Inyo County Health and Human Services

Behavioral Health

Behavioral Health Services Act (BHSA)
Integrated Plan

Narrative Report

Plan Period: July 1, 2026 – June 30, 2029

Prepared from the County's Integrated Plan submission and associated responses

Table of Contents

Table of Contents 2
1. Introduction and Purpose 4
2. Inyo County Behavioral Health System 4
2.1 Technology and Information Exchange 5
2.2 Care Transitions 5
3. Populations Served and Baseline Service Data 5
3.1 Children and Youth Under Age 21 5
3.2 Adults and Older Adults Age 21 and Older 6
4. Data Infrastructure, Limitations, and Continuous Improvement 7
4.1 Data Interpretation in a Small County 7
5. CARE Act Integration and Referral Pathways 7
6. Behavioral Health Service Delivery Landscape 8
6.1 Opioid Settlement Funds 8
6.2 Bronzan-McCorquodale Act Services 8
6.3 Public Safety Realignment 8
6.4 Medi-Cal Specialty Mental Health Services 9
6.5 Drug Medi-Cal 9
7. Statewide Behavioral Health Goals and Local Priorities 9
7.1 Access to Care 10
7.2 Homelessness 10
7.3 Institutionalization 11
7.4 Justice Involvement 11
7.5 Removal of Children from Home 11
7.6 Untreated Behavioral Health Conditions 12
7.7 Additional County-Selected Priority: Overdoses 12
8. Community Planning and Stakeholder Engagement 12
8.1 Stakeholder Organizations 13
8.2 Coordination with Public Health and Managed Care Plans 13
9. Public Comment, Hearing, and Plan Approval 13
10. Provider Monitoring, Quality Improvement, and Medi-Cal Coordination 14
11. Behavioral Health Services and Supports (BHSS) 15
11.1 Family Strengthening Program 15
11.2 Adult and Older Adult System of Care 15
11.3 Early Intervention 16
11.4 Coordinated Specialty Care for First Episode Psychosis 16

11.5 Workforce Education and Training 17
12. Full-Service Partnership (FSP) Program 17
13. Assertive Field-Based Substance Use Disorder Treatment 18
13.1 Existing SUD Program 18
13.2 Mobile Crisis Unit 18
13.3 Open-Access Clinics 19
13.4 New Targeted Outreach Function 19
14. Medications for Addiction Treatment 19
15. Housing Interventions 19
15.1 Housing Supply Gaps 19
15.2 Housing Strategy and Partnerships 20
15.3 BHSA Housing Funding Structure 21
16. Workforce, Education, and Training 22
17. Capital Facilities and Technological Needs 22
17.1 Information Services Capacity 22
17.2 Credible EHR Optimization 22
17.3 Bishop Wellness Center Bathroom Renovation 22
18. Innovative Behavioral Health Pilots 23
19. Budget and Prudent Reserve 23
20. Implementation Priorities for 2026–2029 23
Appendix A. Statewide Behavioral Health Measure Matrix 25
Appendix B. Stakeholder Engagement Record 27
Appendix C. Program and Service Inventory 29
Appendix D. Source Data, Suppression, and Items Requiring Future Update 30
Appendix E. BHSA Budget Submission 31
Appendix F. Inyo County Board of Supervisors Approved Integrated Plan 41

1. Introduction and Purpose

The Behavioral Health Services Act (BHSA) requires California counties to prepare three-year Integrated Plans describing how behavioral health resources will be organized, funded, and used to improve behavioral health services and outcomes. Inyo County's 2026–2029 Integrated Plan provides the framework for the County's behavioral health system during the July 1, 2026 through June 30, 2029 planning period.

This public narrative report converts the County's completed Integrated Plan responses from a question-and-answer format into a cohesive report suitable for public distribution. It retains the data, service descriptions, implementation commitments, funding references, identified gaps, workforce information, stakeholder engagement record, and planning limitations contained in the source plan. Where the source document identifies information as not applicable, unavailable, suppressed, or still to be submitted, that status is preserved rather than replaced with an estimate.

Inyo County operates as a small, rural and frontier behavioral health system within an integrated Health and Human Services agency. This structure is central to the County's approach: behavioral health planning is linked with public health, social services, child welfare, adult protective services, aging, housing, corrections, reentry, and community partners.

County information:

Item	Information
County	Inyo County
Behavioral Health Agency	Inyo County Department of Health and Human Services
Mailing Address	1360 North Main Street, Suite 201, Bishop, CA 93514
Plan Period	July 1, 2026 – June 30, 2029

2. Inyo County Behavioral Health System

The County's behavioral health system encompasses specialty mental health services, Drug Medi-Cal services, substance use disorder prevention and treatment, housing-related supports, crisis response, care coordination, outreach, early intervention, Full Service Partnerships, and services delivered through an integrated Health and Human Services structure.

The Integrated Plan identifies rural geography, workforce capacity, provider availability, housing supply, transportation, and fragmented information systems as factors that shape how services can be delivered in Inyo County. The County therefore emphasizes strengthening existing infrastructure and partnerships while building new capabilities where BHSA requirements or local outcomes identify a gap.

2.1 Technology and Information Exchange

The County uses the Qualifacts Credible electronic health record (EHR) and participates in the SacValley MedShare Qualified Health Information Organization (QHIO). The County reports that it uses an EHR and participates in a QHIO, and it reports no implementation concerns with its API requirements or admission, discharge, and transfer data-sharing requirements.

Infrastructure Element	County Status
Electronic Health Record	Yes – Qualifacts Credible
Qualified Health Information Organization	Yes – SacValley MedShare
Behavioral Health API	County behavioral health website identified as the API endpoint location
API implementation concerns	No
Admission/discharge/transfer data-sharing concerns	No
Care Transition Tool	Implemented for adult and youth Medi-Cal mental health services
MOU care-transition description	Yes

2.2 Care Transitions

The County has implemented the state-mandated Transition of Care Tool for Medi-Cal mental health services for adults and youth. The County's memorandum of understanding also includes a system for transitioning members between the mental health plan and managed care plan based on the member's health condition.

3. Populations Served and Baseline Service Data

The Integrated Plan provides a baseline picture of individuals served through the County behavioral health system. The counts below may overlap because a person can meet more than one criterion.

3.1 Children and Youth Under Age 21

Children/Youth Criterion	Count
Received Medi-Cal Specialty Mental Health Services (SMHS)	90
Received at least one SUD individual-level prevention and/or early intervention service	11
Received Drug Medi-Cal (DMC) or DMC-ODS services	11

Received both MH and SUD services through the MHP and DMC county/DMC-ODS plan	101
Accessed Early Psychosis Intervention Plus, Coordinated Specialty Care, or similar early psychosis/mood-disorder services	0
Chronically homeless, experiencing homelessness, or at risk of homelessness	13
In juvenile justice system	0
Reentered community from a youth correctional facility	0
Served by MHP and had an open child welfare case	18
Served by DMC/DMC-ODS and had an open child welfare case	0
Received acute psychiatric care	0

3.2 Adults and Older Adults Age 21 and Older

Adults/Older Adults Criterion	Count
Dual-eligible Medicare and Medicaid members	73
Received Medi-Cal SMHS	285
Received DMC or DMC-ODS services	54
Received both MH and SUD services through MHP and DMC/DMC-ODS	20
Chronically homeless, experiencing homelessness, or at risk	22
Experienced unsheltered homelessness	0
Moved from unsheltered homelessness to sheltered housing	0
Of those moved to shelter, transitioned into permanent housing	0
In justice system on parole/probation and not incarcerated	0
Incarcerated, including state prison and jail	1,484
Reentered community from state prison or county jail	0
Received acute psychiatric services	0
72-hour evaluation/treatment detention	0
14-day or 30-day intensive treatment admission	0
180-day post-certification intensive treatment	0
Enrolled in DSH LPS Act programs	0
Enrolled in DSH community solution projects	0

Source: County Behavioral Health System Overview baseline data in the Integrated Plan. Counts may be duplicated across categories.

4. Data Infrastructure, Limitations, and Continuous Improvement

The County identifies data capacity as both a planning challenge and a major implementation priority. Inyo County is a small and rural jurisdiction, and its ability to capture and report the full range of information requested under the BHSA Integrated Plan is affected by limited staffing, fragmented or non-integrated data systems, and geographic barriers that complicate consistent data collection and reporting workflows.

Local planning data were drawn from multiple County and partner sources. Much of the information originated in fragmented electronic health record systems that are being integrated across additional areas of the agency. Additional information came from the County Jail and Probation systems, which include electronic records, legacy systems with duplicative entries, and anecdotal or staff-reported information. The County reports that meaningful planning insights were obtained, but substantial reconciliation and validation were required.

The County's response is to strengthen data infrastructure, system integration, staff capacity, data tracking, and reporting. These investments are intended to improve transparency, program evaluation, service delivery outcomes, and the reliability of future planning.

4.1 Data Interpretation in a Small County

The County repeatedly notes that very small numbers can make rates unstable, suppress data for privacy reasons, or cause a change of one or a few clients to produce a noticeable change in a rate. For this reason, the report distinguishes between measures that are above or below statewide benchmarks and measures for which reliable local subgroup comparisons are not available.

5. CARE Act Integration and Referral Pathways

Inyo County will integrate Community Assistance, Recovery, and Empowerment (CARE) participants into the broader behavioral health continuum through priority access and specialized coordination in Full-Service Partnerships and housing.

The CARE program is organized within the Adult Protective Services division of the integrated Health and Human Services agency, while using the Behavioral Health electronic health record. A monthly CARE multidisciplinary team meeting is being organized to strengthen coordination.

Referrals may originate from behavioral health staff, hospitals, law enforcement, family members, or courts. A social worker conducts an initial review to determine whether the individual appears to meet CARE eligibility criteria, including qualifying serious mental illness, functional impairment, and indicators of untreated behavioral health needs. When a formal CARE petition is not appropriate, the County redirects the individual to the least restrictive and

most clinically appropriate voluntary pathway addressing behavioral health, housing, medical, or social-service needs. These activities are documented in the electronic health record.

6. Behavioral Health Service Delivery Landscape

The County's service landscape is built around multiple state, federal, county, and settlement funding streams. The plan identifies planned use of Opioid Settlement Funds (OSF), 1991 and 2011 Realignment, Substance Use Block Grant (SUBG), Community Mental Health Block Grant (MHBG), Federal Financial Participation (FFP), BHSA funding, and County Corrections Partnership and other local resources.

6.1 Opioid Settlement Funds

- 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).

The County reports no implementation concerns with OSF requirements.

6.2 Bronzan-McCorquodale Act Services

- Case management.
- Comprehensive evaluation and assessment.
- Group services.
- Individual service plan.
- Medication education and management.
- Pre-crisis and crisis services.
- Rehabilitation and support services.
- Residential services.
- Services for homeless persons.
- Twenty-four-hour treatment services.
- Vocational rehabilitation.

The County identifies a significant rural placement challenge under this service framework. It reports an increase in clients requiring conservatorship, with placements lasting longer than a year and available placements generally located at least five hours from Inyo County.

6.3 Public Safety Realignment

- Drug Courts.
- Medi-Cal Specialty Mental Health Services, including EPSDT.
- Regular and perinatal Drug Medi-Cal services.
- Regular and perinatal DMC-ODS services, including EPSDT.
- Regular and perinatal non-Drug Medi-Cal services.

The County is a State DMC Plan county. Residential treatment is not a covered adult service under this structure, and the County has no residential treatment services within Inyo County. Adults generally must travel to another county to qualify for DMC-ODS residential services. The County has also experienced longstanding difficulty securing residential treatment capacity for perinatal and youth clients because local demand is insufficient to support holding a dedicated bed.

6.4 Medi-Cal Specialty Mental Health Services

- Adult residential treatment services; crisis intervention; crisis residential treatment; crisis stabilization.
- Day rehabilitation; day treatment intensive; mental health services; medication support services.
- Mobile crisis services; psychiatric health facility services; psychiatric inpatient hospital services.
- Targeted case management.
- Functional Family Therapy, High Fidelity Wraparound, Intensive Care Coordination, Intensive Home-Based Services, Multisystemic Therapy, Parent-Child Interaction Therapy, Therapeutic Behavioral Services, Therapeutic Foster Care, and other medically necessary SMHS for individuals under age 21.
- Peer Support Services are identified as an opted-in SMHS service as of June 30, 2026.

The County reports no implementation concerns with SMHS requirements.

6.5 Drug Medi-Cal

- All other medically necessary services for individuals under age 21.
- Intensive outpatient treatment services.
- Medications for Addiction Treatment, including medication, counseling, and behavioral therapy.
- Mobile crisis services.
- Narcotic Treatment Program services.
- Outpatient treatment services.
- Perinatal residential SUD treatment for pregnant and postpartum women.
- Peer Support Services are identified as an opted-in DMC service.

The County reports no implementation concerns with DMC requirements.

7. Statewide Behavioral Health Goals and Local Priorities

The Integrated Plan evaluates Inyo County against the statewide behavioral health goals using primary and supplemental measures. Six statewide priority goals are addressed directly, and the County selected Overdoses as an additional local priority because the County's overdose measures remain a significant concern.

7.1 Access to Care

Inyo County performs above the statewide rate for SMHS penetration among adults/older adults and children/youth, and above the statewide rate for NSMHS penetration among both groups. The County is below the statewide rate for adult DMC penetration, while DMC-ODS is not applicable. The Initiation of SUD Treatment (IET-INI) measure is below the statewide rate.

The County Population-Level Behavioral Health Measure Workbook identifies an Inyo County IET-INI rate of 28.4% in 2023 compared with 36.6% statewide. The County notes that demographic subgroup data are not available locally at a level that permits reliable comparison.

The County's response is to strengthen current programs rather than rely primarily on creating new programs. Behavioral Health leadership will build relationships with local providers, review state requirements, assess staff strengths, update policies and procedures, and transition from a historically DUI-only SUD model toward implementation of Proposition 36 and other required SUD programs. The County reports increased client engagement over the preceding year.

Funding identified for Access to Care:

- BHSA Behavioral Health Services and Supports (BHSS)
- 1991 Realignment
- 2011 Realignment
- SUBG
- MHBG

7.2 Homelessness

The County's homelessness measures show a mixed picture. The 2024 Point-in-Time (PIT) rate is identified as comparable to the relevant Continuum of Care benchmark in the measure response, while the County's written disparity analysis reports an Inyo County PIT rate of 32.4 per 10,000 compared with a statewide rate of 48.0 per 10,000. The behavioral health subpopulation rates are also lower than statewide: 6.1 per 10,000 for people experiencing homelessness with severe mental illness compared with 11.5 statewide, and 6.1 per 10,000 for the SUD subpopulation compared with 11.0 statewide.

The County identifies important disparities within the local homeless population. The 2025 PIT Count shows greater concentration among adults ages 25–64, particularly those age 55 and older; men are disproportionately represented; and American Indian/Alaska Native individuals are overrepresented relative to the general population. Chronic homelessness is concentrated among unsheltered adults. Homeless student enrollment is below the statewide rate, but housing instability persists among American Indian/Alaska Native and Hispanic/Latino school-aged children and families.

Service access through the local CoC is below the statewide CoC average. The County attributes this to geographic barriers, limited provider capacity, transportation challenges, and inconsistent HMIS data entry.

The County will relocate its Housing Program into Behavioral Health, strengthen Coordinated Entry and HMIS training and expectations, implement a flex pool approach, and expand

transitional rent supports through managed care plan contracts. Supports will be tracked in HMIS. Social Services and Reentry funding will also be used when appropriate.

7.3 Institutionalization

The County's primary inpatient administrative-day measure is not applicable, as are the reported involuntary detention and conservatorship comparison measures. Crisis stabilization utilization for adults is below the statewide benchmark, with the County noting that in a small frontier county a change of approximately one client can materially affect the comparison.

Local data show a 14-day involuntary detention rate of 32.4 per 10,000 compared with 40.0 statewide, and a 30-day rate of 5.2 compared with 5.3 statewide. The County will strengthen early crisis intervention, revise its MOU with Kern County regarding the nearest Crisis Stabilization Unit, and continue use of its Crisis Care Mobile Unit to support field de-escalation, stabilization, and diversion from involuntary holds.

Funding identified: 1991 Realignment and 2011 Realignment.

7.4 Justice Involvement

Adult and juvenile arrest rates are identified as above statewide benchmarks. The County reports clear differences by age and gender: adult incarceration is substantially higher than juvenile involvement, and the jail population is overwhelmingly male. The County lacks sufficient local disaggregated data to fully quantify racial and ethnic disparities, although statewide and rural trends suggest potential overrepresentation of Native American and Latino residents.

The County's adult incarceration rate is described as approximately 4,122 per 100,000. Fewer than 10 minors are incarcerated annually. The statewide three-year recidivism conviction rate for individuals released from CDCR in FY 2019–20 is reported as 39.1%; an Inyo-specific CDCR rate is not available.

The County will strengthen SUD and Reentry services, maintain a full-time Behavioral Health clinician embedded at the jail, and use newly filled Reentry positions to provide consistent transition planning and linkage to treatment, housing, and supportive services after release.

Funding identified: 1991 Realignment, 2011 Realignment, FFP, and County Corrections Partnership Funding.

7.5 Removal of Children from Home

Children in foster care, open child welfare cases with SMHS penetration, and child maltreatment substantiation measures are identified as below statewide benchmarks. Because the number of children in foster care is very small, reliable demographic disparity rates cannot be calculated without unstable or suppressed results.

The County's integrated HHS structure supports close coordination between Child Welfare Services and Behavioral Health. The County is revisiting the use of the Child and Adolescent Needs and Strengths (CANS) assessment within Child and Family Teams, strengthening referral expectations, and conducting monthly checks to ensure active Child Welfare caseloads receive a behavioral health referral. If a youth is not receiving County Mental Health services, the County verifies connection to another provider, including local Indian Health Services when appropriate.

7.6 Untreated Behavioral Health Conditions

Follow-up after emergency department visits for substance use (FUA-30) and mental illness (FUM-30) are above statewide benchmarks. However, the CHIS measure for adults who needed help for emotional/mental health or alcohol/drug issues but had no related visit in the prior year is below the statewide rate.

The available CHIS disparity analysis identifies higher unmet behavioral health need among Alaska Native/American Indian females. The County identifies potential barriers including stigma, geographic access, and limited provider availability. Planned responses include culturally responsive outreach, stronger referral pathways with Tribal and community partners, integrated care coordination, and telehealth when appropriate.

Funding identified: BHSA BHSS, BHSA FSP, 2011 Realignment, 1991 Realignment, and FFP for SMHS and DMC/DMC-ODS.

7.7 Additional County-Selected Priority: Overdoses

The County selected Overdoses as an additional priority because its overdose measures are above the statewide benchmark and remain a significant local concern. Specific demographic disparities cannot be reported because the numbers are small enough that doing so could risk client identification.

County-level data cited in the plan indicate an opioid overdose rate of 16.3 per 100,000 residents in 2023, equivalent to approximately three opioid overdoses/deaths given the County's population of about 18,500. DHCS Opioid Response data report an approved naloxone distribution rate of 91,477 per 100,000 residents for 2018–2025, equivalent to approximately 16,900 naloxone kits based on the County population.

The County will use opioid settlement funds for an annual media campaign, community-event outreach, community-partner engagement, and annual training for community members, stakeholders, and medical staff. The goal is to improve awareness of overdose prevention and harm reduction, increase knowledge of Narcan availability and use, and improve early recognition and response.

8. Community Planning and Stakeholder Engagement

The County reports that all required stakeholders were engaged in the planning process. Planning activities included social and traditional media outreach, focus groups, key informant interviews, County meetings, data-sharing activities, surveys, and workgroups/committee meetings. The planning process also drew on the County Public Health Community Health Assessment, the two local hospitals' Community Health Needs Assessment work, and the Community Health Improvement Plan.

Mental health services and access to care emerged as major priorities through community meetings and survey results. Public Health and Behavioral Health collaborate closely within the

HHS structure, and the County maintains regular meetings with managed care plans, quarterly HHS meetings, monthly CoC meetings, and individual program meetings.

8.1 Stakeholder Organizations

- Northern Inyo Hospital
- Indian Head Start
- Inyo County Office of Education
- Bishop Police Department
- UCLA Hospital
- Inyo County Superior Courts and Judges
- University Cooperative Extension
- Eastern Sierra Council of Governments
- Bishop Paiute Tribe representatives
- Inyo County Board of Supervisors
- Inyo County Probation
- Cerro Coso Community College
- Bishop Union High School
- Southern Inyo Healthcare District
- Owens Valley Career Development
- Inyo County HHS divisions
- Toiyabe Indian Health
- Inyo County Administration
- Local business owners
- Inyo County Sheriff's Department
- Inyo County District Attorney
- High school Hispanic liaison
- Wild Iris
- Inyo/Mono Child Support
- Inyo Mono Advocates for the Handicap
- Salvation Army
- Legal Self Help
- Bishop School Board Members
- Victim Witness Program
- Kern Regional Center
- Anthem Managed Care Plan representatives
- Health Net Managed Care Plan representatives

8.2 Coordination with Public Health and Managed Care Plans

Behavioral Health and Public Health used the County Community Health Assessment and hospital Community Health Needs Assessment information in planning. Public Health's Community Health Improvement Plan included behavioral health priorities related to maternal mental health and substance use disorder, and Behavioral Health staff participated in these subgroups.

The County worked with Anthem and Health Net on managed care plan community reinvestment planning. Health Net identified Access to Care, Homelessness, and Untreated Behavioral Health Conditions as its top three priorities. Anthem identified Homelessness, Justice Involved, and Untreated Behavioral Health Conditions. The plans state that the MCPs committed to sharing draft community reinvestment plans with the County for review before their September 1, 2026 submission to DHCS.

9. Public Comment, Hearing, and Plan Approval

Milestone	Date / Status
Draft Integrated Plan released for stakeholder comment	April 1, 2026
Stakeholder comment period closed	May 4, 2026

Behavioral Health Board public hearing	May 13, 2026
Public posting location	Inyo County Behavioral Health Advisory Board webpage
Draft circulation methods	Public posting and email outreach
Behavioral Health Advisory Board substantive revisions	None reported
Board of Supervisors substantive revisions	None reported
Additional stakeholder revisions	Source plan contains TBD language to be finalized after the public hearing

The source Integrated Plan contains both completed public-hearing information and placeholders indicating that some stakeholder information would be submitted after the public hearing. For publication, those items should be reconciled against the final hearing record before the report is formally adopted.

