la Tierra presentado por Estela Padilla

II. **Announcements/Anuncios by/por Leydi Garcia De Luna**
   a. **2025 Vet Fest-November 19**
   Festival de Veteranos 2025-noviembre 19
   b. **Cultural Competence Resource Committee – Invitation to join (Ongoing)**
   Comité de recursos de Competencia Cultural – Invitación continua para unirse
   c. **KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing)**
   Voluntarios para la Línea de Crisis de KernBHRS – Reclutamiento continuo
   d. **Prepare U – FREE Access to mental health education (Ongoing)**

Prepárese Usted – Acceso GRATUITO a educación para la salud mental continuo

III. **MHSA Education by Leydi Garcia De Luna**
Educación sobre la MHSA presentada por Leydi Garcia De Luna

IV. **Behavioral Health Services Act Transformation Update by Leydi Garcia De Luna**
Actualizaciones sobre la Reforma de la Ley de Servicios de Salud Conductual presentadas por Leydi Garcia De Luna

a. **Local-Level Stakeholder changes and updates**
Cambios y actualizaciones de las partes interesadas a nivel local

b. **Funding Streams changes and updates**
Cambios y actualizaciones en los Fondos de Financiación

i. **10% State-Wide Investments**
10 % para Inversiones a Nivel Estatal
C: I like how well everything is detailed. They are paying more attention to all this.
C: Me parece muy bien que está todo muy detallado. Le están poniendo más atención a todo esto.

ii. **30% Housing Funding Allocation Breakdown**
30% para Viviendas, Explicación de Asignación de Fondos

iii. **35% Full-Service Partnerships (FSP)**
35% para Asociación de Servicio Completo (FSP)

iv. **35% Behavioral Health Services and Supports (BHSS)**
35% para Servicios y Apoyos de Salud Conductual (BHSS)

V. **Behavioral Health Transormation Upcoming Changes to Programs by Leydi Garcia De Luna**
La Reforma de la Ley de Servicios de Salud Conductual Próximos Cambios en los Programas por Leydi Garcia De Luna

a. **PEI Homeless Outreach Team with Flood Ministries sunsetted on June 30th, 2025**
El Equipo de Alcance para las Personal Sin Vivienda de PEI con Flood Ministries se finalizó el 30 de junio del 2025

b. **New PEI program Homeless Response Coordination with Flood Ministries started on July 16, 2025**
Nuevo programa de PEI Coordinación de Respuesta para Desamparados con Flood Ministries comenzó el 16 de Julio del 2025

c. **What We Know to Date:**
Lo que Sabemos Hasta Hoy:

i. **Workforce, Education & Training (WET) $60k allocation for training:**
Fuerza Laboral, Educación y Entrenamiento (WET) asigno $60k para los siguientes entrenamientos:

- **Forensic Assertive Community Treatment (FACT)**
Tratamiento Comunitario Asertivo Forense (FACT)
- **Substance Use Disorder (SUD) training for SB43: American Society of Addiction Medicine & Motivational Interviewing**

Capacitación sobre Trastorno por Consumo de Sustancias (SUD) para la legislatura SB43: Sociedad American de Medicina de Adicciones y Entrevistas Motivacionales

- **Creation of overdose outreach through EMS reporting to support assertive field-based services**
  Creación de un sistema de alcance para la sobredosis a través de informes de EMS para apoyar servicios asertivos en el campo
- **Creation of Adult Crisis Response Team to support Medical Hospitals and Emergency Departments in Kern County with Crisis Behavioral Health needs**
  Creación del Equipo de Respuesta de Adultos en Crisis para apoyar Hospitales Médicos y Departamentos de Emergencia en el Condado de Kern con necesidades de Salud Conductual en Crisis.
- **Creation of new Youth Crisis Team to focus on responding to Emergency Departments, Inpatient Facilities and Crisis Stabilization Units**
  Creación del nuevo Equipo de Crisis Juvenil para enfocarse a responder al Departamento de Emergencia, Instalaciones para Pacientes Hospitalizados y Unidades para Estabilización de Crisis
- **Cultural Competence is not sunsetting**
  El Equipo de Competencia Cultural no se cerrará

VI. BHSA Three Year Integrated Plan by Leydi Garcia De Luna
Plan Integrado Trianual de la BHSA por Leydi Garcia De Luna

a. **Redefining Mental Health, Expanding Access to Care, Enhancing Culturally Responsive Services, Addressing Social Needs, Strengthening Quality Infrastructure, Building a Robust and Diverse Workforce**
   Redefinir la Salud Mental, Expandir el Acceso al Cuidado, Mejorar los Servicios Culturalmente Receptivos, Abordar las Necesidades Sociales, Fortalecimiento de la Infraestructura de Calidad, Construir una fuerza laboral sólida y diversa
b. **Behavioral Health Transition Population Health Strategy**
   Transformación de Salud Conductual Estrategia de Salud Poblacional
   i. **Priority Goals: Increase Access to Care, Reduce Homelessness, Reduce Institutionalization, Reduce Justice-Involvement, Reduce Removal of Children from Home, Reduce Untreated Behavioral Health Conditions**
      Metas Prioritarias: Incrementar el Acceso al Cuidado, Reducir la Falta de Vivienda, Reducir la Institucionalización, Reducir la Involucración con la Justicia, Reducir la Retirada de los Niños del Hogar, Reducir las Condiciones de Salud Conductual No Tratadas
   ii. **Additional Goal: Reduce Overdoses**
      Meta Adicional: Reducir las Sobredosis
c. **Integrated Plan Breakdown: Priority Goals and 1 Additional Goal**
   Explicación del Plan Integrado: Metas Prioritarias y 1 Meta Adicional

i. **Locate and review publicly available data for each measure, analyze and understand the data; identify disparities, develop hunches; engage in the community planning process, draft initial BHSA integrated plan**
Localizar y revisar información disponible públicamente para cada medida, analizar y entender la información; identificar disparidades, desarrollar presentimientos; participar en el proceso de planificación comunitaria, crear copia inicial del plan integrado de la BHSA

ii. **Develop hunches; Engage in the Community Planning Process**
Desarrollar Presentimientos; Involucración en el Proceso de Planificación Comunitaria

iii. **Integrated Plan Substance Use Disorder (SUD) Data**
Datos de Trastorno por Uso de Sustancias (SUD)

VII. **Public Forum Incentive Program July 2025 to June 2026 by Leydi Garcia De Luna**
Programa de Incentivos para Foros Comunitários Júlio 2025 a Júnio 2026 por Leydi Garcia De Luna

VIII. **Listening Session by Leydi Garcia De Luna**
Sesión de Escucha presentada por Leydi Garcia De Luna
C: Everything is well and I'm grateful for these meetings, even though there are less of us now, we feel special because we get to learn all this information. Hopefully there will be more participants in the upcoming year. I want to wish you all a Happy Thanksgiving Day, they say we should give thanks every day, but this is a special day. Thank you all for setting that time aside to share the information with us.
C: Todo está bien y estoy agradecida por estas juntas, aunque seamos menos hoy, nos sentimos alagados porque aprendamos toda esta información. Ojalá que vengan más participantes en el año entrante. Quiero desearles a todos un Feliz Dia de Acción de Gracias, dicen que debemos de dar gracias todos los días, pero este es un día especial. Gracias a todos ustedes por dar de su tiempo para compartir información con nosotros.

IX. **Welcome Folder by Leydi Garcia De Luna**
Folleto de Bienvenida por Leydi Garcia De Luna

a. **CPPP English Community Forum on Wednesday, July 9th, here at the Westchester Training Room from 12 to 2 PM**
CPPP Foro Comunitario en Ingles el Miércoles, Julio 9, aquí en el Cuarto de Entrenamiento Westchester de 12 a 2 PM

b. **CPPP Spanish Community Forum on Wednesday, July 16th, here at the Westchester Training Room from 12 to 2 PM**
CPPP Foro Comunitario en Ingles el Miércoles, Julio 16, aquí en el Cuarto de Entrenamiento Westchester de 12 a 2 PM

X. **Numbers to Know by Leydi Garcia De Luna**
Números para Saber presentado por Leydi Garcia De Luna

XI. **End of meeting/ Final de la junta**

CPPP – Community Forum Minutes

December 10, 2025

12:00 PM – 2:00 PM

Westchester Training Room

Number of stakeholders in attendance:

In Person & Virtual: 1(1), 2(3), 2(5), 1(6), 1(11), 2(16), 2(18), 2(26), 1(30)

MHSA Team members in attendance:

Cassie Deras-Coker **Leydi Garcia De Luna** **Mariliea Prado**

Tia Flores **Mark Kimmel**

Facilitator: Mark Kimmel **Scribe:** Mariliea Prado

Other presenters: Tia Flores

Minutes

I. **Welcome and Land Acknowledgement by Tia Flores**

II. **Announcements by Tia Flores**
   - **. NOR Annual Christmas Parade 12/13/25**
   - **. Cultural Competence Resource Committee – Invitation to join (Ongoing)**
   - **. Kern BHRS Crisis Hotline Volunteers – Recruitment (Ongoing)**
   - **. Prepare U – FREE Access to mental health education (Ongoing)**

     Q: Do we scan the QR code to sign up? Is there a fee to get the Prepare U license?
     A: sign up and review the program and the it is completely free.

III. **MHSA Education by Tia Flores**

IV. **Behavioral Health Services Act Transformation June 2026**
   - **. Local-Level Stakeholder changes and updates by Tia Flores**

V. **Behavioral Health Services Act Transformation Update by Mark Kimmel**

- **. Funding Breakdown**
  - **. Housing Allocation**
  - **. Full-Service Partnerships (FSP)**
  - **. BHSS**
- **. Questions & Comments from the Audience after the presentation:**

  Q: Will there be a new approval process for these new categories or will teams be grandfathered in? And would they have to fill out new applications?

  A: Teams that are already there will continue. There is no application process.

  Q: Is Kern Behavioral Health funding the big tower up the street?

  A: We do have beds that we are assisting with funding, but not under BHSA funding, it could move into that but haven't got to that yet.

  Q: Will there be an increase in passing expenditures?

  A: Yes, we have a bucket of housing funds that need to be utilized.

VI. Upcoming Changes to Programs by Mark Kimmel

- . **PEI Homeless Outreach team with Flood ended June 30th, 2025**
- **. New PEI program with flood Ministries July 16, 2025**

VII. BHSA Integrated Plan by Mark Kimmel

- **. IP SUD Data**
- **. Population Health Strategy**
- **. IP Draft Schedule**
- **. Questions & Comments from the Audience after the presentation**

  Q: if we are already collecting metrics, can we provide these to you?

  A: Yes, please send them to our MHSA team to send to the executive team.

  Q: Is the goal to reduce overdose in all ages?

  A: It is not age specific, the goal is to reduce overdose, data received did not specify age.

  Q: Are you asking for input from the community?

  A: Yes, we have been

  Q: is the county going to prioritize the areas in the county with the highest overdose rates?

  A: It is one of our directions and still being discussed.

  Q: Are the accredited agencies still involved?

  A: Yes, EQRO is still present

VIII. Incentive Drawing by Tia Flores

IX. Listening Session by Tia Flores

Kimberlyn Sandoval- Program manager for Prop 47 with Clarvida
Prop 47 program is closing March 1st and is looking for housing resources to provide to their 34 patients who will be affected. She is also looking for a position for a Clarvida employee who is an IPS worker.
Mark- MHSA will take Kimberlyn's contact info and send over all information MHSA can provide

X. Next meetings:

- **. CPPP Spanish Community Forum on Wednesday, December 17, at the Westchester Training Room from 12 to 2 PM**
- **. CPPP English Community Forum on Wednesday, January 14, at the Westchester Training Room from 12 to 2 PM**

XI. Numbers to Know by Tia Flores

XII. End of meeting

CPPP – Community Forum Minutes (Spanish in Person & Virtual)

December 17, 2025

12:00 PM – 2:00 PM

Westchester Training Room

Foro Comunitario en Persona (español en Persona y Virtual)

17 de diciembre del 2025

Sala de Entrenamiento de Westchester

Number of stakeholders in attendance/Total de Asistencia:

In Person/En Persona: 3 (3 family and 1 client) **Virtual/Virtual: 0**

MHSA Team members in attendance/Miembros del Equipo MHSA Presentes:

Estella Padilla **Camden Trapp** **Mari Prado**
Mark Kimmel

Facilitator/Facilitadora: Estela Padilla **Scribe/Escriba: Mari Prado**

Other presenters: n/a

Minutes/Minutos

I. **Welcome and Land Acknowledgement by Estela Padilla**
Bienvenida y Reconocimiento de la Tierra presentado por Estela Padilla

II. **Announcements/Anuncios by/por Estela Padilla**
- **Cultural Competence Resource Committee – Invitation to join (Ongoing)**
Comité de recursos de Competencia Cultural – Invitación continua para unirse
- **KernBHRS Crisis Hotline Volunteers – Recruitment (Ongoing)**
Voluntarios para la Línea de Crisis de KernBHRS – Reclutamiento continuo
P: ¿Es muy seguro el programa?
Q: So, the program is very safe?

R: Si, es 24 horas, y pueden llamar al 988 y atienden en otros idiomas aparte de ingles
A: Yes, it's 24 hours, you can call 988 and they offer other languages besides English
P: ¿Es para cualquier crisis?
Q: Is this for any crisis?
R: La especialidad es salud mental
A: The specialization is in mental health.

. **Prepare U – FREE Access to mental health education (Ongoing)**

Q: will it get canceled?
P: ¿lo van a cancelar?
A: If the licenses do not get used and there are no changes there is a possibility it will get canceled.
R: Si las licencias no se utilizan, y no vemos cambios, existe la posibilidad que sea cancelada.
Q: has this been offered in schools?
P: ¿se ha ofrecido en escuelas?
A: Yes, i believe it was in Delano, Taft and a school here in Bakersfield
R: Si, creo que fue en Delano, Taft y una escuela aquí en Bakersfield.
Q: What information do they ask for when registering?
P: ¿qué información piden para registrarse?
A: I believe they ask for name, email and phone number. And everything is confidential
R: Creo que piden nombre, correo electrónico y número de teléfono. Y todo es confidencial.
Q: Can we see this information on our phones or only on a computer?
P: ¿Se puede ver en el teléfono o solamente en computadora?
A: Yes, you can use your phone and its in English and Spanish.
R: Si, lo puede ver desde su teléfono, y esta en ingles y español.

Prepárese Usted – Acceso GRATUITO a educación para la salud mental continuo

III. **MHSA Education by Estela Padilla**
Educación sobre la MHSA presentada por Estela Padilla

IV. **Behavioral Health Services Act Transformation Update by Estela Padilla**
Actualizaciones sobre la Reforma de la Ley de Servicios de Salud Conductual presentadas por Estela Padilla

- **Local-Level Stakeholder changes and updates**
  Cambios y actualizaciones de las partes interesadas a nivel local
- **Your role as a Stakeholder**
  Su papel como parte interesada
- **Funding Streams changes and updates**
  Cambios y actualizaciones en los Fondos de Financiación
  i. **10% State-Wide Investments**
  10 % para Inversiones a Nivel Estatal
  C: I like how well everything is detailed. They are paying more attention to all this.
  C: Me parece muy bien que está todo muy detallado. Le están poniendo más atención a todo esto.
  ii. **30% Housing Funding Allocation Breakdown**
  30% para Viviendas, Explicación de Asignación de Fondos
  iii. **35% Full-Service Partnerships (FSP)**
  35% para Asociación de Servicio Completo (FSP)
  iv. **35% Behavioral Health Services and Supports (BHSS)**
  35% para Servicios y Apoyos de Salud Conductual (BHSS)

V. **Behavioral Health Transformation Upcoming Changes to Programs by Estela Padilla**
La Reforma de la Ley de Servicios de Salud Conductual Próximos Cambios en los Programas por Estela Padilla

- **PEI Homeless Outreach Team with Flood Ministries sunsetted on June 30th, 2025**
  El Equipo de Alcance para las Personal Sin Vivienda de PEI con Flood Ministries se finalizó el 30 de junio del 2025
- **New PEI program Homeless Response Coordination with Flood Ministries started on July 16, 2025**
  Nuevo programa de PEI Coordinación de Respuesta para Desamparados con Flood Ministries comenzó el 16 de Julio del 2025
- **What We Know to Date:**
  Lo que Sabemos Hasta Hoy:

i. **Workforce, Education & Training (WET) $60k allocation for training:**
Fuerza Laboral, Educación y Entrenamiento (WET) asigno $60k para los siguientes entrenamientos:

- **Forensic Assertive Community Treatment (FACT)**
  Tratamiento Comunitario Asertivo Forense (FACT)
- **Substance Use Disorder (SUD) training for SB43: American Society of Addiction Medicine & Motivational Interviewing**
  Capacitación sobre Trastorno por Consumo de Sustancias (SUD) para la legislatura SB43: Sociedad American de Medicina de Adicciones y Entrevistas Motivacionales
- **Creation of overdose outreach through EMS reporting to support assertive field-based services**
  Creación de un sistema de alcance para la sobredosis a través de informes de EMS para apoyar servicios asertivos en el campo
- **Creation of Adult Crisis Response Team to support Medical Hospitals and Emergency Departments in Kern County with Crisis Behavioral Health needs**
  Creación del Equipo de Respuesta de Adultos en Crisis para apoyar Hospitales Médicos y Departamentos de Emergencia en el Condado de Kern con necesidades de Salud Conductual en Crisis.
- **Creation of new Youth Crisis Team to focus on responding to Emergency Departments, Inpatient Facilities and Crisis Stabilization Units**
  Creación del nuevo Equipo de Crisis Juvenil para enfocarse a responder al Departamento de Emergencia, Instalaciones para Pacientes Hospitalizados y Unidades para Estabilización de Crisis
- **Cultural Competence is not sunsetting**
  El Equipo de Competencia Cultural no se cerrará

VI. BHSA Three Year Integrated Plan by Estela Padilla
Plan Integrado Trianual de la BHSA por Estela Padilla

. **Redefining Mental Health, Expanding Access to Care, Enhancing Culturally Responsive Services, Addressing Social Needs, Strengthening Quality Infrastructure, Building a Robust and Diverse Workforce**
Redefinir la Salud Mental, Expandir el Acceso al Cuidado, Mejorar los Servicios Culturalmente Receptivos, Abordar las Necesidades Sociales, Fortalecimiento de la Infraestructura de Calidad, Construir una fuerza laboral sólida y diversa

. **Behavioral Health Transition Population Health Strategy**
Transformación de Salud Conductual Estrategia de Salud Poblacional

i. **Priority Goals: Increase Access to Care, Reduce Homelessness, Reduce Institutionalization, Reduce Justice-Involvement, Reduce Removal of Children from Home, Reduce Untreated Behavioral Health Conditions**

Metas Prioritarias: Incrementar el Acceso al Cuidado, Reducir la Falta de Vivienda, Reducir la Institucionalización, Reducir la Involucración con la Justicia, Reducir la Retirada de los Niños del Hogar, Reducir las Condiciones de Salud Conductual No Tratadas

ii. **Additional Goal: Reduce Overdoses**
Meta Adicional: Reducir las Sobredosis

. **Integrated Plan Breakdown: Priority Goals and 1 Additional Goal**
Explicación del Plan Integrado: Metas Prioritarias y 1 Meta Adicional

i. **Locate and review publicly available data for each measure, analyze and understand the data; identify disparities, develop hunches; engage in the community planning process, draft initial BHSA integrated plan**
Localizar y revisar información disponible públicamente para cada medida, analizar y entender la información; identificar disparidades, desarrollar presentimientos; participar en el proceso de planificación comunitaria, crear copia inicial del plan integrado de la BHSA

ii. **Develop hunches; Engage in the Community Planning Process**
Desarrollar Presentimientos; Involucración en el Proceso de Planificación Comunitaria

iii. **Integrated Plan Substance Use Disorder (SUD) Data**
Datos de Trastorno por Uso de Sustancias (SUD)

VII. **Public Forum Incentive Program July 2025 to June 2026 by Estela Padilla**
Programa de Incentivos para Foros Comunitários Júlio 2025 a Júnio 2026 por Estela Padilla

VIII. **Listening Session by Estela Padilla**
Sesión de Escucha presentada por Estela Padilla

C: Thank you so much for this program; it has helped us a lot with the information you've provided. We want to continue learning more. I am very grateful to the people who have come forward to help me and have guided me despite the language barrier. I love you all so much, I see you as family because you have helped and guided me.