10. Provider Monitoring, Quality Improvement, and Medi-Cal Coordination

The County maintains a Quality Assurance Plan for SFY 2026–2027 and does not operate a standalone DMC-ODS program. The County reports one contracted BHSA provider location offering mental health services only. There are no contracted BHSA provider locations identified as SUD-only or both MH and SUD. None of the reported contracted BHSA locations also participate in the County's Medi-Cal Behavioral Health Delivery System.

Provider / Oversight Measure	Count / Status
BHSA contracted provider locations – MH only	1
BHSA contracted provider locations – SUD only	0
BHSA contracted provider locations – both MH and SUD	0
Contracted locations participating in SMHS only	0
Contracted locations participating in DMC/DMC-ODS only	0
Contracted locations participating in both	0
BHSA-funded SMHS providers contracting with an MCP for NSMHS	0%
Standalone DMC-ODS program	No

Beginning July 1, 2027, the County will support eligible BHSA-funded providers in seeking reimbursement from Medi-Cal managed care plans and commercial health plans. Assistance will include billing guidance, connections with MCP representatives, documentation and

reimbursement technical assistance, and information about credentialing and contracting expectations.

The County intends to adopt the recommended provider monitoring schedule for BHSA-funded providers, including providers that participate in the County's Medi-Cal Behavioral Health Delivery System and those that do not. Monitoring will include periodic site visits and preservation of monitoring records, including Corrective Action Plans and resolution documentation.

11. Behavioral Health Services and Supports (BHSS)

The BHSS portfolio includes the Children's System of Care, Adult and Older Adult System of Care, Early Intervention Programs, Workforce Education and Training, Capital Facilities and Technological Needs, and related outreach and engagement functions.

11.1 Family Strengthening Program

The Family Strengthening Program, formerly known as the Families Intensive Response Strengthening Team (FIRST), is a voluntary, intensive, family-driven and strengths-based planning process using the Wraparound approach. It follows the ten guiding principles of Wraparound, including family voice and choice, team approach, natural supports, collaboration, community-based services, cultural responsiveness, individualized planning, strengths-based practice, persistence, and outcome orientation.

The program works with children and youth at risk of out-of-home placement through Child Protective Services, Probation, schools, Behavioral Health, and other partners. Families may enter voluntarily or through system involvement. Referrals commonly come from the Student Attendance Review Board, Behavioral Health, Probation, CPS, schools, and other local agencies.

Fiscal Year	Projected Individuals Served
FY 2026–2027	71
FY 2027–2028	71
FY 2028–2029	71

Projection basis: historical case counts.

11.2 Adult and Older Adult System of Care

The adult and older adult BHSS program provides outreach to directly reach and engage adults and older adults who may benefit from behavioral health services and to encourage ongoing participation in treatment. Outreach will occur at Wellness Centers, Senior Centers, and planned community events.

Fiscal Year	Projected Individuals Served
FY 2026–2027	50

FY 2027–2028	50
FY 2028–2029	50

Projection basis: historical data.

11.3 Early Intervention

The Northstar Early Intervention Children's Services Program includes screening, assessment, and referral components. The program is intended to improve early identification and access to care, child development and functioning, family capacity and stability, prevention of higher-level interventions, cross-system coordination, equity, and data-driven continuous improvement.

Early Intervention Program	Components / Focus	Projected Annual Service Volume
Northstar	Screenings, assessments, referrals; child/family outcomes	50 per year
Outreach	Community education, access and linkage; multiple towns and Tribal events	200 per year

Neither program is identified as using EBPs or CDEPs from the biennial EI list. No additional priority uses of BHSS EI funds beyond those identified in the policy framework were selected.

11.4 Coordinated Specialty Care for First Episode Psychosis

Inyo County plans to build its Coordinated Specialty Care (CSC) capacity by training all staff, including clinicians and case managers, in First Episode Psychosis. The County has requested technical assistance to identify required training and develop policies and procedures. The program is anticipated to be operational in FY 2027–2028.

CSC Planning Measure	Value
Estimated Medi-Cal enrolled eligible population	<11 (suppressed)
Estimated uninsured eligible population	0
Estimated practitioners needed for total eligible population	4
Estimated teams needed	1
Planned practitioners – FY 2026–2027	6
Planned practitioners – FY 2027–2028	6
Planned practitioners – FY 2028–2029	6
Planned teams each year	1
Other non-BHSA funding	No

11.5 Workforce Education and Training

The County's WET activity is Behavioral Health Training, categorized as continuing education. A training plan was developed in FY 2025–2026 for clinicians, counselors, and case managers. Training is intended to include culturally and linguistically competent content and may involve community partners such as schools and Tribal health professionals. The County also identifies three vacant Peer Support Specialist positions and intends to consider lived experience during recruitment.

12. Full-Service Partnership (FSP) Program

The County is rebuilding its FSP program around a level-of-care assessment, Intensive Case Management, multidisciplinary coordination, whole-person and trauma-informed practice, and staff training in required evidence-based practices. Because Inyo County is a small frontier county with limited staff, individual practitioners may be trained to provide more than one evidence-based practice.

FSP Population / Practice	Estimated Eligible Population	Practitioner / Team Need	County Planned Staffing
Adult FSP overall	39 Medi-Cal; <11 uninsured	—	—
Justice-system involvement within FSP	21	—	—
ACT	<11 Medi-Cal; 0 uninsured	<11 practitioners; <11 teams	0 practitioners; 0 teams annually
FACT	3 Medi-Cal; 1 uninsured	Included with ACT planning	0 practitioners; 0 teams annually
FSP ICM	30 Medi-Cal; <11 uninsured	5 practitioners; 1 team	8 practitioners; 1 team annually
HFW	14 Medi-Cal; <11 uninsured	5 practitioners; 1 team	5 practitioners; 1 team annually
IPS	44 Medi-Cal; 9 uninsured	5 practitioners; 2 teams	0 practitioners; 0 teams annually

The County is requesting technical assistance and exemptions for ACT, FACT, and IPS based on limited workforce and limited need. The plan indicates an intent to work toward compliance as

requirements mature, with the ACT and FACT exemptions supported by County demographic data.

FSP services are designed around whole-person needs. Current ICM activities include transportation and bus passes, assistance with Social Security applications, housing supports, job seeking, and socialization. Participants identify one or two goals, with staff meeting weekly or monthly according to need.

The County has reinstituted multidisciplinary teams for families with complex needs. Weekly meetings are used for families with significant complexity, with staff response reduced as needs stabilize. The FSP process is being rebuilt in partnership with the Credible EHR and updated policies and procedures.

The County's FSP allocation is intended to support Access to Care, Homelessness, Justice Involvement, Untreated Behavioral Health Conditions, Prevention of Co-occurring Physical Health Conditions, Social Connection, and Quality of Life.

For underserved populations, the County emphasizes broad access rather than separate targeted programs. Staff training, relationships with Probation and Child Welfare, monthly foster care meetings, and collaboration with Adult Protective Services and senior programs are used to incorporate the needs of justice-involved, child-welfare-involved, older, LGBTQ+, and other populations.

13. Assertive Field-Based Substance Use Disorder Treatment

The County plans to expand existing SUD infrastructure into a more assertive, field-based continuum. The strategy is intentionally phased, with planning and gap assessment in the early implementation period, workflow and capacity expansion through 2027–2028, and full implementation of required assertive field-based SUD treatment initiation elements by July 1, 2029.

13.1 Existing SUD Program

Inyo County Substance Use Disorder Services will remain the core platform for outreach, screening, engagement, referral, and treatment initiation. BHSA changes include expanded field-based engagement, stronger outreach workflows, coordination with justice, health and social-service partners, and additional staff capacity.

Current funding: DMC, SUBG, and 2011 Realignment.

13.2 Mobile Crisis Unit

The Mobile Crisis Unit will be expanded as a field-based entry point for people with substance use needs. The County will incorporate SUD-specific screening, brief intervention, direct linkage to treatment, and warm handoffs, while strengthening coordination with SUD providers, law enforcement, EMS, and hospitals.

Current funding: FFP and 1991/2011 Realignment.

13.3 Open-Access Clinics

Inyo County Behavioral Health will strengthen open-access capacity so people can receive same-day screening, assessment, and initiation into SUD treatment without a prior appointment. The County will review counselor schedules and ensure daily availability to meet this requirement.

Current funding: FFP and 1991/2011 Realignment.

13.4 New Targeted Outreach Function

BHSA funding will establish a formal Targeted Outreach for Assertive Field-Based SUD Treatment Services function. The new service will proactively identify and engage individuals who are not connected to treatment, including screening, brief intervention, linkage or treatment initiation, and coordinated partnerships. Potential staffing roles include counselors, peer support specialists, and care coordination staff.

Planned funding: DMC, SUBG, and 2011 Realignment.

Full implementation target: July 1, 2029.

14. Medications for Addiction Treatment

The County identifies same-day MAT access as an area requiring deliberate capacity development. Only two local MAT providers are currently identified, and appointment scheduling can delay treatment initiation.

The County will contract directly with local MAT providers and establish referral agreements with other providers, including providers participating in Medi-Cal managed care and fee-for-service Medi-Cal. The County will work with local providers to change scheduling practices and create same-day appointment capacity.

MAT forms identified in the plan include buprenorphine, naltrexone, and Suboxone.

15. Housing Interventions

Housing is one of the most significant structural challenges identified in the Integrated Plan. The County is the lead agency for the Alpine, Inyo, and Mono Continuum of Care and the lead administrator for HMIS. The County already operates a housing program using Social Services and Reentry resources and is integrating BHSA Housing Interventions into that existing infrastructure.

15.1 Housing Supply Gaps

Housing Resource	County-Identified Gap
Supportive housing	Medium
Apartments / master-lease apartments	Large

Single- and multi-family homes	Large
Mobile home communities	Large
Permanent SRO	Large
Interim SRO	Large
Accessory dwelling units	Large
Permanent tiny homes	Large
Shared housing	Large
Permanent recovery/sober living housing	Large
Interim recovery/sober living housing	Large
Assisted living / board and care	Large
License-exempt room and board	Large
Hotel/motel stays	Medium
Non-congregate interim housing	Large
Small-room congregate settings	Large
Recuperative care	Large
Short-term post-hospitalization housing	Large
Emergency cabins / stabilization units	Large
Peer respite	Large
Permanent rental subsidies	Medium
Housing supportive services	Medium

15.2 Housing Strategy and Partnerships

The County will combine BHSA resources with Social Services funding, Reentry funding, managed care plan transitional rent, HHAP resources, and housing voucher opportunities. A flex pool approach will screen referrals and determine the funding source for which each client is eligible.

The County's housing case worker will help clients locate affordable housing and address barriers such as identification, Social Security Disability applications, employment, past utility bills, utility assistance, CalFresh, Medi-Cal, and budgeting. After placement, continued case management and short-term subsidies will support housing retention.

The County does not plan to use BHSA Housing Interventions for capital development because local capital development opportunities are minimal and several proposed developments have

experienced little progress over multiple years. The County will continue participating in development workgroups and looking for opportunities to include affordable housing.

15.3 BHSA Housing Funding Structure

Housing Intervention	Provided?	Annual / Unit Planning Information
Rental subsidies	Yes	<11 individuals annually; <11 permanent; <11 interim; 10 units
Operating subsidies	No	CoC provides operating subsidies; one local facility has unresolved financial issues
Landlord outreach and mitigation	Yes	<11 individuals annually; 5 units
Participant assistance funds	Yes	<11 individuals annually
Housing transition navigation / tenancy sustaining	Yes	<11 individuals annually
Housing outreach and engagement	Yes	<11 individuals annually
Capital development	No	No BHSA capital development planned
Family housing	Yes	Will accommodate family housing
Subsidy type	Tenant-based	Individual/participant-based

The County requests use of 15% of the BHSF Housing Intervention Component, with 15% transferred from BHSS, and requests an exemption from the standard 30% Housing Intervention allocation based on the need to build the program and reassign staff. The County also requests that 25% of the Housing Intervention allocation be used for chronically homeless individuals, citing the same implementation and capacity considerations.

The County is contracted or planning to be contracted with managed care plans for Housing Transition Navigation Services, Housing Deposits, and Transitional Rent. Transitional Rent, Housing Transition Navigation, and Housing Deposits are identified with a January 1, 2026 implementation date in the source plan.

The County reports an operating Flex Pool and plans to participate as a Housing Supportive Services Provider. Inyo County Health and Human Services, as the CoC lead agency for Alpine, Inyo, and Mono, is identified as the operator. BHSA Housing Interventions planned for coordination through the Flex Pool include rental subsidies, operating subsidies, landlord outreach and mitigation funds, participant assistance funds, and housing transition/navigation and tenancy-sustaining services.

The County does not currently receive Homekey+ funding. The CoC has access to HHAP Round 6 funding for the three-county region.

16. Workforce, Education, and Training

The County reports an overall vacancy rate of 24% for permanent clinical/direct service behavioral health positions, including county-operated providers. The positions identified as having the greatest vacancy rates are Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Psychologist, Substance Use Disorder Counselor, and Licensed Professional Clinical Counselor.

At the time of the plan response, the County reported only one mental health clinician vacancy and anticipated that a student intern could become eligible to apply. At the same time, an Addiction Counselor and Addiction Counselor Supervisor position had been vacant for more than six months. The County added an Addiction Counselor trainee to its career ladder and anticipated filling that position.

The County expects targeted training, supervision, and fidelity monitoring to support adoption of evidence-based practices under Behavioral Health Transformation and BH-CONNECT. An orientation and training plan is being developed for current and new Behavioral Health employees.

The County does not plan to use the BH-CONNECT Behavioral Health Scholarship Program, Student Loan Payment Program, Recruitment and Retention Program, Community-Based Provider Training Program, or Residency Program at this time. Instead, monthly team meetings will continue to provide training, using the FY 2025–2026 training plan to organize education during the three-year period.

17. Capital Facilities and Technological Needs

17.1 Information Services Capacity

The County continues to fund 50% of an Information Services staff position to address ongoing technology issues and support system maintenance and improvements across programs.

17.2 Credible EHR Optimization

The County plans to integrate and optimize the Credible EHR within Behavioral Health workflows. The project supports electronic health record functionality and the broader goal of improving information flow and operational consistency.

17.3 Bishop Wellness Center Bathroom Renovation

The County plans to renovate a client-use bathroom at a Wellness Center. The project addresses prior water damage and is intended to restore shower access and improve physical infrastructure. The project is on the County's deferred maintenance list and is anticipated to be completed before FY 2028–2029.

18. Innovative Behavioral Health Pilots

The County's Integrated Plan does not include a new Innovative Behavioral Health Pilot or Project. The implementation approach instead emphasizes strengthening and expanding existing programs, meeting new requirements, improving workflows, and building infrastructure.

19. Budget and Prudent Reserve

The Integrated Plan identifies multiple versions of the County's BHSA Integrated Plan Budget Template as supporting documents, including March 31, April 6, June 24, and June 29, 2026 versions. The narrative plan itself does not reproduce the detailed dollar amounts contained in those spreadsheets.

The last prudent reserve assessment date reported in the plan is March 29, 2026. The source plan indicates no planned use of excess prudent reserve funds for BHSS, FSP, or Housing Interventions.

For public publication, the final approved budget workbook should be incorporated as a companion appendix or financial schedule so that the narrative commitments in this report can be viewed alongside the corresponding planned expenditures.

20. Implementation Priorities for 2026–2029

Taken together, the Integrated Plan establishes a three-year implementation strategy centered on strengthening the County's existing behavioral health infrastructure while building capacity required by BHSA and improving outcomes identified through statewide and local data.

Priority	Three-Year Direction
Improve access to SUD treatment	Increase initiation into treatment, move beyond the historical DUI-only model, implement Proposition 36 and other required SUD services, strengthen provider relationships, and build same-day access.
Build assertive field-based SUD capacity	Expand SUD outreach, Mobile Crisis screening and linkage, open-access treatment, and a new targeted outreach function, with full implementation targeted for July 1, 2029.
Strengthen housing stability	Integrate BHSA housing resources into the existing HHS housing program, use transitional rent and flex pool strategies, improve HMIS participation, and expand rental and participant supports.
Reduce crisis-related institutionalization	Expand mobile crisis response, field de-escalation, regional crisis partnerships, and early intervention.

Reduce justice involvement and improve reentry	Maintain jail-based behavioral health services, strengthen SUD and Reentry services, and improve continuity from custody to community.
Protect children and strengthen family stability	Improve behavioral health referral follow-through for Child Welfare cases, revisit CANS processes, and strengthen Family Strengthening/Wraparound services.
Reduce untreated behavioral health needs	Strengthen outreach, culturally responsive engagement, Tribal partnerships, referral pathways, care coordination, and telehealth.
Address overdose risk	Use opioid settlement funds for harm reduction education, naloxone awareness, media outreach, community events, and training.
Build the workforce	Address vacancies, expand training, recruit lived-experience staff and peer specialists, and prepare staff for BHT and BH-CONNECT requirements.
Improve data quality and system integration	Optimize the Credible EHR, strengthen interoperability, improve HMIS participation, increase staff capacity, and develop more reliable performance reporting.

Appendix A. Statewide Behavioral Health Measure Matrix

Goal	Measure	County Status
Access to Care	SMHS penetration – adults/older adults	Above
Access to Care	SMHS penetration – children/youth	Above
Access to Care	NSMHS penetration – adults/older adults	Above
Access to Care	NSMHS penetration – children/youth	Above
Access to Care	DMC penetration – adults/older adults	Below
Access to Care	DMC penetration – children/youth	Not Applicable
Access to Care	DMC-ODS penetration – adults/older adults	Not Applicable
Access to Care	DMC-ODS penetration – children/youth	Not Applicable
Access to Care	IET-INI initiation of SUD treatment, 2023	Below; 28.4% vs 36.6% statewide
Homelessness	PIT rate, 2024	Same / local narrative reports 32.4 per 10,000 vs 48.0 statewide
Homelessness	Homeless student enrollment, 2023–24	Below
Homelessness	PIT rate with severe mental illness	Same; 6.1 per 10,000 vs 11.5 statewide
Homelessness	PIT rate with chronic substance abuse	Same; 6.1 per 10,000 vs 11.0 statewide
Homelessness	People accessing CoC services, 2023	Below
Institutionalization	Inpatient administrative days	Not Applicable
Institutionalization	14-day involuntary detention	Not Applicable in benchmark field; local narrative: 32.4 vs 40.0 per 10,000
Institutionalization	30-day involuntary detention	Not Applicable in benchmark field; local narrative: 5.2 vs 5.3 per 10,000
Institutionalization	180-day involuntary detention	Not Applicable
Institutionalization	Temporary conservatorships	Not Applicable
Institutionalization	Permanent conservatorships	Not Applicable

Institutionalization	Adult crisis stabilization	Below
Justice Involvement	Adult arrest rate	Above
Justice Involvement	Juvenile arrest rate	Above
Justice Involvement	Adult recidivism conviction rate	Not Applicable; County-specific rate unavailable
Justice Involvement	DSH-funded IST count	Above
Removal of Children from Home	Children in foster care	Below
Removal of Children from Home	Open child welfare case SMHS penetration	Below
Removal of Children from Home	Child maltreatment substantiations	Below
Untreated Behavioral Health	FUA-30	Above
Untreated Behavioral Health	FUM-30	Above
Untreated Behavioral Health	CHIS unmet behavioral health need	Below
Care Experience	CPS cultural appropriateness/quality – adults/older adults	Above
Care Experience	CPS cultural appropriateness/quality – children/youth	Above
Engagement in School	On-time high school graduation	Below
Engagement in School	Meaningful participation at school	Above
Engagement in School	Chronic absenteeism	Above
Engagement in Work	Unemployment rate	Below
Engagement in Work	Unable to work due to mental problems	Above
Overdoses	All drug-related overdose deaths – full population	Above
Overdoses	All drug-related overdose deaths – adults/older adults	Above
Overdoses	Overdose ED visits – full population	Above
Overdoses	Overdose ED visits – adults/older adults	Above

Overdoses	Overdose ED visits – children/youth	Above
Co-occurring Physical Health	Adult preventive/ambulatory care	Above
Co-occurring Physical Health	Child/adolescent well-care visits	Below
Co-occurring Physical Health	Diabetes screening for adults on antipsychotics	Above
Co-occurring Physical Health	Child/adolescent metabolic monitoring	Not Applicable
Quality of Life	CPS functioning – full population	Above
Quality of Life	CPS functioning – adults/older adults	Above
Quality of Life	Poor mental health days	Above
Social Connection	CPS social connectedness – full population	Above
Social Connection	CPS social connectedness – adults/older adults	Above
Social Connection	Caring adult relationships at school	Below
Suicides	Suicide deaths	Below
Suicides	Non-fatal ED visits due to self-harm – full population	Above
Suicides	Non-fatal ED visits due to self-harm – adults/older adults	Above
Suicides	Non-fatal ED visits due to self-harm – children/youth	Above

The matrix preserves the status language used in the source Integrated Plan. Where the narrative response provides a local numerical comparison that differs in presentation from the benchmark field, both are retained.

Appendix B. Stakeholder Engagement Record

Engagement Type	**Date**
Survey participation	August 18, 2023
County meeting	January 9, 2025
County meeting	February 28, 2025
County meeting	March 27, 2025

County meeting	May 4, 2025
County meeting	July 23, 2025
Focus group	April 3, 2025
Focus group	May 1, 2025
Focus group	June 5, 2025
Focus group	July 10, 2025
Focus group	August 7, 2025
Focus group	September 4, 2025
Focus group	October 2, 2025
Focus group	October 9, 2025
Focus group	October 23, 2025
Focus group	November 5, 2025
Focus group	November 13, 2025
Workgroup / committee	January 14, 2025
Workgroup / committee	February 11, 2025
Workgroup / committee	March 11, 2025
Workgroup / committee	April 15, 2025
Workgroup / committee	June 4, 2025
Workgroup / committee	July 23, 2025
Workgroup / committee	August 17, 2025
Workgroup / committee	September 17, 2025
Workgroup / committee	October 7, 2025
Workgroup / committee	November 13, 2025
Workgroup / committee	December 3, 2025
Survey participation	November 30, 2025
Survey participation	December 31, 2025

Appendix C. Program and Service Inventory

Program / Activity	Plan Area	Primary Function
Family Strengthening Program	BHSS – Children's System of Care	Mental health and supportive services
Adult/Older Adult Outreach	BHSS – Adult/Older Adult System of Care	Mental health and SUD outreach
Northstar	BHSS – Early Intervention	Screening, assessment, referral
Outreach	BHSS – Early Intervention	Community education, access and linkage
CSC	BHSS – Early Intervention	First Episode Psychosis response
Behavioral Health Training	WET	Continuing education
Information Services staffing	CFTN	Technology and system support
Credible EHR optimization	CFTN	EHR workflow integration
Bishop Wellness Center bathroom renovation	CFTN	Capital facility improvement
FSP ICM	BHSA FSP	Intensive case management
HFW	BHSA FSP	High Fidelity Wraparound
ACT/FACT	BHSA FSP	Exemption requested; no planned staffing currently
IPS	BHSA FSP	Exemption requested; no planned staffing currently
Inyo SUD	Assertive field-based SUD	Outreach, screening, engagement, treatment initiation
Mobile Crisis Unit	Assertive field-based SUD	Field screening, linkage and warm handoffs
Open-Access Clinics	Assertive field-based SUD	Same-day screening and treatment initiation
Targeted Outreach	Assertive field-based SUD	New formal field-based outreach function
MAT	SUD treatment	Same-day buprenorphine, naltrexone and Suboxone access
Housing Program	Housing Interventions	Rental assistance, navigation, participant and landlord supports

Flex Pool	Housing	Braiding funding and coordinating housing supports

Appendix D. Source Data, Suppression, and Items Requiring Future Update

The source Integrated Plan includes a DHCS data suppression notice stating that values between 1 and 10 are displayed as “<11” under applicable de-identification standards. This report preserves those suppressed values and does not attempt to infer the underlying count.

The source document contains several “Not Applicable” entries, which are preserved because the County did not report a comparable measure or program applicability in those fields. Not Applicable should not be interpreted as zero service activity unless the source specifically reports zero.

The source document also contains some TBD language associated with stakeholder feedback and final public hearing documentation. Before publication as an adopted County report, those items should be updated from the final hearing record.

The source plan references multiple supporting files, including the County Quality Assurance Plan, budget templates, housing data presentations, population data, Community Health Assessment and Community Health Needs Assessment documents, and certification forms. Those supporting files were not incorporated into this narrative unless their contents were explicitly represented in the Integrated Plan itself.

This report is a narrative conversion of the supplied Integrated Plan. It is not an independent audit, validation, or reconciliation of the County’s underlying administrative data.

Appendix E. BHSA Budget Submission

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	☑	$ 105,366.00	$ 105,366.00	$ 105,366.00	$ 2,700.00	$ 2,700.00	$ 2,700.00	54.00	11.00
Early Intervention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Outpatient Services	☑	$ 819,168.00	$ 819,168.00	$ 819,168.00	$ 17,550.00	$ 17,550.00	$ 17,550.00	54	11.00
Intensive Outpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Crisis and Field-Based Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Residential Treatment Services	☐	$ 125,000.00	$ 125,000.00	$ 125,000.00	$ 25,000.00	$ 25,000.00	$ 25,000.00	2	1.00
Inpatient Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Mental Health (MH) Services									
Primary Prevention Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Early Intervention Services	☐	$ -	$ -	$ -	$ 80,000.00	$ 80,000.00	$ 80,000.00	0	100
Outpatient and Intensive Outpatient Services	☑	$ 5,296,874.00	$ 5,296,874.00	$ 5,296,874.00	$ 1,747,903.00	$ 1,747,903.00	$ 1,747,903.00	285	90
Crisis Services	☑	$ 170,000.00	$ 170,000.00	$ 170,000.00	$ -	$ -	$ -	100	10
Residential Treatment Services	☐	$ -	$ -	$ -	$ -	$ -	$ -	#	#
Hospital and Acute Services	☐	$ 30,000.00	$ 30,000.00	$ 30,000.00	$ -	$ -	$ -	2	2
Subacute and Long-Term Care Services	☐	$ 395,777.00	$ 395,777.00	$ 395,777.00	$ -	$ -	$ -	7	0
Housing Services (MH + SUD)									
Housing Services	☑	$ 244,236.00	$ 244,236.00	$ 244,236.00	$ 104,672.00	$ 104,672.00	$ 104,672.00	10	3
Total Projected Expenditures and Individuals Served									

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	$ 199,310.00	$ 199,310.00	$ 199,310.00
Workforce Investment Activities	$ 152,500.00	$ 152,500.00	$ 152,500.00
Quality & Accountability, Data Analytics, and Plan Management & Administrative Activities (including indirect administrative activities)	$ 302,386.00	$ 302,386.00	$ 302,386.00
Other County Behavioral Health Agency Services/Activities (e.g., Public Guardian, CARE Act, LPS Conservatorships, DSH for Housing, Court Diversion Programs)	$ 1,586,623.00	$ 1,586,623.00	$ 1,586,623.00

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	$ 2,628,437.00	$ 2,628,437.00	$ 2,628,437.00
1991 Realignment (Bronzan-McCorquodale Act)	$ 2,034,239.00	$ 2,034,239.00	$ 2,034,239.00
2011 Realignment (Public Safety Realignment)	$ 1,611,020.00	$ 1,611,020.00	$ 1,611,020.00
State General Fund	$ 150,000.00	$ 150,000.00	$ 150,000.00
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 2,040,242.00	$ 2,040,242.00	$ 2,040,242.00
Projects for Assistance in Transition from Homelessness (PATH)	$ 166,000.00	$ 166,000.00	$ 166,000.00
Community Mental Health Block Grant (MHBG)	$ 336,881.00	$ 336,881.00	$ 336,881.00
Substance Use Block Grant (SUBG)	$ 432,264.00	$ 432,264.00	$ 432,264.00
Commercial Insurance	$ 25,000.00	$ 25,000.00	$ 25,000.00
County General Fund	$ 23,857.00	$ 23,857.00	$ 23,857.00
Opioid Settlement Funds	$ 315,000.00	$ 315,000.00	$ 315,000.00
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)	$ 1,477,625.00	$ 1,477,625.00	$ 1,477,625.00
Other county mental health or SUD funding	$ 164,500.00	$ 164,500.00	$ 164,500.00
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)	$ 11,405,065.00	$ 11,405,065.00	$ 11,405,065.00
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 9,164,246.00	$ 9,164,246.00	$ 9,164,246.00
Auto-validation: Table 2: Other County Expenditures	$ 2,240,819.00	$ 2,240,819.00	$ 2,240,819.00

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)	$ 697,815.00	$ 814,118.00	$ 814,118.00	$ 2,326,051.00
Year Two Component Allocation (dollars)	$ 697,815.00	$ 814,118.00	$ 814,118.00	$ 2,326,051.00
Year Three Component Allocation (dollars)	$ 697,815.00	$ 814,118.00	$ 814,118.00	$ 2,326,051.00
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)	15%	35%	50%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 348,907.50	$ 814,118.00	$ 1,163,025.71	$ 2,326,051.21
Unspent Mental Health Services Act (MHSA) to BHSA	$ -	$ 11,042,935.11	$ 1,342,935.11	$ 12,385,870.22
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)	15%	35%	50%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 348,907.50	$ 814,118.00	$ 1,163,025.71	$ 2,326,051.21
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)	15%	35%	50%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ 348,907.50	$ 814,118.00	$ 1,163,025.71	$ 2,326,051.21

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	$ 45,420.00	$ 45,420.00	$ 45,420.00	$ 350,000.00	$ 350,000.00	$ 350,000.00
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ 16,806.00	$ 16,806.00	$ 16,806.00	$ -	$ -	$ -
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)	$ 5,000.00	$ 5,000.00	$ 5,000.00	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ 20,000.00	$ 20,000.00	$ 20,000.00	$ 50,000.00	$ 50,000.00	$ 50,000.00
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ 191,682.00	$ 191,682.00	$ 191,682.00	$ 173,261.00	$ 173,261.00	$ 173,261.00
Other Housing Supports: Outreach and Engagement (2)	$ 24,500.00	$ 24,500.00	$ 24,500.00	$ -	$ -	$ -
Capital Development Projects	$ -	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ 50,000.00	$ 50,000.00	$ 50,000.00	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 353,408.00	$ 353,408.00	$ 353,408.00	$ 573,261.00	$ 573,261.00	$ 573,261.00

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)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FSP Intensive Case Management	$ 603,410.00	$ 1,274,878.00	$ 1,274,877.00	$ -	$ -	$ -	$ -	$ -	$ -
High Fidelity Wraparound	$ 5,000.00	$ 5,000.00	$ 5,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Individual Placement and Support (IPS) Model of Supported Employment (2)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Assertive Field-Based Initiation for SUD Treatment Services	$ 5,000.00	$ 5,000.00	$ 5,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Other mental health or supportive services not already captured above (e.g., outreach, other recovery-oriented services, peers, etc.): Please define	$ 90,000.00	$ 90,000.00	$ 90,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.): Please define	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative FSP Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

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)	$ 313,967.00	$ 313,967.00	$ 313,967.00	$ -	$ -	$ -	$ -	$ -	$ -
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2)-Non FSP	$ 32,476.00	$ 32,476.00	$ 32,476.00	$ -	$ -	$ -	$ -	$ -	$ -
Early Intervention Expenditures	$ 335,925.00	$ 707,393.00	$ 707,393.00	$ -	$ -	$ -	$ -	$ -	$ -
Coordinated Specialty Care for First Episode Psychosis	$ 25,000.00	$ 25,000.00	$ 25,000.00	$ -	$ -	$ -	$ -	$ -	$ -
All Other EI Expenditures	$ 310,925.00	$ 682,393.00	$ 682,393.00	$ -	$ -	$ -	$ -	$ -	$ -
Outreach and Engagement		$ 300,000.00	$ 300,000.00	$ -	$ -	$ -	$ -	$ -	$ -
Workforce Education and Training (WET)	$ 152,500.00	$ 152,500.00	$ 152,500.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA WET funds	$ 152,500.00	$ 152,500.00	$ 152,500.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA WET funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Capital Facilities and Technological Needs (CFTN)	$ 199,310.00	$ 199,310.00	$ 199,310.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated BHSA CF/TN funds	$ 199,310.00	$ 199,310.00	$ 199,310.00	$ -	$ -	$ -	$ -	$ -	$ -
Dedicated MHSA CF/TN funds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative BHSS Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ 1,034,178.00	$ 1,705,646.00	$ 1,705,646.00	$ -	$ -	$ -	$ -	$ -	$ -

Table Eight: BHSA Plan Administration			
INTEGRATED PLAN ADMINISTRATION AND MONITORING	**Year One**	**Year Two**	**Year Three**
Total Projected Improvement and Monitoring Expenditures	$ 93,042.00	$ 93,042.00	$ 93,042.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 116,302.00	$ 116,302.00	$ 116,302.00
New and Ongoing Administrative Costs	$ 93,042.00	$ 93,042.00	$ 93,042.00

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 416,717.69
Local Prudent Reserve Maximum (1)	$ 553,134.11
Excess Prudent Reserve Funds (auto-populated)	$ (136,416.42)
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)	$ -

Appendix F. Inyo County Board of Supervisors Approved Integrated Plan

You may view the Integrated Plan Document at www.inyocounty.us/behavioralhealth or request a copy by calling 760-873-6533.

In the Rooms of the Board of Supervisors
County of Inyo, State of California

I, HEREBY CERTIFY, that at a regular meeting of the Board of Supervisors of the County of Inyo, State of California, held in their rooms at the County Administrative Center in Independence on the 9th day of June 2026 an order was duly made and entered as follows:

HHS-Behavioral Health – Behavioral Health Integrated Plan

Supervisors received a presentation from HHS Director Anna Scott on the Behavioral Health Integrated Plan (Fiscal Year 2026-2027 through Fiscal Year 2028-2029).

Moved by Supervisor Wadelton and seconded by Supervisor Marcellin to:
A) Approve the plan and authorize the Behavioral Health Director to make non-substantive revisions if further revisions are requested by the California Department of Health Care Services; and
B) Authorize the HHS Director and County Administrator to sign the plan submission documents.
Motion carried unanimously.

WITNESS my hand and the seal of said Board this 9th Day of June, 2026

DAVID FRASER
Clerk of the Board of Supervisors

By: _____

Routing
CC Purchasing Personnel Auditor CAO Other: HHS DATE: June 17, 2026

INYO COUNTY BOARD OF SUPERVISORS
TRINA ORRILL • JEFF GRIFFITHS • SCOTT MARCELLIN • JENNIFER ROESER • WILL WADELTON
DAVID FRASER, County Administrative Officer
DARCY ISRAEL, Asst. Clerk of the Board

CA 175 AMERICA 250

AGENDA ITEM REQUEST FORM

June 9, 2026

Reference ID: 2026-324

Behavioral Health Integrated Plan Presentation and Approval

Health & Human Services - Behavioral Health

ACTION REQUIRED

ITEM SUBMITTED BY
Melissa Best-Baker, Deputy Director - Fiscal Oversight and Special Operations

ITEM PRESENTED BY
Anna Scott, Health & Human Services Director

RECOMMENDED ACTION:
A) Receive a presentation on the Behavioral Health Integrated Plan (Fiscal Year 2026-2027 through Fiscal Year 2028-2029); B) Approve the plan and authorize the Behavioral Health Director to make non-substantive revisions if further revisions are requested by the California Department of Health Care Services; and C) Authorize the HHS Director and County Administrator to sign the plan submission documents.

BACKGROUND / SUMMARY / JUSTIFICATION:
In March 2024, the voters passed Proposition 1, a transformation of California's behavioral health system. The Behavioral Health Services Act (BHSA) modernizes the Mental Health Services Act, passed by voters in 2004, to address today's behavioral health system and needs. These reforms expand services to include treatment for people with substance use disorders, prioritize care for individuals with the most serious mental illnesses, provide ongoing resources for housing interventions and workforce, and continue investments in prevention, early intervention, and innovative pilot programs. Housing is an essential component of behavioral health treatment, recovery, and stability. Beginning in 2026 under the Behavioral Health Services Act, 30 percent of each county's funding allocation must be used for housing interventions for Californians with the most significant behavioral health needs who are homeless or at risk of homelessness. Half of that amount is prioritized for those experiencing chronic homelessness.

California counties are required under the Behavioral Health Services Act (BHSA) to develop three-year Integrated Plans (IPs) that outline how they will use behavioral health funding to meet statewide and local outcome measures, reduce disparities, and address unmet needs along the behavioral health care continuum. An integrated plan is a strategic document that identifies funding sources; sets goals for mental health and substance use disorder services; addresses housing, recovery and community supports; and ensures transparency thorough a community planning process. IPs were required to facilitate local and statewide data collection by providing data on services and planned expenditures and supporting analysis of county goals and outcomes. The IP has 14 State Goals and one local goal.

Fortunately, the Inyo County HHS Public Health Division completed a Community Health Assessment in 2024 and Northern Inyo Healthcare District and Southern Inyo Healthcare District jointly completed a

Community Health Needs Assessment in late 2025. Both assessments had input from the community and stakeholders. Mental Health and Substance Use Disorder issues were identified as top priorities in both needs assessments.

HHS submitted the draft plan to the California Department of Health Care Services on March 30, 2026 and received revision requests on April 30, 2026. The revisions requested were data corrections, clearer narrative information and timelines on interventions, and three new questions about CARE Court that were added for all counties in April.

In accordance with the requirement for a 30-day comment period, HHS posted the integrated plan on the County website on April 2, 2026 and disseminated the plan throughout the County. The Department held a public hearing on May 13, 2026 as part of the Behavioral Health Advisory Board meeting to incorporate public comment into the draft of the Plan. At that time, the Behavioral Health Advisory Board reviewed and approved the Plan.

While no additional funding is being provided, counties are now responsible for serving a broader population, which includes both individuals with severe mental illness and individuals with substance use disorders, and for adding a housing component.

The three BHSA-funded programs included in Plan are:
1. Housing Interventions- The Department has requested the ability to spend less than the required 30% of the total BHSA allocation and will be incorporating these new housing requirements into the housing program that is already administered by HHS.
2. Behavioral Health Services and Supports (BSS), which include the following programs:
Children's System of Care- Family Strengthening Team
Adult and Older System of Care- Education by Behavioral Health Nurse
Early Intervention Programs- Northstar Counseling Services contract and Outreach and Engagement activities
Workforce, Education and Training- used for staff and community trainings
Capital Facilities and Technology Needs- Electronic Health Record, Bishop Wellness Center Bathroom repair, and Information Services staff

The final draft of the Integrated Plan must be submitted to the California Department of Healthcare Services by June 30, 2026. HHS will continue to incorporate non-substantive changes to the document, if and as requested by DHCS, until receiving final state approval on the three-year plan.

FISCAL IMPACT:

Funding Source	State Behavioral Health Services Act funds	**Budget Unit**	505303
Budgeted?	Yes	**Object Code**	2200
Recurrence	Ongoing Expenditure	**Sole Source?**	N/A

If Sole Source, provide justification below

Current Fiscal Year Impact
Funds are deposited into the BHSA trust and budgeted as revenue in the BHSA budget (045201). BHSA expenses are tracked and transfers occur quarterly.
Future Fiscal Year Impacts
Funds are deposited into the BHSA trust and budgeted as revenue in the BHSA budget (045201). BHSA expenses are tracked and transfers occur quarterly.
Additional Information

ALTERNATIVES AND/OR CONSEQUENCES OF NEGATIVE ACTION:
Your Board could choose not to approve the Behavioral Health Integrated Plan. This would prohibit further use of these funds until an acceptable Plan that can meet BHSA regulations can be formulated. BHSA funds currently comprise approximately one third of all funds available for mental health services in Inyo.

OTHER DEPARTMENT OR AGENCY INVOLVEMENT:
None.

STRATEGIC PLAN ALIGNMENT:
Thriving Communities I Improve Housing Opportunities
Thriving Communities I Enhanced Health, Social, & Senior Services

APPROVALS:

Lucy Vincent	Created/Initiated - 05/05/2026
Melissa Best-Baker	Approved - 05/05/2026
Lucy Vincent	Approved - 05/05/2026
Darcy Israel	Approved - 05/12/2026
Anna Scott	Approved - 05/14/2026
Amy Shepherd	Approved - 05/14/2026
John Vallejo	Approved - 05/15/2026
Denelle Carrington	Final Approval - 05/15/2026

ATTACHMENTS:
1. Behavioral Health Integrated Plan Presentation
2. Inyo County 2026-2029 Integrated Plan
3. Inyo Integrated Plan Budget

BEHAVIORAL HEALTH SERVICES ACT

The Behavioral Health Services Act modernizes the Mental Health Services Act, passed by voters in 2004, to address today's behavioral health system and needs. These reforms expand services to include treatment for people with substance use disorders, prioritize care for individuals with the most serious mental illnesses, provide ongoing resources for housing interventions and workforce, and continue investments in prevention, early intervention, and innovative pilot programs. Housing is an essential component of behavioral health treatment, recovery, and stability.

INYO COUNTY BEHAVIORAL HEALTH INTEGRATED PLAN

Supporting Our Community's Health & Wellbeing

DATA

THE DATA IS TO PROVIDE A HIGH-LEVEL OVERVIEW OF THE COUNTY BEHAVIORAL HEALTH SYSTEM'S POPULATIONS SERVED, TECHNOLOGICAL INFRASTRUCTURE, AND SERVICES PROVIDED.

DEPARTMENT OF HEALTH CARE SERVICES REQUIRED DATA BE BASED ON FY 2023-2024

GIVES US AN IDEA OF WHAT WE SHOULD BE COLLECTING AND WHAT WILL BE REQUESTED IN THE FUTURE.

UNFORTUNATELY, STATEWIDE, WE ARE GROUPED WITH OTHER SMALL COUNTIES AND INYO SPECIFIC DATA NOT AVAILABLE.

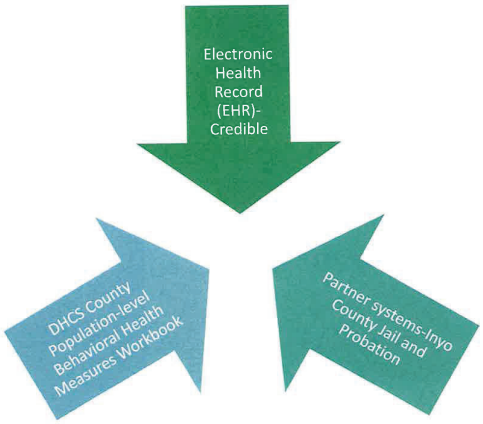
WHAT DO WE MEAN BY INYO COUNTY BEHAVIORAL HEALTH?

- Mental Health
- Substance Use Disorder
- Driving Under the Influence program
- Progress House
- Wellness Centers
- Crisis Care Mobile Unit
- Crisis Response
- Family Strengthening Team
- Drug Court

STATE GOALS

- Access to Care
- Homelessness
- Institutionalization
- Justice-Involvement
- Removal of Children from Home
- Untreated Behavioral Health Conditions
- Care experience
- Engagement in School
- Engagement in Work
- Overdoses
- Prevention and Treatment of Co-Occurring Physical Health Conditions
- Quality of Life
- Social Connection
- Suicides

WHERE DID THIS DATA COME FROM?



COMMUNITY PLANNING PROCESS

INYO COUNTY PUBLIC HEALTH COMMUNITY HEALTH ASSESSMENT (CHA) 2024

INYO COUNTY PUBLIC HEALTH COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) 2025-2028

INYO COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) BY NORTHERN INYO HEALTHCARE DISTRICT AND SOUTHERN INYO HEALTHCARE DISTRICT 2026

Both included the required outreach to stakeholder organizations.