C: Muchas gracias por este programa, nos a ayudado bastante con la información que nos han dado. Queremos seguir aprendiendo más. Estoy muy agradecida con la gente que a salido a ayudarme y me han guiado a pesar del idioma. Los quiero mucho, los veo como mi familia porque me ayudan y me guían.

IX. **Welcome Folder by Estela Padilla**
Folleto de Bienvenida por Estela Padilla

. **CPPP English Community Forum on Wednesday, January 26th, here at the Westchester Training Room from 12 to 2 PM**
CPPP Foro Comunitario en Ingles el Miércoles, 26 de enero, aquí en el Cuarto de Entrenamiento Westchester de 12 a 2 PM

. **CPPP Spanish Community Forum on Wednesday, January 21st, here at the Westchester Training Room from 12 to 2 PM**

CPPP Foro Comunitario en Ingles el Miércoles, 21 de enero, aquí en el Cuarto de Entrenamiento Westchester de 12 a 2 PM

X. Numbers to Know by Estela Padilla
Números para Saber presentado por Estela Padilla

XI. End of meeting
Final de la junta

Attachment D

Emails: Attempting to Engage Stakeholder Groups

Outlook

Public Forum

From Tia Flores <TFlores@kernbhrs.org>

Date Thu 8/7/2025 2:27 PM

To MHSA Team <MHSATeam@kernbhrs.org>

Bcc jgolden@bakersfieldcity.us <jgolden@bakersfieldcity.us>; cpeters@cbbakersfield.com <cpeters@cbbakersfield.com>; avaldez <avaldez@bakersfieldcity.us>; mayor <mayor@bakersfieldcity.us>; info@cityserve.us <info@cityserve.us>; avaldez <avaldez@bakersfieldcity.us>; jburdick@bakersfieldpd.us <jburdick@bakersfieldpd.us>; Marcos Sifuentes <sifuentesm@kernprobation.org>; TR Merickel <merickelt@kernprobation.org>; nanderberg <nanderberg@bakersfieldpd.us>; ealegria@wascopd.org <ealegria@wascopd.org>; nanderberg <nanderberg@bakersfieldpd.us>; Austin Mead <AustinMead@kernprobation.org>; Kayla Shaffstall <kshaffstall@bakersfieldpd.us>; DANIELLE HENDERSON <Henderson@kernsheriff.org>; ELVIE MARTINEZ <MARTINEZEL@kernsheriff.org>; NICOLE ASTORGA <ASTORGA@kernsheriff.org>; antoniomalfred@gmail.com <antoniomalfred@gmail.com>; Chris Cruz_Boone <ccruzboone@gmail.com>; butterfly.patterson@gmail.com <butterfly.patterson@gmail.com>; dannyvasquez7@yahoo.com <dannyvasquez7@yahoo.com>; deniselnorris@gmail.com <deniselnorris@gmail.com>; nsolis10@gmail.com <nsolis10@gmail.com>; Craig Panek <panekcraig@yahoo.com>; singhmedicalclinic@gmail.com <singhmedicalclinic@gmail.com>; SolisN@cintas.com <SolisN@cintas.com>; SZiehler@yahoo.com <SZiehler@yahoo.com>; ynmiss@gmail.com <ynmiss@gmail.com>; pastormikemccc@gmail.com <pastormikemccc@gmail.com>; richard.hofferd@gmail.com <richard.hofferd@gmail.com>; kimmeeflagg06@gmail.com <kimmeeflagg06@gmail.com>; ruiztyonna@gmail.com <ruiztyonna@gmail.com>; picorivera878@gmail.com <picorivera878@gmail.com>; deniselnorris@gmail.com <deniselnorris@gmail.com>; dessylaw@aol.com <dessylaw@aol.com>; fredrowemd@yahoo.com <fredrowemd@yahoo.com>; Jaclynalmaguer@yahoo.com <Jaclynalmaguer@yahoo.com>; mlpetty05@gmail.com <mlpetty05@gmail.com>; pastor@canyonhills.com <pastor@canyonhills.com>; nicosmom.ds@gmail.com <nicosmom.ds@gmail.com>; loreewebb@gmail.com <loreewebb@gmail.com>; srgm3570@yahoo.com <srgm3570@yahoo.com>; shatrice2005@yahoo.com <shatrice2005@yahoo.com>; lovekayla95@yahoo.com <lovekayla95@yahoo.com>; mbagga@gmail.com <mbagga@gmail.com>; mintydillon@gmail.com <mintydillon@gmail.com>; oscareartiga@hotmail.com <oscareartiga@hotmail.com>; TOM MITCHEL <raidertom63@gmail.com>; Jen.a287@gmail.com <Jen.a287@gmail.com>; lia.intheflesh@gmail.com <lia.intheflesh@gmail.com>; alisia.sanchez1985 <alisia.sanchez1985@gmail.com>; Curt Williams <cuwilliams@kern.org>; dspsdesk@bakersfieldcollege.edu <dspsdesk@bakersfieldcollege.edu>; analfaro@bakersfieldcollege.edu <analfaro@bakersfieldcollege.edu>; rebecca.core@bakersfieldcollege.edu <rebecca.core@bakersfieldcollege.edu>; Katrina.marquez@bakersfieldcollege.edu <Katrina.marquez@bakersfieldcollege.edu>; domriver@bakersfieldcollege.edu <domriver@bakersfieldcollege.edu>; jespinoza@kern.org <jespinoza@kern.org>; Jayme Stuart <jastuart@kern.org>; albaptiste@kern.org <albaptiste@kern.org>; ssilva7@csub.edu <ssilva7@csub.edu>; outreach@bakersfieldcollege.edu <outreach@bakersfieldcollege.edu>; outreach@csub.edu <outreach@csub.edu>; eeterno@bakersfieldaihp.com <eeterno@bakersfieldaihp.com>; John.Rogers2@commonspirit.org <John.Rogers2@commonspirit.org>; jdelgado@bakersfieldaihp.com <jdelgado@bakersfieldaihp.com>; mgalvez@bakersfieldaihp.com <mgalvez@bakersfieldaihp.com>; jbehill <jbehill@ovcdc.com>; jessica.orozco2@commonspirit.org <jessica.orozco2@commonspirit.org>; lsalcido@bakersfieldaihp.org <lsalcido@bakersfieldaihp.org>; alondra.rivas@clinicasierravista.org <alondra.rivas@clinicasierravista.org>; Don Davis <don.davis@clinicasierravista.org>; Jennifer Williamson <Jennifer.Williamson@clinicasierravista.org>; Jose Soria <jose.soria@clinicasierravista.org>; KAREN MONIZ-SMITH <karenm@hwmcgc.org>; Kassie Vallejo <kassie.vallejo@clinicasierravista.org>; Linda Hoyle <lindah@hwmcgc.org>; MARCIE LESSER <MarcieL@hwmcgc.org>; marisa.garciatrebizo@clinicasierravista.org <marisa.garciatrebizo@clinicasierravista.org>; candyc@hwmcgc.org <candyc@hwmcgc.org>; Jacqueline Smith <jacqueline.smith@clinicasierravista.org>; execdirector@thecenterbak.org <execdirector@thecenterbak.org>; alyssa.olivera@thecenterbak.org <alyssa.olivera@thecenterbak.org>; Dani Muñoz <youthoutreach@thecenterbak.org>; dani.munoz <dani.munoz@thecenterbak.org>;

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Hello Everyone,

Kern Behavioral Health and Recovery Services and the Mental Health Services Act (MHSA) team will be hosting an upcoming Community Forum open to the public and our partners.

The forum is on Wednesday, August 13 and we will be hybrid. The community forum will be held at the Westchester Training Room between 12:00 p.m. to 2:00 p.m., 2001 28th St., Bakersfield, CA, or you can join us virtually at https://rb.gy/bzjwzh . Hope to see you all there.

The following topics will be covered:

Behavioral Health Transition
Integrated Plan
Innovation
Listening Session

We will be providing a light lunch and refreshments

Tia Flores
Program Specialist II
MHSA Program
Cell Phone: 661.301.9778
Office Phone: 661.868.7526
Email: tflores@KernBHRS.org
PO Box 1000, Bakersfield, CA 93302
www.kernbhrs.org

Community Forum (CPPP/Stakeholder) questions? Contact us at MHSATeam@KernBHRS.org

Outlook

Public Forum

From Tia Flores <TFlores@kernbhrs.org>

Date Wed 12/3/2025 10:16 AM

To MHSA Team <MHSATeam@kernbhrs.org>

Bcc jgolden@bakersfieldcity.us <jgolden@bakersfieldcity.us>; cpeters@cbbakersfield.com <cpeters@cbbakersfield.com>; mayor <mayor@bakersfieldcity.us>; info@cityserve.us <info@cityserve.us>; Jeff Burdick <jburdick@bakersfieldpd.us>; Marcos Sifuentes <sifuentesm@kernprobation.org>; TR Merickel <merickelt@kernprobation.org>; nanderberg <nanderberg@bakersfieldpd.us>; ealegria@wascopd.org <ealegria@wascopd.org>; nanderberg <nanderberg@bakersfieldpd.us>; Austin Mead <AustinMead@kernprobation.org>; Kayla Shaffstall <kshaffstall@bakersfieldpd.us>; DANIELLE HENDERSON <Henderson@kernsheriff.org>; ELVIE MARTINEZ <MARTINEZEL@kernsheriff.org>; NICOLE ASTORGA <ASTORGA@kernsheriff.org>; antoniomalfred@gmail.com <antoniomalfred@gmail.com>; Chris Cruz_Boone <ccruzboone@gmail.com>; butterfly.patterson@gmail.com <butterfly.patterson@gmail.com>; dannyvasquez7@yahoo.com <dannyvasquez7@yahoo.com>; deniselnorris@gmail.com <deniselnorris@gmail.com>; 03arcelihernandez@gmail.com <03arcelihernandez@gmail.com>; nsolis10@gmail.com <nsolis10@gmail.com>; Craig Panek <panekcraig@yahoo.com>; singhmedicalclinic@gmail.com <singhmedicalclinic@gmail.com>; SolisN@cintas.com <SolisN@cintas.com>; SZiehler@yahoo.com <SZiehler@yahoo.com>; ynmiss@gmail.com <ynmiss@gmail.com>; pastormikemccc@gmail.com <pastormikemccc@gmail.com>; richard.hofferd@gmail.com <richard.hofferd@gmail.com>; kimmeeflagg06@gmail.com <kimmeeflagg06@gmail.com>; ronimunoz1@gmail.com <ronimunoz1@gmail.com>; ruiztyonna@gmail.com <ruiztyonna@gmail.com>; picorivera878@gmail.com <picorivera878@gmail.com>; deniselnorris@gmail.com <deniselnorris@gmail.com>; dessylaw@aol.com <dessylaw@aol.com>; fredrowemd@yahoo.com <fredrowemd@yahoo.com>; briannava_12@yahoo.com <briannava_12@yahoo.com>; Jaclynalmaguer@yahoo.com <Jaclynalmaguer@yahoo.com>; mlpetty05@gmail.com <mlpetty05@gmail.com>; sheepamy@gmail.com <sheepamy@gmail.com>; pastor@canyonhills.com <pastor@canyonhills.com>; nicosmom.ds@gmail.com <nicosmom.ds@gmail.com>; loreewebb@gmail.com <loreewebb@gmail.com>; srgm3570@yahoo.com <srgm3570@yahoo.com>; shatrice2005@yahoo.com <shatrice2005@yahoo.com>; mbagga@gmail.com <mbagga@gmail.com>; mintydillon@gmail.com <mintydillon@gmail.com>; oscareartiga@hotmail.com <oscareartiga@hotmail.com>; raidertom63@gmail.com <raidertom63@gmail.com>; Jen.a287@gmail.com <Jen.a287@gmail.com>; lia.intheflesh@gmail.com <lia.intheflesh@gmail.com>; Curt Williams <cuwilliams@kern.org>; dspsdesk@bakersfieldcollege.edu <dspsdesk@bakersfieldcollege.edu>; analfaro@bakersfieldcollege.edu <analfaro@bakersfieldcollege.edu>; rebecca.core@bakersfieldcollege.edu <rebecca.core@bakersfieldcollege.edu>; Katrina.marquez@bakersfieldcollege.edu <Katrina.marquez@bakersfieldcollege.edu>; domriver@bakersfieldcollege.edu <domriver@bakersfieldcollege.edu>; jespinoza@kern.org <jespinoza@kern.org>; Jayme Stuart <jastuart@kern.org>; albaptiste@kern.org <albaptiste@kern.org>; aherrera5@csub.edu <aherrera5@csub.edu>; ssilva7@csub.edu <ssilva7@csub.edu>; outreach@bakersfieldcollege.edu <outreach@bakersfieldcollege.edu>; outreach@csub.edu <outreach@csub.edu>; eeterno@bakersfieldaihp.com <eeterno@bakersfieldaihp.com>; John.Rogers2@commonspirit.org <John.Rogers2@commonspirit.org>; jdelgado@bakersfieldaihp.com <jdelgado@bakersfieldaihp.com>; mgalvez@bakersfieldaihp.com <mgalvez@bakersfieldaihp.com>; jbehill <jbehill@ovcdc.com>; jessica.orozco2@commonspirit.org <jessica.orozco2@commonspirit.org>; Lawrence Salcido <lsalcido@bakersfieldaihp.org>; alondra.rivas@clinicasierravista.org <alondra.rivas@clinicasierravista.org>; Don Davis <don.davis@clinicasierravista.org>; Jennifer Williamson <Jennifer.Williamson@clinicasierravista.org>; Jose Soria <jose.soria@clinicasierravista.org>; KAREN MONIZ-SMITH <karenm@hwmcgc.org>; Kassie Vallejo <kassie.vallejo@clinicasierravista.org>; Linda Hoyle <lindah@hwmcgc.org>; MARCIE LESSER <MarcieL@hwmcgc.org>; marisa.garciatrebizo@clinicasierravista.org <marisa.garciatrebizo@clinicasierravista.org>; candyc@hwmcgc.org <candyc@hwmcgc.org>; Jacqueline Smith <jacqueline.smith@clinicasierravista.org>; execdirector@thecenterbak.org <execdirector@thecenterbak.org>;

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1 attachment (4 MB)

MHSA Forum 12.10.25 English .png;

Good morning,

Kern Behavioral Health and Recovery Services and the Mental Health Services Act (MHSA) team will be hosting an upcoming Community Forum open to the public and our partners.

The hybrid forum is on Wednesday, December 10th. Join us in person at the Westchester Training Room between 12:00 p.m. to 2:00 p.m., 2001 28th St., Bakersfield, CA, or virtually on TEAMS:
https://rb.gy/6kmz0y

Hope to see you all there.

The following topics will be covered:

Behavioral Health Transition
Integrated Plan
Listening Session

We will be providing a light lunch and refreshments.

Thank you,

Tia Flores

Program Specialist II

MHSA Program

Cell Phone: 661.301.9778

Office Phone: 661.868.7526

Email: tflores@KernBHRS.org

PO Box 1000, Bakersfield, CA 93302

www.kernbhrs.org

Community Forum (CPPP/Stakeholder) questions? Contact us at MHSATeam@KernBHRS.org

Outlook

Focus Group Discussion

From Tia Flores <TFlores@kernbhrs.org>
Date Tue 8/19/2025 10:42 AM
To execdirector@thecenterbak.org <execdirector@thecenterbak.org>
Cc Mark Kimmel <MKimmel@kernbhrs.org>

Good Morning,

I am reaching out to you in regards to setting up a public group discussion with your consumers. I currently facilitate Kern BHRS's monthly public forums and would like to take them out on the road to targeted groups to reach a broader audience. I would briefly review upcoming changes to Kern BHRS services and welcome all feedback. I will also provide food and beverages. I am hoping to have groups of at least 10-15 people per session. Please let me know if this something you believe your consumers would benefit from and how we can get something set up in the next few weeks.

Thank you,

Tia Flores
Program Specialist II
MHSA Program
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Office Phone: 661.868.7526
Email: tflores@KernBHRS.org
PO Box 1000, Bakersfield, CA 93302
www.kernbhrs.org

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Attachment E

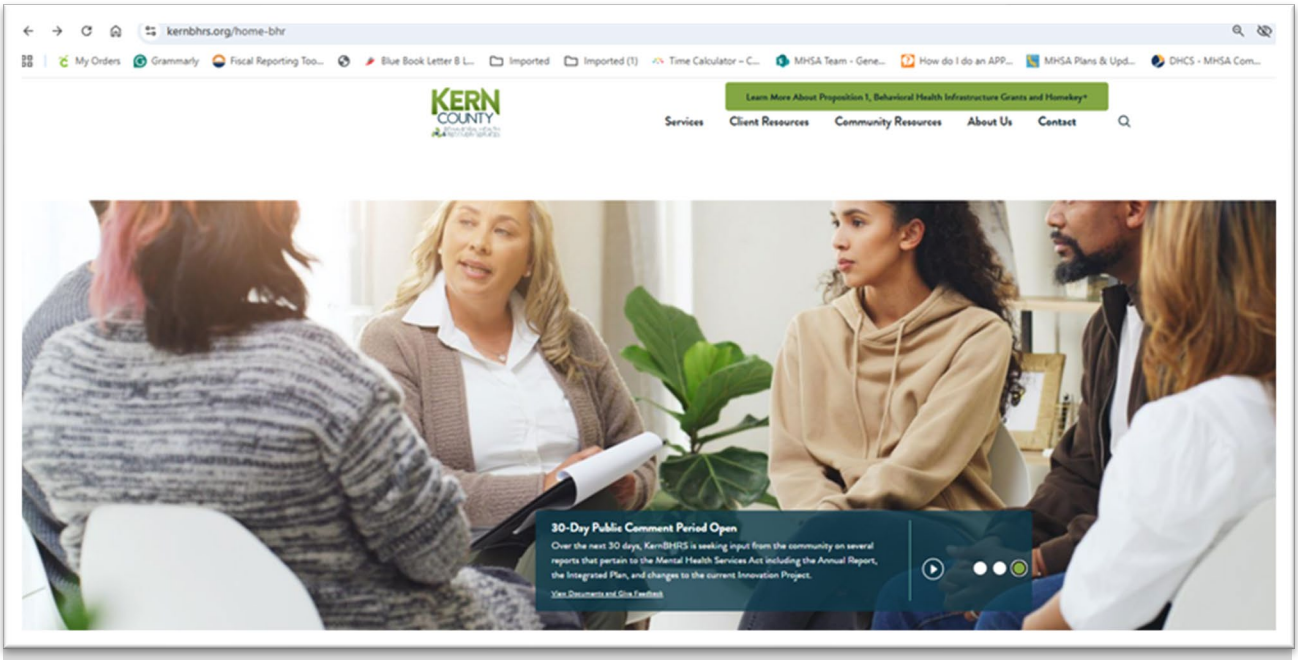
30-Day Public Comment Period

Three-Year Integrated Plan (DRAFT)

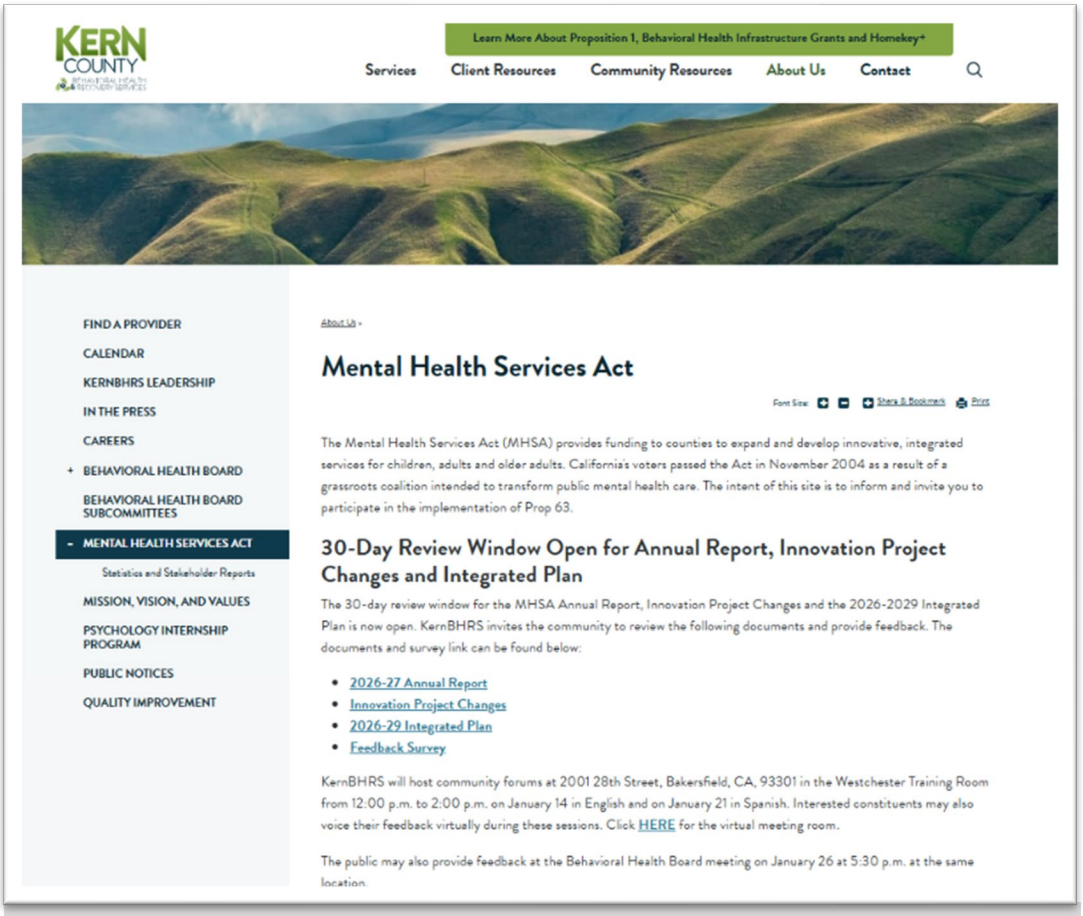


Kern Behavioral Health and Recovery Services (Kern BHRS) would like to thank those who were interested and participated in the 30-day public review and comment portion of the stakeholder planning process that occurred from **January 12, 2026, through February 11, 2026**. During this time, Kern BHRS promoted the 30-day public posting and provided informational meetings related to the **Three-Year Integrated Plan (DRAFT)**. A press release notifying the public of the posting and a Public Hearing, was sent to **67** media contacts and community influencers. Email blasts were sent to over **500** community partners, contracted agencies, cultural committees, and regularly scheduled stakeholder meetings attendees. This information was also advertised on Kern BHRS social media sites, including Instagram and Twitter. Copies of the **Three-Year Integrated Plan (DRAFT)** were available online for electronic viewing, and hard copies were available upon request.