Both had Mental Health and SUD as a priority health need

STATEWIDE BH GOALS

All measures are publicly available and provided by DHCS

There are 14 goals.

Goals may have primary measures, supplemental measures, disparities analysis and cross-measure questions

BHSA ESTIMATES

We receive an average of $2,300,000 each year

This is a three-year budget estimate. We used FY 25/26 spending to develop the budgets. We are required to do an annual update each year.

For this reporting period, we reduced housing to 15% and moved that % to BSS

MHSA VS. BHSA

Mental Health Services Act

- 76% Community Services and Supports
  - 50% Full Service Partnerships
  - 50% General System Delivery and Outreach & Engagement
- 19% Prevention and Early Intervention
  - 51% spent on youth
- 5% Innovation (INN)
- Transfer of up to 20% CSS to:
  - Workforce Education and Training (WET)
  - Capital Facilities/Technological Needs

Behavioral Health Services Act

- 35% Full Service Partnerships
- 35% Behavioral Health Services & Support (BHSS)
  - 50% on Early Intervention (EI)
    - 50% on youth
  - 50% on Adult System of Care, WET, INN, Outreach & Engagement
- 30% Housing Interventions

MANAGED CARE M/C PLAN

Health Net will be focusing on Access to Care, Homelessness, Untreated BH Conditions

Anthen will be focusing on Homelessness, Justice Involved and Untreated BH Conditions

BHSA FUNDED PROGRAMS

Behavioral Health Services and Supports (BSS)

- Children's System of Care
  - Family Strengthening Team
- Adult and Older System of Care
  - Education by Nurse
- Early Intervention Programs
  - Northstar contract
- Workforce, Education and Training

Full Service Partnership Program (FSP)

- Wellness Centers
- Evidence Based Programs
- As a small county, we are waived until 2029

Housing

- Planning
- Interventions

COMMENT PERIOD AND PUBLIC HEARING

Public Comment
- April 1, 2026 – May 4, 2026

BHAB Public Hearing
- May 13, 2026

Inyo Board of Supervisors
- May 26, 2026 or June 23, 2026

NEXT STEPS

Waiting for the State to review and submit comments and requested changes

Collect Public Comments and prepare a final version

Work with the County Administrator and HHS Director to review plan and approve it

2026 - 2029 Integrated Plan

Inyo County

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

General Information

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

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
Inyo County

Behavioral Health Agency Name
Inyo County Department of Health and Human Services

Behavioral Health Agency Mailing Address
1360 North Main Street, Suite 201 Bishop, CA 93514

Primary Mental Health Contact

Name
Melissa Best-Baker

Email
mbestbaker@inyocounty.us

Phone
7608780232

Secondary Mental Health Contact

Name
Joshua Vega

Email
jvega@inyocounty.us

Phone
7608720904

Primary Substance Use Disorder Contact

Name
Melissa Best-Baker

Email
mbestbaker@inyocounty.us

Phone
7608780232

Secondary Substance Use Disorder Contact

Name
Vacant Addiction Supervisor

Email
mbestbaker@inyocounty.us

Phone
7608736533

Primary Housing Interventions Contact

Name
Stephanie Rubio

Email
srubio@inyocounty.us

Phone
7608720905

Compliance Officer for Specialty Mental Health Services (SMHS)

Name
Lori Bengochia

Email
lbengochia@inyocounty.us

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

Name
NA

Email

Behavioral Health Services Act (BHSA) Coordinator

Name	Email address
Joshua Vega	jvega@inyocounty.us

Substance Abuse and Mental Health Services Administration (SAMHSA) liaison

Name	Email address
Melissa Best-Baker	Mbestbaker@inyocounty.us

Quality Assurance or Quality Improvement (QA/QI) lead

Name	Email address
Lori Bengochia	lbengochia@inyocounty.us

Medical Director

Name	Email address
Dr. Anne Goshgarian	annegoshgarian@gmail.com
Dr. William Lofthouse	wlofthouse@namhs.com

County Behavioral Health System Overview

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

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

Populations Served by County Behavioral Health System

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

Children and Youth

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

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	90
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	11
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	11
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	101

Criteria	Number of Children and Youth Under Age 21
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	0
Were chronically homeless or experiencing homelessness or at risk of homelessness	13
Were in the juvenile justice system	0
Have reentered the community from a youth correctional facility	0
Were served by the Mental Health Plan and had an open child welfare case	18
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	0

Criteria	Number of Children and Youth Under Age 21
Have received acute psychiatric care	0

Adults and Older Adults

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

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	73
Received Medi-Cal SMHS	285
Received DMC or DMC-ODS services	54
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	20
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	22

Criteria	Number of Adults and Older Adults
Experienced unsheltered homelessness	0
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	0
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	0
Were in the justice system (on parole or probation and not currently incarcerated)	0
Were incarcerated (including state prison and jail)	1484
Reentered the community from state prison or county jail	0
Received acute psychiatric services	0

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

Admitted or detained for 72-hour evaluation and treatment rate
0

Admitted for 14-day and 30-day periods of intensive treatment
0

Admitted for 180-day post certification intensive treatment
0

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
0

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
0

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

Please explain
Inyo County, as a small and rural jurisdiction, faces longstanding infrastructure limitations that impact its ability to fully capture and report the level of data requested by DHCS for the BHSA Integrated Plan. Challenges include limited staffing capacity, reliance on fragmented or non-integrated data systems, and geographic barriers that affect consistent data collection and reporting workflows. These constraints make comprehensive, timely, and standardized reporting difficult under current conditions. However, addressing these gaps is a key priority within the BHSA Integrated Plan. The plan includes a focused effort to strengthen data infrastructure, improve system integration, and enhance staff capacity for data tracking and reporting. Through these investments, Inyo County aims to build a more reliable and efficient data system that supports improved transparency, program evaluation, and service delivery outcomes. These concerns reflect the lack of data in some areas.

Please describe the local data used during the planning process
Local data used during the planning process was drawn from multiple sources across Inyo County and partner agencies. Much of this information originated from fragmented electronic health record (EHR) systems that are currently in the process of being integrated across additional areas of the agency to improve data quality, consistency, and accessibility. Additional data inputs were provided by partner systems, including Inyo County Jail and Probation, where data collection remains a combination of electronic records, legacy systems with duplicative entries, and anecdotal or staff-reported information. As a result, while the County was able to compile meaningful insights to inform planning, the data required

significant reconciliation and validation. Strengthening data integration and reducing system fragmentation will be a key focus moving forward to support more accurate, efficient, and comprehensive data-driven planning. These concerns reflect the lack of data in some areas.

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

Local CARE Act Implementation

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

Describe how CARE referral pathways will be integrated into existing referral and service pathways within the county behavioral health system.
We are a Health and Human Services Agency. The CARE program is organized out of our Adult Protective Services (APS) division but they use the Behavioral Health electronic health record. A monthly CARE multidisciplinary team meeting is being organized to ensure collaboration.

Describe the process for identifying and redirecting individuals who are potentially eligible for CARE to alternative pathways when a formal petition is not required or appropriate. For individuals redirected from CARE, describe how the county will confirm and document successful connection to services.
We have established a collaborative screening and engagement process to identify individuals who may meet criteria for the Community Assistance, Recovery, and Empowerment (CARE) Act while ensuring that individuals are redirected to the least restrictive and most clinically appropriate services whenever possible.

Referrals may originate from behavioral health staff, hospitals, law enforcement, family members, or courts. Upon referral, the identified Social Worker conducts an initial review of available information to determine whether the individual appears to meet CARE eligibility criteria, including the presence of a qualifying serious mental illness, functional impairment, and indicators of untreated behavioral health needs.

When staff determine that a formal CARE petition is not appropriate, the individual is redirected to alternative pathways to address their immediate behavioral health, housing, medical, or social service needs in a voluntary and person-centered manner.

All activities are documented in our electronic health record. Staff will document any individuals identified and redirected to an alternative pathway.

County Behavioral Health Technical Infrastructure

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

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

Please select which of the following EHRs the county uses
Qualifacts credible.

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

Please select which QHIO the county participates in
SacValley MedShare

Application Programming Interface Information

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

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://www.inyocounty.us/behavioral-health

Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056, 23-057, and 24-016. Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

County Behavioral Health System Service Delivery Landscape

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

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

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?
No

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

Community Mental Health Services Block Grant (MHBG)

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

Please select all set asides that the county behavioral health system plans to participate in under the MHBG
Discretionary/Base Allocation
Dual Diagnosis Set-Aside
First Episode Psychosis Set-Aside

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

Please describe these challenges or concerns:
While we accept the FEP Set-Aside, there is a very low client count for this funding (1). However, we continue to provide training opportunities to staff for when that case is identified.

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

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

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

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

Opioid Settlement Funds (OSF)

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

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

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

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).
a. Case Management
b. Comprehensive Evaluation and Assessment
c. Group Services
d. Individual Service Plan
e. Medication Education and Management
f. Pre-crisis and Crisis Services
g. Rehabilitation and Support Services
h. Residential Services
i. Services for Homeless Persons
j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:
Not Applicable

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

Please describe these challenges or concerns:
Over the last few years we have seen an increase in clients who have had to be conserved, and their placements have been for longer than a year. Finding placements has been difficult and is always at least 5 hours from our county.

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)
a. Drug Courts
b. Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
c. Regular and Perinatal Drug Medi-Cal Services
d. Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
e. Regular and Perinatal Non-Drug Medi-Cal Services

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

Please describe these challenges or concerns
Since we are a State DMC Plan county, residential treatment services are not a covered service for adults. We have no residential treatment services in our county and most clients have to move to another county to qualify for DMC-ODS services and get the treatment they need. We have struggled for over a decade to get a contract with a residential treatment program for perinatal or youth clients. We don't have enough of the need to pay a facility to hold a bed for us.

Medi-Cal Specialty Mental Health Services (SMHS)

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

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

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

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

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

Select which of the following services the county behavioral health system participates in
DMC Program

Drug Medi-Cal Program (DMC)
The county behavioral health system is mandated to provide the following services as a part of the DMC Program (no action required)
a. All Other Medically Necessary Services for individuals under age 21
b. Intensive Outpatient Treatment Services
c. Medications for Addiction Treatment (including medication, counseling services, and behavioral therapy) (MAT)
d. Mobile Crisis Services
e. Narcotic Treatment Program (NTP) Services
f. Outpatient Treatment Services
g. Perinatal Residential Substance Use Disorder (SUD) Treatment for pregnant women and women in the postpartum period

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

Has the county behavioral health system opted to provide the specific services identified in the list below?
Peer Support Services

Other Programs and Services

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

Program or service

Care Transitions

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

Yes

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

Statewide Behavioral Health Goals

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

Population-Level Behavioral Health Measures

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

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

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

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

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

Mark page as complete

Priority statewide behavioral health goals for improvement

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

Access to care: Primary measures

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Below

For children/youth
Not Applicable

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

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

How does your county status compare to the statewide rate?

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

Access to care: Supplemental Measures

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

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

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

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
As noted in the BH workbook Inyo County reflects disparity data for the initiation of SUD treatment. With new leadership in Behavioral Health, we will be working to develop relationships with all the local providers and identify opportunities to work together. We are strengthening our services by reviewing State requirements, staff strengths, and policies and procedures. We are not necessarily looking at starting new programs but strengthening the current programs. We are showing below statewide average for initiation of SUD treatment. We are moving from a DUI only focus and implementing Prop 36 and other required SUD programs. We have already seen an increase in clients in the last year.

Access to care: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes
With new leadership in Behavioral Health, we will be working to develop relationships with all the local providers and identify opportunities to work together. We are strengthening our services by reviewing State requirements, staff strengths, and policies and procedures. We are not necessarily looking at starting new programs but strengthening the current programs. We are showing below statewide average for initiation of SUD treatment. We are moving from a DUI only focus and implementing Prop 36 and other required SUD programs. We have already seen an increase in clients in the last year.

File Upload

Please identify the category or categories of funding that the county is using to address the access to care goal
BHSA Behavioral Health Services and Supports (BHSS)
1991 Realignment
2011 Realignment
Substance Use Block Grant (SUBG)
Community Mental Health Block Grant (MHBG)

Homelessness: Primary measures

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

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

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

Please describe other
Other [The 2025 PIT Count shows a higher concentration of adults ages 25-64 particularly individuals aged 55 and older. Men are disproportionately represented among people experiencing homelessness. Racial disparities are evident, with American Indian/Alaska Native individuals overrepresented relative to the general population. Chronic homelessness is largely concentrated among unsheltered adults, indicating structural barriers to housing stability for older and long-term unhoused individuals.]

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

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

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

Please describe other
Other [Homelessness student enrollment in Inyo County remains lower than the statewide average. However, disparities persist among school-aged children from American/Alaska Native and Hispanic/Latina/o backgrounds. Housing instability among families continues to intersect with poverty, geographic isolation, and limited housing stock, particularly in rural areas.]

Homelessness: Supplemental Measures

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

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

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

Please describe other
Other [Adults with serious mental illness represent a substantial portion of the homeless population, with prevalence highest among unsheltered adults and those experiencing chronic homelessness. Older adults are disproportionately impacted, suggesting the need for integrated housing, behavioral health, and long-term supportive services.]

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

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

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

Please describe other
[Chronic substance abuse is more prevalent among adults ages 35-64 and among individuals experiencing unsheltered and chronic homelessness. The overlap between substance abuse disorders and long-term homelessness highlights the need for harm-reduction-based outreach and permanent supportive housing models within the CoC

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

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

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

Please describe other
Other [Service access rated within the ESCoC are lower than the statewide CoC average, reflecting geographic barriers, limited provider capacity, and transportation challenges common in rural regions. Individuals who are unsheltered, older, and chronically homeless are less likely to access services consistently, underscoring the need for expanded outreach and mobile service delivery models.]

Homelessness: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
We utilized the data from our Homeless Management Information System (HMIS) and Point in Time (PIT) Count. The PIT count is done each year in late January, which is not during favorable weather conditions. We antidotally know that there are more homeless individuals during the warmer weather months. In 2022, Inyo County Health and Human Services became the lead for the Continuum of Care. We have spent the last few years training staff and partners how to use Coordinated Entry and HMIS. We believe that services are being provided to clients but partners are not using HMIS. We will be focusing on training partners to use the systems and collecting the data.

Homelessness: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
We are a Health and Human Services Department and have a housing program. We will be moving that program into the Behavioral Health division. In 2022, Inyo County Health and Human Services became the lead for the Continuum of Care. We have spent the last few years training staff and partners how to use Coordinated Entry and HMIS. We believe that services are being provided to clients but partners are not using HMIS. We will be focusing on training partners to use the systems and collecting the data.
We received a grant to develop a flex pool policy/program. We are also contracting with the managed care plans to provide transitional rent. All of these programs will be tracked in HMIS.

File Upload

Please identify the category or categories of funding that the county is using to address the homelessness goal
BHSA Housing Interventions
Other

Please describe other
We will be utilizing Social Services funding and ReEntry monies when appropriate for our housing program.

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.
Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment. (no action)

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023

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

For adults/older adults
Not Applicable

For children/youth
Not Applicable

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

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

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

14-day involuntary detention rates per 10,000
Not Applicable

30-day involuntary detention rates per 10,000
Not Applicable

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

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

Conservatorships, FY 2021 - 2022

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

Temporary Conservatorships
Not Applicable

Permanent Conservatorships
Not Applicable

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

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

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

Crisis Intervention

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Crisis Residential Treatment Services

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Crisis Stabilization

For adults/older adults
Below

For children/youth
Not Applicable

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

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
As a small frontier county, our numbers are so minimal that we are usually grouped with other small counties. This gives us guidance on data points to collect and consider locally. The only measure with data shows that we are below the state average by .01 for adult crisis stabilization. For a small county, that could be one client.

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)
We have an excel worksheet that we track this data which is very minimal.

File Upload

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)
With new leadership in Behavioral Health, we will be working to develop relationships with all the local providers and identify opportunities to work together. We will be looking into our relationship and Memorandum of Understanding with Kern County who has our closest Crisis Stabilization Unit.
We have implemented a Crisis Care Mobile Unit. This includes working with law enforcement to respond to crisis events in the field. We believe this partnership has been a huge success and will decrease our transports to Crisis Stabilization and Institutionalizations.

File Upload

Please identify the category or categories of funding that the county is using to address the institutionalization goal
1991 Realignment
2011 Realignment

Justice-Involvement: Primary Measures

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

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

For adults/older adults
Above

For juveniles
Above

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

Please describe other
Inyo County has limited locally available jail and arrest data disaggregated by race, gender, and age. However, clear disparities are evident by age, with very low juvenile incarceration and much higher adult incarceration, and by gender, as the jail population is overwhelmingly male. Based on statewide and rural California trends, racial and ethnic disparities—particularly impacting Native American and Latino residents—are also likely present, though they cannot yet be fully quantified due to data limitations.

Justice-Involvement: Supplemental Measures

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

How does your county status compare to the statewide rate/average?
Not Applicable

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

Please describe other
No Data Available / Cannot Determine The statewide three-year recidivism conviction rate for individuals released from California Department of Corrections and Rehabilitation in FY 2019-20 was 39.1 percent, based on CDCR's recidivism report. Inyo County's specific recidivism conviction rate is not available in the CDCR data; therefore, a direct comparison to the statewide average cannot be determined from currently published sources.

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

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

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

Please describe other
No Disparities Data Available Inyo County's DSH-funded IST population is small in absolute numbers, but individuals found incompetent to Stand Trial are disproportionately people with serious mental illness and co-occurring substance use disorders. Even with low counts, this population represents a high-need, high-risk group that experiences longer jail stays, delayed access to treatment, and greater barriers to restoration and re-entry compared to the general justice-involved population. Limited local forensic and community-based restoration capacity may further impact rural residents who must wait longer or travel farther to access DSH-funded services.

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Inyo County data show disparities in justice system involvement by age and gender, with adult incarceration rates (~4,122 per 100,000) above the statewide average and jail populations predominantly male. Juvenile involvement is very low, with fewer than 10 minors incarcerated annually, resulting in a rate well below the statewide juvenile arrest rate. Although local data are limited, statewide and rural trends suggest Native American and Latino residents are likely overrepresented in justice-involved populations. The small IST population highlights additional disparities for individuals with serious mental illness and co-occurring substance use disorders, who face longer jail stays and limited access to DSH-funded restoration programs in rural areas.

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
We will be strengthening SUD and ReEntry services. With new leadership in Behavioral Health, we will be working to develop relationships with all the local providers and identify opportunities to work together. We are strengthening our services by reviewing State requirements, staff strengths, and policies and procedures. We are lucky to have a clinician assigned to provide Mental Health and SUD services at the jail full time. We have also had a long time vacancy in our ReEntry staff. All of those positions are filled and working together to better serve the clients at the jail and as they are released.

File Upload

Please identify the category or categories of funding that the county is nusing to address the justice-involvement goal
1991 Realignment
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)
Other

Please describe other
County Corrections Partnership Funding

Removal Of Children from Home: Primary Measures

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

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

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

Removal Of Children from Home: Supplemental Measures

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

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

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

Child Maltreatment Substantiations (CWIP), 2022

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

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

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Inyo County has a very small population of children in foster care. Due to the limited number of children in care at any given time, calculating demographic differences—such as by age, gender, race/ethnicity, sex, or spoken language—would result in unstable rates or suppressed data. As a result, no reliable disparities data is available for the county report. This is consistent with patterns observed in other small, rural counties where low volumes of foster care placements limit the ability to identify statistically meaningful disparities.

Although disparities data are not available, Inyo County continues to provide equitable services and support to all children and families in the foster care system. Case management, placement decisions, and supportive services are guided by California Child Welfare Digital Services protocols and best practice standards, ensuring that every child receives timely access to appropriate care regardless of demographic characteristics. The county emphasizes family and kinship placements whenever possible and collaborates closely with regional partners to meet the unique needs of children in care.

The county also monitors trends and changes in foster care populations over time. Even with low numbers, Inyo County reviews all placements, services, and outcomes to identify potential areas of concern and opportunities for improvement. Should the foster care population increase or demographic patterns shift, the county will update its analysis and report any identified disparities in future Integrated Plan submissions. These ongoing monitoring and quality improvement efforts reflect Inyo County's commitment to equitable outcomes for all children in foster care.

Removal Of Children from Home: Cross-Measure Questions

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

With the support of anecdotal data as well as data supported from the BH Workbook, this area of focus remains high importance.

The integrated structure allows behavioral health, social services, and supportive services to share information, align interventions, and provide timely support to children and families. Our HHS agency leads the Interagency Leadership Team. We are revisiting the use of CANS in CFTs and who can complete the CANS. The new Deputy Director of Behavioral Health will be reaching out to mental health partners to complete the CANS for our foster youth in their care and participating in the CFT meetings.

We are working with our Child Welfare Services to ensure that every child removed from a home or receiving services from their team are referred to Mental Health. A contractor has been hired to work on their policies and procedures. We also do a check each month to ensure that referrals have been made for the current active case loads. If a youth is not being seen by County Mental Health, we ensure they are being provided services at a different provider (i.e. local Indian Health Services).

File Upload

Please identify the category or categories of funding that the county is nusing to address the removal of children from home goal
1991 Realignment
2011 Realignment

Untreated Behavioral Health Conditions: Primary Measures

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

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

For the full population measured
Above

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

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

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

For the full population measured
Above

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

Untreated Behavioral Health Conditions: Supplemental Measures

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

How does your county status compare to the statewide rate?

For the full population measured
Below

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

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Due to the county's small population and low service utilization, disparity data was not available for the FUM and FUA measures because the number of cases was too small to produce reliable demographic comparisons. However, disparity data weas available for the CHIS measure of adults reporting unmet behavioral health needs. Review of this data identified a disparity among Alaska Native/American Indian females, who reported higher rates of needing help for emotional/mental health or substance use issues but having no behavioral health visits in the past year, compared to other gender and racial/ethnic groups. The finding suggests that Alaska Native/American Indian women in the country may experience great barriers to accessing behavioral health services, including factors such as stigma, geographic access challenges, and limited provider availability in our community.

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
Beginning July 1, 2026, Inyo County plans to strengthen existing outreach, engagement, and care coordination efforts to help decrease the number of residents experiencing untreated behavioral health conditions. As a small rural county operating within a Health and Human Services super-agency, Behavioral Health collaborates closely with other county programs, community providers, and regional partners to identify individuals with unmet behavioral health needs and connect them to appropriate services. The county will continue strengthening partnerships with primary care providers, Tribal partners, and

community organizations to improve outreach and engagement for populations that may face barriers to accessing services.

Data from the CHIS measure identifying higher unmet behavioral health need among Alaska Native/American Indian females will help inform outreach and engagement strategies. Planned efforts include increasing culturally responsive outreach, strengthening referral pathways with Tribal and community partners, and improving access to services through integrated care coordination and telehealth options where appropriate. These efforts will build on existing county programs designed to identify individuals in need of behavioral health services and connect them to care earlier, with the goal of reducing untreated behavioral health conditions and improving access to services for all residents.

File Upload

Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal
BHSA BHSS
BHSA FSP
2011 Realignment
1991 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Additional statewide behavioral health goals for improvement

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

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

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

Care Experience: Primary Measures

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

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

For adults/older adults
Above

For children/youth
Above

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

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

For adults/older adults
Not Applicable

For children/youth
Not Applicable

Engagement In School: Primary Measures

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

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

Engagement In School: Supplemental Measures

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

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

Student Chronic Absenteeism Rate (Data Quest), 2022

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

Engagement In Work: Primary Measures

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

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

Engagement In Work: Supplemental Measures

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

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

Overdoses: Primary Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Not Applicable

Overdoses: Supplemental Measures

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

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

For the full population measured
Above

For adults/older adults
Above

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

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

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

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

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

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

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

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

For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)
Not Applicable

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Not Applicable

Quality Of Life: Supplemental Measures

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

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

For the full population measured
Above

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Not Applicable

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

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

Suicides: Primary Measures

Suicide Deaths, 2022

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

For the full population measured
Below

Suicides: Supplemental Measures

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

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

For the full population measured
Above

For adults/older adults
Above

For children/youth
Above

County-selected statewide population behavioral health goals

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

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

Overdoses

Please describe why this goal was selected
We are above the statewide average and this is a concern within our county.

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
We cannot identify specific disparities because the number is minimal and could lead to identification of clients. Our tribal health clinic has a robust harm reduction program for their clients. We would like to develop similar outreach and education to the remaining county.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Overdoses and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
With opioid settlement monies, we will develop an annual media campaign about harm reduction strategies, participate in local community events and work with stakeholders to hold an annual training for the community and medical staff. The goal of these activities is to increase overdose awareness. We will also work with our partners and community to increase awareness of Narcan distribution points throughout the county. The expectation of these activities will reduce our drug overdose rates.

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

Please describe other
Opioid settlement funds

Community Planning Process

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

Stakeholder Engagement

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

---

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

County outreach through social media
County outreach through traditional media (e.g., television, radio, newspaper)
Focus group discussions
Key informant interviews with subject matter experts
Meeting(s) with county
Provided data to county
Survey participation
Workgroups and committee meetings

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

Type of engagement
Survey participation

Date
8/18/2023

Type of engagement
Meeting(s) with county

Date
7/23/2025

Type of engagement
Meeting(s) with county

Date
5/4/2025

Type of engagement
Meeting(s) with county

Date
3/27/2025

Type of engagement
Meeting(s) with county

Date
2/28/2025

Type of engagement
Meeting(s) with county

Date
1/9/2025

Type of engagement
Focus group discussions

Date
4/3/2025

Type of engagement
Focus group discussions

Date
5/1/2025

Type of engagement
Focus group discussions

Date
6/5/2025

Type of engagement
Focus group discussions

Date
7/10/2025

Type of engagement
Focus group discussions

Date
8/7/2025

Type of engagement
Focus group discussions

Date
9/4/2025

Type of engagement
Focus group discussions

Date
10/2/2025

Type of engagement
Focus group discussions

Date
10/9/2025

Type of engagement
Focus group discussions

Date
10/23/2025

Type of engagement
Focus group discussions

Date
11/5/2025

Type of engagement
Focus group discussions

Date
11/13/2025

Type of engagement
Workgroups and committee meetings

Date
4/15/2025

Type of engagement
Workgroups and committee meetings

Date
6/4/2025

Type of engagement
Workgroups and committee meetings

Date
7/23/2025

Type of engagement
Workgroups and committee meetings

Date
8/17/2025

Type of engagement
Workgroups and committee meetings

Date
9/17/2025

Type of engagement
Workgroups and committee meetings

Date
11/13/2025

Type of engagement
Workgroups and committee meetings

Date
10/7/2025

Type of engagement
Workgroups and committee meetings

Date
12/3/2025

Type of engagement
Workgroups and committee meetings

Date
1/14/2025

Type of engagement
Workgroups and committee meetings

Date
2/11/2025

Type of engagement
Workgroups and committee meetings

Date
3/11/2025

Type of engagement
Survey participation

Date
11/30/2025

Type of engagement
Survey participation

Date
12/31/2025

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
Northern Inyo Hospital, Indian Head Start, Inyo County Office of Education, Bishop Police Department, UCLA Hospital, Inyo County Superior Courts and Judges, University Cooperative Extension, Eastern Sierra County of Government, Bishop Paiute Tribe representatives, Inyo County Board of Supervisors, Inyo County Probation, Cerro Coso Community College, Bishop Union High School, Southern Inyo Healthcare District, Owens Valley Career Development, Inyo County HHS Divisions (Public Health, Behavioral Health, Social and Placement Services and Public Assistance and Aging), Toiyabe Indian Health, Inyo County Administration, Local business owners, Inyo County Sheriff's Department, Inyo County District Attorney, High school Hispanic liaison, Wild Iris, Inyo/Mono Child Support, Inyo Mono Advocates for the Handicap, Salvation Army, Legal Self Help, Bishop School Board Members, Victim Witness Program, Kern Regional Center, Anthem Managed Care Plan representatives, Health Net Managed Care Plan representatives

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	NA
2	NA
3	NA
4	NA
5	NA

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

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities
Utilizing the information from the meetings and survey results from the Inyo County Health and Human Services/ Public Health Community Health Assessment and the two hospitals in our county-Community Health Needs Assessment-Mental Health services and Access to Care are both priorities.

Upload File
Lindsay Inyo_2025 CHNA_Board Report_2.24.26.pdf
Inyo County Community Health Assessment Report_5.29.2024_0.pdf
Inyo County CHIP 2025 - 2028 Final_0.pdf
INYO_CHNA_FINAL_3.18.26 (2).pdf

Local Health Jurisdiction (LHJ)

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

---

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

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities
We are a county Health and Human Services agency. Behavioral Health and Public Health work closely. We have multiple meetings with our managed care plans including a quarterly HHS meeting, monthly CoC meetings and individual program meetings.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?
No

Collaboration

Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

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

Was data shared?
No

Data-Sharing from MCPS and LHJs to Support IP development

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

Was data shared?
No

Stakeholder Activities

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

Please describe how the county has coordinated stakeholder activities for IP development and the CHA/CHIP
Staff participated in stakeholder meetings for the CHA and are active participants in two of the three Objectives in their CHIP.

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

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

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP
We are able to use the data from our County Public Health Community Health Assessment and our two hospitals came together and did their Community Needs Assessment. Public Health also began holding subgroups for their Community Health Improvement Plan. Two of their goals were aimed at Behavioral Health (Maternal Mental Health and Substance Use Disorder). We have actively participated in these subgroups.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

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

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

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?
The MCPs have engaged the County in a collaborative Community Reinvestment planning process and have committed to sharing their draft MCP Community Reinvestment Plan with the County for review prior to submission to DHCS by the September 1, 2026, due date.

Health Net will be focusing on these top three priorities: Access to Care, Homelessness, Untreated BH Conditions.

Anthem will be focusing on these top three priorities: Homelessness, Justice Involved, Untreated BH Conditions.

Comment Period and Public Hearing

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

Comment Period and Public Hearing

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

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

Date the draft Integrated Plan (IP) was released for stakeholder comment
4/1/2026

Date the stakeholder comment period closed
5/4/2026

Date of behavioral health board public hearing on draft IP
5/13/2026

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

Please provide the link to the public posting
https://www.inyocounty.us/behavioral-health/behavioral-health-advisory-board

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
NA

File Upload

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

Attach email
Public Notice email.pdf

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

Stakeholder group that provided feedback
TBD

Summarize the substantive revisions recommended this stakeholder during the comment period
This will be submitted after public hearing

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

Substantive recommendations
TBD. This will be submitted after public hearing

County Behavioral Health Services Care Continuum

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

County Behavioral Health Services Care Continuum

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

Mark section as complete

County Provider Monitoring and Oversight

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

Medi-Cal Quality Improvement Plans

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

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

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

Contracted BHSA Provider Locations

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

Services Provided

Number of contracted BHSA provider locations

Services Provided	Number of contracted BHSA provider locations
Mental Health (MH) services only	1
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	0

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

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

All BHSA Provider Locations

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

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?
0

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
The county will not support the BHSA-funded providers with contracting with MCPs due to capacity.

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

Does the county wish to describe implementation challenges or concerns with these requirements?
No

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

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

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

Behavioral Health Services Act/Fund Programs

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

Behavioral Health Services and Supports (BHSS)

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

General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan
Children's System of Care (non-Full Service Partnership (FSP))
Adult and Older Adult System of Care (non-FSP)
Early Intervention Programs (EIP)
Workforce, Education and Training (WET)
Capital Facilities and Technological Needs (CFTN)
Outreach and Engagement (O&E)

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

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

Please select the service types provided under Program
Mental health services
Supportive services

Please describe the specific services provided
The Family Strengthening Program, formerly known as the Families Intensive Response Strengthening Team (FIRST), is a voluntary, intensive, family-driven, strengths-based planning process that uses the Wraparound approach. The program follows the ten guiding principles of Wraparound including: family-centered voice and choice, a team approach, use of natural supports, collaborative efforts, community-based services, a culturally responsive and respectful focus, an individualized approach, and a strengths-based lens, that is persistent and informed by outcomes. A small team works with the families of children/youth who have been identified as at risk of out of home placement through Child Protective Services, Probation, schools, or Behavioral Health. The team predominantly works with families that have identified as needing substantial support in multiple areas of challenge, but a family can come to the strengthening team voluntarily or through system involvement thanks to diverse braided funding. Families are often referred to the program though Student Attendance Review Board, Behavioral Health, Probation, CPS, area schools and other local agencies - often with referrals coming from multiple service partners at the same time. The Family Strengthening Team works with families to set and accomplish goals that strengthen the entire family as a unit. The vision of the Family Strengthening Team is to empower families to overcome complex challenges to live together in the community independent of government systems.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	71
FY 2027 – 2028	71
FY 2028 – 2029	71

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

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

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

Please select the service types provided under Program
Mental health services
Substance Use Disorder (SUD) treatment services

Please describe the specific services provided
Outreach to directly reach and engage adults and older adults who may benefit from behavioral health services and engagement to support and encourage ongoing participation of the eligible population in behavioral health treatment. Outreach will occur at Wellness Centers, Senior Centers and planned community events.

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	50
FY 2027 – 2028	50
FY 2028 – 2029	50

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
Historic Data

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" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name
Northstar

Please select which of the three EI components are included as part of the program or service
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

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

Please describe intended outcomes of the program or service
Intended Outcomes: Northstar Early Intervention Children's Services Program
1. Improved Early Identification and Access to Care
Children with developmental, behavioral, or mental health needs are identified earlier through screening and referral pathways
Increased timely access to appropriate services, reducing delays in care
Strengthened coordination between schools, healthcare providers, and social services
2. Enhanced Child Development and Functioning
Measurable improvements in cognitive, emotional, social, and behavioral development
Increased ability for children to engage successfully in school and daily activities
Reduction in severity or progression of developmental and behavioral concerns
3. Strengthened Family Capacity and Stability
Caregivers demonstrate increased knowledge, skills, and confidence in supporting their child's needs

Improved family functioning and resilience
Reduced caregiver stress through access to education, coaching, and support services
4. Prevention of Higher-Level Interventions
Decreased need for crisis services, special education intensification, or out-of-home placements
Reduction in emergency room visits or acute behavioral health episodes
Early support helps prevent long-term system involvement (e.g., child welfare, juvenile justice)
5. Improved Coordination Across Systems
Increased integration of services across behavioral health, primary care, education, and social services
Development of clear care pathways and shared care planning
Improved communication between providers leading to more holistic, child-centered care
6. Increased Equity in Service Access and Outcomes
Reduction in disparities for underserved and high-risk populations
Culturally responsive and linguistically appropriate services improve engagement and retention
More equitable developmental and behavioral health outcomes across populations
7. Data-Driven Continuous Improvement
Use of screening, assessment, and outcome data to track progress and adjust interventions
Improved program accountability and demonstrated effectiveness
Ongoing refinement of services based on community needs and performance metrics

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

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

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	50
FY 2027 – 2028	50
FY 2028 – 2029	50

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

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" button. For related policy information, refer to 7.A.7 Early Intervention Programs.

Program or service name
Outreach

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

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

Please describe intended outcomes of the program or service
Behavioral Health staff will organize outreach activities to provide education of the services we provide. It will also focus on access and linkage services and supports that eligible individuals can be connected to. These activities will be in multiple towns in our county including tribal events.

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

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

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

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

Coordinated Specialty Care for First Episode Psychosis (CSC) program

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

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

CSC program name
Inyo County Behavioral Health current program staff

CSC program description
As a small frontier county with limited staff, we require all staff (clinicians to case managers) to take training on First Episode Psychosis. All staff must be able to respond to a client's needs when identified. We have requested Technical Assistance for CSC. The first step will be to identify the trainings that are required and begin assigning them to staff. Once staff are trained, we can develop the program policies and procedures for staff to follow. We anticipate that this program will be operational in FY 27/28.

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

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

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	<11*
Number of Uninsured Individuals	0

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	4
Number of Teams Needed to Serve Total Eligible Population	1

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

County Actuals	FY 26-27	FY 27-28	FY 28-29

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	6	6	6
Total Number of Teams	1	1	1

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

Outreach and Engagement (O&E) Program

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

Program or activity name
Outreach and Engagement

Please describe the program or activity
Behavioral Health staff will organize outreach activities to provide education of the services we provide. It will also focus on access and linkage services and supports that eligible individuals can be connected to. These activities will be in multiple towns in our county including tribal events.

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

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

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

County Workforce, Education, and Training (WET) Program

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

Program or activity name
Behavioral Health Training

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

Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9
In Fiscal Year 2025/26, the Behavioral Health team developed a training plan to meet the needs for clinicians, counselors and case managers. Each year we ensure that trainings include a culturally and linguistically competent so that the workforce that can meet the behavioral health needs of individuals of all backgrounds. We will also be looking at training with community partners (i.e. schools, tribal health professionals). We have three Peer Support Specialist positions that are vacant. During the hiring process, we will looking to hire individuals with lived experience with mental health and SUD issues.

Capital Facilities and Technological Needs (CFTN) Program

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

Project name
Information Services Staff Person

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Electronic health record system
Data exchange and interoperability
Data security and privacy
Individual/family access to computing resources
Telemedicine

Please describe the project
We continue to fund 50% of an Information Services staff position to address ongoing technological issues, supporting system maintenance and improvements across programs.

Capital Facilities and Technological Needs (CFTN) Program

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

Project name
Credible EHR

Please select the type of project
Technological needs project

If Technological Needs Project, please select the focus area(s) of the project
Electronic health record system

Please describe the project
Integrated/optimize EHR into Behavioral Health workflows

Capital Facilities and Technological Needs (CFTN) Program

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

Project name
Renovation of Bishop Wellness Center Bathrooms

Please select the type of project
Capital facilities project

If capital facilities project, please indicate which of the following categories the project falls under
Acquiring, renovating, or constructing buildings that are or will be county-owned. The building can be owned and operated by a non-profit if the non-profit is providing behavioral health services under contract with the county.

Please indicate if the project involves leasing or renting to own a building
No

Please describe the project
Improvement of physical infrastructure to deliver higher quality care to clients ultimately improving enrollment, compliance, and outcomes. We are hoping to renovate a bathroom that is used by clients at one of our Wellness Centers. A few years ago, there was some water damage. We are planning to have that damage fixed and the shower available for client's. We have this project on our county's deferred maintenance list and hope that it will be completed before FY 2028/2029.

Full Service Partnership Program

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

---

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

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	39
Number of Uninsured Individuals	<11*
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	21

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

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

ACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	<11*
Number of Uninsured Individuals	0

FACT Eligible Population (ACT with Justice-System Involvement)	Estimates
Number of Medi-Cal Enrolled Individuals	3
Number of Uninsured Individuals	1

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

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

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	0	0	0

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Teams	0	0	0

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

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

FSP ICM Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	30
Number of Uninsured Individuals	<11*

FSP ICM Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	5
Number of Teams Needed to Serve Total Eligible Population	1

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

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

High Fidelity Wraparound (HFW) Eligible Population

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

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	14
Number of Uninsured Individuals	<11*

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	5
Number of Teams Needed to Serve Total Eligible Population	1

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

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

Individual Placement and Support (IPS) Eligible Population

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

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	44
Number of Uninsured Individuals	9

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	5
Number of Teams Needed to Serve Total Eligible Population	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.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	0	0	0
Total Number of Teams	0	0	0

Full Service Partnership (FSP) Program Overview

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

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

Please describe how the estimated practitioners will provide more than one EBP
As a small frontier county with limited staff, we require all staff (clinicans to case managers) to be trained and particpate in required practices (i.e. EBP). All staff must be able to respond to a clients needs when identified.

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports
As an integrated health and human services agency and a small frontier county, all staff are expected to know the resources in our communities. We use staff team meetings to bring in training from partners to provide knowledge of available resources. The CHIP has a project of updating our 211 page and begin using that as a community resource. We provide training to all of our HHS staff on being trauma-informed when working with clients and providing services.

Please describe the county's efforts to reduce disparities among FSP participants
Our department mission is "Strengthening Resilience & Well-Being in our Community". We strive to hire staff with lived experience in our Wellness Centers. We have two Wellness Centers in our county. We offer showers, laundry, SUD and MH classes and case management to clients in each facility. During this reporting period, we will look at the demographic information of clients coming to the wellness centers. We will identify those underserved populations and develop strategies to provide opportunities for them to access our Wellness Centers.

Select which goals the county is hoping to support based on the county's allocation of FSP funding
Access to care
Homelessness
Justice involvement
Untreated behavioral health conditions
Prevention of co-occurring physical health conditions
Social connection
Quality of life

Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM
Clients who have been identified as FSP will continue to receive the same services they had been receiving. As staff are trained on EBPs, they will incorporate those practices into the services they are providing new and old FSP clients. We are rebuilding our Intensive Case Management (ICM) program. We are currently providing transportation, bus passes, assistance with Social Security applications, housing supports, job seeking and socialization. Each identified client identifies 1-2 goals to work on and then staff meet with them weekly/monthly to assist them meet theclient's goals.

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

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.)
We have developed criteria in our FSP process that includes an assessment to determine the level of case management needed. Our FSP program has been rebuilt and lunched in parentship with Kingsview Credible EHR and new P&P will be implemented. As we are rebuilding our FSP process, we have identified several families that have multiple needs. We have reinstituted multidisciplinary teams (MDT) to ensure that all partners are on the same page with treatment and messaging. As the needs of the families are complex, those MDTs are weekly. As the family needs change, we will reduce the staff responses.

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

Primary substance use disorder (SUD) FSPs
No

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)
No

Other recovery-oriented services
No

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"
NA

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

In, or at-risk of being in, the juvenile justice system
We are a small frontier county and work with the Probation Office regularly in Mental Health and SUD. The FSP program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
We are a small frontier county and provide services to all clients requesting needs in the youth population. Staff are offered training to address LGBTQ+ clients needs. The FSP program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population.

In the child welfare system
We are a small frontier county and work with Child Welfare regularly in Mental Health and SUD. We have a monthly foster care meeting to ensure that eligible children and youth are receiving Behavioral Health services. The FSP program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population.

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

Older adults
We are a health and human services department. We work closely with our APS and Senior program staff.

The FSP program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
We are a small frontier county and provide services to all eligible clients. Staff are offered training to address LGBTQ+ clients needs. The FSP program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population.

In, or are at risk of being in, the justice system
We are a small frontier county and work with the Probation Office regularly in Mental Health and SUD. The FSP program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services.

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

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

Existing programs
Inyo SUD

Program descriptions
Existing Program: Inyo County Substance Use Disorder Services
Role in BHSA Requirement: Serves as the core existing platform for outreach, screening, engagement, referral, and initiation into SUD treatment services.
BHSA Service Expansion: Expand field-based engagement capacity, improve assertive outreach workflows, increase coordination with justice, health, and social service partners, and support staff capacity needed to initiate treatment in community-based settings.
Expected Timeline: Planning and gap assessment in the early implementation phase; phased program expansion and workflow development through 2027–2028; full implementation of required assertive field-based SUD treatment initiation elements by July 1, 2029.

Current funding source
DMC, SUBG, 2011 Realignment

BHSA changes to existing programs to meet BHSA requirements
Data tracking and reporting. We will work with our community stakeholders to identify the data that is available for overdose rates, overdose reversals, drug-related arrests and other relevant statistics. Using that data, we will work with our stakeholders to provide community awareness of harm reduction and review our program activities and modify them to meet the assertive field based requirements.

Expected timeline of operation
July 1, 2029

Mobile-field based programs

Existing programs
Mobile Crisis Unit

Program descriptions
Existing Program: Mobile Field-Based Programs – Mobile Crisis Unit
Role in BHSA Requirement: Provides field-based, rapid response services that can identify individuals with substance use needs in real-time and serve as an entry point for screening, engagement, and initiation into SUD treatment services in community settings.
BHSA Service Expansion: Expand the role of the Mobile Crisis Unit to incorporate SUD-specific screening, brief intervention, and direct linkage to treatment services in the field; enhance coordination with SUD providers, law enforcement, EMS, and hospitals; and strengthen protocols for initiating treatment or warm handoffs at the point of contact.
Expected Timeline: Initial integration of SUD screening and referral protocols during early implementation;

expanded field-based SUD engagement capacity and cross-system coordination through 2027–2028; full alignment with assertive field-based SUD initiation requirements by July 1, 2029.