> WIC § 5848 states that an MHSA Three Year Plan or Annual Update shall be prepared and circulated for review and comment for at least 30 days to representative of stakeholder interests and any interested party who has requested a copy.
>
> Additionally, the mental health board shall conduct a public hearing on the draft Three Year Plan or Annual Update at the close of the 30 day comment period



Website Banner at https://www.kernbhrs.org/home-bhr

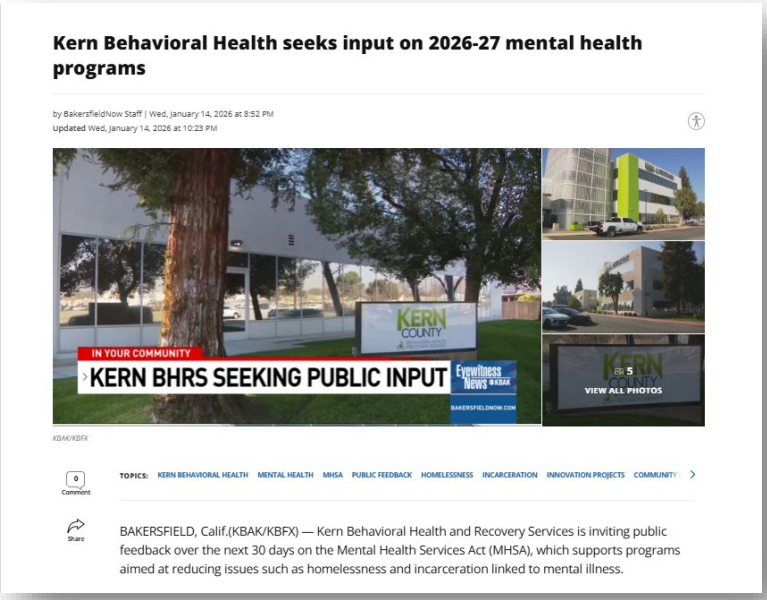


Website posting of downloadable reports at
https://www.kernbhrs.org/about-us/mental-health-services-act

In addition, the press releases garnered interest from the local media outlets, which conducted radio and TV interviews and published articles about the MHSA Annual Update, **Three-Year Integrated Plan (DRAFT)**, and Innovation Program request for changes, and the 30-Day public comment period.

Eyewitness News (KBAK) Media coverage

https://www.bakersfield.com/news/public-comment-opens-on-county-mental-health-services/article_79e22c78-8f6d-4551-a085-904047cc83af.html

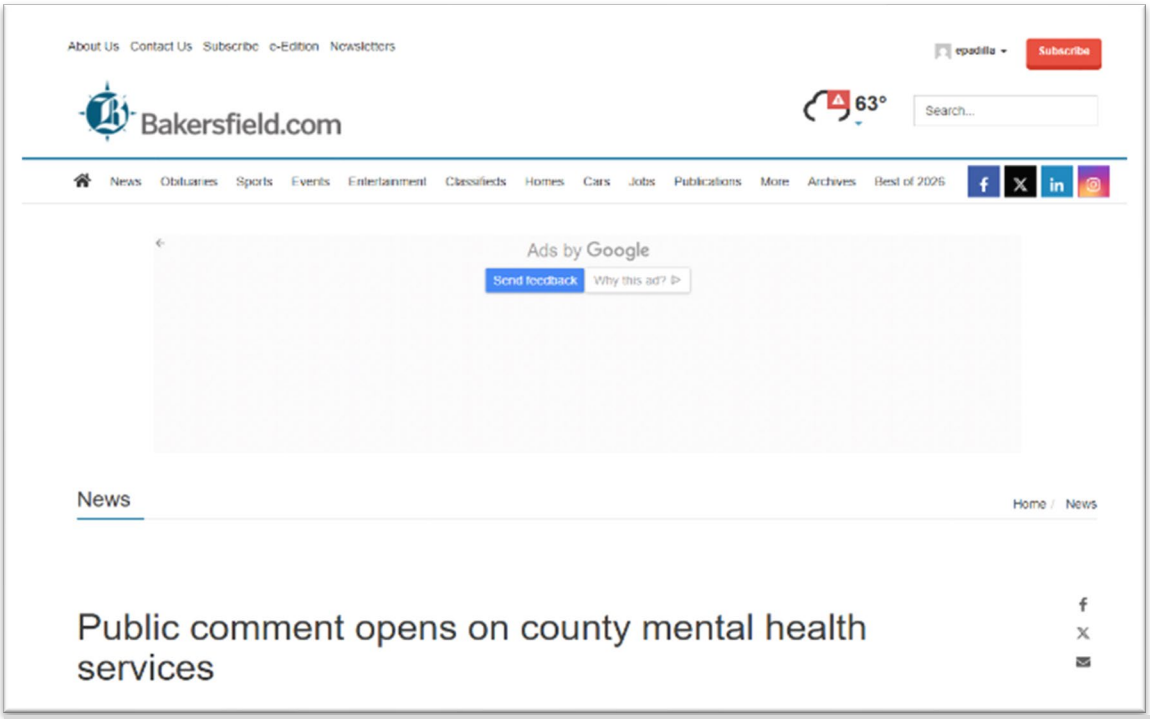


Kern Behavioral Health seeks input on 2026-27 mental health programs

by BakersfieldNow Staff | Wed, January 14, 2026 at 8:52 PM
Updated Wed, January 14, 2026 at 10:23 PM

TOPICS: KERN BEHAVIORAL HEALTH | MENTAL HEALTH | MHSA | PUBLIC FEEDBACK | HOMELESSNESS | INCARCERATION | INNOVATION PROJECTS | COMMUNITY

BAKERSFIELD, Calif.(KBAK/KBFX) — Kern Behavioral Health and Recovery Services is inviting public feedback over the next 30 days on the Mental Health Services Act (MHSA), which supports programs aimed at reducing issues such as homelessness and incarceration linked to mental illness.



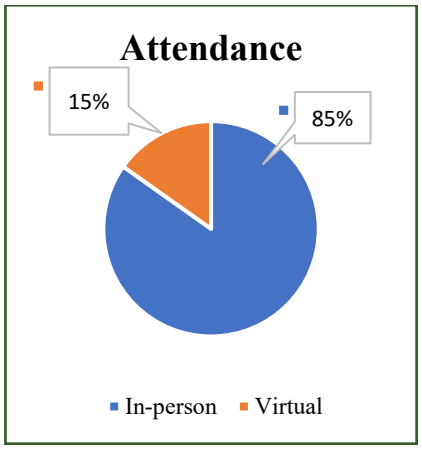
The Bakersfield Californian Online Newspaper
https://www.bakersfield.com/news/public-comment-opens-on-county-mental-health-services/article_79e22c78-8f6d-4551-a085-904047cc83af.html

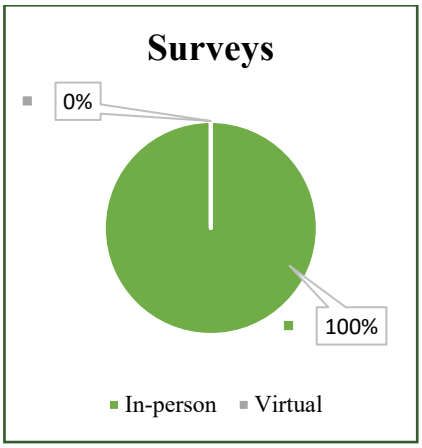
Overall, the posted Annual Report, **Three-Year Integrated Plan (DRAFT)**, and Innovation Project Changes were primarily electronically accessed, with over **1,228** social media impressions, and over **270k** subscribers had access to the video interview and online article about the draft of the documents up for 30-Day public review.

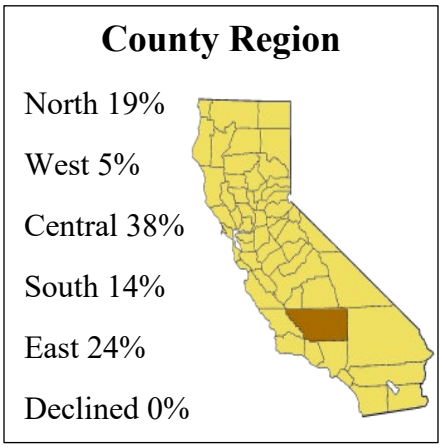
The outreach efforts about the 30-Day Public Review period resulted in several hundred views.		
1,228 Social Media Impressions	**850** Views of the posted documents for review	**270K** Subscribers to a local media outlet

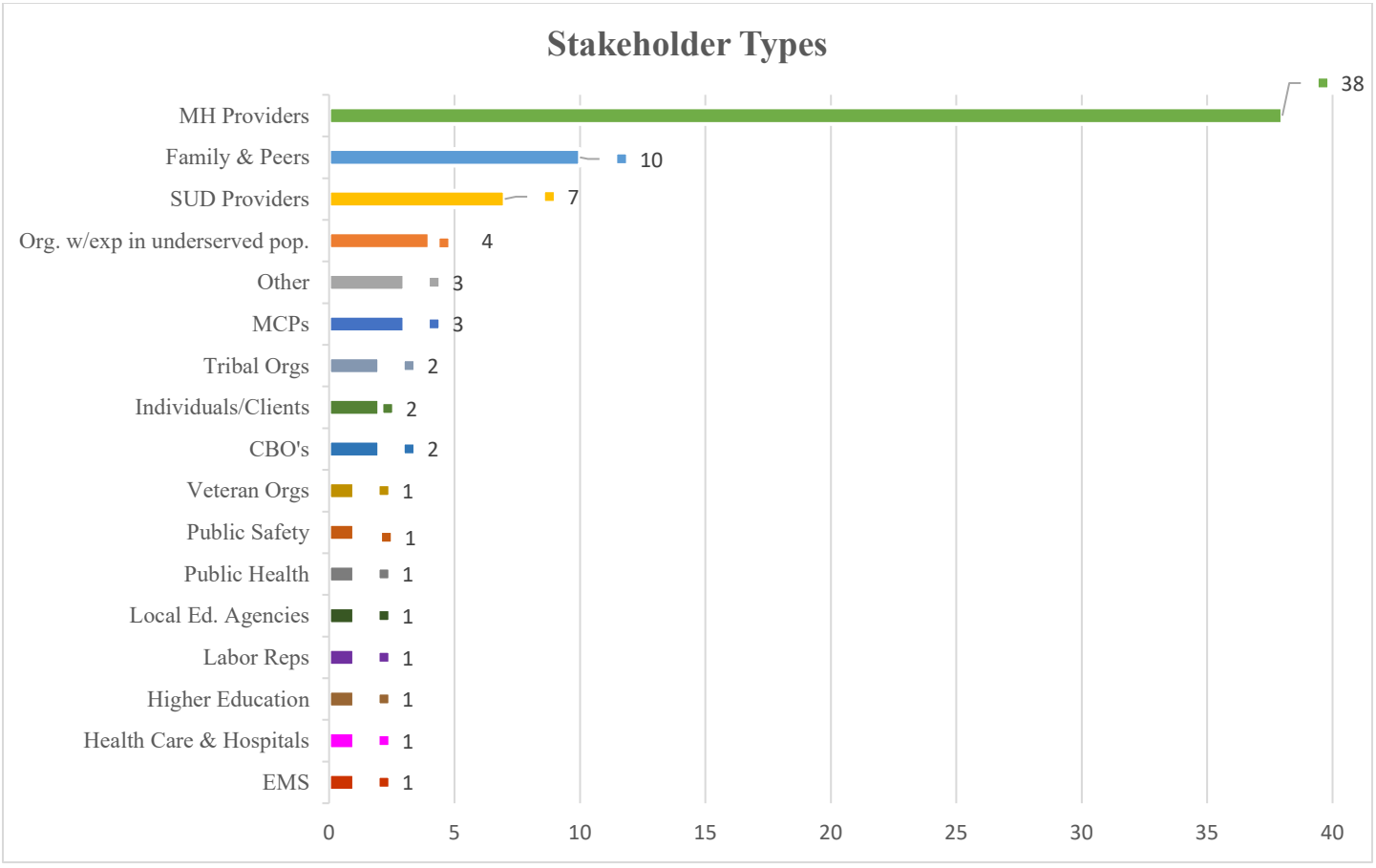
During the 30-Day Circulation & Public period, we received a total of **9** comment forms, which provided general comments and support for the Draft of the Annual Update. Overall, **75%** of stakeholders who specifically responded to the 30-Day public posting indicated they were satisfied with the draft.

Meaningful Engagement – Stakeholder Representation









SUMMARY AND ANALYSIS OF SUBSTANTIVE COMMENTS/RECOMMENDATIONS

Kern BHRS would like to thank everyone who provided feedback during the 30-Day circulation period. The following contains a summary and analysis of a sample of comments, along with responses, that were received.

Date	Q5. Do you have any comments or additional recommendations for the proposed Three-Year Integrated Plan (DRAFT)?
01/13/26	The proposed 2026–2029 Kern County Integrated Plan reflects a comprehensive and data-informed approach to improving behavioral health access, equity, and outcomes across the county. The plan clearly demonstrates thoughtful alignment with statewide priorities, strong cross-system collaboration, and a continued commitment to outreach, field-based services, workforce development, and non-traditional models of care. One recommendation is to further strengthen the plan by more explicitly identifying and operationalizing rural and geographically isolated community needs across planning, implementation, and evaluation activities. While the plan acknowledges access barriers, workforce shortages, and the use of mobile and field-based services, clearer rural framing would help ensure that these strategies are consistently designed and resourced to meet the realities of outlying agricultural, desert, and mountain communities within Kern County. In addition, the plan presents an opportunity to more intentionally leverage rural community strengths as part of prevention, early intervention, and recovery-oriented services. Community-embedded, place-based, and relationship-driven approaches—particularly those that incorporate peer support, family systems, and connection to land and community—may enhance engagement for individuals who are less likely to access clinic-based services and may reduce later system escalation. Continued investment in local workforce development pipelines, including training and retention of providers who live and work in rural communities, would further support sustainability and cultural responsiveness. Explicitly incorporating rural considerations into innovation planning, stakeholder engagement, and outcome measurement would strengthen the plan's ability to demonstrate equitable reach and impact across all regions of Kern County. Overall, the Integrated Plan provides a strong foundation, and with clearer rural operationalization, it has the potential to further advance access, prevention, and recovery for residents across Kern County's most geographically isolated communities.
Response/ Outcome:	*Thank you for your thoughtful and detailed feedback on the proposed 2026–2029 Kern County Integrated Plan. We appreciate your recognition of the plan's comprehensive, data-informed*

	approach, its alignment with statewide priorities, and its emphasis on cross-system collaboration, outreach, workforce development, and non-traditional models of care. *Your recommendation to more explicitly identify and operationalize the needs of rural and geographically isolated communities is well taken. We agree that strengthening a clear rural lens across planning, implementation, and evaluation activities will help ensure that strategies such as mobile, field-based, and outreach services are consistently designed and resourced to reflect the unique realities of Kern County's agricultural, desert, and mountain regions. The emphasis you place on leveraging rural community strengths—through community-embedded, place-based, and relationship-driven approaches that incorporate peer support, family systems, and connection to community—is particularly valuable and aligns with our goals for prevention, early intervention, and recovery-oriented care.* *We also appreciate your emphasis on continued investment in rural workforce development pipelines, including the training, recruitment, and retention of providers who live and work in rural communities, as a critical component of sustainability and cultural responsiveness. Your recommendation to explicitly integrate rural considerations into innovation planning, stakeholder engagement, and outcome measurement will help strengthen the plan's ability to demonstrate equitable reach and impact across all regions of Kern County.* *This feedback will be carefully considered as we refine the Integrated Plan, and it provides important guidance for strengthening our approach to serving Kern County's most geographically isolated communities.*
01/13/26	Better explanation to the public. What does this mean for the average resident? For the taxpayer?
Response/ Outcome:	*Thank you for this feedback. We agree that clearly communicating how the Integrated Plan affects everyday residents and taxpayers is essential. The 2026–2029 Kern County Integrated Plan is intended to translate state and county policy into tangible, community-level benefits.* *For the average resident, this plan means improved access to behavioral health services, earlier intervention, expanded outreach and field-based care, and more coordinated support across systems such as public health, healthcare, education, justice, and social services. These strategies are designed to help individuals and families receive the right level of support sooner, closer to home, and in ways that are responsive to their needs.* *For taxpayers, the plan emphasizes accountability, transparency, and responsible use of public funds. By prioritizing early intervention, and community-based services, the plan aims to reduce reliance on more costly crises, emergencies, and institutional care over time. Investments in*

	workforce development, data-driven planning, and program evaluation are intended to improve service effectiveness, reduce duplication, and ensure that funding is directed toward strategies that demonstrate measurable outcomes and community impact. *We also welcome and encourage ongoing community participation. All community members are invited to attend our stakeholder and community forums, which are held on the second Wednesday of each month. Forums are offered both virtually and in Spanish to ensure broad access and inclusion. For more information or to get involved, please contact us at MHSATeam@kernbhrs.org.*
01/26/26	BEST program, does this account for any transportation costs? Does targeted population include all ERs across Kern or only Metro Bakersfield? The targeted population for the First Episode Psychosis is based on referrals received from past two years, is this truly reflective of those that would benefit from the program, most providers aren't familiar with the current program, is this a fair estimate?
Response/ Outcome:	*Thank you for this feedback and for raising important questions regarding program scope, access, and assumptions used in planning.* *With respect to the BEST program, transportation is a recognized barrier to access, particularly for individuals and families in rural or outlying areas. While transportation costs may not always be identified as a standalone line item, transportation-related supports are considered within outreach, field-based, and mobile service strategies to help reduce access barriers. Feedback such as this is valuable in informing whether transportation needs should be more explicitly articulated and assessed within program planning and implementation moving forward.* *Regarding the targeted population and emergency room (ER) referrals, the intent of the Integrated Plan is to support countywide access. While referral patterns may currently reflect higher utilization from Metro Bakersfield, this is influenced by factors such as provider awareness, service proximity, and existing referral relationships. The plan recognizes the need to strengthen outreach and coordination with ERs and referral sources across all regions of Kern County to ensure equitable identification and access for individuals who may benefit from services, including First Episode Psychosis (FEP) programs.* *The observation about reliance on referral data from the past two years is also well taken. While historical referral data provides a starting point for planning, it may not fully capture unmet need, particularly when provider familiarity with the program is limited. As such, the Integrated Plan emphasizes continued outreach, education, and engagement with providers,*

	schools, hospitals, and community-based organizations to improve awareness, expand referral pathways, and more accurately identify individuals who could benefit from FEP services. Ongoing evaluation and data refinement will remain important to ensure that targeted populations reflect both current utilization and underlying community need. *This feedback highlights the importance of continuously reassessing assumptions related to access, geography, and referral patterns. It will help inform future planning, outreach strategies, and data collection efforts to strengthen equity, accuracy, and countywide impact within the 2026–2029 Integrated Plan.*
01/26/26	Minor edit on SUD DIVISION ADMINISTRATOR's phone number: it should list 661 868-7596. Looks like section 7 and 8 are empty on page 57.
Response/ Outcome:	*Thank you for bringing these items to our attention. We appreciate the identification of the correction needed to our SUD Division Administrator phone number and will update it accordingly. We also acknowledge the note regarding Sections 7 and 8 appearing empty on page 57. This page refers to the stakeholder feedback we would receive during the 30-Day circulation period which is happening after this DRAFT is published. Once the 30-Day period ends, we will complete this section of the Integrated Plan.* *This feedback is helpful in improving the clarity, accuracy, and overall quality of the 2026–2029 Kern County Integrated Plan, and we appreciate your careful review of the document.*
01/26/26	Public Comment on the BHSA Integrated Plan, Crisis Services, and Public Safety Members of the Board, Behavioral Health leadership, and community partners. I serve Kern County as a 988 crisis counselor and as a frontline behavioral health professional working directly with individuals and families at their most critical breaking points. I want to speak today about the Behavioral Health Services Act Integrated Plan and what it means — not in theory, but in lived reality — for crisis response, public safety, and community stability in Kern County. Crisis mental health services are the front door to our behavioral health system. For many people, they are also the last point of contact before someone ends up incarcerated, hospitalized, unhoused, or dead. These are not abstract outcomes — they are daily realities we are navigating on the front lines. The BHSA Integrated Plan presents a rare opportunity to do something different: to move away from fragmented, reactionary crisis response and toward a coordinated, integrated system of care that bridges gaps between crisis hotlines, mobile response, inpatient treatment, community-based services, institutions, and law enforcement. Right now, too many individuals cycle endlessly between emergency rooms, jails, temporary holds, and the streets — not because they don't want help, but because the system is not designed to hold them long enough, or

	comprehensively enough, to stabilize, treat, and transition them forward. Expanding crisis mental health services must mean more than answering calls. It must include: Stronger coordination between 988, mobile crisis teams, hospitals, inpatient psychiatric facilities, and outpatient providers Real-time collaboration with law enforcement that prioritizes diversion, safety, and treatment over arrest Expanded access to inpatient and residential treatment options that provide comprehensive, clinically appropriate care, not short-term containment Seamless integration of CARE Act criteria so individuals with severe mental illness receive structured intervention before they become a danger to themselves or others When crisis systems are underfunded or disconnected, the cost does not disappear — it simply shifts. It shows up as repeat incarceration, chronic homelessness, high-risk individuals cycling through public spaces, and frontline workers burning out under impossible conditions. When crisis systems are strengthened, integrated, and aligned with public safety goals, the return is measurable: Reduced recidivism Reduced homelessness Fewer high-risk individuals living untreated on the streets Safer outcomes for law enforcement, clinicians, families, and the broader community This is not about being punitive or permissive. It is about being effective. Public health and public safety are not competing values — they are interdependent. A community cannot be safe if people with untreated severe mental illness are left without pathways to care. And people cannot recover if crisis response ends the moment the immediate danger passes. The BHSA Integrated Plan gives Kern County the ability to build a system that does more than react to crisis — one that interrupts cycles, stabilizes lives, and restores dignity while protecting the public. I urge you to ensure that crisis services are treated as core infrastructure: fully funded, properly staffed, and structurally integrated across agencies and systems. The decisions made here will determine whether Kern County continues to manage crisis — or finally resolve it. Thank you for listening — and for recognizing that the lives behind these policies are real, present, and waiting for action.
Response/ Outcome:	*Thank you for your powerful and deeply informed public comment. We sincerely appreciate you sharing your perspective as a 988 crisis counselor and frontline behavioral health professional, and we acknowledge the critical role you and your colleagues play in supporting individuals and families at their most vulnerable moments.* *Your comments underscore an essential truth reflected in the intent of the Behavioral Health Services Act (BHSA) Integrated Plan: crisis services are not peripheral—they are foundational to an effective behavioral health system and to broader public safety and community stability.* *We agree that crisis response must move beyond fragmented, reactive approaches and toward a*

	coordinated, integrated continuum of care that connects 988 services, mobile crisis response, emergency departments, inpatient and residential treatment, outpatient care, community-based supports, and law enforcement diversion efforts. *The concerns you raise regarding repeated cycling through emergency rooms, jails, temporary holds, and homelessness are precisely the system gaps the BHSA Integrated Plan seeks to address. Strengthening crisis services under BHSA includes improving cross-system coordination, expanding diversion-oriented partnerships with law enforcement, increasing access to clinically appropriate inpatient and residential treatment, and aligning CARE Act implementation to support earlier, more structured intervention for individuals with severe mental illness.* *We also recognize your emphasis on the broader consequences of underfunded or disconnected crisis systems, including workforce burnout, increased incarceration, homelessness, and risks to both individuals in crisis and first responders. As you note, investments in integrated crisis infrastructure yield measurable public health and public safety outcomes, including reduced recidivism, improved stabilization, and safer communities overall. These outcomes are central to BHSA's goals and to the County's ongoing planning efforts.* *Your feedback reinforces the importance of treating crisis services as core infrastructure—fully staffed, adequately funded, and structurally integrated across systems. We are grateful for your advocacy, lived experience, and professional insight, and your comments will be considered as we continue refining and implementing the BHSA Integrated Plan. Thank you for your dedication to this work and for elevating the real human impact behind these policy decisions.*
01/26/26	(Public Hearing) What do you do with the feedback received from the 30-Day Public Comment period?
Response/ Outcome:	*Thank you for the question regarding how public feedback from the 30-Day Public Comment period is used. Public input is a critical component of the planning and oversight process.* *Once the 30-day public comment period concludes, all feedback received is compiled and formally shared with County administration and program leadership. Comments are carefully reviewed to identify common themes, concerns, and recommendations. When feasible and appropriate, this feedback is used to inform revisions to the Integrated Plan, clarify language, strengthen program alignment, and guide implementation priorities. Input may also influence future planning, evaluation measures, and stakeholder engagement strategies, even when immediate changes to the current plan are not possible due to statutory, fiscal, or timeline constraints.*

	In addition, public comments are documented as part of the official planning record to ensure transparency and accountability. This process helps ensure that the Integrated Plan reflects community-identified needs, lived experience, and local priorities, and that public input meaningfully informs both current and future behavioral health planning efforts.
01/26/26	Has the feedback been good?
Response/ Outcome:	*To date, the feedback received has been limited in volume but generally positive in nature. Commenters have expressed support for the overall direction of the plan and appreciation for its focus on access, coordination, and community-based approaches. We continue to welcome additional input throughout the public comment period and value all feedback as an important part of strengthening the plan and ensuring it reflects community priorities and needs.*
01/27/26	Feedback in form of a letter was received from the California Pan-Ethnic Health Network (CPEHN) and the Bakersfield American Indian Health Project (BAIHP). (Copy of this letter can be found at the end of this section.)
Response/ Outcome:	*Thank you to the Bakersfield American Indian Health Project (BAIHP) and the California Pan-Ethnic Health Network (CPEHN) for your comprehensive and thoughtful recommendations regarding Kern County Behavioral Health and Recovery Services' Behavioral Health Services Act (BHSA) Integrated Plan. We appreciate the time, expertise, and community-informed perspective reflected in your comments, as well as your shared commitment to advancing behavioral health equity for Kern County residents.* *Your recommendations highlight critical considerations as the County transitions from the Mental Health Services Act (MHSA) to the broader and more integrated BHSA framework. We acknowledge the importance of incorporating a racial equity lens across funding strategies, outreach and engagement, service delivery, workforce development, and system communication. The emphasis on cultural and linguistic responsive approaches, community-defined evidence practices, and meaningful partnerships with trusted community-based organizations aligns with BHSA requirements and the County's ongoing efforts to reduce disparities and improve access for historically underserved populations.* *We also recognize the significance of proactively addressing potential funding constraints, Medi-Cal eligibility challenges, and workforce sustainability—especially for immigrant, refugee, undocumented, and limited-English-proficiency communities. Your recommendations related to leveraging multiple funding sources, strengthening community health worker and*

	promotor workforce capacity, expanding language access, and improving transparency and communication will be carefully considered as part of continued planning, implementation, and evaluation under BHSA. *As the Integrated Plan is refined and implemented, this feedback will inform ongoing discussions with County leadership, program teams, and community stakeholders to ensure alignment with state requirements, responsiveness to community-identified needs, and equitable impact across Kern County. We value your partnership and look forward to continued engagement as BHSA planning evolves and annual updates are developed.* *Thank you again for your advocacy and for contributing to a shared vision of a more equitable, accessible, and community-responsive behavioral health system in Kern County.*
02/02/26	Program sections should be clearly and consistently referenced. FSP Youth Crisis Engagement Team on p61 says Program One; Youth MIST says Children's System of Care (Non-Full Service Partnership (FSP)) Program #2 and is in a box on p62; AOT says Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program #2 and is not in a box on p66; Crisis Hotline says Early Intervention (EI) Programs #2 on p70 (and it says programs instead of programs). These are a few examples - there are many others. First Episode Psychosis is on p68; Early Psychosis Intervention on Plus (EPI Plus) is on p89 - are these the same programs? I believe this is a typo on page 112 - LGBTQIA2S2SLGBTQIA+
Response/ Outcome:	*Thank you for your careful review and for identifying these inconsistencies. We agree that program sections should be clearly and consistently referenced throughout the Integrated Plan. The examples you provided regarding program numbering, system-of-care labels, formatting, and terminology are helpful and will be reviewed to ensure consistency and clarity across the document. We will also clarify the relationship between First Episode Psychosis and Early Psychosis Intervention Plus (EPI Plus) to avoid confusion, and correct the noted typographical error related to LGBTQIA+ terminology.* *We appreciate this detailed feedback, which will help improve the accuracy, readability, and overall quality of the Integrated Plan.*

BEHAVIORAL HEALTH BOARD (BHB) – PUBLIC HEARING

The required Public Hearing hosted by the Kern County Behavioral Health Board was conducted on January 26, 2026, from 5:30 PM to 7:00 PM at the Kern BHRS – Westchester Training Room located at 2001 28th Street, Bakersfield, CA 93301.

The agenda, public comment forms, and a copy of the presentation were accessible to all attendees during the meeting. As with all public meetings, interpretive services and materials were provided upon request.

During the Behavioral Health Board's **MHSA/BHSA** Public Hearing, there were no community members' comments.

Consistent with WIC 5604.2(a)(4), the BHB reviewed and approved the procedures used to ensure that citizen and professional involvement in the planning process met regulations. Recommendations for future planning were noted and will be kept for future planning efforts (*see attached BHB Public Hearing Minutes for more information*).

KERN COUNTY BEHAVIORAL HEALTH BOARD
REGULAR MEETING MINUTES

January 26, 2026
5:30 p.m.
In Person: 2001 28th Street- 1st Floor, Training Room

BOARD MEMBERS PRESENT:

Michael Bryant (Dist. 3) – Chair
Bryson Gholston (Dist. 3) – 2nd Vice Chair
Sonia Silva (Dist. 1)
BreAnne Patterson (Dist. 4) Parliamentarian
Jeff Burdick (Dist. 1) – 1st Vice Chair
Tiara King (Dist. 2)
Michael Herrera (Dist. 1)
Ishmeet Singh (Dist. 2)
LaShawna Stowe (Dist. 3)

Maria Gonzalez – BHB Coordinator

OTHERS PRESENT: 4 Public Attendees – Catlin Payne, Johnny Delgado, Carlos Herrera, Sindhua Payulu

KERNBHRS STAFF: Mark Kimmel (Behavioral Health Program Supervisor), Jessica Armstrong (BHRS Deputy Director), Robin Taylor (BHRS Deputy Director), Heather Hornibrook (BHRS Deputy Director), Alison Burrowes (BHRS Director).

1. **Welcome and Introductions:** Michael Bryant, Chair, welcomed everyone; each board member introduced themselves.

2. **Establish Quorum:** Present (6).

3. **Approval of Draft Minutes:**
   - November 17, 2025 Regular Meeting MOTION by Bryson Gholston and SECONDED by Sonia Silva. ALL AYES: MOTION PASSED.

4. **Presentation(s):** None

5. **Public Comment:** None

6. **Unfinished Business**
   - Bylaws approved by BOS January 6, 2026
   - Brown Act Law changes effective January 2026
   - Subcommittee Co Chairs and Frequency of Meetings

7. **New Business** – Michael Byant
   - **Election of Officer** – Parliamentarian MOTION by Bryson Gholston and SECONDED by Jeff Burdick. ALL AYES. MOTION PASSED.
   - **MHSA Annual Plan** – Mark Kimmel MOTION by Sonia Silva and SECONDED by BreAnne Patterson. ALL AYES. MOTION PASSED.
   - **BHSA Integrated Plan**
     - PowerPoint Presentation, "BHSA Integrated Plan" by Mark Kimmel. *Time allowed for Questions & Answers.* (Mark Kimmel is requesting feedback).
   - **Learning Healthcare Network Innovation Change** – Mark Kimmel MOTION by Michael Bryant and SECONDED by Bryson Gholston. ALL AYES. MOTION PASSED.

8. **Chair Report** – Michael Bryant
   - **CalBHBC Meeting/ Training Update**
     - First session held via Zoom, covering advanced directives for mental health and effective board participation, including Brown Act updates. Next session for new members is February 2, 2026, from 5:00 PM–6:30 PM. Training materials and Zoom links will be shared in advance.
   - **Ad Hoc Committee for Annual Report**
     - Volunteers needed for the annual report Ad HOC Committee; Jeff and the Chair volunteered. Additional details to be shared via email.

9. **KernBHRS Administrative Services** – Heather Hornibrook, Deputy Director
   - **Clinical Plan Services**
     - Partnering with Boston Consulting Group (BCG) to improve service capture and documentation. Pilot launches in February with QID support.
     - Four PCIT clinicians certified; eight families graduated; caseloads being coordinated with PCIT International.
       - Cultural Competence: African American/Black Subcommittee planning Black History Month events.
       - BHSA: 30-day review underway for Integrated Plan, Annual Plan, and INN Project change request (Early Psychosis LHN).
       - Clinical Plan Services Administration: Prop 47 Cohort 3 programming ends 3/1/26; referrals accepted through 1/31/26 for final client support and data submission.
   - **Finance**
     - Medi-Cal rates published on January 14, 2026, reflect a 3.08% increase.
   - **QID**
     - External Quality Review (EQR) for 2026 will include combined Performance Measure Validation (PMV) and Network Adequacy Validation (NAV), conducted by HSAG for MHP and DMC-ODS. Virtual review scheduled for April 6, 2026.
     - DHCS FY 2024–25 review will focus on DMC-ODS and SUBG services. Audit period is July 1, 2024–June 30, 2025. Virtual compliance review on May 5, 2026, with a brief closing session on May 6, 2026.

10. **KernBHRS Clinical Services Report** –Jessica Armstrong, Deputy Director
    - **Adult System of Care**
      - Two Day Treatment Intensive vendors awarded via RFQ: Charlie Health (adult/children) and Kern Medical (adult). Charlie Health contract nearing completion; anticipated start July 1, 2026.
    - **Kern Linkage**
      - Point-in-Time Count was held January 28, 2026.
      - Transitional Rent launched January 1, 2026, offering up to six months of Medi-Cal housing support for eligible members; must be used before other KBHRS housing funds.
    - **Substance Use Disorder Division**
      - Prop 47 Cohort 5 contract executed; implementation begins next month to expand participant support, housing, and treatment services.

- Clarvida Tehachapi approved to launch Contingency Management services, becoming the 9th program in Kern County.
- Outpatient SUD RFP is under evaluation, with awards anticipated for a July service start.

11. KernBHRS Specialty Clinical Services Report – Robin Taylor, Deputy Director

- **Infrastructure and Technology**
  - Document Management System RFP in development.
  - Collaborating with CalMHSA on State-required enhancements (Close Loop Referral, Prior Authorization Modules).
  - Recent network penetration test rated security as average; recommended improvements are in progress.
- **Crisis Services**
  - Mobile Evaluation Team Communication Center with BPD and KCSO received a Challenge Award from the California State Association of Counties for innovative services.
  - SB 43 went live January 1,26, expanding involuntary holds/conservatorships for severe SUD or co-occurring MH/SUD. Kern has had 3 SUD-only 5150 holds (all discontinued) and 1 dual MH/SUD Temporary Conservatorship.
  - Ongoing enhancements to SUD assessment and treatment within Crisis Services.
- **Children's System of Care**
  - Youth MIST team recertified for Treatment Foster Care Oregon.
  - First Episode Psychosis Program expanding outreach and referrals.
  - Developing the One County Plan for High Fidelity Wrap with DHS and Probation; effective July 1, 2026, with UC Davis training in progress.
  - Focus on braided funding, quality improvement, and data/outcome measurement.

12. KernBHRS Department Report – Alison Burrowes, Director

- **Department Initiatives**
  - Implementing the BHSA integrated plan while expanding evidence-based practices, SUD services, day/residential treatment, and staff training.
- **Financial & Community Considerations**
  - High costs for new services; tracking funding, H1 medical changes, and client impact with managed care and CAO.
- **Board Presentations & Planning**
  - Ongoing staff/provider presentations. Open to topic feedback. Summer planning in progress.

13. Board Member Item: None

14. Committee Reports:

Adult Treatment & Recovery Services (quarterly): Bryson Gholston:

- Next meeting will be held on February 11, 2026.

Children's Treatment & Recovery Services (quarterly): Jeff Burdick:

- Last meeting was held on January 8, 2026. (Unable to attend).

System Quality Improvement Committee (bi-monthly): David Kessler Chair.

- Last meeting was held on January 26, 2026.

15. Announcements to the Public: None

16. Adjourn: MOTION by BreAnne Patterson to adjourn to the next regular meeting in person on February 23, 2026, and SECONDED by Michael Herrera. ALL AYES: MOTION PASSED. Adjourned at 7:00 PM.

Mental Health Services Act

The Mental Health Services Act (MHSA) provides funding to counties to expand and develop innovative, integrated services for children, adults and older adults. California's voters passed the Act in November 2004 as a result of a grassroots coalition intended to transform public mental health care. The intent of this site is to inform and invite you to participate in the implementation of Prop 63.

Proposed Annual Documents/Updates

- Innovation Project Changes
- 2026-29 Integrated Plan

2025 Innovation Plan

The KernBHRS' Innovation Plan (INN) has been approved by the Behavioral Health Board and the County of Kern. This is a stand-alone INN Project Plan, in which KernBHRS has joined together with other counties in collaboration with CalMHSA to participate in an Electronic Health Record (EHR) solution, SmartCare.

- Multi-County Innovations Plan

2026-27 Annual Plan

The KernBHRS Annual Report entails continuing, new, and proposed mental health programs to serve children, transitional-age youth, adults, and older adults. An approved version of the Annual Plan is posted below.

- MHSA Annual Update Plan for Fiscal Year 2026-27

Three-Year Plan Published

The Kern County Mental Health Services Act (MHSA) 3 Year Plan 2023-2026 is now published. As per the Mental Health Services Act regulatory requirements, there was a 30-day public comment period that is now closed.

Between April 21, 2023 and May 20, 2023, the public was able to review the draft of the Kern Behavioral Health and Recovery Services Kern County Mental Health Services Act 3 Year Plan 2023-2026 and provide public comments. Comments were collected, summarized, and added to the plan if they were deemed applicable.

If you have questions, please contact us via email at MHSATeam@kernbhrs.org.