Current funding source
FFP and 1991/2011 Realignment

BHSA changes to existing programs to meet BHSA requirements
Data tracking and reporting. We will have to stand-up the ability for staff to do field-based engagement and identify settings where individuals living with SUD are located. We will work with our stakeholders to provide community awareness of harm reduction and review our program activities and modify them to meet the assertive field based requirements.

Expected timeline of operation
July 1 2029

Open-access clinics

Existing programs
Inyo County Behavioral Health

Program descriptions
Existing Program: Open-Access Clinics – Inyo County Behavioral Health
Role in BHSA Requirement: Provides low-barrier, same-day access points for individuals seeking services, supporting immediate screening, assessment, and initiation into SUD treatment services without requiring prior appointments.
BHSA Service Expansion: Enhance open-access capacity to better integrate SUD screening and same-day treatment initiation; strengthen linkages from field-based contacts (e.g., Mobile Crisis, outreach teams) into clinic-based services; and expand walk-in availability, care coordination, and rapid access to SUD treatment pathways.
Expected Timeline: Strengthening of open-access workflows and SUD integration in the early implementation phase; expanded same-day access and improved coordination with field-based programs through 2027–2028; full implementation of programmatic requirements supporting timely SUD treatment initiation by July 1, 2029.

Current funding source
FFP and 1991/2011 Realignment

BHSA changes to existing programs to meet BHSA requirements
We will have to stand-up the ability for open-access clinics where individuals living with SUD can receive same-day access to screening, assessment and initiation of SUD treatment services. We will look at counselor's schedules and ensure that there is someone available every day to meet this requirement.

Expected timeline of operation
July 1 2029

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
Targeted Outreach for Assertive Field-Based SUD Treatment Services

Program descriptions
New Program: Targeted Outreach for Assertive Field-Based SUD Treatment Services
Role in BHSA Requirement: Establishes a new, dedicated field-based outreach function that builds upon the existing SUD treatment program but expands beyond current service delivery, which is primarily clinic-based, to proactively identify, engage, and initiate individuals with SUD needs who are not currently connected to services.
BHSA Service Expansion: While Inyo County currently operates an SUD treatment program, targeted and assertive field-based outreach is not a formalized service component. BHSA funding will support the development of this new program function by expanding SUD staffing and defining outreach-specific roles (e.g., counselors, peer support specialists, and care coordination staff) to conduct field-based engagement, screening, brief intervention, and direct linkage or initiation into treatment; this includes establishing formal workflows and strengthening partnerships with community and system partners.
Expected Timeline: Program design, staffing expansion, and workflow development in the early implementation phase; phased implementation of field-based outreach services through 2027–2028; full implementation of assertive field-based outreach and SUD treatment initiation capacity by July 1, 2029.

Planned funding
DMC, SUBG, 2011 Realignment

Planned operations
We will have to stand-up the ability for staff to do field-based engagement and identify settings where individuals living with SUD are located. We will work with our stakeholders to provide community awareness of harm reduction and review our program activities and modify them to meet the assertive field based requirements.

Expected timeline of implementation
July 1 2029

Mobile-field based programs

New programs
NA

Program descriptions
NA

Planned funding
NA

Planned operations
NA

Expected timeline of implementation
NA

Open-access clinics

New programs
NA

Program descriptions
NA

Planned funding
NA

Planned operations
NA

Expected timeline of implementation
NA

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

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
We will be working on contracting with local providers who provide MAT services or enter into referral agreements if they don't want to become DMC providers. Our gaps are that there are only two local providers for MAT services and scheduling appointments can lead to delays in the start of treatment. We will work with the local providers to change scheduling practices and work to have same day appointments available.

Select the following practices the county will implement to ensure same day access to MAT
Contract directly with MAT providers in the County
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

What forms of MAT will the county provide utilizing the strategies selected above?
Buprenorphine
Naltrexone
Other

Please specify other forms of MAT
Suboxone

Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question.

Supportive housing
Medium gap

Apartments, including master-lease apartments
Large gap

Single and multi-family homes
Large gap

Housing in mobile home communities
Large gap

(Permanent) Single room occupancy units
Large gap

(Interim) Single room occupancy units
Large gap

Accessory dwelling units, including junior accessory dwelling units
Large gap

(Permanent) Tiny homes
Large gap

Shared housing
Large gap

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

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

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

License-exempt room and board
Large gap

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Large gap

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

Recuperative Care
Large gap

Short-Term Post-Hospitalization housing
Large gap

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

Peer Respite
Large gap

Permanent rental subsidies
Medium gap

Housing supportive services
Medium gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals?
Inyo County Health and Human Services is the lead agency for the local Continuum of Care (Alpine, Inyo and Mono). We are the lead administrator for HMIS. When we took over the CoC administration and received housing funding, we created a housing program within our department. We currently have Social Services and ReEntry funding for eligible clients. In the last year, we have applied for technical assistance for creating a flex pool process. Using that concept, we will screen clients who are referred into the program and determine the funding they are eligible for. As the CoC lead, we also entered into contract with three managed care plans to lead transitional rent for Alpine, Inyo and Mono counties.

Our Housing Authority is based out of San Joaquin county. We regularly attend their meetings virtually to see of housing voucher opportunities for our clients.

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?
Inyo County Health and Human Services is the lead agency for the local Continuum of Care (Alpine, Inyo and Mono). We are the lead administrator for HMIS. When we took over the CoC administration and received housing funding, we created a housing program within our department. We currently have Social Services and ReEntry funding for eligible clients. In the last year, we have applied for technical assistance for creating a flex pool process. Using that concept, we will screen clients who are referred into the program and determine the funding they are eligible for. As the CoC lead, we also entered into contract with three managed care plans to lead transitional rent for Alpine, Inyo and Mono counties.

Our Housing Authority is based out of San Joaquin county. We regularly attend their meetings virtually to see of housing voucher opportunities for our clients.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?
Our housing program develops relationships with landlords of local permanent housing opportunities. However, most local housing opportunities are unaffordable for most clients so we have to consider low income housing that is located in other locations which are typically outside of Inyo. Our housing case worker will work with each client to find affordable housing. This includes supportive services of applying for Social Security Disability; finding a job; getting identification; paying past utility bills; applying for low income utility assistance; applying for CalFresh or MediCal; and/or budget planning. Once a client is placed in permanent housing, we will provide continued case management and subsidies for the first few months. There are regular check-ins before and after housing has been obtained.

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)?
There is currently minimal capital development opportunities in Inyo County. There are discussions about future developments but they have been ongoing plan for over 5 years now with little to no movement. We will continue to participate in those workgroups looking for opportunities to fund capital development that will include low income housing. In the meantime, we will find housing opportunities that our clients can afford and provide subsidies for the first 3-6 months while working on budgeting strategies.

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
Our housing case manager looks at all clients with a Whole Person lens. They will work with the clients to access behavioral health and primary health services. Our housing case worker will work with each client to find affordable housing. Once permanent housing is located, the case worker will ensure that clinical and supportive behavioral health care services are available. This may include a warm handoff when appropriate. Most Mental Health clients have a case manager. That case manager will be a part of the team and included in the housing decision.

Eligible Populations

Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions
As the only Medi-Cal provider in Inyo County for Severely Mental Health services, we will develop a referral process in our system to ensure that clients with housing needs are referred to the internal housing program. As a Health and Human services department, we are trained to know what other programs offer and how to ensure that clients are referred in a timely manner. We will modify our housing program presentation to include BHSA housing and transitional rent programs. This presentation will be given to HHS partners, community partners and the public in the fall 2026.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only?
Yes

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

In, or at-risk of being in, the juvenile justice system
We have regular meetings with Probation in our Mental Health team and SUD team. We have a working relationship with Probation in our housing program due to ReEntry funding for adults. They know the referral process and services available. The housing program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population. We will modify our housing program presentation to include BHSA housing and transitional rent programs. This presentation will be given to HHS partners, community partners and the public in the fall 2026.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
No outreach was done for this population. We participate in multiple collaboratives but Inyo County does not have specific LGBTQ+ groups that have regular meetings. The housing program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population. We will modify our housing program presentation to include BHSA housing and transitional rent programs. This presentation will be given to HHS partners, community partners and the public in the fall 2026.

In the child welfare system
We have regular joint meetings between Child Welfare, Behavioral Health, and other stakeholders to review high-risk cases and ensure families receive comprehensive services before removal becomes necessary. The housing program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population. We will modify our housing program presentation to include BHSA housing and transitional rent programs. This presentation will be given to HHS partners, community partners and the public in the fall 2026.

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

Older adults
We are a Health and Human Services agency. We currently have Social Services funding for Home Safe which are older adults or dependent adults involved with Adult Protective Services. We also work with our Area Agency on Aging programs who serve older adults with supportive and nutritional assistance. The housing program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population. We will modify our housing program presentation to include BHSA housing and transitional rent programs. This presentation will be given to HHS partners, community partners and the public in the fall 2026.

In, or are at risk of being in, the justice system
We have regular meetings with Probation in our Mental Health team and SUD team. We have a working relationship with Probation in our housing program due to ReEntry funding for adults. They know the referral process and services available. The housing program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population. We will modify our housing program presentation to include BHSA housing and transitional rent programs.

This presentation will be given to HHS partners, community partners and the public in the fall 2026.

In underserved communities
As a small frontier county, all of our communities are underserved. We provide services throughout our entire county. The housing program was developed through broader stake holder meetings to address the needs of all clients including this population. As a small frontier county, we don't have a lot of community organizations or social groups that focus on one targeted population. We will modify our housing program presentation to include BHSA housing and transitional rent programs. This presentation will be given to HHS partners, community partners and the public in the fall 2026.

Local Housing System Engagement

How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?
Inyo County Health and Human Services is the lead agency for the local Continuum of Care (Alpine, Inyo and Mono). We are the lead administrator for HMIS. When we took over the CoC administration and received housing funding, we created a housing program within our department. We currently have Social Services and ReEntry funding for eligible clients. In the last year, we have applied for technical assistance for creating a flex pool process. Using that concept, we will screen clients who are referred into the program and determine the funding they are eligible for. As the CoC lead, we also entered into contract with three managed care plans to lead transitional rent for Alpine, Inyo and Mono counties.

Our Housing Authority is based out of San Joaquin county. We regularly attend their meetings virtually to see of housing voucher opportunities for our clients.

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

Local CoC
Inyo County Health and Human Services is the lead agency for the local Continuum of Care (Alpine, Inyo and Mono). We are the lead administrator for HMIS. When we took over the CoC administration and received housing funding, we created a housing program within our department. We currently have Social Services and ReEntry funding for eligible clients.

Public Housing Agency
Our Housing Authority is based out of San Joaquin county. We regularly attend their meetings virtually to see of housing voucher opportunities for our clients.

MCPs
In the last year, we have applied for technical assistance for creating a flex pool process. Using that concept, we will screen clients who are referred into the program and determine the funding they are eligible for. As the CoC lead, we also entered into contract with three managed care plans to lead transitional rent for Alpine, Inyo and Mono counties.

ECM and Community Supports Providers
In the last year, we have applied for technical assistance for creating a flex pool process. Using that concept, we will screen clients who are referred into the program and determine the funding they are eligible for. As the CoC lead, we also entered into contract with three managed care plans to lead transitional rent for Alpine, Inyo and Mono counties. A requirement of transitional rent is that we refer the client for ECM. We have two local ECM/CS providers. We work with them regularly when we have clients in common. Their ability to pay deposits for rentals is limited and delayed.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
Inyo County Health and Human Services is the lead agency for the local Continuum of Care (Alpine, Inyo and Mono). We are the lead administrator for HMIS. When we took over the CoC administration and received housing funding, we created a housing program within our department. We currently have Social Services and ReEntry funding for eligible clients. In the last year, we have applied for technical assistance for creating a flex pool process. Using that concept, we will screen clients who are referred into the program and determine the funding they are eligible for. As the CoC lead, we also entered into contract with three managed care plans to lead transitional rent for Alpine, Inyo and Mono counties.

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?
Our CoC and Inyo County do not receive Homekey+ funding at this time.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
Yes

How will the county coordinate the use of HHAP dollars to support the housing needs of BHSA eligible individuals in your community?
Inyo County Health and Human Services is the lead agency for the local Continuum of Care (Alpine, Inyo and Mono). We are the lead administrator for HMIS. When we took over the CoC administration and received housing funding, we created a housing program within our department. We currently have Social Services and ReEntry funding for eligible clients. The CoC also has access to HHAP funding that is available for all three counties.

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed).
For more information, please see 7.C.9 Allowable expenditures and related requirements.

Rental Subsidies (Chapter 7, Section C.9.1)
The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?
Yes

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

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
<11*

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
<11*

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
<11*

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?
Estimate is using data from other housing programs and the amount of funding available. Estimate is from past PIT counts and historical knowledge of housing availability.

For which setting types will the county provide rental subsidies?
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Non-congregate interim housing models
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Short-Term Post-Hospitalization housing
Time Limited Interim Settings: Peer respite
Non-Time-Limited Permanent Settings: Supportive housing

Will this Housing Intervention accommodate family housing?
Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
We will assist clients with interim and permanent housing. We always only look at permanent housing that is affordable to the client. We look at any structure that meets occupancy standards (ADU, rooms, mobile homes, travel trailers, apartments, or houses)

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?
Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in
Inyo County Health and Human Services is the lead agency for the local Continuum of Care (Alpine, Inyo and Mono). We are the lead administrator for HMIS. When we took over the CoC administration and received housing funding, we created a housing program within our department. We currently have Social Services and ReEntry funding for eligible clients. In the last year, we have applied for technical assistance for creating a flex pool process. Using that concept, we will screen clients who are referred into the program and determine the funding they are eligible for. As the CoC lead, we also entered into contract with three managed care plans to lead transitional rent for Alpine, Inyo and Mono counties. We will not Master Lease because there is limited stock of apartments that affordable for clients and limited funds that having a master lease and no one in the apartment is not spending the money wisely.

Total number of units funded with BHSA Housing Interventions per year
10

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
NA

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
Our CoC provides operating subsidies to the very small amount of low income housing units in our three counties. The one housing facility in our county is for older adults and has financial issues that have not been corrected and the future of the facility is unknown.

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
<11*

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
We currently work with many of the landlords with local rental options. We don't provide financial incentives to landlords due to being a frontier county and perceived conflicts of interest. We are working with our County Counsel to develop a Landlord Partnership Program that will allow a landlord to apply for reimbursement for up to $5,000 of damange done by one of our clients.

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

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

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
<11*

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
We will work with our clients to complete rental applications, credit checks, security deposits and utility deposits. If a client is currently housed, they are our priority to keep them housed by providing support with rent and utility arrears. We will also work with them on budgeting.

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)

Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2), **BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
<11*

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
We will fund our housing Integrated Case Worker out of BHSA funds to provide housing navigation and tenancy sustaining services to clients in Behavioral Health. We will also redirect case management staff to assist with these services and support the clients.

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

Is the county providing this intervention?
Yes

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

Anticipated number of individuals served per year
<11*

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
We will fund our housing Integrated Case Worker out of BHSA funds to provide housing outreach and engagement services to clients in Behavioral Health. We will also redirect case management staff to assist with these services and support the clients. Our housing case worker will work with each client to find affordable housing. This includes supportive services of applying for Social Security Disability; finding a job; getting identification; paying past utility bills; applying for low income utility assistance; applying for CalFresh or MediCal; and/or budget planning. Once a client is placed in permanent housing, we will provide continued case management and subsidies for the first few months. There are regular check-ins before and after housing has been obtained.

Capital Development Projects (Chapter 7, Section C.10)

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
No

Please explain why the county is not providing this intervention
There is currently minimal capital development opportunities in Inyo County. There are discussions about future developments but they have been ongoing plan for over 5 years now with little to no movement. We will continue to participate in those workgroups looking for opportunities to fund capital development that will include low income housing.

Other Housing Interventions

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

Is the county providing this intervention to chronically homeless individuals?
No

Anticipated number of individuals served per year
0

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
If there is a housing program that is ending, we will look at the current clients being assisted and move them to other programs if they are eligible. BHSA may be used if Home Safe funding ends. We did not use BHBH monies for housing assistance. Our BHBH monies was used for room and board charges. We may consider this use in future years.

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services.

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?
Housing Transition Navigation Services
Housing Deposits
Transitional Rent

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

Housing Transition Navigation Services
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
1/1/2026

Housing Deposits
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
1/1/2026

Housing Tenancy and Sustaining Services
No

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Yes

When does the county behavioral health system plan to become an MCP-contracted provider?
1/1/2026

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs **(including Transitional Rent)?**
Our housing program is already contracted with our Managed Care plans for transitional rent and a few housing community support services. We have a referral process in place and will be standing up the Managed Care plans in the next few months.

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
Our housing program is already contracted with our Managed Care plans for transitional rent and a few housing community support services. We have a referral process in place and will be standing up the Managed Care plans in the next few months.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?
No

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?
Our housing program is already contracted with our Managed Care plans for transitional rent and a few housing community support services. We have a referral process in place and will be standing up the Managed Care plans in the next few months. We will use HMIS to track clients program use and be able to move them to BHSA funding after Transitional Rent has been exhausted.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource. Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools.

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
Yes

Is the county behavioral health system participating in or planning to participate in the Flex Pool?
Yes

What role does the county behavioral health system have or plan to have in the Flex Pool?
Housing Supportive Services Provider

What organization is serving as the Operator?
Inyo County Health and Human Services as the lead agency for the CoC (Alpine, Inyo and Mono)

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?
Yes

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?
Rental Subsidies
Operating Subsidies
Landlord Outreach and Mitigation Funds
Participant Assistance Funds
Housing Transition Navigation Services and Tenancy and Sustaining Services

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
NA

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

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

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

Workforce Strategy

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

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served. Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

Maintains and monitors **a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and**

Meets federal and state standards **for timely access to care and services, considering the urgency of the need for services.**

The county must ensure **that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.**

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

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

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training.

Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
24

Upload any data source(s) used to determine vacancy rate

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

Please describe any other key workforce gaps in the county
We are very fortunate to have only one Mental Health clinician vacancy at this time. We do have a student intern who will be eligible to apply in the next few months. We also have an Addiction Counselor and Addiction Counselor Supervisor vacancy that have been vacant for over 6 months. We have added an Addiction Counselor trainee to our career ladder recently and hope to hire in the next month.

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)?
The county believes it will be able to effectively train its workforce in evidence-based practices to meet the requirements of Behavioral Health Transformation (BHT) and BH-CONNECT. Through targeted training investments, ongoing supervision, and integration of fidelity monitoring, staff will be supported in adopting and sustaining these practices across programs. We are developing an orientation and training plan for the Behavioral Health division. This will ensure that all current employees and new employees are aware of the requirements and changes.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
No

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training
We currently use a team meeting each month to provide training. Those trainings have included on-call process, Narcan administration, other programs coming in to discuss the services they provide and other business practices. We will continue with monthly trainings in our team meetings and will use the training plan drafted in FY 25/26 to plan the trainings for the next three years.

Budget and Prudent Reserve

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

Budget and Prudent Reserve

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

Please upload the completed budget template
March 31st 2026 Draft Submission - Inyo County_Integrated Plan Budget Template Version 3_2026-03-31.xlsx
Inyo Integrated-Plan-Budget-Template_v3 04.06.26.xlsx

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

Behavioral Health Services and Supports (BHSS)
NA

Full Service Partnership (FSP)
NA

Housing Interventions
NA

Enter date of last prudent reserve assessment
3/29/2026

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

BHSS
NA

FSP
NA

Housing Interventions
NA

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
Behavioral Health Director Certification UNSIGNED.pdf
Behavioral Health Director Certification SIGNED.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
County Administrator or Designee Certification UNSIGNED.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
Board of Supervisors Certification UNSIGNED.pdf
Confirm that the data is up to date and reflects the correct information for a Draft Plan

Requests

Behavioral Health Services Fund (BHSF) Housing Intervention Component

What percentage of funds is the county requesting to utilize for the Housing Intervention Component?
15

Of the percentage of funds above or below the required 30 percent being utilized for Housing Interventions, identify which allocation components and the percentage the funding will transfer from or into

Components	Percentage of funds transferring
Full Service Partnerships	0
Behavioral Health Services and Supports	15

Please select which Housing Interventions exemptions criteria the county meets
Other considerations

Other considerations
Requesting time to build the program and reassign staff.

Please provide justification for your request
Inyo County Health and Human Services currently has a housing program and is the lead agency for the regional Continuum of Care (CoC). We currently utilize Social Services and County Corrections Program funds for our housing assistance. We would like to build the BHSA housing funds into our already established program. Since we are building the program out, it will take some time to get it fully functional and would like to ease into this with all the changes we are making.

We have entered into contracts with our two management care plans to provide transitional rent in Inyo County. This program is just beginning.

Supporting data

Please upload supporting data
CoC_Dash_CoC_CA-530-2023_CA_2023.pdf

What is the data source?
Point in time count

Housing Intervention Funds for Chronically Homeless

What percentage of Housing Intervention Component allocation is the county requesting to use for those who are chronically homeless?
25

Please select which Housing Interventions exemptions criteria the county meets
Other considerations

Please provide justification for your request:
Inyo County Health and Human Services currently has a housing program and is the lead agency for the regional Continuum of Care (CoC). We currently utilize Social Services and County Corrections Program funds for our housing assistance. We would like to build the BHSA housing funds into our already established program. Since we are building the program out, it will take some time to get it fully functional and would like to ease into this with all the changes we are making.

We have entered into contracts with our two management care plans to provide transitional rent in Inyo County. This program is just beginning.

Supporting Data

Please upload supporting data
Housing Data Presentation updated 02.05.2026.pdf

What is the data source?
Homeless Management Information System Data

Assertive Community Treatment (ACT)

Justification for appeal

Describe your reason for appeal
Requesting Technical assistance for this request for an exemption.