Community Forums

KernBHRS hosts community forums each month, focusing on department updates, community feedback and the transition to the Behavioral Health Services. The forums are held on the second Wednesday in English and on the third Wednesday in Spanish at the Westchester Building on 2001 28th Street in Bakersfield. You can also join them virtually HERE. Each forum is from 12:00 to 2:00 p.m. A light lunch is provided for all attendees.

Prevention & Early Intervention

- AB114 Prevention & Early Intervention and Innovative Program Plan
- Three-Year Evaluation Report for FY 2021-2024

Community Services And Support Plan

- Mental Health Services Act CSS Amendments
- Plan Summary
- Plan Summary (Spanish Version)

California Department of Mental Health Information

- CA DHCS - Mental Health Services Division

Innovation Projects

- The Healing Project Final Report (FY 2021-2024)

Attachment G

Kern Behavioral Health and Recovery Services

Quality Improvement Work Plan FY 2025-2026

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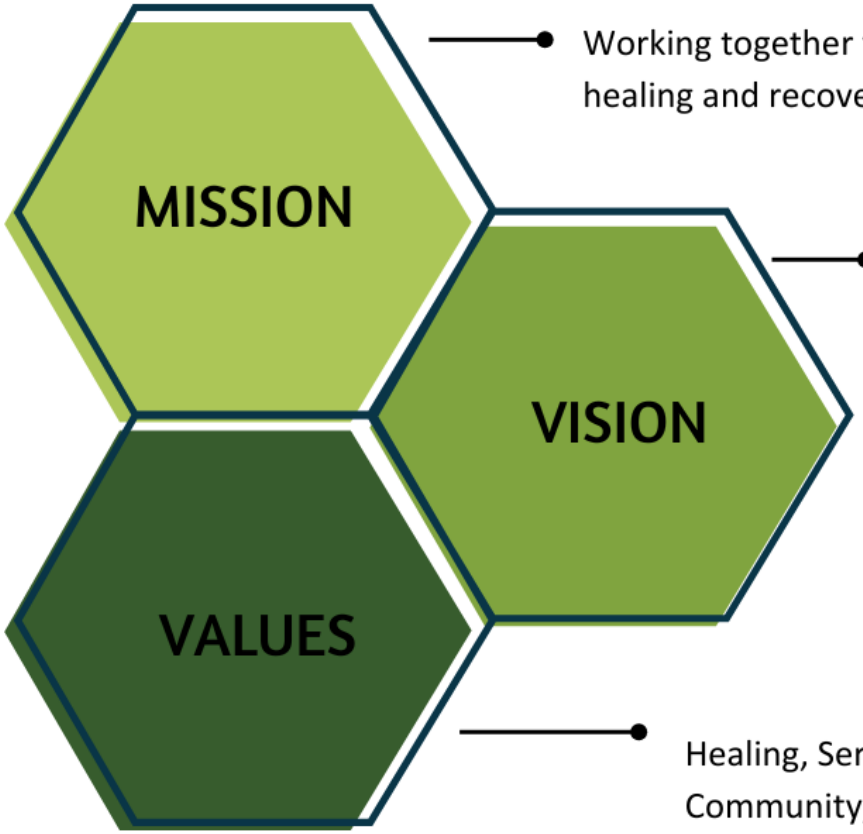
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MISSION VISION VALUES



Working together to support hope, healing and recovery

Delivering excellent behavioral health care to support the well-being of our community.

Healing, Service Excellence, Community, Innovation.

KERN QUALITY ASSESSMENT AND IMPROVEMENT PROGRAM DESCRIPTION

Kern Behavioral Health and Recovery Services (KernBHRS) is committed to delivering high-quality, person-centered, and recovery-oriented behavioral health care that is inclusive, culturally responsive, and integrated with primary health services. Our approach prioritizes the unique needs, voices, and lived experiences of each beneficiary, with a focus on advancing service equity and reducing disparities across all populations we serve.

Our mission is to empower individuals facing mental health and substance use challenges by supporting their journey toward wellness, resilience, and full participation in community life. We recognize that true quality extends beyond compliance encompasses access, effectiveness, safety, equity, and client satisfaction.

KernBHRS continuously strengthens its programs through the Quality Assessment and Improvement Program (QAIP), which aligns with the requirements of the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) agreements with the Department of Health Care Services (DHCS). The Kern BHRS QAIP is a structured framework that encompasses quality improvement and evaluation activities designed to enhance the delivery of high-quality behavioral health services. The QAIP also integrates performance improvement priorities identified by the California External Quality Review Organization (CAEQRO).

Oversight of the QAIP is provided by the KernBHRS Director, a licensed mental health professional under the authority of the Kern County Board of Supervisors. Day-to-day development and implementation are led by the Administrator of the Quality Improvement Division (QID), ensuring that KernBHRS remains accountable, data-driven, and responsive to the evolving needs of our community.

REPORTING AND IMPROVING

A vital component of the Quality Assessment and Improvement Program (QAIP) is the annual implementation of the Quality Improvement (QI) Work Plan. This plan serves as a strategic framework for advancing KernBHRS's commitment to high-quality, equitable, and person-centered behavioral health care. It reflects a continuous quality improvement cycle that is responsive to the evolving needs of our diverse beneficiary population.

The QI Work Plan outlines KernBHRS's quality priorities for the current fiscal year and includes:

- Monitoring activities, such as the review of beneficiary grievances, appeals (including expedited and fair hearings), provider appeals, and clinical record reviews. These activities ensure transparency, accountability, and compliance with regulatory standards.
- Evidence of impact, demonstrating how QI activities—including Performance Improvement Projects (PIPs)—have led to measurable improvements in clinical care, service delivery, and beneficiary outcomes.

- Descriptions of completed and ongoing QI initiatives, including:
    - Monitoring and resolution of previously identified issues
    - Defined objectives, scope, and timelines for each QI activity
    - Targeted improvements in service delivery, access, and program design
    - Monitoring of key performance indicators and benchmarks
- Mechanisms to assess service accessibility, including goals for:
    - Responsiveness of the 24-hour toll-free telephone line
    - Timeliness of routine and urgent appointments
    - Access to after-hours care
- Cultural and linguistic competence, with evidence of compliance and an annual update to the Cultural Competence Plan included as an appendix to the QI Work Plan.

The QI Work Plan is structured around the fiscal year and includes clearly defined goals, objectives, and responsible parties. Its effectiveness is evaluated annually through the KernBHRS Annual Report and Work Plan Evaluation process. This evaluation helps prioritize improvement areas for the upcoming year. Each goal and objective is assessed using a standardized template that guides authors through reflective questions on implementation and outcomes. Goals are rated as Met, Partially Met, or Not Met.

The Quality Improvement Committee (QIC) oversees the implementation of the QI Work Plan. The QIC meets quarterly to review progress on each goal and receives additional reports on:

- Timeliness of services for both the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Performance Improvement Projects
- Corporate compliance investigations
- Other quality-related initiatives

Three QIC subcommittees meet more frequently to conduct deeper reviews of Work Plan objectives and performance measures. These subcommittees support in-depth analysis, discussion, and targeted intervention planning.

In addition to Work Plan goals, KernBHRS incorporates other performance measures and compliance standards into its QAIP. These are monitored through the QIC subcommittees. When trends in underperformance or noncompliance are identified, targeted quality improvement interventions are initiated. Data is used to assess the impact of these interventions and inform QIC decision-making. While Work Plan goals may change annually, QAIP performance measures and compliance standards are updated only when deemed necessary by the QIC. The following section outlines key performance indicators and regulatory compliance metrics that are integral to the KernBHRS Quality Assessment and Performance Improvement framework.

KEY PERFORMANCE INDICATORS

Key Performance Indicators (KPIs) are quantifiable measures used to evaluate the effectiveness, efficiency, and impact of KernBHRS programs and services. These indicators provide objective data that help identify trends, monitor progress toward strategic goals, and highlight areas requiring improvement. KPIs are selected based on regulatory requirements, clinical priorities, and organizational values such as equity, access, and client-centered care.

Key Performance Indicator	Benchmark/Purpose	MHP or DMC-ODS
7 - Day Inpatient Discharge to Outpatient Appointment	All (100%) clients discharged from the hospital will receive a face-to-face outpatient mental health service within seven (7) calendar days.	MHP
Client Satisfaction Consumer Perception Survey	Achieve a cumulative minimum satisfaction rating of 85% or greater on the Consumer Perception Survey.	MHP
Client Satisfaction Treatment Perception Survey	Achieve a cumulative minimum satisfaction rating of 85% or greater on the Treatment Perception Survey.	DMC-ODS
Initial Request to First Rendered Service	80% of routine mental health services will be provided within 14 calendar days (10 business days) of initial request for service.	MHP
Initial Request to First Offered Service	80% of routine mental health services will be offered within 14 calendar days (10 business days) of initial request for service.	MHP
Non-Urgent First Offered Follow-up Appointments	80% of follow-up services will be offered within 14 calendar days of the initial service rendered.	MHP, DMC-ODS
Non-Urgent First Rendered Follow-up Appointments	80% of follow-up services will be provided within 14 calendar days of the initial service rendered.	MHP, DMC-ODS
Inpatient Hospital Recidivism Rate	Less than or equal to 14%. This report tracks the number of clients who return to inpatient within 30 days of discharge.	MHP
No Show Rate - Other Clinicians	No-show rates for other clinical appointments (non-psychiatric) will not exceed 15%.	MHP
No Show Rate - Psychiatric Appointments	No-show rates for psychiatric appointments will not exceed 18%.	MHP
No Show/Cancellation Rate	No-show rates for outpatient appointments will not exceed 60%. No-show rates for NTP and Residential service appointments will not exceed 30%.	DMC-ODS
Penetration Rate	Penetration rates of 4.2 percent or higher in each service area.	MHP
Penetration Rate	The percentage of clients entering the DMC-ODS system stratified by: Age, Race & Gender.	DMC-ODS
Request for Psychiatric Service First Kept	80% of first psychiatric services must be scheduled within 21 days (15 business days) of initial request.	MHP
Request for Psychiatric Service First Offered	80% of first psychiatric services must be done within 21 calendars days (15 business days) of initial request.	MHP
Residential Discharge to Lower Level of Care	At least 85% of clients discharged from residential treatment will have a lower level follow up service within 7 days.	DMC-ODS

Key Performance Indicator	Benchmark/Purpose	MHP or DMC-ODS
Residential Recidivism Rate	Less than or equal to 20%. This report tracks the number of clients who return to residential services within 30 days of discharge.	DMC-ODS
Timeliness of Initial Request to First Service	80% routine SUD services will be conducted within 14 calendar days (10 business days) of initial request for service. NTP: 80% of SUD services will be conducted within 5 days (3 business days).	DMC-ODS
Timeliness of Initial Request to First Offered- Urgent Service	80% of initial requests for an urgent appointment will be scheduled within 48 hours of initial request.	MHP, DMC-ODS
Timeliness of Initial Request to First Offered Service	80% of routine SUD services will be conducted within 14 calendars days (10 business days) of initial request for service. NTP: 80% of SUD services will be conducted within 5 days (3 business days) of initial request for service.	DMC-ODS
Withdrawal Management Recidivism Rate	Less than or equal to 2%. This report tracks the number of clients who return to withdrawal management within 30 days of discharge.	DMC-ODS
HEDIS: Follow-up After Emergency Department (ED) visit for Mental Illness (FUM) 7 and 30 Day	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 53.82%; HPL: 73.12%	MHP
HEDIS: Follow-up After Hospitalization for Mental Illness (FUH) 7 and 30 day	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 59.85%; HPL: 75.56%	MHP
HEDIS: Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 60.22%; HPL: 74.14%	MHP
HEDIS: Adherence to Antipsychotic Medication for Individuals with Schizophrenia (SAA)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 62.56%; HPL: 74.83%	MHP
HEDIS: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL TBD	MHP

Key Performance Indicator	Benchmark/Purpose	MHP or DMC-ODS
HEDIS: Follow-up After Emergency Department (ED) visit for Substance Use (FUA) 7 and 30 Day	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 36.18%; HPL: 49.40%	DMC-ODS
HEDIS: Pharmacotherapy for Opioid Use Disorder (POD)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 25.28%; HPL: 36.71%	DMC-ODS
HEDIS: Use of Pharmacotherapy for Opioid Use Disorder (OUD)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 60.20%; HPL: N/A	DMC-ODS
HEDIS: Initiation and Engagement of Substance Use Disorder Treatment (IET-I) (Initiation)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 44.51%; HPL: 54.92%	DMC-ODS
HEDIS: Initiation and Engagement of Substance Use Disorder Treatment (IET-E) (Engagement)	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL 2024 2024 MPL: 14.39%; HPL: 26.72%	DMC-ODS
HEDIS: Follow-up After High Intensity Care for Substance Use Disorder (FUI) 7 and 30 day	The system is required to meet the Minimum Performance Level (MPL) threshold set by the Department of Health Care Services (DHCS). If the system fails to meet the MPL each year, it must achieve a five percent (5%) increase over baseline in the following measurement year. DHCS Established MPL TBD	DMC-ODS

REGULATORY COMPLIANCE STANDARDS

The list below outlines key regulatory compliance standards that are actively monitored through the Regulatory Compliance Committee. While not exhaustive, these standards represent critical areas of oversight within the broader KernBHRS compliance framework. KernBHRS maintains a comprehensive system of checks and balances to ensure adherence to all applicable laws, regulations, and contractual obligations. This includes structured processes such as contract monitoring, site visits, quality assurance reviews, documentation audits, and utilization management activities—all of which contribute to a culture of accountability and continuous improvement

TOPIC	COMPLIANCE STANDARD	Application
Change of Provider	100% of MHP change of Provider Requests are addressed.	MH
Corporate Compliance Training	100% of the staff will complete the Corporate Compliance training each year	MH, SUD
Documentation Compliance	95% of MHP documents within the electronic health record will be written according to all DHCS guidance and Clinical guidelines.	MH
Documentation Compliance	SUD teams will achieve a score of 95% or better on their semester progress note reviews.	SUD
Documentation Timeliness	75% of "Routine Services", will be documented in the EHR within 3 business days of the provided service	MH, SUD
Documentation Timeliness	100% of "Crisis Services" will be documented in the EHR within 24 hours of provided service	MH, SUD
Grievance and Appeals	98% of grievance and appeals will be processed according to DHCS policy.	MH, SUD
HIPAA Training	100% of staff will complete the annual HIPAA training each year	MH, SUD
No Show Indicator	100% of the time when using scheduler, and a client does not show up for a scheduled appointment, staff will change the indicator to reflect "No Show."	MH, SUD
NOABD	95% of all MH NOABDs will be provided to a beneficiary upon an adverse determination	MH
NOABD	90% of all SUD NOABDs will be provided to a beneficiary upon an adverse determination	SUD
Privacy and Security Training	100% of the staff will complete the Privacy and Security training each year.	MH, SUD
Privacy Breach Investigation	100% of all Potential Breaches will be reported to CCO within 24 hours of discovery of the event	MH, SUD
Records Request	100% of Client request for records will be processed within 15 days.	MH, SUD
Service Verification	95% of all mental health and substance use services captured in the electronic health record will be an honest and accurate account of a service.	MH, SUD

ORGANIZATION OF QUALITY IMPROVEMENT COMMITTEE (QIC)

The Quality Improvement Committee (QIC) plays a central role in evaluating and enhancing the quality of KernBHRS's service delivery system. Its primary aim is to improve care processes and ensure services effectively meet the needs of beneficiaries. The QIC provides oversight, guidance, and accountability for quality improvement activities across the organization. Its responsibilities include:

- Providing oversight and active involvement in Quality Improvement (QI) activities, including Performance Improvement Projects (PIPs)
- Recommending policy decisions that support system-wide quality goals
- Reviewing and evaluating the outcomes of QI initiatives
- Initiating and supporting necessary quality improvement actions
- Ensuring timely follow-up and resolution of QI processes
- Documenting decisions and actions through formal meeting minutes
- Monitoring key performance standards to assess system performance and identify areas for improvement
- Through these functions, the QIC ensures that KernBHRS maintains a culture of continuous improvement, regulatory compliance, and client-centered service delivery.

The Quality Improvement Committee (QIC)—also referred to as the **Executive QIC**—provides oversight of three key subcommittees: the System-wide Quality Improvement Committee, the Key Performance Indicator Committee, and the Regulatory Compliance Committee. These subcommittees are essential to the effective oversight and evaluation of compliance efforts and performance outcomes across KernBHRS.

Given the breadth and complexity of content reviewed by the Executive QIC, the subcommittees play a critical role in supporting focused monitoring, deeper analysis, and more actionable quality improvement. Together, the Executive QIC and its subcommittees are responsible for the following activities:

- Collecting and analyzing data to assess progress toward established goals and priority improvement areas
- Identifying opportunities for improvement and determining which to pursue based on impact and feasibility
- Coordinating with relevant internal and external committees to ensure effective communication and alignment
- Gathering input from providers, beneficiaries, and family members to identify barriers to clinical care and administrative services
- Designing and implementing targeted interventions to improve performance
- Measuring the effectiveness of interventions and integrating successful strategies into system operations
- Reviewing beneficiary grievances, appeals (including expedited and fair hearings), provider appeals, and clinical record reviews

This structure ensures that quality improvement efforts are data-driven, inclusive, and aligned with KernBHRS's mission to deliver equitable, person-centered behavioral health services.

The Quality Improvement Committee (QIC) and its subcommittees actively engage providers, beneficiaries, family members, community stakeholders, and direct service staff in the planning, design, and implementation of the Quality Assessment and Performance Improvement (QAPI) program. The use of multiple subcommittees reporting to the Executive QIC enables more focused oversight, broader stakeholder input, and more effective tracking of performance and compliance efforts.

Subcommittee membership is tailored to the focus of each group and is described in detail later in this document. Notably, the System-wide Quality Improvement Committee (SQIC) is open to the public and includes a diverse range of stakeholders. Each meeting includes time for public comment, reinforcing KernBHRS's commitment to transparency and community engagement.

The QIC subcommittees are responsible for:

- Collecting and analyzing data to assess progress toward established goals and priority areas for improvement
- Identifying and prioritizing opportunities for system enhancement
- Coordinating with internal and external committees to ensure effective information exchange
- Gathering input from beneficiaries and families to identify barriers to care and service delivery
- Recommending and supporting the implementation of targeted interventions
- Measuring the effectiveness of interventions and integrating successful strategies into system operations
- Recommending policy changes and reporting significant findings to the Executive QIC
- Reviewing beneficiary grievances, appeals (including expedited and fair hearings), provider appeals, and clinical records

The Quality Improvement Division (QID) supports the QIC by leading measurement, monitoring, and reporting activities. While QID plays a central role, performance monitoring occurs at multiple levels throughout the system. All QID activities align with current behavioral health industry standards and are designed to improve access, quality of care, and service outcomes.
QID's monitoring responsibilities include, but are not limited to:

- Beneficiary and system outcomes
- Utilization management and review
- Provider capacity and credentialing
- Documentation compliance and service verification
- Medication monitoring and network adequacy
- Client and family perception surveys
- Oversight of the problem resolution process

- Corporate compliance and privacy functions
- QID also leads system-wide improvement initiatives using evidence-based methodologies such as Lean Six Sigma and Plan-Do-Study-Act (PDSA) cycles, ensuring that quality improvement efforts are both strategic and sustainable.

The QIC has several other system committees that are tasked with the oversight of specific areas and/or system functions. These committees are not sub-committees of the QIC. However, they provided the QIC regular updates on their improvement activities. These committees include:

- Length of Stay Committee
- Morbidity and Mortality Committee
- Internal Psychiatric Strategy meeting
- Cultural Competency Resource Committee
- Full-Service Partnership Committee

The Cultural Competence Plan works synchronously with our Quality Improvement Plan. The goal of the plan is to improve services for all diverse groups. In addition to the state and federal cultural competence requirements, we also integrate requirements specific to our funding, substance use delivery system, and mental health plan.