Upload files

For counties seeking an exemption to the requirement to include ACT in the county's FSP program

Please select which FSP exemptions criteria the county meets
Limited workforce (e.g. qualified providers)
Limited need (e.g., estimated population with a clinical need for ACT)

Please provide justification for this FSP exemption request
As a small rural county, we are unable to staff or train to this level at this time. We will be looking to be compliant by July 2029.

Supporting Data

Please upload supporting data
Inyo population data.pdf

Please select the data source
County demographic data

Forensic Assertive Community Treatment (FACT)

Justification for appeal

Describe your reason for appeal
Requesting Technical assistance for this request for an exemption.

Upload files

For counties seeking an exemption to the requirement to include FACT in the county's FSP program

Please select which FSP exemptions criteria the county meets
Limited workforce (e.g. qualified providers)
Limited need (e.g., estimated population with a clinical need for FACT)

Please provide justification for this FSP exemption request
As a small rural county, we are unable to staff or train to this level at this time. We will be looking to be compliant when required.

Supporting Data

Please upload supporting data
Inyo population data.pdf

Please select the data source
County demographic data

Individual Placement and Support (IPS) Supported Employment

Justification for appeal

Describe your reason for appeal
Requesting Technical assistance for this request for an exemption.

Upload files

For counties seeking an exemption to the requirement to include IPS in the county's FSP program

Please select which FSP exemptions criteria the county meets
Limited workforce (e.g. qualified providers)
Limited need (e.g., estimated population with a clinical need for IPS)

Please provide justification for this FSP exemption request
As a small rural county, we are unable to staff or train to this level at this time. We will be looking to be compliant when required.

Supporting Data

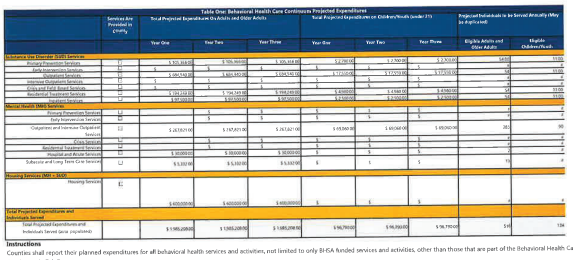
Please upload supporting data
Inyo population data.pdf

Please select the data source
County demographic data

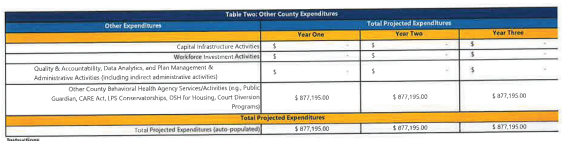
Data Suppression Notice:
Values marked with "*" have been suppressed per DHCS de-identification standards. Counts between 1–10 are displayed as "<11"

Instructions
Counties shall report their planned expenditures for all behavioral health funding sources, For Annual Updates, counties should review and make updates only to the next fiscal year
Column C: counties shall indicate whether they provide each category of services using th
Columns D through I: counties shall include their estimated total expenditures for the Int by each Behavioral Health Care Continuum category. Counties should consider children/y
Columns J and K: counties shall input their estimated total count of all individuals served These counts may be duplicated. Counties should consider eligible children/youth as 21 a
Row 38: the total projected expenditures in columns D through I and total projected indi
Note: For a list of all funding streams that should be included in the projected expenditur Services Act (BHSA) County Policy Manual Chapter 3, Section A.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all app regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must pr in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-fund Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbur These policies apply only to non-Housing services that are eligible for both BHSA funding

	Services Are Provided in County	Total Projected Expenditures On Adults and Older Adults (Year One)
Substance Use Disorder (SUD) Services		
Primary Prevention Services	☑	$ 105,366.00
Early Intervention Services	☐	$ -
Outpatient Services	☑	$ 819,168.00
Intensive Outpatient Services	☐	$ -
Crisis and Field-Based Services	☐	$ -
Residential Treatment Services	☐	$ 125,000.00
Inpatient Services	☐	$ -
Mental Health (MH) Services		
Primary Prevention Services	☐	$ -
Early Intervention Services	☐	$ -
Outpatient and Intensive Outpatient Services	☑	$ 4,540,798.00
Crisis Services	☑	$ 170,000.00
Residential Treatment Services	☐	$ -



Instructions
Counties shall report their planned expenditures for all behavioral health services and activities, not limited to only BHSA funded services and activities, other than those that are part of the Behavioral Health Care Continuum in Tab Two.
Rows 18 through 21: counties shall include their estimated total expenditures for the Integrated Plan period across all behavioral health funding sources and programs for each category listed. These costs are those that do not easily fit under the categories in Tab One, "BH CoC Expenditures."
Row 23: total projected expenditures will be auto-populated from rows 18 through 21.
For a list of all funding streams that should be included in the projected expenditures calculation for Table Two: Other County Expenditures please see the Behavioral Health Services Act County Policy Manual Chapter 3 Section A.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.



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 Medi-Cal), 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	$ -	$ -	$ -
1991 Realignment (Bronzan-McCorquodale Act)	$ -	$ -	$ -
2011 Realignment (Public Safety Realignment)	$ 564,352.00	$ 564,352.00	$ 564,352.00
State General Fund	$ -	$ -	$ -
FFP (SMHS, DMC/DMC-ODS, NSMHS)	$ 145,501.00	$ 145,501.00	$ 145,501.00
Projects for Assistance in Transition from Homelessness (PATH)	$ -	$ -	$ -
Community Mental Health Block Grant (MHBG)	$ 336,881.00	$ 336,881.00	$ 336,881.00
Substance Use Block Grant (SUBG)	$ 432,264.00	$ 432,264.00	$ 432,264.00
Commercial Insurance	$ -	$ -	$ -
County General Fund	$ -	$ -	$ -
Opioid Settlement Funds	$ 315,000.00	$ 315,000.00	$ 315,000.00
Other Funding Sources	**Total Annual Projected Expenditures (Year One)**	**Total Annual Projected Expenditures (Year Two)**	**Total Annual Projected Expenditures (Year Three)**
Other federal grants	$ 10,815.00	$ 10,815.00	$ 10,815.00
Other state funding (including DSH funding)	$ 995,950.00	$ 995,950.00	$ 995,950.00
Other county mental health or SUD funding	$ 158,430.00	$ 158,430.00	$ 158,430.00
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)	$ 2,959,193.00	$ 2,959,193.00	$ 2,959,193.00
Total Projected Expenditure Variance	$ -	$ -	$ -
Auto-validation: Table 1: Behavioral Health Care Continuum Projected Expenditures	$ 2,081,998.00	$ 2,081,998.00	$ 2,081,998.00
Auto-validation: Table 2: Other County Expenditures	$ 877,195.00	$ 877,195.00	$ 877,195.00

Instructions
Counties shall report their base BHSA funding allocations, approved Housing Intervention Component Exemptions, and planned transfers on this sheet. **All counties must complete this sheet. Rows 39-41:** input your county's base BHSA funding allocation by component and year
Rows 45-54: this section will be auto populated from the sections below it
Rows 45, 50, and 53: the total adjusted allocation percentages for each component, inclusive of both exemptions and transfers
Rows 46, 51, and 54: is the projected amount of funding, in dollars, based on the adjusted total allocation percentages
Row 47: reflects the unspent MHSA funding that will be transferred to each of the Behavioral Health Services Act (BHSA) component allocations
Row 48: reflects the excess prudent reserve funding that will be transferred to each of the BHSA components
Rows 59, 82, and 105: the base funding amount for Housing Interventions will auto populate from Column C, rows 39-41
Rows 60, 83, and 106: if your county has an approved housing exemption, enter the percent of funds you are moving out of Housing Interventions into the other components. Enter this percentage as a positive value. It will automatically display as a negative value in the cell
Rows 61, 84, and 107: if your county has an approved housing exemption, enter the percent of funds you are moving out of the other components and into Housing Interventions. Enter this percentage as a positive value
Rows 64, 87, 110: the base funding amount for Full Service Partnerships will auto populate from Column D, rows 39-41
Rows 69, 92, 115: the base funding amount for Behavioral Health Services and Supports will auto populate from Column E, rows 39-41
Rows 65, 70, 88, 93, 111, and 116: enter the percentage transferred out of Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS) into Housing Interventions, respectively. **Rows 66, 71, 89, 94, 112, and 117:** enter the percentage transferred from Housing Interventions into Full Service Partnerships (FSP) and Behavioral Health Services and Supports (BHSS), respectively. **Rows 75, 98, 121:** the updated base percentage will be auto populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states "Row Equals 100%."
Rows 76, 99, 122: enter the amount you are transferring out of each component as a positive number. It will automatically display as a negative value. Ensure the validation states, "Row Does Not Exceed 14%."
Rows 77, 100, 123: enter the amount you are transferring into each component as a positive number. Ensure the validation states, "Transfers Out and In Equal."
Note: If your county plans to use Housing Intervention funds (up to 7 percent) to provide outreach and engagement, the amount of funds the county can transfer out of the Housing Intervention component (Row 76) must be decreased by the corresponding amount. Counties will document the amount dedicated to outreach and engagement in Tab 5 Housing Interventions
Rows 78, 101, 124: the updated base percentage will be auto populated for Housing Interventions, FSP, and BHSS, respectively. Ensure the validation states, "Row Equals 100%."
Rows 127-132: enter the amount of MHSA funds by component allocation transferring to each BHSA component. Encumbered unspent MHSA funds tied to WET, CFTN, or INN should be included. Unencumbered INN funds should also be included. Please see Policy Manual Chapter 6, Section 7 for additional information
Row 133: the total dollar amount of MHSA Transfers to BHSA is auto populated. **Row 136:** enter the dollar amount of prior year prudent reserve ending balance. **Row 137:** enter the prudent reserve maximum for your county
Row 138: the dollar amount of excess prudent reserve funding to be transferred out of the prudent reserve will auto populate. **Negative values indicate no transfer is necessary. Rows 139-141:** enter the amount of excess prudent reserve funds allocated to each component
Row 142: the total transferred excess prudent reserve is auto populated
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA funded providers to
bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance.
These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Four: BHSA Transfers

County Base BHSA Funding Allocations	Housing Intervention	Full-Service Partnership	Behavioral Health Services and Support	Total
Year 1 Component Allocation (dollars)	$ 697,815.00	$ 814,118.00	$ 814,118.00	$ 2,326,051.00
Year 2 Component Allocation (dollars)	$ 697,815.00	$ 814,118.00	$ 814,118.00	$ 2,326,051.00
Year 3 Component Allocation (dollars)	$ 697,815.00	$ 814,118.00	$ 814,118.00	$ 2,326,051.00
Summary (auto-populated)	**Housing Intervention**	**Full-Service Partnership**	**Behavioral Health Services and Support**	**Totals**
Year One				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	0%	35%	65%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ -	$ 814,118.00	$ 1,511,933.43	$ 2,326,051.43
Unspent Mental Health Services Act (MHSA) to BHSA	$ -	$ -	$ -	$ -
Excess Prudent Reserve (PR) to BHSA	$ -	$ -	$ -	$ -
Year Two				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	0%	35%	65%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ -	$ 814,118.00	$ 1,511,933.43	$ 2,326,051.43
Year Three				
Adjusted Total Allocation Percentages (Exemptions and Transfers)	0%	35%	65%	100%
Projected Component Allocation (Based on Adjusted Allocation Percentages)	$ -	$ 814,118.00	$ 1,511,933.43	$ 2,326,051.43

Funding Transfer Request Allocations

Year 1

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 697,815.00
Percentage Reduced	30%	$ 697,815.00
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto populated)	0%	$ -
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 814,118.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto populated)	35%	$ 814,118.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 814,118.00
Percentage Reduced	0%	$ -
Percentage Added	30%	$ 697,815.43
New BHSS Base Percentage (auto populated)	65%	$ 1,511,933.43

Transfers	Housing Intervention (1)	Full-Service Partnership	Behavioral Health Services and Support	Validation
Base Percentage after Housing Intervention Component Exemption (auto populated)	0%	35%	65%	
Amount Transferring Out	0%	0%	0%	
Amount Transferring In	0%	0%	0%	
New Base Percentage after Funding Transfer Request (auto populated)	0%	35%	65%	

Year 2

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 697,815.00
Percentage Reduced	30%	$ 697,815.00
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto populated)	0%	$ -
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 814,118.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto populated)	35%	$ 814,118.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 814,118.00
Percentage Reduced	0%	$ -
Percentage Added	30%	$ 697,815.43
New BHSS Base Percentage (auto populated)	65%	$ 1,511,933.43

Transfers	Housing Intervention (1)	Full-Service Partnership	Behavioral Health Services and Support	Validation
Base Percentage after Housing Intervention Component Exemption (auto populated)	0%	35%	65%	
Amount Transferring Out	0%	0%	0%	
Amount Transferring In	0%	0%	0%	
New Base Percentage after Funding Transfer Request (auto populated)	0%	35%	65%	

Year 3

Behavioral Health Services Fund (BHSF) Housing Intervention Component Exemption (Ability to change component's overall percentage)		
Base Component	**Housing Intervention Percentage**	**Housing Intervention Funds**
Base Percentage and Funding	30%	$ 697,815.00
Percentage Reduced	30%	$ 697,815.00
Percentage Added	0%	$ -
New Housing Interventions Base Percentage (auto populated)	0%	$ -
Transferred To/From	**Full Service Partnership Percentage**	**Full Service Partnership Funds**
Base Percentage and Funding	35%	$ 814,118.00
Percentage Reduced	0%	$ -
Percentage Added	0%	$ -
New FSP Base Percentage (auto populated)	35%	$ 814,118.00
Transferred To/From	**Behavioral Health Services and Support Percentage**	**Behavioral Health Services and Support Funding**
Base Percentage and Funding	35%	$ 814,118.00
Percentage Reduced	0%	$ -
Percentage Added	30%	$ 697,815.43
New BHSS Base Percentage (auto populated)	65%	$ 1,511,933.43

Transfers	Housing Intervention (1)	Full-Service Partnership	Behavioral Health Services and Support	Validation
Base Percentage after Housing Intervention Component Exemption (auto populated)	0%	35%	65%	
Amount Transferring Out	0%	0%	0%	
Amount Transferring In	0%	0%	0%	
New Base Percentage after Funding Transfer Request (auto populated)	0%	35%	65%	

MHSA Transfers to BHSA

MHSA Component	Available Unspent BHSA Funds	Transferred to Housing Intervention	Transferred to Full-Service Partnership	Transferred to Behavioral Health Services and Support
CSS	$ 2,438,582.40	$ -	$ -	$ -
PEI	$ -	$ -	$ -	$ -
Encumbered INN	$ -	$ -	$ -	$ -
Unencumbered INN	$ 450,724.00	$ -	$ -	$ -
WET	$ -			$ -
CFTN	$ -			$ -
Total (auto populated)	$ 2,889,306.40	$ -	$ -	$ -

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	$ 479,169.03
Local Prudent Reserve Maximum (2)	$ 500,534.08
Excess Prudent Reserve Funding that must be transferred	($ 21,365.05)
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)(1) (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)(3)(B) states prudent reserve funding cannot be spent on capital development
4. W&I Code § 5892, subdivision (b)(3)(A) states counties must spend prudent reserve funds on Housing Intervention, FSP, and/or BHSS programs or services only.

Instructions
Counties shall report their projected expenditures for their BHSA Housing Interventions allocation component. Counties shall report projected expenditures for all other non-BHSA funding sources in Tab Five.
Rows 40-43: input the estimated total Housing Intervention component allocation received for each year. Row 40 will auto-populate from Tab Four in the BHSA Transfers tab. Input unspent MHSA dollars carried over to this component into row 42. Row 43 will auto-populate the sum of rows 40-42 to account for total funding
Row 41: input the total dollar amount projected to be added to Housing Intervention component funds from the prudent reserve, if applicable. If you reported on Tab 4, row 139 that you will be transferring excess PR funds to Housing Interventions please report them here
Rows 49-66: input the projected expenditures for each Housing Intervention component service category or program for each year
Row 48: the aim of Housing Interventions is to help individuals achieve permanent housing stability. To the maximum extent possible, counties should seek to place individuals in permanent housing settings. Housing Interventions may only be used for placement in interim settings for a limited time, 6 months for BHSA eligible individuals who have exhausted the Transitional Rent benefit and 12 months for BHSA eligible individuals not eligible to receive Transitional Rent through their Medi-Cal MCP.
Row 53: pursuant to W&I Code section 5830, subdivision (c)(2), BHSA Housing Interventions may not be used for housing services covered by Medi-Cal Managed Care Plans (MCP). Please indicate the projected expenditures for BHSA funding ONLY in columns C, D, and E. Please indicate the projected expenditures for all other funding sources excluding BHSA in columns F, G, and H.
Row 65: input expenditures for BHSA-funded innovation pilots or projects
Row 66: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above
Row 67: the sub-total will be auto-populated, excluding the percentage of rental and operating subsidies administered through Flex Pools
Row 69: input the total dollar amount projected to be transferred out of Housing Intervention component funds into the prudent reserve
Row 71: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6, BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs)
Row 72: the overall total of Housing Intervention expenditures will be auto-populated from rows 67, 69, and 71
Row 74: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to the chronically homeless population. This amount should equal 50% of Housing Interventions component allocation
Row 75: input the total dollar amount for Housing Intervention component programs and services that will be dedicated to serving individuals with only a substance use disorder, if provided by the county. DHCS recognizes there may be duplication with funds captured in row 74.
Row 77: the proportion of funds dedicated to capital development will be auto-populated.
Row 78: the proportion of funds dedicated to the chronically homeless population will be auto-populated. **Row 79:** the proportion of funds dedicated to Outreach and Engagement will be auto-populated
Rows 81-82: input the estimated unduplicated count of individuals that will be served across all Housing Intervention component services
Row 84: auto-populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA HI component for each year.
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual
2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to
seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Five: BHSA Components

Total Housing Interventions Funding (1)	Year 1	Year 2	Year 3
Total Estimated Housing Intervention Funding Received (BHSA Funds)	$ -	$ -	$ -
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)	$ -	$ -	$ -

Type of Service	Projected Expenditures - Unspent MHSA and BHSA Funding Only: Year 1	Year 2	Year 3	Projected Expenditures - All Other Funding Sources: Year 1	Year 2	Year 3
Housing Interventions Component Programs/Services						
Non-Time Limited Permanent Settings (e.g., supportive housing, apartments, single and multi-family homes, shared housing) (3)						
Rental Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
Bundled Rental and Operating Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
% of Rental and Operating Subsidies Administered through Flex Pools	0%	0%	0%	0%	0%	0%
Time Limited Interim Settings (e.g., hotel and motel stays, non-congregate interim housing models, recuperative care) (2)						
Rental Subsidies	$ -	$ -	$ -	$ -	$ -	$ -
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)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Participant Assistant Funds (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Housing Transition Navigation Services and Housing Tenancy Sustaining Services (2)	$ -	$ -	$ -	$ -	$ -	$ -
Other Housing Supports: Outreach and Engagement (2)	$ -	$ -	$ -	$ -	$ -	$ -
Capital Development Projects	$ -	$ -	$ -	$ -	$ -	$ -
Housing Flex Pool Expenditures (start-up expenditures)	$ -	$ -	$ -	$ -	$ -	$ -
BHSA Innovative Housing Intervention Pilots and Projects	$ -	$ -	$ -	$ -	$ -	$ -
MHSA INN Projects	$ -	$ -	$ -	$ -	$ -	$ -
Subtotal (auto-populated)	$ -	$ -	$ -	$ -	$ -	$ -

Housing Interventions Transfer Information	Year 1	Year 2	Year 3
Transfers out of Housing Intervention component into Local Prudent Reserve (6)	$ -	$ -	$ -
Housing Interventions Component Administrative Information	**Year 1**	**Year 2**	**Year 3**
Housing Interventions Component Admin Expenses	$ -	$ -	$ -
Total Housing Interventions Expenditures (auto-populated)	$ -	$ -	$ -
Housing Interventions Populations to be Served	**Year 1**	**Year 2**	**Year 3**
Total Housing Interventions Component Funds Dedicated to Chronically Homeless Population (5)	$ -	$ -	$ -
Total Housing Interventions Component Funds Dedicated to Serving Individuals with a SUD only (5)	$ -	$ -	$ -
Housing Interventions Component Funds Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**
Housing Intervention Component Funds Dedicated to Capital Development/Total Housing Interventions Funding (7) (auto-populated)	#DIV/0!	#DIV/0!	#DIV/0!
Housing Interventions Component Funds Dedicated to Chronically Homeless Population/Total Housing Intervention Component Funding (8) (auto-populated)	#DIV/0!	#DIV/0!	#DIV/0!
Housing Interventions Component Funds Used for Outreach and Engagement (2) (auto-populated)	#DIV/0!	#DIV/0!	#DIV/0!
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)	#	#	#
Eligible Adults/Older Adults	#	#	#
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
MHSA "Encumbered" INN	$ -	$ -	$ -

References

1. W&I Code § 5892, subdivision (a)(1)(A)(i) states 30% of BHSA funds distributed to counties shall be used for Housing Interventions
2. See Policy Manual Section 7.C.9 Allowable Expenditures and Related Requirements for further information regarding allowable Housing Interventions expenditures
3. Single room occupancy and recovery housing can be interim or permanent. If interim, Housing Interventions is limited to 6 months for those who have exhausted Transitional Rent or 12 months for those not eligible for Transitional Rent. Appendix B of the Policy Manual includes a crosswalk of coverage by select programs
4. Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) and does not include behavioral health residential treatment settings
5. Counties must provide Housing Intervention services to eligible children, youth, and adults (defined in W&I Code section 5892) who are chronically homeless, experiencing homelessness, or at risk of homelessness. The provision of BHSA-funded Housing Interventions specifically for individuals with a substance use disorder is optional for counties, per W&I Code section 5891, subdivision (a)(2)
6. W&I Code § 5892, subdivision (b)(2)
7. W&I Code § 5892, subdivision (a)(1)(A)(iii) states no more than 25% of Housing Interventions funds may be used for capital development
8. W&I Code § 5892, subdivision (a)(1)(A)(ii) states 50% of Housing Interventions funds shall be used for housing interventions for persons who are chronically homeless, with a focus on those in encampments