KernBHRS
QI Program



EXECUTIVE QUALITY IMPROVEMENT COMMITTEE (QIC)

PARTICIPANTS

A. Director
B. Deputy Directors
C. System of Care Administrators
D. Resource Operations Manager (Infrastructure & Technology)
E. Finance Director
F. Senior Human Resources Manager
G. Public Information Officer
H. Members of the Quality Improvement Division

SCOPE/ AREAS OF RESPONSIBILITY (MHP AND DMC-ODS)

A. Delegation of data and analysis of data to measure work plan goals.
B. Determine policy decisions
C. Monitor and evaluate result of PIP's
D. Institute needed quality improvement actions
E. Ensure follow up of quality improvement processes
F. Prioritize areas of improvement; identify opportunities for improvement
G. Ensure appropriate exchange of information
H. Oversee the design and implementation of interventions to improve performance
I. Ensure Incorporation of successful interventions into operations
J. Develop and oversee the implementation of the Annual Work Plan
K. Conduct an annual evaluation of the Work Plan goals
L. Conduct an annual evaluation of the QAPI program
M. Share relevant information with stakeholders and staff
N. Document minutes including any decisions and actions
O. Oversee implementation of practice guidelines

SYSTEM-WIDE QUALITY IMPROVEMENT COMMITTEE (SQIC)

PARTICIPANTS

A. Behavioral Health Board member(s) (CHAIR)
B. Direct service staff
C. Ethnic Services Manager
D. QID staff person(s)
E. Representative from each contract provider
F. Consumer Family Learning Center (CFLC)
G. Clients
H. Family Members
I. Community Stakeholders
J. Members of the public

SCOPE/ AREAS OF RESPONSIBILITY (MHP AND DMC-ODS)

A. Provide feedback to guide system improvement
B. Make recommendations to Executive QIC
C. Progress toward Work Plan goals
D. Identify system improvement opportunities
E. Incorporate perspectives and feedback from direct service staff, clients, family members, stakeholders, and contract providers.
F. Hold open meetings advertised to the public

KEY PERFORMANCE INDICATOR COMMITTEE (KPIC)

PARTICIPANTS

A. Director
B. Deputy Directors
C. System of Care Administrators
D. Contract Providers
E. QID Staff
F. Finance Director
G. Direct Services staff

SCOPE/ AREAS OF RESPONSIBILITY (MHP AND DMC-ODS)

A. Kery Performance Indicators
B. Network Adequacy
C. Performance Improvement Projects
D. Culturally appropriate services review
E. Access to Services
F. Provider Relations
G. Service Utilization
H. Service Capacity
I. Penetration
J. Client Perception
K. Timeliness of Services
L. Review effectiveness of service measures
M. Ensure validity and reliability of measures
N. Clinical Outcomes
O. Data Governance

REGULATORY COMPLIANCE COMMITTEE (RCC)

PARTICIPANTS

A. Privacy/Compliance Office (CHAIR) and staff
B. Resource Operation Manager (Infrastructure & Technology)
C. QID Administrator or designated staff system of care
D. System of Care Administrators
E. Human Resources representative
F. Patient's Rights Supervisor
G. QID Staff
H. Appointed Supervisors

SCOPE/ AREAS OF RESPONSIBILITY (MHP AND DMC-ODS)

A. Regulatory compliance monitoring results
B. Service Verification
C. Compliance investigations
D. Security breaches
E. HIPPA violations
F. Relevant trainings
G. Program Integrity
H. Risk Management
I. Exclusions Reporting
J. Confidentiality/Privacy
K. Staff Education and Training
L. Credentialing
M. Quality Monitoring Results
N. Documentation Compliance Reviews
O. Timeliness of documentation compliance reviews
P. Information Notice implementation efforts
Q. Beneficiary Protection reports

PERFORMANCE IMPROVEMENT PROJECTS

A Performance Improvement Project (PIP) is a process that involves setting goals, implementing systemic changes, measuring outcomes, and making subsequent appropriate improvements. Kern BHRS is mandated to conduct four PIPs, one Clinical and one Non-Clinical for both the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS).

The purpose of a PIP is to assess and improve processes and outcomes of treatment provided by KernBHRS. PIPs are presented at the Quality Improvement Committee, and two of the QIC subcommittees, the Key Performance Indicator Committee, and the System Quality Improvement Committee. The goal of a PIP is to drive measurable, sustained improvements in the quality of care and outcomes for individuals served by the behavioral health plans.

Each PIP and current Problem Statement is listed in the table below.

PIP Title/Topic	AIM/Problem Statement	Measure Definition
DMC-ODS Clinical: Pharmacotherapy for Opioid Use Disorder (POD)	By December 31, 2027, KernBHRS will use targeted interventions to increase the percentage, by 5% points each year, of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members ages 16 and older with a diagnosis of OUD.	The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.
DMC-ODS Non-Clinical: Increasing SUD Peer Support Service Delivery	By December 31, 2027, Kern Behavioral Health and Recovery Services (KernBHRS) System of Care will use targeted interventions to increase the number of unique clients, ages 18+, who received at least one SUD Peer Support Service by at least 5% points.	The percentage of unique SUD members who received at least one peer support service by a certified Peer Support Specialist during the measurement period.
MH Clinical: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	Will the targeted interventions provided to adult members, ages 18 and older, with a schizophrenia or schizoaffective diagnosis, who were dispensed and remained on an antipsychotic medication for at least 80% of the treatment period, increase by 5% points each measurement year?	The percentage of adults, 18 years of age and older, who have schizophrenia or schizoaffective disorder diagnosis, and was dispensed and remained on an antipsychotic medication for at least 80% of the treatment period.
MH Non-Clinical: Increasing Mental Health Peer Support Service Delivery	By December 31, 2027, Kern Behavioral Health and Recovery Services (KernBHRS) will use targeted interventions to increase the number of unique members, ages 18+, who received at least one specialty mental health Peer Support Service by at least 5% points.	The percentage of unique MH members, who received at least one peer support service by a certified Peer Support Specialist during the measurement period.

UTILIZATION MANAGEMENT

Kern BHRS behavioral health plans operate a Utilization Management Program that is under the oversight of the QIC. The utilization management program is designed to ensure Medi-Cal beneficiaries have access to the services they need when they need them. The program includes processes for making utilization decisions and monitoring those decisions. It also includes mechanisms for detecting under and over utilization of services. The Utilization Management Program is outlined in a variety of Kern BHRS policies and procedures including an umbrella policy that describes the overarching Utilization Management Program. The Utilization Management Program includes an array of standards and reports monitored through the various QIC committees. Elements of the Utilization Management program are monitored through the Work Plan, the Regulatory Compliance Committee, and the Key Performance Indicator Committee. The UM program evaluates medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively and retrospectively.

Kern Behavioral Health and Recovery Services (KernBHRS) operates a comprehensive Utilization Management (UM) Program as an essential component of its Quality Assessment and Performance Improvement (QAPI) framework.

The UM Program supports KernBHRS's commitment to delivering high-quality, equitable, and cost-effective care by:

- Ensuring medical necessity and service appropriateness through systematic utilization reviews (UR) of clinical documentation, treatment plans, and service authorizations.
- Promoting timely access to care by monitoring appointment availability, service timeliness, and network adequacy.
- Preventing over- and under-utilization of services through data-driven analysis and real-time monitoring of service patterns.
- Aligning with CalAIM documentation reform to streamline workflows and reduce administrative burden while maintaining clinical integrity.
- Detecting and preventing fraud, waste, and abuse through integrated compliance monitoring and audit processes

Oversight of the UM Program is provided by the Quality Improvement Committee (QIC). Executive QIC and the subcommittees receive regular reports regarding utilization management activities. In addition, QID collaborates with clinical teams, providers, and administrative staff to ensure that UM activities are integrated into daily operations and aligned with KernBHRS's mission and strategic goals.

Performance metrics related to utilization—such as service penetration rates, authorization turnaround times, and denial rates—are routinely analyzed to identify trends, disparities, and opportunities for improvement. Findings from UM activities inform system-wide quality improvement initiatives and are incorporated into the annual QI Work Plan and Evaluation.

2025-2026 WORK PLAN GOALS

Goal #1 Provider Financial Appeals: 100% of Provider Financial Appeals will be processed and sent final response within 60 calendar days of appeal.	Responsible Party Training and Compliance Administrator
Objectives 1. Ensure 100% of provider appeals are logged and acknowledged within 5 business days of receipt from Patients' Rights, to initiate timely processing and maintain with the 60 days turnaround requirement. 2. Conduct bi-weekly audits of open provider appeals to ensure each case is progressing toward resolution and identify any that are at risk of exceeding the 60-day limit.	

Goal #2 Psychiatric No Show: 90% Decrease the Psychiatric No-Show rate for KernBHRS to below 18%	Responsible Party Medical Services Administrator
Objectives: 1. Monitor the already implemented standardized follow-up process for 100% of no-show appointments within 2 business days to identify barriers and reschedule as appropriate. 2. All Clinical Outpatient teams will Review no-show data monthly with their administrator as necessary to identify trends (e.g., location, time, provider) and conduct targeted outreach or adjustments to scheduling practices based on findings	

Goal #3 Contract Processing Cycle Time: The Reduce the average contract processing cycle time by 25% from the current 87 days to approximately 65 days.	Responsible Party Clinical Plan Services Administrator
Objective: 1. Within 90 days, conduct a full review of the current contract processing workflow with internal and external stakeholders to identify systemic challenges that contribute to the 87-day processing average. 2. Identify, design, and implement two process changes with internal and external stakeholders within the next quarter to streamline the contract review and approval process. 3. Track and report contract cycle time metrics monthly to monitor progress toward the 65-day target and make data-driven adjustments per recommendations as needed	

Goal #4 DMC-ODS Client and Family Satisfaction Rate – TPS: The Substance Use Division and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Treatment Perception Survey	Responsible Party Substance Use Disorder Administrator
Objective: 1. Complete the TPS. 2. Ensure at least 90% of eligible clients and family members are offered the TPS during the designated survey periods by training staff and monitoring distribution compliance. 3. Review TPS results quarterly to identify areas of concern and implement at least one targeted service improvement initiative per quarter based on client and family feedback.	

Goal #5 MHP UM Review: 95% of reviewed medical necessity determination on MH assessments will be consistent between assessor and reviewer.	Responsible Party QID, Documentation Compliance Supervisor
Objective: 1. Complete Assessment Reviews for all MH teams to ensure appropriate determination of medical necessity Begin re-credentialing internal and contracted staff as required based on their original credentialing approval date. 2. Provide feedback and recommendations to supervisors and administrators if any areas of concerns or improvement are identified during the reviews. 3. Provide Assessment training to all new MH clinicians to ensure everyone is using the same process and criteria when determining medical necessity	

Goal #6 DMC-ODS UM Review: 95% of reviewed medical necessity determination on ASAM assessments will be consistent between assessor and reviewer.	Responsible Party Substance Use Disorder Administrator
Objective: 1. Maintain quarterly audit process to review a random sample of ASAM assessments, track consistency rates, and provide individualized feedback and coaching to staff as needed. 2. Share results with providers after quarterly reviews to help improve assessment determinations.	

Goal #7 Consumer and Family Satisfaction - CPS: The Mental Health Plan and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Consumer Perception Survey.	Responsible Party QID, Quality Monitoring Supervisor
Objective: 1. Complete the CPS. 2. Work with DHS to support efforts to provide alternative placement options for youth with complex needs.	

Goal #8 24/7 Access Line: The MHP 24/7 access line logs will contain the names, disposition, date, and time of 100% of test calls	Responsible Party Crisis Administrator
Objective: 1. Ensure that all calls are logged with accurate information. 2. 2. Ensure that all DHCS access line standards are met by call takers	

Goal #9 Fair Hearing: 100% of State Fair Hearings will be conducted within 90 calendar days of the request	Responsible Party QID, Administrative Coordinator
Objective: 1. Check CDSS Appeals Case Management System website every day. 2. Log 100% of Fair Hearing requests within 2 business days of receipt and immediately notify all relevant parties to initiate the scheduling process. 3. Ensure all Fair Hearings are scheduled within 30 calendar days of the request date to allow sufficient time for preparation and to meet the 90-day completion requirement.	

Goal #10 <u>Access to After Hours Service</u>: 90% of service providers will have service available outside the typical service hours (8-5. Mon-Fri).	Responsible Party QID Administrator
Objective: 1. Improve client accessibility to outpatient care providers. 2. Reduce use of emergency and crisis services by increasing availability of outpatient provider. 3. Provide flexible service hours.	

Goal #11 <u>Credentialing</u>: 100% of KernBHRS staff and contract provider staff will complete the credentialing process.	Responsible Party Training and Compliance Administrator
Objective: 1. Reduce the process time needed per application by improving internal and inter-agency communication, for example to improve responsiveness from internal teams and from contract providers. 2. Implement or update a centralized credentialing tracking system to monitor the status of all staff and contract provider credentialing, with updates and alerts for missing or expiring documentation 3. Conduct monthly audits of credentialing files to verify completeness and compliance and follow up with staff or providers who are out of compliance within 5 business days.	

Goal #12 <u>Medication Monitoring</u>: Each provider will achieve a combined rating of 85% or higher on peer review medication monitoring evaluation	Responsible Party Medical Services Administrator
Objective: 1. Complete monthly reviews of prescribers (internal and contracted) utilizing the Medication Monitoring tool, revised to reflect updated standards Monitor logged outreach events to ensure staff are engaging and educating the community on the program. 2. Provide individual provider and Medical Staff group feedback based on quarterly/ monthly findings. 3. Identify system-wide improvements to support improved medication services to clients 4. Contractors that have elected to complete their own reviews internally will submit them to QID for processing	

Goal #13 <u>DMC-ODS Access Line</u>: 95% of all DMC-ODS access test calls will be given a customer service rating of standard or above	Responsible Party Substance Use Disorder Administrator
Objective: 1. QID will perform monthly test calls and provide results to SUD Access Line. 2. SUD Access Line supervisors will review results with all staff to encourage ongoing excellent customer service.	

Goal #14 Treatment Court Referrals: Establish a baseline for number of Treatment Court referrals that access SUD Treatment services.	Responsible Party Substance Use Disorder Administrator
Objective: 1. Develop and implement a standardized data collection process within 30 days to track all Treatment Court referrals and their subsequent access to SUD (Substance Use Disorder) treatment services. 2. Train staff to provide additional wrap around support to clients referred by Treatment Court 3. Establish processes for accurate data tracking after clients enter treatment, ensuring needed communication with the courts.	

Goal #15 <u>Reduce Overdose Rate:</u> Implement strategies to reduce rate of overdoses in Kern County including outreach to individuals that have had overdoses utilizing shared data from Managed Care Plans and other county departments.	Responsible Party Substance Use Disorder Administrator
Objective: 1. Develop processes to obtain data from Managed Care Plans and the county Public Health department to identify individuals who have experienced an overdose. 2. Initiate a targeted outreach program to engage 100% of identified individuals who have experienced a recent overdose, offering linkage to SUD treatment, harm reduction services, and peer support. 3. Track and analyze overdose incidents quarterly using EMS, hospital, and law enforcement data to evaluate the effectiveness of outreach efforts and adjust strategies as needed to reduce overdose rates.	

Goal #16 <u>Enhance Date Exchange</u>: Develop and enhance data exchange initiative with partner agencies and MCP's.	Responsible Party Resource Operations Manager
Objective: 1. Develop a data governance framework and secure data-sharing infrastructure within 90 days to support compliant and efficient exchange of information with partner agencies and MCPs. 2. Collaborate with stakeholders to identify and prioritize key data elements (e.g., client demographics, service utilization, outcomes) to be shared, ensuring alignment with program goals and privacy regulations. 3. Launch a data exchange project with two additional MCPs meeting the requirements as specificized in the State MCP MOU.	

Goal #17 <u>Position Recruitment</u>: Increase recruitment of clinical and administrative positions.	Responsible Party Senior Human Resources Manager
Objective: 1. Enhance outreach and visibility of job opportunities through targeted marketing and community engagement. 2. Streamline and optimize the recruitment process SUD QID will run providers' training reports and follow up with providers before their annual review.	

Goal #18 <u>High Fidelity Wrap</u>: Implement High Fidelity Wrap Around	Responsible Party Children's Administrator
Objective: 1. Establish a dedicated High Fidelity Wraparound team by identifying and training staff in the HFW model, including facilitators, family support partners, and youth support partners 2. Create and adopt standardized policies, procedures, and documentation tools aligned with state and national HFW fidelity standards to guide consistent implementation across all participating agencies.	

Goal #19 <u>Leverage Fiscal Data</u>: Develop and implement fiscal performance dashboards to monitor and enhance FFP drawdown tracking	Responsible Party Resource Operations Manager
Objective: 1. Identify and define at least five key fiscal performance indicators related to FFP drawdown. 2. Develop and launch interactive fiscal dashboards Meet with Health Plans to increase provider engagement and send referrals to MAT providers.	

Goal #20 <u>Enable Service Capture</u>: Identify and implement three quality improvement initiatives aimed at enhancing FFP drawdown through improved service capture processes.	Responsible Party Clinical Plan Services Administrator
Objective: 1. Complete a baseline audit of service documentation accuracy and completeness across all programs within 60 days to identify common gaps that impact FFP eligibility and drawdown. 2. Prioritize the findings based on fiscal impact; systematically develop and deliver targeted training sessions every quarter and resources for supervisory, clinical, and administrative staff on proper service documentation, coding, and billing practices to improve FFP-eligible service capture. 3. Develop systems to monitor billable service delivery at the staff and team levels within 90 days. Track trends monthly with a goal of increasing FFP eligibility and drawdown to 20% over the next year.	

Goal #21 <u>Outpatient Adult Timeliness Accuracy</u>: RAWC Teams will improve the accuracy of timeliness performance data by ensuring that the number of enrolled clients aligns within 10% of the number of assigned timeliness forms.	Responsible Party Adult System of Care Administrator
Objective: 1. Conduct monthly reconciliation of enrolled client lists and assigned timeliness forms to identify and correct discrepancies, ensuring alignment within a 10% margin. 2. Provide quarterly training to RAWC team members on accurate client enrollment tracking and timeliness form assignment procedures to reduce data entry errors and improve reporting accuracy. 3. Develop and implement a real-time dashboard or tracking tool that compares enrolled clients to submitted timeliness forms, with automated alerts for variances exceeding 10%.	

Goal #22 <u>Service Integration</u>: Ensure KLD is able to bill for services under the DMC-ODS plan by securing AOD and DMC certification.	Responsible Party Kern Linkage Administrator
Objective: 1. Complete all required documentation and facility readiness tasks 2. Submit and secure Drug Medi-Cal certification with DHCS.	

Goal #23 <u>Financial Information Dissemination</u>: Complete development of team expense reports in Allocap which includes the revenue generated in the programs	Responsible Party Finance Director
Objective: 1. Collaborate with fiscal and program leads to finalize the structure and key data elements (e.g., expenses, revenue, cost per service unit) to be included in the Allocap team expense reports within 30 days. 2. Work with IT and fiscal teams to ensure accurate integration of program-level revenue data into Allocap, with automated data feeds or manual entry protocols established within 60 days. 3. Provide training to all relevant staff on accessing and interpreting the new Allocap reports within 2 weeks of launch and establish a monthly reporting schedule for ongoing financial transparency.	

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Behavioral Health Director Certification

Certification

1. I hereby certify that [Kern] 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

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

Kern County

4. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update
- ( ) ..... Update

4a. Submission type

- (•) Draft
- ( ) Final

5. County Behavioral Health Agency Director name

Alison Burrowes

6. County Behavioral Health Agency Director phone number

661 868-6609

7. County Behavioral Health Agency Director email

aburrowes@kernbhrs.org

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

Alison Burrowes

13. Title

Director

14. Date

3-24-26

15. Signature

Alison Burrowes Digitally signed by Alison Burrowes
Date: 2026.03.24 10:47:40 -07'00'

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

17. Title

18. Date

19. Signature

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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

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Signature

3. Print name
   Nancy Anderson
4. Date
   March 24, 2026
5. Signature
   

Contact information

6. County Name
   Kern
7. Certification for
   - (•) Three-Year Integrated Plan
   - ( ) Annual Update
8. County Chief Administration Officer Name
   Nancy Anderson
9. County Chief Administration Officer Phone number
   661-868-3198
10. County Chief Administration Officer Email
    andersonn@kerncounty.com

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Board of Supervisors Certification

Certification

1. Kern County Board of Supervisors certifies the following:

   ✓ Kern County Board of Supervisors has reviewed and approved this Integrated Plan for the period of FY 26/29

   ✓ 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

   Phillip Peters

4. Title

   Chairman

5. Date

JUN 16 2026

6. Signature

COUNTY OF KERN

By _____

Chairman, Board of Supervisors

PHILLIP PETERS

Instructions

Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six.

Rows 24-27: input the total estimated FSP component allocation received for each year. Row 24 will auto-populate from Tab Four in the BHSA Transfers tab.

Input unspent MHSA dollars carried over to this component into row 26. Row 27 will auto-populate the sum of rows 24-26 to account for total funding.

Row 26: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable. If you reported on Tab 4, row 137 that you will be transferring excess PR funds to FSP please report them here.

Rows 31-40: input the projected expenditures for each FSP service category or program for each year.

Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 31-36. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 37-38, accordingly.

Row 39: input expenditures for BHSA-funded innovation pilots or projects.

Row 40: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 41: the subtotal of FSP programs/services will be auto-populated from rows 31-40.

Row 43: input the total dollar amount projected to be transferred out of FSP into the prudent reserve.

Row 45: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 46: total projected expenditures for FSP for each year will be auto-populated from rows 41, 43, and 45.

Rows 48 and 49: input the estimated unduplicated count of individuals that will be served across all FSP programs.

Row 51: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA FSP component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Six: BHSA Components

	Total Full Service Partnership (FSP) Funding (Year One)	Total Full Service Partnership (FSP) Funding (Year Two)	Total Full Service Partnership (FSP) Funding (Year Three)
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 31,840,492.00	$ 30,248,467.00	$ 29,643,498.00
Transfers into Full Service Partnership component from Local Prudent Reserve		$ -	$ -
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)		$ 5,000,000.00	$ 5,000,000.00
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 31,840,492.00	$ 35,248,467.00	$ 34,643,498.00

Full Service Partnership Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)	$ 3,910,715.62	$ 4,028,037.09	$ 4,148,878.20	$ 535,882.48	$ 551,958.95	$ 568,517.72	$ 222,627.79	$ 229,306.62	$ 236,185.82
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ 2,426,864.95	$ 2,499,670.90	$ 2,574,661.03	$ 273,952.92	$ 282,171.51	$ 290,636.65	$ 51,075.23	$ 52,607.48	$ 54,185.71
FSP Intensive Case Management	$ 9,190,265.00	$ 9,465,973.00	$ 9,749,952.00	$ 634,505.41	$ 653,540.57	$ 673,146.79	$ 31,524.03	$ 32,469.75	$ 33,443.84
High Fidelity Wraparound	$ 1,511,867.26	$ 1,557,223.28	$ 1,603,939.98	$ 90,650.00	$ 102,655.00	$ 105,749.00	$ 500.00	$ 500.00	$ 500.00
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ 1,171,317.84	$ 1,206,457.37	$ 1,242,651.10	$ -	$ -	$ -	$ -	$ -	$ -

Assertive Field-Based Initiation for SUD Treatment Services	$ 235,962.00	$ 243,040.86	$ 250,332.09	$ -	$ -	$ -	$ -	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ 2,499,160.80	$ 2,574,135.63	$ 2,651,359.70	$ -	$ -	$ -	$ 444,000.00	$ 444,000.00	$ 444,000.00
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ 4,822,319.66	$ 6,247,902.01	$ 6,435,339.07	$ 6,628,399.24	$ 514,830.45	$ 530,275.37	$ 546,183.63	$ 84,913.94	$ 90,791.36
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 25,768,473.14	$ 27,822,440.14	$ 28,657,113.15	$ 8,163,390.05	$ 2,105,156.48	$ 2,168,325.53	$ 1,295,910.67	$ 843,797.80	$ 859,106.73

FSP Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of FSP component into Local Prudent Reserve	$ -	$ -	$ -

FSP Administrative Information	**Year One**	**Year Two**	**Year Three**
FSP Component Admin Expenses	$ 3,349,902.00	$ 3,616,918.00	$ 3,725,425.00
Total Full Service Partnership Expenditures (auto-populated)	$ 29,118,375.14	$ 31,439,358.14	$ 32,382,538.15

Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	5410	5410	5410
Eligible Adults/Older Adults	10154	10154	10154

Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References
1. W&I Code § 5892, subdivision (a)(2)(A) states 35% of BHS funds distributed to counties shall be used for Full Service Partnership Programs.
2. May be bundled or un-bundled depending on county BH-CONNECT opt-in.

Instructions

Counties shall report their planned expenditures for all behavioral health funding sources, not limited to only BHSA, along the Behavioral Health Care Continuum in Tab One.
For Annual Updates, counties should review and make updates only to the next fiscal year. For Intermittent Updates, counties should review and make updates to the current fiscal year.
Column C: counties shall indicate whether they provide each category of services using the check box.
Columns D through I: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs by each Behavioral Health Care Continuum category. Counties should consider children/youth as 21 and under for Columns G - I.
Columns J and K: counties shall input their estimated total count of all individuals served through the county behavioral health system across all funding sources/programs. These counts may be duplicated. Counties should consider eligible children/youth as 21 and under for Column K.
Row 38: the total projected expenditures in columns D through I and total projected individuals served annually in columns J and K will be auto-populated from rows 20 through 36.
Note: For a list of all funding streams that should be included in the projected expenditures calculation for each BH Care Continuum Category, please see the Behavioral Health Services Act (BHSA) County Policy Manual Chapter 3, Section A.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table One: Behavioral Health Care Continuum Projected Expenditures

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (Year One)	Total Projected Expenditures On Adults and Older Adults (Year Two)	Total Projected Expenditures On Adults and Older Adults (Year Three)	Total Projected Expenditures on Children/Youth (under 21) (Year One)	Total Projected Expenditures on Children/Youth (under 21) (Year Two)	Total Projected Expenditures on Children/Youth (under 21) (Year Three)	Projected Individuals to be Served Annually (May be duplicated) Eligible Adults and Older Adults	Projected Individuals to be Served Annually (May be duplicated) Eligible Children/Youth (under 21)
Substance Use Disorder (SUD) Services									
Primary Prevention Services	☑	$ 671,432.00	$ 691,575.00	$ 712,323.00	$ 1,007,149.00	$ 1,037,363.00	$ 1,068,484.00	16776.00	20502.00
Early Intervention Services	☑	$ 5,871,158.00	$ 6,047,293.00	$ 6,228,712.00	$ 135,399.00	$ 139,461.00	$ 143,645.00	8398	357.00
Outpatient Services	☑	$ 28,873,425.00	$ 29,739,628.00	$ 30,631,817.00	$ 634,209.00	$ 653,236.00	$ 672,833.00	6511	170.00
Intensive Outpatient Services	☑	$ 1,921,859.00	$ 1,979,515.00	$ 2,038,900.00	$ 49,344.00	$ 50,824.00	$ 52,349.00	758	8.00
Crisis and Field-Based Services	☑	$ 1,709,797.00	$ 1,761,091.00	$ 1,813,924.00	$ 89,989.00	$ 92,689.00	$ 95,470.00	348	23.00
Residential Treatment Services	☑	$ 6,792,000.00	$ 6,995,760.00	$ 7,205,633.00	$ 220,203.00	$ 226,809.00	$ 233,613.00	633	5.00
Inpatient Services	☑	$ 3,826,831.00	$ 3,941,636.00	$ 4,059,885.00	$ 98,124.00	$ 101,068.00	$ 104,100.00	195	5.00
Mental Health (MH) Services									
Primary Prevention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Early Intervention Services	☑	$ 3,243,029.00	$ 3,340,320.00	$ 3,440,529.00	$ 9,078,856.00	$ 9,351,222.00	$ 9,631,759.00	544	999
Outpatient and Intensive Outpatient Services	☑	$ 84,942,419.00	$ 87,775,691.00	$ 90,408,962.00	$ 55,239,308.00	$ 56,911,488.00	$ 58,618,832.00	10300	14021
Crisis Services	☑	$ 27,798,465.00	$ 28,632,419.00	$ 29,491,392.00	$ 4,640,175.00	$ 4,779,381.00	$ 4,922,762.00	8605	2723
Residential Treatment Services	☑	$ 1,000,000.00	$ 1,030,000.00	$ 1,060,900.00	$ 2,713,000.00	$ 2,794,390.00	$ 2,878,222.00	101	93
Hospital and Acute Services	☑	$ 21,159,857.00	$ 21,794,652.00	$ 22,448,492.00	$ 11,459,317.00	$ 11,803,097.00	$ 12,157,190.00	1883	729
Subacute and Long-Term Care Services	☑	$ 10,107,900.00	$ 10,411,137.00	$ 10,723,471.00	$ 102,100.00	$ 105,163.00	$ 108,318.00	466	5
Housing Services (MH + SUD)									
Housing Services	☑	$ 27,607,926.00	$ 22,253,092.00	$ 22,253,092.00	$ 853,853.00	$ 688,240.00	$ 688,240.00	1171	43
Total Projected Expenditures and Individuals Served									
Total Projected Expenditures and Individuals Served (auto-populated)		$ 225,526,098.00	$ 226,393,809.00	$ 232,518,032.00	$ 86,321,026.00	$ 88,734,431.00	$ 91,375,817.00	56689	39683

Instructions

Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activities, other than those that are part of the Behavioral Health Care Continuum in Tab Two.

Rows 17 through 20: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Tab One, "BH CoC Expenditures."

Row 22: total projected expenditures will be auto-populated from rows 17 through 20.

For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Two: Other County Expenditures			
Other Expenditures	**Total Projected Expenditures (Year One)**	**Total Projected Expenditures (Year Two)**	**Total Projected Expenditures (Year Three)**
Capital Infrastructure Activities	$ 15,775,127.00	$ 4,500,000.00	$ 4,500,000.00
Workforce Investment Activities	$ 3,505,474.00	$ 3,610,639.00	$ 3,718,958.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 57,831,351.00	$ 59,566,291.00	$ 61,353,279.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 100,891,310.00	$ 101,444,777.00	$ 102,388,120.00
Total Projected Expenditures			
Total Projected Expenditures (auto-populated)	$ 178,003,262.00	$ 169,121,707.00	$ 171,960,357.00

Instructions

Counties shall report their planned revenue across the county behavioral health delivery system to support all behavioral health services and programs by funding source in Tab Three.

Rows 18 through 33: counties shall report projected expenditures for each funding source/program.

Row 21: for State General Fund, include funds received for the non-federal share of Medi-Cal payments.

Row 26: for Commercial Insurance (including Medicare), reporting reflects planned reimbursement obtained by county-operated providers, not county-contracted providers.

Row 35: total expenditures will be auto-populated from rows 18 through 33.

Row 36: will be auto-validated by DHCS against rows 35, 37, and 38. Validation: total projected expenditure variance should total out to $0.

Rows 37 and 38: will be auto-validated by DHCS against total projected expenditures in Tabs One and Two.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Three: Projected Annual Expenditures by County BH Funding Source			
	Total Annual Projected Expenditures (Year One)	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
BHSA	$ 91,010,152.00	$ 91,503,559.00	$ 92,952,303.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 22,657,898.00	$ 22,657,898.00	$ 22,657,898.00
2011 Realignment (Public Safety Realignment)	$ 80,828,827.00	$ 80,828,827.00	$ 80,828,827.00
State General Fund	$ 18,011,450.00	$ 18,551,794.00	$ 19,108,347.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 129,355,967.00	$ 133,620,968.00	$ 138,102,719.00
Projects for Assistance in Transition from Homelessness (PATH)	$ 220,614.00	$ 227,232.00	$ 234,049.00
Community Mental Health Block Grant (MHBG)	$ 1,718,315.00	$ 1,769,864.00	$ 1,822,960.00
Substance Use Block Grant (SUBG)	$ 4,024,385.00	$ 4,151,878.00	$ 4,283,195.00
Commercial Insurance	$ 1,959,000.00	$ 1,957,000.00	$ 2,015,710.00
County General Fund	$ 3,574,366.00	$ 3,681,597.00	$ 3,792,046.00
Opioid Settlement Funds	$ 10,687,656.00	$ 11,001,525.00	$ 11,324,811.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ -	$ -	$ -
Other state funding (including DSH funding)	$ 35,964,160.00	$ 20,699,708.00	$ 21,320,699.00
Other county mental health or SUD funding	$ 89,837,596.00	$ 93,598,097.00	$ 97,410,642.00
Other foundation funding	$ -	$ -	$ -

Summary	Total Annual Projection (Year One)	Total Annual Projection (Year Two)	Total Annual Projection (Year Three)
Total projected expenditures (all BH funding streams/ programs) (auto-populated)	$ 489,850,386.00	$ 484,249,947.00	$ 495,854,206.00
Total Projected Expenditure Variance	$ -	$ -	$ (0.00)
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 311,847,124.00	$ 315,128,240.00	$ 323,893,849.00
Auto-validation: Table 2: Other County Expenditures	$ 178,003,262.00	$ 169,121,707.00	$ 171,960,357.00

Instructions

Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet.**

Rows 38-40: input your county's base BHSA funding allocation by component and year.

Rows 43-54: this section will be auto-populated from the sections below it.

Rows 43, 49, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers.

Rows 44, 50, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages.

Row 45: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations.

Row 46: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components.

Rows 58, 80, and 102: the base funding amount for Housing Interventions will auto-populate from Column C, rows 38-40.

Rows 59, 81, and 103: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value. It will automatically display as a negative value in the cell.

Rows 60, 82, and 104: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing interventions. Enter this percentage as a positive value.

Rows 63, 85, 107: the base funding amount for Full Service Partnerships will auto-populate from Column D, rows 38-40.

Rows 68, 90, 112: the base funding amount for Behavioral Health Services and Supports will auto-populate from Column E, rows 38-40.

Rows 64, 69, 86, 91, 108, and 113: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively.

Rows 65, 70, 87, 92, 109, and 114: enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively.

Rows 74, 96, 118: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."

Rows 75, 97, 119: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."

Rows 76, 98, 120: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."

Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 75) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5. Housing Interventions.

Rows 77, 99, 121: the updated base percentage will be auto-populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."

Rows 124-130: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included; unencumbered INN funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information.

Row 130: the total dollar amount of MHSA Transfers to BHSA is auto-populated.

Row 133: enter the dollar amount of prior year prudent reserve ending balance

Row 134: enter the prudent reserve maximum for your county.

Row 135: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto-populate. **Negative values indicate no transfer is necessary.**

Rows 136-138: enter the amount of excess prudent reserve funds allocated to each component.

Row 139: the total transferred excess prudent reserve is auto-populated.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Four: BHSA Transfers				
	County Base BHSA Funding Allocations Housing Intervention	County Base BHSA Funding Allocations Full-Service Partnership	County Base BHSA Funding Allocations Behavioral Health Services and Support	County Base BHSA Funding Allocations Total
Year One Component Allocation (dollars)	$ 27,291,850.00	$ 31,840,492.00	$ 31,840,492.00	$ 90,972,834.00
Year Two Component Allocation (dollars)	$ 25,927,258.00	$ 30,248,467.00	$ 30,248,467.00	$ 86,424,192.00
Year Three Component Allocation (dollars)	$ 25,408,713.00	$ 29,643,498.00	$ 29,643,498.00	$ 84,695,709.00

BHSA Transfers Year One Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 27,291,850.00	$ 31,840,492.00	$ 31,840,492.00	$ 90,972,834.00
Unspent Mental Health Services Act (MHSA) to BHSA	$ -	$ 52,428,740.00	$ 63,250,435.00	$ 115,679,175.00
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -

BHSA Transfers Year Two Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 25,927,258.00	$ 30,248,467.00	$ 30,248,467.00	$ 86,424,192.00

BHSA Transfers Year Three Summary (auto-populated)				
	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Totals
Adjusted Total Allocation Percentages (Exemptions and Transfers)	30%	35%	35%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 25,408,713.00	$ 29,643,498.00	$ 29,643,498.00	$ 84,695,709.00

Funding Transfer Request Allocations

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year One)		
Base Component (Year One)	**Housing Intervention Percentage (Year One)**	**Housing Intervention Funds (Year One)**
Base Percentage and Funding	30%	$ 27,291,850.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 27,291,850.00
Transferred To/From	**Full Service Partnership Percentage (Year One)**	**Full Service Partnership Funds (Year One)**
Base Percentage and Funding	35%	$ 31,840,492.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 31,840,492.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year One)**	**Behavioral Health Services and Support Funding (Year One)**
Base Percentage and Funding	35%	$ 31,840,492.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 31,840,492.00

Funding Transfers (Year One)				
	Housing Intervention (Year One) (1)	Full-Service Partnership (Year One)	Behavioral Health Services and Support (Year One)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Two)		
Base Component (Year Two)	**Housing Intervention Percentage (Year Two)**	**Housing Intervention Funds (Year Two)**
Base Percentage and Funding	30%	$ 25,927,258.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 25,927,258.00
Transferred To/From	**Full Service Partnership Percentage (Year Two)**	**Full Service Partnership Funds (Year Two)**
Base Percentage and Funding	35%	$ 30,248,467.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 30,248,467.00
Transferred To/From	**Behavioral Health Services and Support Percentage (Year Two)**	**Behavioral Health Services and Support Funding (Year Two)**
Base Percentage and Funding	35%	$ 30,248,467.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 30,248,467.00

Funding Transfers (Year Two)				
	Housing Intervention (Year Two) (1)	**Full-Service Partnership (Year Two)**	**Behavioral Health Services and Support (Year Two)**	**Validation**
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage) (Year Three)		
Base Component	**Housing Intervention Percentage (Year Three)**	**Housing Intervention Funds (Year Three)**
Base Percentage and Funding	30%	$ 25,408,713.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto-populated)	30%	$ 25,408,713.00
Transferred To/From	**Full Service Partnership Percentage (Year Three)**	**Full Service Partnership Funds (Year Three)**
Base Percentage and Funding	35%	$ 29,643,498.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto-populated)	35%	$ 29,643,498.00

Transferred To/From	Behavioral Health Services and Support Percentage (Year Three)	Behavioral Health Services and Support Funding (Year Three)
Base Percentage and Funding	35%	$ 29,643,498.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New BHSS Base Percentage (auto-populated)	35%	$ 29,643,498.00

Funding Transfers (Year Three)				
	Housing Intervention (Year Three) (1)	Full-Service Partnership (Year Three)	Behavioral Health Services and Support (Year Three)	Validation
Base Percentage after Housing Intervention Component Exemption (auto-populated)	30%	35%	35%	Row Equals 100%
Amount Transferring Out	0%	0%	0%	Row Does Not Exceed 14%
Amount Transferring In	0%	0%	0%	Transfers Out and In Equal
New Base Percentage after Funding Transfer Request (auto-populated)	30%	35%	35%	Row Equals 100%

MHSA Transfers to BHSA				
MHSA Component	Available Unspent BHSA Funds	Transferred to Housing Intervention	Transferred to Full-Service Partnership	Transferred to Behavioral Health Services and Support
CSS	$ 61,098,365.00	$ -	$ 30,549,183.00	$ 30,549,182.00
PEI	$ 27,305,480.00	$ -	$ 13,652,740.00	$ 13,652,740.00
Encumbered INN	$ 12,452,184.00	$ -	$ -	$ 12,452,184.00
Unencumbered INN	$ 8,226,817.00	$ -	$ 8,226,817.00	$ -
WET	$ 1,716,100.00			$ 1,716,100.00
CFTN	$ 4,880,229.00			$ 4,880,229.00
Total (auto-populated)	$ 115,679,175.00	$ -	$ 52,428,740.00	$ 63,250,435.00

Excess Prudent Reserve to BHSA Components	
Transfer from Prudent Reserve to BHSA Component Allocation	Amount
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 8,716,008.00
Local Prudent Reserve Maximum (2)	$ 13,926,411.31
Excess Prudent Reserve Funding that must be transferred	**$ (5,210,403.31)**
Housing Intervention (3)	$ -
FSP	$ -
BHSS (4)	$ -
Total Transferred Excess Prudent Reserve (auto-populated)	$ -

References

1. BHSA County Policy Manual section 6.B.5 states counties may use up to seven percent of Housing Interventions component funds on outreach and engagement. The amount of funds transferred out of the Housing Interventions component into another funding component must be decreased by a corresponding amount. Counties are not required to use Housing Intervention component funding for outreach and engagement, or other funding transfer requests. It remains at the discretion of the counties to transfer up to a total of 14 percent of its BHSA funds in a fiscal year.
2. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).
3. W&I Code § 5892, subdivision (b)(6)(B) states prudent reserve funding cannot be spent on capital development.

Instructions

Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Tab Five.

Rows 39-42: input the estimated total Housing Intervention component allocation received for each year. Row 39 will auto-populate from Tab Four in the BHSA Transfers tab. Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-populate the sum of rows 40-42 to account for total funding.

Row 40: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 136 that you will be transferring excess PR funds to Housing Interventions please report them here.

Rows 47-64: input the projected expenditures for each Housing Intervention component service category or program for each year.