Instructions
Counties shall report their projected expenditures of their Full Service Partnership (FSP) funding for their BHSA allocation component, federal financial participation, and all other non-BHSA funding sources in Tab Six
Rows 25-28: input the total estimated FSP component allocation received for each year. Row 25 will auto populate from Tab Four in the BHSA Transfers tab. Input unspent MHSA dollars carried over to this component into row 27. Row 28 will auto populate the sum of rows 25-27 to account for total funding
Row 26: input the total dollar amount projected to be added to FSP from the prudent reserve, if applicable. If you reported on Tab 4, row 140 that you will be transferring excess PR funds to FSP please report them here
Rows 33-42: input the projected expenditures for each FSP service category or program for each year
Note: DHCS expects other required uses of FSP funding (e.g., mental health services, supportive services, substance use disorder (SUD) treatment services, ongoing engagement services) to be captured within rows 33-38. Any mental health and supportive service or SUD treatment service expenditures not included in these rows should be accounted for in rows 39-40 accordingly
Row 41: input expenditures for BHSA funded innovation pilots or projects
Row 42: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above
Row 43: the subtotal of FSP programs/services will be auto populated from rows 33-42
Row 45: input the total dollar amount projected to be transferred out of FSP into the prudent reserve
Row 47: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6, BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs)
Row 48: total projected expenditures for FSP for each year will be auto populated from rows 43, 45, and 47.
Rows 50 and 51: input the estimated unduplicated count of individuals that will be served across all FSP programs
Row 53: auto populates projected estimated amount of MHSA Encumbered INN funds that will be available in the BHSA FSP component for each year
Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual
2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance
These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Six: BHSA Components

Total Full Service Partnership (FSP) Funding	Year 1	Year 2	Year 3
Total Estimated Full Service Partnership Funding Received (BHSA Funds)	$ 814,118.00	$ 814,118.00	$ 814,118.00

	Year 1	Year 2	Year 3
Transfers into Full Service Partnership component from Local Prudent Reserve	$	$	$
Total Estimated Full Service Partnership Funding Allocated (MHSA - Unspent Carryover Funds)	$	$	$
Total Estimated Full Service Partnership Funding (BHSA + MHSA Funds)	$ 814,118.00	$ 814,118.00	$ 814,118.00

Type of Service	Full Service Partnership Category (1) Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - Federal Financial Participation			Projected Expenditures - All Other Funding Sources		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
FSP Programs/Services									
Assertive Community Treatment (ACT)(2)		$	$	$	$	$	$	$	$
Forensic Assertive Community Treatment (FACT) Fidelity (2)	$	$	$	$	$	$	$	$	$
FSP Intensive Case Management	$ 603,410.00	$ 603,410.00	$ 603,410.00	$	$	$	$	$	$
High Fidelity Wraparound	$	$	$	$	$	$	$	$	$
Individual Placement and Support (IPS) Model of Supported Employment (2)	$	$	$	$	$	$	$	$	$
Assertive Field Based Initiation for SUD Treatment Services	$ 100,000.00	$ 100,000.00	$ 100,000.00	$	$	$	$	$	$
Other mental health or supportive services not already captured above (e.g. outreach, other recovery oriented services, peers, etc.) Please define	$	$	$	$	$	$	$	$	$
Other substance use disorder treatment services not already captured above (primary SUD FSP programs, innovation, etc.) Please define	$	$	$	$	$	$	$	$	$
BHSA Innovative FSP Pilots and Projects	$	$	$	$	$	$	$	$	$
MHSA INN Projects	$	$	$	$	$	$	$	$	$
Subtotal (auto-populated)	$ 703,410.00	$ 703,410.00	$ 703,410.00	$	$	$	$	$	$

FSP Transfer Information	Year 1	Year 2	Year 3
Transfers out of FSP component into Local Prudent Reserve	$	$	$
FSP Administrative Information	**Year 1**	**Year 2**	**Year 3**
FSP Component Admin Expenses	$ 110,708.00	$ 110,708.00	$ 110,708.00
Total Full Service Partnership Expenditures (auto-populated)	$ 814,118.00	$ 814,118.00	$ 814,118.00
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)			
Eligible Adults/Older Adults			
Projected MHSA-Origin Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
MHSA "Encumbered" INN	$	$	$

References
1. W&I Code § 5892, subdivision (a)(2)(A) states 35% of BHS funds distributed to counties shall be used for Full Service Partnership Programs
2. May be bundled or un-bundled depending on county BH CONNECT opt in

Instructions

Counties shall report their projected expenditures of their Behavioral Health Services and Supports funding for their BHSA allocation component, federal financial participation, and all other non BHSA funding sources in Tab Seven

Row 27-30: input the total estimated BHSS component allocation received for each year. Row 27 will auto populate from Tab Four in the BHSA Transfers tab

Row 28: input the total dollar amount projected to the BHSS funding component from the prudent reserve (if applicable). If you reported on Tab 4, row 141 that you will be transferring excess PR funds to BHSS please report them here Input unspent MHSA dollars carried over to this component into row 29. Row 30 will auto populate the sum of rows 27-29

Rows 35-48: input the projected expenditures for each BHSS service category or program for each year. Rows 37, 41, and 44 auto populate from their sub rows

Row 47: input expenditures for BHSA funded innovation pilots or projects

Row 48: input expenditures for any encumbered MHSA INN Projects with services that do NOT align with the sub-allocations above

Row 49: the subtotal for projected expenditures will be auto populated from rows 35 - 37, 40, 41, 44, 47, and 48

Row 51: input the total dollar amount projected to be transferred out of the BHSS funding component into the prudent reserve

Row 53: enter the total amount of direct and indirect costs required to implement this component. (See Policy Manual Chapter 6 BHT Fiscal Policies, Section B.8.2 Direct Costs and Indirect Costs)

Row 54: the total for projected BHSS expenditures will be auto populated from rows 49, 51, and 53

Row 56: input the total dollar amount of Youth Focused (25 years and younger) Early Intervention Expenditures

Row 58: the proportion of EI funds will auto populate from rows 30 and 37. Note: MHSA WET, INN and CF/TN funds in Rows 67-69 will be deducted from the revenue (excluded from the denominator)

Row 59: the proportion of Youth Focused (25 years and younger) EI funds will auto populate from rows 37 and 56. **Rows 61-62:** input the estimated unduplicated count of individuals that will be served across all BHSA funded programs **Rows 64-65:** input the estimated amount of BHSS funds that will be transferred to WET and CF/TN for each year

Rows 67-69: auto populates projected estimated amount of MHSA WET, CF/TN, and Encumbered INN funds that will be available in the BHSA BHSS component for each year **Reminder:** 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual. 2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Seven: BHSA Components

Total Behavioral Health Services and Supports (BHSS) Funding	Year 1	Year 2	Year 3
Total Estimated Behavioral Health Services and Support Funding Received (BHSA Funds)	$ 1,511,933.00	$ 1,511,933.00	$ 1,511,933.00
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)	$	$	$
Total Estimated Behavioral Health Services and Support Funding (BHSA + MHSA Funds)	$ 1,511,933.00	$ 1,511,933.00	$ 1,511,933.00

Type of Service	Behavioral Health Services and Supports Category (1) Projected Expenditures - Unspent MHSA and BHSA Funding Only			Projected Expenditures - Federal Financial Participation			Projected Expenditures - All Other Funding Sources		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
BHSS Programs/Services									
Children's System of Care Non FSP (25 years and younger)	$ 313,967.00	$ 313,967.00	$ 313,967.00	$	$	$	$	$	$
Adult and Older Adult System of Care, Excluding Populations Identified in 5892(a)(1) and 5892(a)(2) from FSP	$ 32,476.00	$ 32,476.00	$ 32,476.00	$	$	$	$	$	$
Early Intervention Expenditures	$ 538,637.00	$ 538,637.00	$ 538,637.00	$	$	$	$	$	$
Coordinated Specialty Care for First Episode Psychosis		$	$	$	$	$	$	$	$
All Other EI Expenditures	$ 538,637.00	$ 538,637.00	$ 538,637.00	$	$	$	$	$	$
Outreach and Engagement	$ 32,476.00	$ 32,476.00	$ 32,476.00	$	$	$	$	$	$
Workforce Education and Training (WET)	$ 152,500.00	$ 152,500.00	$ 152,500.00	$	$	$	$	$	$
Dedicated BHSA WET funds	$ 152,500.00	$ 152,500.00	$ 152,500.00	$	$	$	$	$	$
Dedicated MHSA WET funds	$	$	$	$	$	$	$	$	$
Capital Facilities and Technological Needs (CFTN)	$ 213,030.00	$ 213,030.00	$ 213,030.00	$	$	$	$	$	$
Dedicated BHSA CF/TN funds	$ 213,030.00	$ 213,030.00	$ 213,030.00	$	$	$	$	$	$
Dedicated MHSA CF/TN funds	$	$	$	$	$	$	$	$	$
BHSA Innovative BHSS Pilots and Projects	$	$	$	$	$	$	$	$	$
MHSA INN Projects	$ 100,000.00	$ 100,000.00	$ 100,000.00	$	$	$	$	$	$
Subtotal (auto-populated)	$ 1,383,086.00	$ 1,383,086.00	$ 1,383,086.00	$	$	$	$	$	$

BHSS Prudent Reserve Transfer Information	Year 1	Year 2	Year 3
Transfers out of BHSS component into Local Prudent Reserve	$	$	$
BHSS Administrative Information	**Year 1**	**Year 2**	**Year 3**
BHSS Component Admin Expenses	$ 128,847.00	$ 128,847.00	$ 128,847.00
Total Behavioral Health Services and Supports Expenditures (auto populated)	$ 1,511,933.00	$ 1,511,933.00	$ 1,511,933.00
Youth Focused Early Intervention Expenditures	**Year 1**	**Year 2**	**Year 3**
Total Youth Focused (25 years and younger) Early Intervention Expenditures	$ 393,967.00	$ 393,967.00	$ 393,967.00
Behavioral Health Services and Supports Validation (auto-populated based on inputs above)	**Year 1**	**Year 2**	**Year 3**
BHSS Funds Early Intervention Expenditures/Total BHSS Funding (2)	[illegible]	[illegible]	[illegible]
Youth Focused (25 years and younger) Early Intervention Expenditures/Total Allocated Early Intervention Funds (3)	73.1%	73.1%	73.1%
Projected Individuals to be Served (Unduplicated)	**Year 1**	**Year 2**	**Year 3**
Eligible Children/TAY (25 years and younger)	78	78	78
Eligible Adults/Older Adults	178	178	178
Projected BHSS Funds transferred to WET or CF/TN	**Year 1**	**Year 2**	**Year 3**
BHSS transfer to WET	$	$	$
BHSS transfer to CF/TN	$	$	$
Projected MHSA-Origin WET, CF/TN and Encumbered INN Funds Available (exempt from suballocation requirements)	**Year 1**	**Year 2**	**Year 3**
Estimated MHSA WET Funds	$	$	$
Estimated MHSA CF/TN Funds	$	$	$
MHSA "Encumbered" INN	$	$ 100,000.00	$ 200,000.00

References
1. W&I Code § 5892, subdivision (a)(3)(A) states 35% of BHS funds distributed to counties shall be used for Behavioral Health Services and Supports
2. W&I Code § 5892, subdivision (a)(3)(B) states counties shall utilize at least 51% of BHSS funding for early intervention programs
3. W&I Code § 5892, subdivision (a)(3)(B)(ii) states that at least 51% of funds allocated for early intervention programs must serve individuals 25 years of age and younger
4. BHSA Policy Manual Ch. 6 § B.7.3 states that MHSA WET or CFTN funds transferred into BHSA BHSS will remain WET or CFTN funds and will not be subject to the suballocation requirements. Counties may set aside BHSS funds for WET and CFTN; the reversion period for these specific funds is ten years. All transfers into WET and CFTN are irrevocable and cannot be transferred out of WET and CFTN. Counties may continue to keep separate fund accounts to track their WET and CFTN funds
5. BHSA Policy Manual Ch. 6 § B.8.2.2 states that the share of indirect costs attributed to BHSA funding should be in proportion to the extent the BHSA program benefits from the support activity. Proportional administrative and indirect costs will be verified through the Behavioral Health Outcomes Accountability and Transparency Report (BHOATR). Counties should ensure that their cost allocation methodology complies with 2 CFR 200 and appropriately distributes costs in proportion.

Instructions

Counties shall report their projected spending for Behavioral Health Services Act (BHSA) plan administration in Tab Eight

Row 27: the total dollar amount of BHSA component allocations dedicated to improvement and monitoring activities, including plan operations, quality and outcomes, data reporting pursuant to W&I Code § 5963.04, and monitoring of subcontractor compliance for all county behavioral health programs, including, but not limited to, programs administered by a Medi-Cal behavioral health delivery system, as defined in subdivision (i) of Section 14184.101, and programs funded by the Projects for Assistance in Transition from Homelessness grant, the Community Mental Health Services Block Grant, and other Substance Abuse and Mental Health Services Administration grants by year. Under W&I Code § 5892 (e)(2)(B), the total amount shall equal 2% or less of total projected annual revenues of the local behavioral health services fund for counties with a population over 200,000 or 4% of the total projected annual revenues of the local behavioral health services fund for counties with a population of less than 200,000. Any costs that exceed that amount will be included in the governor's budget. Administrative costs for improving and monitoring will only be reported on this tab, not the BHSA component tabs.

Row 28: input amounts of BHSA component allocations dedicated to county Integrated Plan annual planning costs, including stakeholder engagement in planning and local Behavioral Health Board activities by year. Under W&I Code § 5892 (e)(1)(B), this amount shall be 5% or less of total projected annual revenues of the local behavioral health services fund. Any costs that exceed that amount will be included in the governor's budget. Planning costs will only be reported on this tab, not the BHSA component tabs.

Row 29: input total dollar amount of new and ongoing county and behavioral health agency administrative costs to implement W&I Code § 5963-5963.06 and § 14197.71.

Row 31: select your county population size. This will ensure the formatting in the Admin Spending Overages section presents accurately.

Row 34: total projected annual revenues of the Local Behavioral Health Services Fund will be auto-populated.

Row 35: the proportion of funding used for improvement and monitoring will be auto-populated from rows 34 and 27.

Row 36: the proportion of funding used for planning expenditures will be auto-populated from rows 28 and 34.

Row 38-40: based upon the county population size selected in row 31, this calculator will auto-populate any Improvement and Monitoring expenditures that exceed (2%/4%) of the total projected annual revenues of the Local Behavioral Health Services Fund and any County Integrated Plan Annual Planning expenditures that exceed 5% of the total projected annual revenues of the Local Behavioral Health Services Fund.

Table Eight: BHSA Plan Administration

INTEGRATED PLAN ADMINISTRATION AND MONITORING	Year 1	Year 2	Year 3
Total Projected Improvement and Monitoring Expenditures	$ 93,042.00	$ 93,042.00	$ 93,042.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 116,302.00	$ 116,302.00	$ 116,302.00
New and Ongoing Administrative Costs	$ 93,042.00	$ 93,042.00	$ 93,042.00
Select County Population Size:	Less than 200k		
Administrative Information Validation			
Total Projected Annual Revenues of Local Behavioral Health Services Fund	$ 2,326,051.00	$ 2,326,051.00	$ 2,326,051.00
Improvement and Monitoring Expenditures/Total Annual Revenues of Local Behavioral Health Services Fund (auto-populated)	4.0%	4.0%	4.0%
Total Projected Planning Expenditures/Total Projected Annual Revenues for Local Behavioral Health Services Fund (auto-populated)	5.0%	5.0%	5.0%
Admin Spending Overages (in Dollars)			
Improvement & Monitoring	$ -	$ -	$ -
Planning	$ -	$ -	$ -
Total	$ -	$ -	$ -

References
1. W&I Code § 5963, subdivision (c) states that any costs incurred for BHSA implementation exceeding the required maximums set forth in W&I Code § 5892, subdivision (e)(1)(B) and W&I Code § 5892, subdivision (e)(2)(B) will be included in the Governors 2024-2025 May Revision

Instructions

Counties shall report their estimated local prudent reserve maximums for each allocation component in Tab Nine.

Rows 18-19: dollar amounts will be auto-populated from Tab 4 rows 136-137.

Row 20: total excess prudent reserve dollars will be auto-populated from rows 18-19.

Rows 21-23: total dollar amounts will be auto-populated from Tab 4, rows 139-141.

Row 24: total excess prudent reserve funds allocated to BHSA components will be auto-populated from rows 21-23.

Row 25: auto-validates from rows 20 and 24 to check if the county has "No Excess" or if county must "Reduce Excess" prudent reserve.

Row 26: the total amount of planned contributions into the prudent reserve from all BHSA components allocations across all plan years will be auto-populated from Tab 5 row 69, Tab 6 row 45, and Tab 7 row 51.

Row 27: the total amount of planned distributions from the prudent reserve into the BHSA component allocations across all plan years will be auto-populated from Tab 5 row 41, Tab 6 row 26, and Tab 7 row 28.

Table Nine: Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance At End of Previous Fiscal Year	$ 479,169.03
Local Prudent Reserve Maximum (1)	$ 500,534.08
Excess Prudent Reserve Funds (auto-populated)	($ 21,365.05)
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 45, 50, and 53.

Rows 26, 29, and 32: the dollar amount allocated to each component for each year of the Integrated Plan will be auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27, respectively.

Row 35: the total amount of BHSA funding for each component auto-populated from Tab 5, row 40; Tab 6, row 25; and Tab 7, row 27.

Rows 36, 43, and 50: the total amount of funding transferred from the prudent reserve into each BHSA component allocation for each plan year will be auto-populated from Tab 5, row 41; Tab 6, row 26; and Tab 7, row 28.

Row 37: the total amount of unspent MHSA-carryover funds from prior fiscal years, will be auto-populated from Tab 4 row 133.

Rows 38, 45, and 52: estimated total available funding will be auto-populated from rows 35-37, 42-44 and 49-51.

Rows 39, 46, and 53: the total amount of funding transferred from each BHSA component into the prudent reserve for each plan year will be auto-populated from Tab 5, row 69; Tab 6, row 45; and Tab 7, row 51.

Rows 40, 47, and 54: estimated expenditures for each component will be auto-populated from Tab 5, row 72; Tab 6, row 48; and Tab 7, row 54.

Rows 44 and 51: auto-populated by adding the existing year's carryover MHSA funds to any remaining funds (from all sources) not spent from the previous year.

Rows 57-59: the total amount of annual BHSA plan administration expenses from Tab 8, rows 27-29.

Reminder: 1) Counties must comply, and must ensure their providers comply, with all applicable conditions for each source of funding, as defined in applicable laws, regulations, and guidance, including the BHSA County Policy Manual.

2) Counties must promote access to care through efficient use of state and county resources as outlined in Chapter 6, Section C of the BHSA County Policy Manual, including requiring BHSA-funded providers to bill appropriately for services covered by the county's Medi-Cal Behavioral Health Delivery System and make a good faith effort to seek reimbursement from Medi-Cal managed care plans and commercial health insurance. These policies apply only to non-Housing services that are eligible for both BHSA funding and another funding source, such as Medi-Cal payment, commercial payment, etc.

Table Ten: BHSA Funding Summary (auto-populated)

	Housing Interventions	Full-Service Partnerships	Behavioral Health Services and Supports	Total
Year One				
Allocation Percentage, with Transfers	0%	35%	65%	100%
Component Allocations	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
Year Two				
Allocation Percentage, with Transfers	0%	35%	65%	100%
Component Allocations	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
Year Three				
Allocation Percentage, with Transfers	0%	35%	65%	100%
Component Allocations	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
BHSA Funding Summary	**Housing Interventions**	**Full Service Partnerships**	**Behavioral Health Services and Supports**	**Totals**
Year One				
Estimated Year One Component Allocations (BHSA Funding Only)	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds) (Unspent Carryover MHSA Funds)	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year One	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year One Expenditures	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
Year Two				
Estimated New Year Two Component Allocations (BHSA Funding Only)	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year Two	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Two Expenditures	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
Year Three				
Estimated New Year Three Component Allocations (BHSA Funding Only)	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
Transfers From PR Into Component	$ -	$ -	$ -	$ -
Estimated Unspent Funds From Prior Fiscal Years (Including MHSA Funds)	$ -	$ -	$ -	$ -
Estimated Total Available Funding for Year Three	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00
Transfers from Component Into PR	$ -	$ -	$ -	$ -
Estimated Total Year Three Expenditures	$ -	$ 814,118.00	$ 1,511,933.00	$ 2,326,051.00

BHSA Plan Admin Expenses

Plan Admin Category	Year One	Year Two	Year Three	Total
Total Projected Improvement and Monitoring Expenditures	$ 93,042.00	$ 93,042.00	$ 93,042.00	$ 279,126.00
Total Projected County Integrated Plan Annual Planning Expenditures	$ 116,302.00	$ 116,302.00	$ 116,302.00	$ 348,906.00

Total Projected New and Ongoing Administrative Expenditures	$ 93,042.00	$ 93,042.00	$ 93,042.00	$ 279,126.00

Budget Template Updates

Version	Revision Date	Description of Changes	Effective Date of Change
2.0	10/25/2025	Tab 10 (BHSA Summary): Formula updated to avoid double counting of MHSA unspent carryover funds.	10/25/2025
2.0	10/25/2025	Tab 7 (BHSS): EI Threshold calculation should exclude MHSA transferred WET and CFTN funds as they are exempt from suballocation requirements, formula revised to remove WET and CFTN. Added a BHSS transfer to WET/CFTN for reversion tracking.	10/25/2025
2.0	10/25/2025	Tab 8 (BHSA Plan Admin): Updated instructions to clarify DHCS will not pre-populate data for "Total Projected Annual Revenues of BHSF". Counties must enter in the data.	10/25/2025
2.0	10/25/2025	Tab 5, 6, 7 (BHSA Components): Added unspent MHSA **funds** row for year 1, 2 and 3.	10/25/2025
2.0	10/25/2025	**Tab 7 (BHSS): Added separat**e 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 Com**ponents): 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 v**alidation** 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 valida**tion 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