Row 46: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent through their Medi-Cal MCP.

Row 51: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns F, G, and H.

Row 63: input expenditures for BHSA-funded innovation pilots or projects.

Row 64: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.

Row 65: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools.

Row 67: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve.

Row 69 enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).

Row 70: the overall total of Housing Intervention expenditures will be auto-populated from rows 65, 67, and 69.

Row 72: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. This amount should equal 50% of Housing Interventions component allocation.

Row 73: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 72.

Row 75: the proportion of funds dedicated to capital development will be auto-populated**.**

Row 76: the proportion of funds dedicated to the chronically homeless population will be auto-populated**.**

Row 77: the proportion of funds dedicated to Outreach and Engagement will be auto-populated.

Rows 79-80: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services.

Row 82: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each year.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Five: BHSA Components

	Total Housing Interventions Funding (Year One)	Total Housing Interventions Funding (Year Two)	Total Housing Interventions Funding (Year Three)
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ 27,291,850.00	$ 25,927,258.00	$ 25,408,713.00
Transfers into Housing Intervention component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Housing Intervention Funding Allocated (MHSA - Unspent Carryover Funds)	$ -	$ -	$ -

Total Estimated Housing Intervention Funding (BHSA + MHSA Funds)	$ 27,291,850.00	$ 25,927,258.00	$ 25,408,713.00			
Housing Interventions Category						
Type of Service	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)**	**Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)**	**Projected Expenditures - All Other Funding Sources (Year One)**	**Projected Expenditures - All Other Funding Sources (Year Two)**	**Projected Expenditures - All Other Funding Sources (Year Three)**
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (2)						
Rental Subsidies	$ 6,736,424.00	$ 6,254,208.00	$ 6,138,944.00	$ 2,760,223.00	$ -	$ -
Operating Subsidies	$ 1,053,694.00	$ 948,036.00	$ 1,052,527.00	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 6,187,380.00	$ 5,785,718.00	$ 5,295,800.00	$ 2,760,224.00	$ -	$ -
Operating Subsidies				$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Other Housing Interventions						
Other Housing Supports: Landlord Outreach and Mitigation Funds (2)	$ 1,685,910.00	$ 1,685,397.00	$ 1,768,245.00	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 1,685,910.00	$ 1,769,665.00	$ 1,768,245.00	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 84,295.00	$ 84,270.00	$ 84,202.00	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ 1,610,297.00	$ 1,529,420.00	$ 1,497,619.00	$ -	$ -	$ -
Capital Development Projects	$ 4,500,000.00	$ 4,500,000.00	$ 4,500,000.00	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ 200,000.00			$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 23,743,910.00	$ 22,556,714.00	$ 22,105,582.00	$ 5,520,447.00	$ -	$ -
Housing Interventions Transfer Information	**Year One**	**Year Two**	**Year Three**			

Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Administrative Information	**Year One**	**Year Two**	**Year Three**
Housing Interventions Component Admin Expenses	$ 3,547,940.00	$ 3,370,544.00	$ 3,303,131.00
Total Housing Interventions Expenditures (auto-populated)	$ 27,291,850.00	$ 25,927,258.00	$ 25,408,713.00
Housing Interventions Populations to be Served	**Year One**	**Year Two**	**Year Three**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ 14,771,941.35	$ 14,105,984.75	$ 13,772,765.00
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ 3,792,859.00	$ 3,629,816.12	$ 3,557,219.82
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	16.5%	17.4%	17.7%
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	54.1%	54.4%	54.2%
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	5.9%	5.9%	5.9%
Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	43	43	43
Eligible Adults/Older Adults	1171	1171	1171
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
MHSA "Encumbered" INN	$ -	$ -	$ -

References

1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions.

2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures.
3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs.
4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings.
5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2).
6. W&I Code § 5892, subdivision (b)(2).
7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development.
8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments.

Instructions

Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Seven.
Row 26-29: input the total estimated BHSS component allocation received for each year. Row 26 will auto-populate from Tab Four in the BHSA Transfers tab.
Row 27: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 138 that you will be transferring excess PR funds to BHSS please report them here.
Input unspent MHSA dollars carried over to this component into row 28. Row 29 will auto-populate the sum of rows 26-28.
Rows 33-46: input the projected expenditures for each BHSS service category or program for each year. Rows 35, 39, and 42 auto-populate from their sub rows.
Row 45: input expenditures for BHSA-funded innovation pilots or projects.
Row 46: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above.
Row 47: the subtotal for projected expenditures will be auto-populated from rows 33 - 35, 38, 39, 42, 45, and 46.
Row 49: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve.
Row 51: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6. BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs).
Row 52: the total for projected BHSS expenditures will be auto-populated from rows 47, 49, and 51.
Row 54: input the total dollar amount of Youth-Focused (25 years and younger) Early Intervention Expenditures.
Row 56: the proportion of EI funds will auto-populate from rows 29 and 35. Note: MHSA WET, INN, and CF/TN funds in Rows 65-67 will be deducted from the revenue (excluded from the denominator).
Row 57: the proportion of Youth-Focused (25 years and younger) EI funds will auto-populate from rows 35 and 54.
Rows 59-60: input the estimated unduplicated count of individuals that will be served across all BHSA-funded programs.
Rows 62-63: input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year.
Rows 65-67: auto-populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Seven: BHSA Components

	Total Behavioral Health Services and Supports (BHSS) Funding (Year One)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Two)	Total Behavioral Health Services and Supports (BHSS) Funding (Year Three)
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 31,840,492.00	$ 30,248,467.00	$ 29,643,498.00
Transfers into Behavioral Health Services and Support component from Local Prudent Reserve	$ -	$ -	$ -
Total Estimated Behavioral Health Services and Support Funding Allocated (MHSA - Unspent Carryover Funds)	$ 5,000,000.00	$ 5,000,000.00	$ 5,000,000.00
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 36,840,492.00	$ 35,248,467.00	$ 34,643,498.00

Behavioral Health Services and Supports Category (1)

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year One)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Two)	Projected Expenditures - Unspent MHSA and BHSA Funding Only (Year Three)	Projected Expenditures - Federal Financial Participation (Year One)	Projected Expenditures - Federal Financial Participation (Year Two)	Projected Expenditures - Federal Financial Participation (Year Three)	Projected Expenditures - All Other Funding Sources (Year One)	Projected Expenditures - All Other Funding Sources (Year Two)	Projected Expenditures - All Other Funding Sources (Year Three)
BHSS Programs/Services									
Children's System of Care-Non FSP (25 years and younger)	$ 4,208,706.32	$ 4,334,967.51	$ 4,465,016.53	$ 510,039.79	$ 525,340.99	$ 541,101.22	$ 55,595.11	$ 57,262.96	$ 58,980.85
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 4,147,913.00	$ 4,272,350.00	$ 4,400,521.00	$ 167,104.46	$ 172,117.59	$ 177,281.12	$ 19,515.41	$ 20,100.87	$ 20,703.89
Early Intervention Expenditures	$ 13,713,830.65	$ 15,288,471.17	$ 15,747,125.31	$ 756,165.15	$ 778,850.10	$ 802,215.60	$ 2,355,191.76	$ 2,425,847.52	$ 2,498,622.94
Coordinated Specialty Care for First Episode Psychosis	$ 89,342.67	$ 1,255,248.56	$ 1,292,906.01	$ 5,098.49	$ 5,251.45	$ 5,408.99	$ 12,624.03	$ 13,002.75	$ 13,392.83
All Other EI Expenditures	$ 13,624,487.98	$ 14,033,222.62	$ 14,454,219.30	$ 751,066.65	$ 773,598.65	$ 796,806.61	$ 2,342,567.73	$ 2,412,844.77	$ 2,485,230.11

Outreach and Engagement	$ 1,536,391.80	$ 1,582,483.56	$ 1,629,958.06	$ 80,277.80	$ 82,686.13	$ 85,166.72	$ 11,280.77	$ 11,619.19	$ 11,967.77
Workforce Education and Training (WET)	$ 3,129,421.00	$ 3,223,304.00	$ 3,320,003.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ 1,413,321.00	$ 3,223,304.00	$ 3,320,003.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ 1,716,100.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 928,218.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ 928,218.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ 2,954,923.27	$ 1,508,107.77	$ 1,553,351.01	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 30,619,404.05	$ 30,209,684.01	$ 31,115,974.91	$ 1,513,587.19	$ 1,558,994.81	$ 1,605,764.65	$ 2,441,583.05	$ 2,514,830.54	$ 2,590,275.46

BHSS Prudent Reserve Transfer Information	**Year One**	**Year Two**	**Year Three**
Transfers out of BHSS component into Local Prudent Reserve	$ -	$ -	$ -

BHSS Administrative Information	**Year One**	**Year Two**	**Year Three**
BHSS Component Admin Expenses	$ 3,980,523.00	$ 3,927,259.00	$ 4,045,077.00
Total Behavioral Health Services and Supports Expenditures (auto-populated)	$ 34,599,927.05	$ 34,136,943.01	$ 35,161,051.91

Youth-Focused Early Intervention Expenditures	**Year One**	**Year Two**	**Year Three**
Total Youth-Focused (25 years and younger) Early Intervention Expenditures	$ 8,170,353.76	$ 8,415,464.37	$ 8,667,928.31

Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year One**	**Year Two**	**Year Three**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	77.1%	70.1%	69.4%
Youth-Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	59.6%	55.0%	55.0%

Projected Individuals to be Served (Unduplicated)	**Year One**	**Year Two**	**Year Three**
Eligible Children/TAY (25 years and younger)	12970	13865	14899
Eligible Adults/Older Adults	19467	20717	22187

Projected BHSS Funds transferred to WET or CF/TN	**Year One**	**Year Two**	**Year Three**
BHSS transfer to WET	$ 1,413,321.00	$ 3,223,304.00	$ 3,320,003.00
BHSS transfer to CF/TN	$ -	$ -	$ -

Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year One**	**Year Two**	**Year Three**
Estimated MHSA WET Funds	$ 1,716,100.00	$ -	$ -
Estimated MHSA CF/TN Funds	$ 4,880,229.00	$ 3,952,011.00	$ 3,952,011.00
MHSA "Encumbered" INN	$ 12,452,184.00	$ 9,497,260.73	$ 7,989,152.96

References
1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports (BHSS).
2. W&I Code § 5892, subdivision (a)(3)(B)(i) states counties shall utilize at least 51% of BHSS funding for early intervention programs.
3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger.
4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds.
5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost-allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Instructions

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in Tab Eight.

Row 27: the total dollar-amount of BHSA component allocations dedicated to improvement and monitoring activities, including plan operations, quality and outcomes, data reporting pursuant to W&I Code § 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants by year. Under W&I Code § 5892 (e)(2)(B), the total amount shall equal 2% or less of total projected annual revenues of the local behavioral health services fund for counties with a population over 200,000 or 4% of the total projected annual revenues of the local behavioral health services fund for counties with a population of less than 200,000. Any costs that exceed that amount will be included in the governor's budget. Administrative costs for improving and monitoring will only be reported on this tab, not the BHSA component tabs.

Row 28: input amounts of BHSA component allocations dedicated to county Integrated Plan annual planning costs, including stakeholder engagement in planning and local Behavioral Health Board activities by year. Under W&I Code § 5892 (e)(1)(B), this amount shall be 5% or less of total projected annual revenues of the local behavioral health services fund. Any costs that exceed that amount will be included in the governor's budget. Planning costs will only be reported on this tab, not the BHSA component tabs.

Row 29: input total dollar amount of new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 30: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately.

Row 32: total projected annual revenues of the Local Behavioral Health Services Fund.

Row 33: the proportion of funding used for improvement and monitoring will be auto-populated from rows 32 and 27.

Row 34: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 32.

Row 36-38: based upon the county population size selected in row 31, this calculator will auto-populate any Improvement and Monitoring expenditures that exceed (2%/4%) of the total projected annual revenues of the Local Behavioral Health Services Fund and any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund.

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ 580,131.00	$ 451,979.00	$ 379,114.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 813,447.47	$ 837,850.89	$ 862,986.42
New and Ongoing Administrative Costs	$ 425,878.09	$ 438,654.43	$ 451,814.07
Select County Population Size:	More than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 90,972,834.00	$ 86,424,192.00	$ 84,695,709.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	0.6%	0.5%	0.4%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	0.9%	1.0%	1.0%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -

Planning	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**

References
1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision.

Instructions

Counties shall report their estimated local prudent reserve maximums for each allocation component in Tab Nine.

Rows 18-19: dollar amounts will be auto-populated from Tab 4 rows 133-134.

Row 20: total excess prudent reserve dollars will be auto-populated from rows 18-19.

Rows 21-23: total dollar amounts will be auto-populated from Tab 4, rows 136-138.

Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21-23.

Row 25: auto-validates from rows 20 and 24 to check if the county has "No Excess" or if county must "Reduce Excess" prudent reserve.

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations across all plan years will be auto-populated from Tab 5 row 67, Tab 6 row 43, and Tab 7 row 49.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations across all plan years will be auto-populated from Tab 5 row 40, Tab 6 row 25, and Tab 7 row 27.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 8,716,008.00
Local Prudent Reserve Maximum (1)	$ 13,926,411.31
Excess Prudent Reserve Funds (auto-populated)	$ (5,210,403.31)
Total prudent reserve funds above prudent reserve maximum allocated to Housing Interventions	$ -
Total prudent reserve funds above maximum allocated to Full Service Partnerships	$ -
Total prudent reserve funds above maximum allocated to Behavioral Health Services and Supports	$ -

Total Excess Prudent Reserve Funds allocated to BHSA Component Allocations (auto-populated)	$ -
Auto-validation: allocation of all excess Prudent Reserve Funds	NO EXCESS
Total Contributions Into the Local Prudent Reserve (auto-populated)	$ -
Total Distributions From the Local Prudent Reserve (auto-populated)	$ -

References
1. W&I Code § 5892, subdivision (b)(3)-(4) states a county's prudent reserve must not exceed 20% of average of the total funds distributed to the county Behavioral Health Services Fund over past five years (25% for counties with a population of less than 200,000).

Instructions

Counties will complete Tabs One through Nine prior to completing Tab Ten. Data on other tabs will auto-populate to Tab Ten.

Rows 25, 28, and 31: the new base percentage for each component will be auto-populated from Tab 4, rows 43, 49, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 39; Tab 6, row 24; and Tab 7, row 26.

Rows 36, 44, and 52: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Rows 38, 46, and 54: estimated total available funding will be auto-populated from rows 35-37, 43-45 and 51-53.

Rows 39, 47, and 55: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 67; Tab 6, row 43; and Tab 7, row 49.

Rows 40, 48, and 56: estimated expenditures for each component will be auto-populated from Tab 5, row 70; Tab 6, row 46; and Tab 7, row 52.

Rows 45 and 53: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.

Rows 59-61: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Ten: BHSA Funding Summary (auto-populated)				
	Housing Interventions	Full-Service Partnerships	Behavioral Health Services and Supports	Total
Year One				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 27,291,850.00	$ 31,840,492.00	$ 31,840,492.00	$ 90,972,834.00
Year Two				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 25,927,258.00	$ 30,248,467.00	$ 30,248,467.00	$ 86,424,192.00
Year Three				
Allocation Percentage, with Transfers	30%	35%	35%	100%
Component Allocations	$ 25,408,713.00	$ 29,643,498.00	$ 29,643,498.00	$ 84,695,709.00

BHSA Funding Summary (Year One)				
	Housing Interventions (Year One)	Full Service Partnerships (Year One)	Behavioral Health Services and Supports (Year One)	Year One Totals
Estimated Year One Component Allocations *(BHSA Funding Only)*	$ 27,291,850.00	$ 31,840,492.00	$ 31,840,492.00	$ 90,972,834.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) *(Unspent Carryover MHSA Funds)*	$ -	$ -	$ 5,000,000.00	$ 5,000,000.00
Estimated Total Available Funding for Year One	$ 27,291,850.00	$ 31,840,492.00	$ 36,840,492.00	$ 95,972,834.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ 27,291,850.00	$ 29,118,375.14	$ 34,599,927.05	$ 91,010,152.18

BHSA Funding Summary (Year Two)				
	Housing Interventions (Year Two)	Full Service Partnerships (Year Two)	Behavioral Health Services and Supports (Year Two)	Year Two Totals
Estimated New Year Two Component Allocations *(BHSA Funding Only)*	$ 25,927,258.00	$ 30,248,467.00	$ 30,248,467.00	$ 86,424,192.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ 7,722,116.86	$ 7,240,564.95	$ 14,962,681.82
Estimated Total Available Funding for Year Two	$ 25,927,258.00	$ 37,970,583.86	$ 37,489,031.95	$ 101,386,873.82
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ 25,927,258.00	$ 31,439,358.14	$ 34,136,943.01	$ 91,503,559.15

BHSA Funding Summary (Year Three)				
	Housing Interventions (Year Three)	Full Service Partnerships (Year Three)	Behavioral Health Services and Supports (Year Three)	Year Three Totals

Estimated New Year Three Component Allocations *(BHSA Funding Only)*	$ 25,408,713.00	$ 29,643,498.00	$ 29,643,498.00	$ 84,695,709.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ 11,531,225.72	$ 8,352,088.94	$ 19,883,314.66
Estimated Total Available Funding for Year Three	$ 25,408,713.00	$ 41,174,723.72	$ 37,995,586.94	$ 104,579,023.66
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ 25,408,713.00	$ 32,382,538.15	$ 35,161,051.91	$ 92,952,303.07

BHSA Plan Admin Expenses

Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	$ 580,131.00	$ 451,979.00	$ 379,114.00	$ 1,411,224.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 813,447.47	$ 837,850.89	$ 862,986.42	$ 2,514,284.78
Total Projected New and Ongoing Administrative Expenditures	$ 425,878.09	$ 438,654.43	$ 451,814.07	$ 1,316,346.59

Budget Template Updates			
Version	**Revision Date**	**Description of Changes**	**Effective Date of Change**
2.0	10/25/2025	Tab 10 (BHSA Summary): Formula updated to avoid double counting of MHSA unspent carryover funds.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): EI Threshold calculation should exclude MHSA transferred WET and CFTN funds as they are exempt from suballocation requirements, formula revised to remove WET and CFTN. Added a BHSS transfer to WET/CFTN for reversion tracking.	10/25/2025
2.0	10/25/2025	Tab 8 (BHSA Plan Admin): Updated instructions to clarify DHCS will not pre-populate data for "Total Projected Annual Revenues of BHSF". Counties must enter in the data.	10/25/2025
2.0	10/25/2025	Tab 5, 6, 7 (BHSA Conponents): Added unspent MHSA funds row for year 1, 2 and 3.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): Added separate rows for unspent MHSA WET/CFTN expenditures.	10/25/2025
2.0	10/25/2025	Tabs 1-10: Fixed formula and instruction errors	10/25/2025
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added Year 2 and Year 3 for exemption requests	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added validation check for funding transfers	2/18/2026
3.0	2/18/2026	Tab 4 (BHSA Transfers): Added two new rows for unspent MHSA “Encumbered” INN Funds and unspent MHSA “Unencumbered” INN Funds.	2/18/2026
3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Moved transfers from prudent reserve into the BHSA component funding section to be included with total revenue	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026
3.0	2/18/2026	Tab 5, 6, and 7 (BHSA Components): Included prudent reserve transfers as an expenditure	2/18/2026

3.0	2/18/2026	Tab 5, 6 and 7 (BHSA Components): Added a row for projected MHSA "Encumbered" INN Project expenditures.	2/18/2026
3.0	2/18/2026	Tab 5 (Housing Interventions): Removed projected encumbered MHSA INN fund expenditures from the 50% HI funds dedicated to chronically homeless suballocation requirement calculation.	2/18/2026
3.0	2/18/2026	Tab 7 (BHSS): Removed projected encumbered MHSA INN fund expenditures from the 51% BHSS funds dedicated to Early Intervention suballocation requirement calculation	2/18/2026
3.0	2/18/2026	Tab 8 (BHSA Plan Admin): Updated to include a validation check for "Improvement and Monitoring" (2% or 4%) and "Planning" (5%)	2/18/2026
3.0	2/18/2026	Tab 9 (Prudent Reserve Assessment): Updated PR validation checks to "No Excess" or "Reduce Excess"	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Included component percentage breakdowns for all three years	2/18/2026
3.0	2/18/2026	Tab 10 (BHSA Summary): Include total administrative and planning expenditures from tab 8	2/18/2026